Timor-Leste

Demographic and Health Survey 2025–26

Key Indicators

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Key Indicators Report

National Institute of Statistics Timor-Leste (INETL, I.P.)
Ministry of Finance and Ministry of Health
Dili, Timor-Leste

The DHS Program
ICF
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The 2025–26 Timor-Leste Demographic and Health Survey (2025–26 TLDHS) was implemented by the National Institute of Statistics Timor-Leste (INETL, I.P.), the Ministry of Finance, and the Ministry of Health. The funding for the 2025–26 TLDHS was provided by the Government of Timor-Leste through the Ministry of Finance, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the Australian Government's Department of Foreign Affairs and Trade (DFAT), the World Food Program (WFP), and the World Bank. ICF provided technical assistance through The DHS Program, which offers support and technical assistance in the implementation of population and health surveys in countries worldwide.

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CONTENTS

TABLES AND FIGURES

FOREWORD

The 2025–26 Timor-Leste Demographic and Health Survey (2025–26 TLDHS) presents the major findings of a nationally representative survey with a sample of 12,880 households. The survey was conducted by the National Institute of Statistics Timor-Leste (INETL, I.P.), an autonomous public institute under the supervision of the Ministry of Finance, in collaboration with the Ministry of Health from September 29, 2025, to January 31, 2026. The 2025–26 TLDHS is the third such survey to be conducted in Timor-Leste, as a follow-up to the 2009–10 and 2016 surveys. In the 2025–26 survey, tablets operating on Android software were used during data collection.

The primary objective of the 2025–26 TLDHS is to provide current demographic and health information for use by policymakers, planners, researchers, and program managers. Specific topics covered in the survey include respondents' demographic characteristics; fertility levels and preferences; family planning; marriage and sexual activity; maternal and child health; nutritional status of women age 15–49 and children under age 5; child, adult, and maternal mortality; factors that impact maternal and neonatal health (e.g., antenatal, delivery, and newborn care); HIV/AIDS-related knowledge, attitudes, and behavior; women's empowerment; prevalence, perpetrators, and forms of violence (physical, sexual, and other forms) among women age 15–49; mental health; gender diversity; tobacco use; knowledge of tuberculosis; and other health issues. Information was also gathered on household sanitation, drinking water, handwashing, wealth status, disability and child functionality, birth registration, children's living arrangements and parental survival, child discipline, early childhood development, household food security, and the presence of iodine in household salt.

The Ministry of Finance is pleased to present the results of the 2025–26 TLDHS, which provides an essential evidence base for national planning, budgeting, and policy dialogue. The Government of Timor-Leste, through the Ministry of Finance, has provided leadership, strategic oversight, and financial support to ensure the smooth implementation of this important survey.

The INETL, I.P. and the Ministry of Finance wish to also acknowledge the strong collaboration of the Ministry of Health throughout the survey process. Similarly, financial and logistical support from various development partners and donors is highly appreciated. Specific mention is due to the following: the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the Australian Government's Department of Foreign Affairs and Trade (DFAT), the World Food Program (WFP), and the World Bank.

INETL, I.P. is grateful to ICF, a global consulting and technology services company that has been the lead agency for the Demographic and Health Surveys (DHS) Program, for providing technical assistance at every stage of the survey. We would also like to extend our appreciation to all of the field personnel for their dedication and commitment to high-quality work and to the trainers from INETL and the Ministry of Health for their untiring technical support and supervision. Most important, we express our sincere appreciation to all of the households that generously gave their time and cooperation during the data collection for this national endeavor.

Santina JRF Viegas Cardoso
Minister of Finance, RDTL

ACKNOWLEDGMENTS

The 2025–26 Timor-Leste Demographic and Health Survey (2025–26 TLDHS) was conducted from September 29, 2025, to January 31, 2026. The main objective of the 2025–26 TLDHS is to provide up-to-date estimates of basic demographic and health indicators. This report presents the key findings from the TLDHS survey and will be followed by the main report that provides thematic analyses depending on the country's program needs. The 2025–26 TLDHS involved many interested groups, including the Ministry of Health, the National Institute of Statistics Timor-Leste (INETL, I.P.), and a consortium of development partners who provided both technical and financial/administrative support in implementing the survey.

As a result of the huge demand for data from the TLDHS, its success was accomplished through the concerted efforts of many organizations, institutions, government ministries, and individuals who assisted in a variety of ways to prepare, collect, process, analyze, and publish the results. The Government of Timor-Leste, through INETL under the Ministry of Finance, wishes to thank them all for their input into this noble process.

We express our deep appreciation to the technical experts from ICF and INETL in collaboration with the Ministry of Health. We also thank the 2025–26 TLDHS staff who worked on the project and members of the survey Steering Committee who provided critical input at all levels. Our appreciation goes to the United Nations Population Fund (UNFPA) for coordinating technical and logistical support, as well as the financial contributions provided by development partners for the 2025–26 TLDHS.

Additionally, we would like to thank the various technical experts in the fields of population and health for their valuable input in the various phases of the survey. Their expertise was invaluable during the finalization of the questionnaires, training of field staff, reviews of the draft tables, and finalization of the report. Our gratitude goes to the national staff who worked during data collection and data capture and cleaning. More important, all the Timorese residents who provided data during interviews deserve special thanks for their patience and willingness to provide the requisite information.

The Government of Timor-Leste extends sincere gratitude to the development partners for their financial contributions to this project, specifically the Ministry of Health, UNFPA, the United Nations Children's Fund (UNICEF), the Australian Government's Department of Foreign Affairs and Trade (DFAT), the World Food Program (WFP), and the World Bank. INETL is grateful to ICF for providing technical assistance at every stage of the survey.

We sincerely hope that the information in this report will be fully utilized in the national development planning process by all stakeholders for the welfare of the Timorese people.

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Ministry of Finance

ACRONYMS AND ABBREVIATIONS

ANC	antenatal care
ARI	acute respiratory infection
ART	antiretroviral therapy
ASFR	age-specific fertility rate
BCG	bacille Calmette-Guérin
CAPI	computer-assisted personal interviewing
CBR	crude birth rate
CSPro	Census and Survey Processing System
DFAT	Department of Foreign Affairs and Trade
DHS	Demographic and Health Survey
DPT	diphtheria, pertussis, and tetanus
EA	enumeration area
ECDI	Early Childhood Development Index
GDS	General Directorate of Statistics
GFR	general fertility rate
GPS	Global Positioning System
HepB	hepatitis B
Hib	*Haemophilus influenzae* type B
HIV	human immunodeficiency virus
INETL	Instituto Nacional de Estatistica Timor-Leste, I.P./National Institute of Statistics Timor-Leste (INETL, I.P.)
IPV	inactivated poliomyelitis vaccine
IT	information technology
ITN	insecticide-treated net
IUD	intrauterine contraceptive device
IYCF	infant and young child feeding
LAM	lactational amenorrhea method
LISIO	Mother and Child Health Booklet (*Livrinho Saude Inan ho Oan*)
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MR	measles-rubella
MUAC	mid-upper-arm circumference
OPV	oral polio vaccine
ORS	oral rehydration salts
PCV	pneumococcal conjugate vaccine
PNC	postnatal care
RV	rotavirus vaccine
SD	standard deviation
SDG	Sustainable Development Goal
SDM	standard days method
STI	sexually transmitted infection
TFR	total fertility rate
TLDHS	Timor-Leste Demographic and Health Survey

TLPHC	Timor-Leste Population and Housing Census
ToT	training of trainers
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WFP	World Food Program
WHO	World Health Organization

1 INTRODUCTION

The 2025–26 Timor-Leste Demographic and Health Survey (TLDHS) was implemented by the National Institute of Statistics Timor-Leste (INETL, I.P.). Data collection took place from September 29, 2025, to January 31, 2026. Financial support for the 2025–26 TLDHS was provided by the Government of Timor-Leste through the Ministry of Finance, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the Department of Foreign Affairs and Trade (DFAT), the World Food Program (WFP), and the World Bank. ICF provided technical assistance through The Demographic and Health Surveys Program (DHS), which offers support and technical assistance for the implementation of population and health surveys in countries worldwide.

This Key Indicators Report presents a first look at selected findings from the 2025–26 TLDHS. A comprehensive analysis of the data will be presented in a final report at the end of 2026.

The primary objective of the 2025–26 TLDHS is to provide up-to-date estimates of basic demographic and health indicators. Specifically, the survey collected information on:

- Fertility levels, fertility preferences, and contraceptive use
- Maternal health, including antenatal and delivery care and maternal mortality
- Child mortality and child health, including childhood diseases and vaccination coverage
- Nutritional status of children under age 5 and women age 15–49 (via weight and height measurements)
- Anemia prevalence among women age 15–49
- Awareness of HIV and behavioral risk factors
- Gender-based violence, women's empowerment, and gender diversity
- Early Childhood Development Index (ECDI) and child discipline
- Disability (age 18 and above) and child functioning (age 2–4 and age 5–17)
- Mental health
- Other health issues (malaria, tuberculosis, smoking)

The information collected through the 2025–26 TLDHS is intended to assist policymakers and program managers in designing and evaluating programs and strategies for improving the health of Timor-Leste's population. The survey also provides indicators relevant to the Sustainable Development Goals (SDGs) for Timor-Leste.

2 SURVEY IMPLEMENTATION

2.1 SAMPLE DESIGN

The sampling frame used for the 2025–26 TLDHS is the 2022 Timor-Leste Population and Housing Census (2022 TLPHC), provided by the National Institute of Statistics Timor-Leste (INETL, I.P.). The sampling frame is a complete list of 2,384 non-empty enumeration areas (EAs) created for the 2022 population census. An EA is a geographical area made up of a convenient number of dwelling units that was created for the 2022 TLPHC and served as the counting unit for the census; there were an average of 105 households per EA. The sampling frame contains information about the administrative unit, the type of residence, the number of residential households, and the population for each EA. Among the 2,384 EAs, 656 are in urban areas and 1,728 are in rural areas. Timor-Leste is divided into 14 municipalities. Each municipality is further subdivided into administrative posts, administrative posts into Sucos, and Sucos into EAs. There are in total 67 municipalities and 452 Sucos.

The sample for the 2025–26 TLDHS was a stratified sample selected in two stages from the 2022 TLPHC frame. Stratification was achieved by separating each of the 14 municipalities into urban and rural areas. In total, 27 sampling strata were created since Atauro municipality has only rural areas. Samples were selected independently in each stratum through a two-stage selection process. Implicit stratification was achieved at each of the lower administrative levels by sorting the sampling frame before sample selection according to administrative units and by using a probability proportional to size selection procedure in the first stage of sampling.

In the first stage of selection, 455 EAs were selected with probability proportional to EA size. The EA size was the number of households in the EA at the time of the census. Because of the small number of EAs (20) in Atauro municipality, all of the EAs in this municipality were included in the survey. The decision was made not to do a new household listing because the census listing was still relatively new. Sample households were selected directly from the census listing, which included GPS coordinates for each household.

In the second stage of selection, a fixed number of 28 households (35 households in Atauro municipality) were randomly selected in every cluster via an equal probability systematic sampling procedure. Household selection was carried out in the central office. The survey interviewers were asked to interview only the preselected households. No replacements and no changes of the preselected households were allowed in the implementation stages to prevent bias. All women age 15–49 who were usual residents of the selected households or who slept in the households the night before the survey were eligible for the survey. Apart from the women's survey, a male survey was conducted at the same time in a subsample of 50% of the households selected for the female survey. All men age 15–59 who were usual residents of the selected households or who stayed in the households the night before the survey were eligible for individual interviews.

Height and weight measurements were carried out for all children under age 5 and women age 15–49 in half of the subsample of households that were selected for the men's survey. Also in this subsample, women from nine households per cluster were randomly selected to be tested for anemia.

2.2 QUESTIONNAIRES

Four questionnaires were used for the 2025–26 TLDHS: the Household Questionnaire, the Woman's Questionnaire, the Man's Questionnaire, and the Biomarker Questionnaire. The questionnaires, based on The DHS Program's model questionnaires, were adapted to reflect the population and health issues relevant to Timor-Leste. In addition, a self-administered Fieldworker Questionnaire collected information about the survey's fieldworkers. All the questionnaires were translated into the Tetum language.

The Household Questionnaire listed all members of and visitors to the selected households. Basic demographic information was collected for each person listed, including age, sex, marital status, education, and relationship to the household head. For children under age 18, parents' survival status was determined. The data on age and sex of household members were used to identify women and men who were eligible for individual interviews and women and children who were eligible for anthropometry measurements. The Household Questionnaire also collected information on characteristics of the household's dwelling unit such as source of water; type of toilet facilities; materials used for flooring, external walls, and roofing; and ownership of various household goods. In addition, all households were eligible to have their salt tested for the presence of iodine. The 2025–26 TLDHS included three additional Household Questionnaire modules on child discipline, disability, and food security.

The Woman's Questionnaire was used to collect information from women age 15–49 on the following topics:

- Background characteristics (including age, education, and media exposure)
- Pregnancy history and childhood mortality
- Knowledge and use of family planning methods
- Fertility preferences
- Antenatal, delivery, and postnatal care, including newborn care
- Breastfeeding and infant feeding practices
- Child health and nutrition
- Vaccinations and childhood illnesses
- Marriage and sexual activity
- Women's work and husbands' background characteristics
- Awareness and behavior related to HIV and other sexually transmitted infections (STIs)
- Other health issues
- Domestic violence
- Mental health
- Gender diversity
- Adult and maternal mortality
- Early childhood development and child functioning

The Man's Questionnaire was administered to men age 15–59. The questionnaire collected information on:

- Background characteristics (including age, education, and media exposure)
- Reproduction
- Contraception
- Marriage and sexual activity

- Fertility preferences
- Employment and gender roles
- Awareness and behavior related to HIV and other STIs
- Other health issues
- Mental health
- Gender diversity

The Biomarker Questionnaire was used to record the results of anthropometry (height and weight) measurements, mid-upper-arm circumference (MUAC) measurements, and anemia testing.

GPS coordinates were collected during household interviews and individual interviews. Moreover, for quality assurance purposes, GPS coordinates were also collected during anthropometry remeasurements for children who had to be remeasured.

The Fieldworker Questionnaire was used to collect basic background information on the people who were collecting data in the field, including supervisors, interviewers, and biomarker specialists.

The 2025–26 TLDHS interviewers used tablet computers to record all questionnaire responses during the interviews. The tablet computers were equipped with Bluetooth® technology to enable remote electronic transfer of files, such as assignment sheets from supervisors to interviewers, Household Questionnaires among survey team members, and completed questionnaires from interviewers to supervisors. The tablet computer programming was created using the Census and Survey Processing System (CSPro), developed by The DHS Program in collaboration with the U.S. Census Bureau.

The survey protocol, including biomarker collection, was reviewed and approved by the ICF Institutional Review Board.

2.3 ANTHROPOMETRY AND ANEMIA TESTING

Anthropometry. In half of all selected households, height and weight measurements were recorded for children age 0–59 months and women age 15–49. Weight measurements were taken using SECA scales with a digital display (model number SECA 874 DR). Height and length were measured with a ShorrBoard® measuring board. Children younger than age 24 months were measured lying down (recumbent length), while older children and women were measured standing (height).

To assess the precision of measurements, one child per cluster was randomly selected to be measured a second time. The DHS Program defines a difference of less than 1 centimeter between the two height measurements as an acceptable level of precision. Children with a *z* score of less than −3 or more than 3 for height-for-age, weight-for-height, or weight-for-age were flagged and measured a second time. The remeasurement of flagged cases was performed to ensure accurate reporting of height.

Anthropometric data for children are used to calculate three indices that reflect nutritional status: height-for-age, weight-for-height, and weight-for-age. In presenting the anthropometric results, the height and weight of children in the survey population were compared with the 2006 WHO Child Growth Standards, which are based on an international sample of ethnically, culturally, and genetically diverse, healthy children living under optimum conditions conducive to achieving a child's full genetic growth potential. Children who were severely malnourished were referred to a local health facility for assessment and treatment. Biomarker specialists provided all households in the biomarker subsample with an informational pamphlet containing the height and weight of all children and women.

Mid-upper-arm circumference. Mid-upper-arm circumference (MUAC) was measured for children age 6–59 months using standard tapes supplied by UNICEF that were calibrated with the 2006 WHO Child Growth Standards.

Anemia. Blood specimens for anemia testing were collected from women age 15–49 who consented to be tested. Blood samples were drawn from venous blood and collected in a microcuvette. Hemoglobin analysis was carried out on-site using a battery-operated portable HemoCue® 201+ device. Results were provided verbally and in writing to those being tested. Women were referred for follow-up care if their hemoglobin levels were below 8 g/dl.

2.4 TRAINING OF TRAINERS AND PRETEST

The 2025–26 TLDHS was designed to train the trainers during the pretest training so that they could become familiar with the content and protocol of the survey, test the instruments and provide feedback on survey data collection materials, and undergo training as trainers to facilitate the main training of the field staff. Therefore, the training integrated theoretical content and training processes based on adult learning principles. The pretest training was conducted from August 11 to August 26, 2025, in the INETL training hall in Dili. Twenty participants from INETL and 11 participants from the Ministry of Health (MoH) were trained during this phase. Five of the MoH participants were biomarker specialists with experience in collecting venous blood for testing. Similarly, five of the participants from INETL were data processing staff who were trained to support the computer-assisted personal interviewing (CAPI) component. These experienced participants went on to serve as trainers in the main training and monitors during the main survey fieldwork.

The training adopted an integrated approach with tablets used as the data collection tool. Technical discussions on paper questionnaires were followed by entering the mock interviews in the tablets. The CAPI components were embedded throughout the training sessions. The biomarker specialists were trained separately on taking height and weight measurements of eligible women and children and mid-upper-arm circumference measurements of children age 6–59 months. They completed a standardization exercise to qualify as measurers and underwent special training on venous blood collection and anemia testing using the HemoCue® 201+ device before the main training.

Five teams were formed to test the instruments in areas with diverse characteristics. Each team was led by a team supervisor and included two female interviewers, one male interviewer, and a biomarker specialist. A data processing staff member was assigned to each team to backstop during the pretest. The pretest fieldwork was carried out from August 27 to August 30, 2025, in Aileu, Baucau, Bobonaro, Ermera, and Lautem with each team assigned to a cluster. Each cluster had 28 households, with half of the households selected for the men's survey. These subsamples of households were also selected for biomarker data collection. The teams were instructed to perform all survey procedures, including conducting household, women's, and men's interviews; conducting anthropometry measurements for eligible women and children; measuring MUAC for eligible children; and performing all closing procedures in the CAPI system. However, anemia testing could not be included because the supplies did not arrive in the country on time.

Following field practice, a debriefing session was held with the pretest participants, and modifications to the questionnaires were made based on the feedback from the exercise.

2.5 TRAINING OF FIELD STAFF

The main training for the 2025–26 TLDHS was conducted from September 2 to September 27, 2025, in three venues in Dili that included the training hall at INETL and two halls at Patrimoniu. In total, 96 participants who had prior experience in data collection were trained as enumerators. The biomarker training was held separately for 28 participants from September 19 to September 27, 2025, in the INETL

conference hall. All of the biomarker training participants were experienced phlebotomists assigned through the Ministry of Health who were selected from health centers in all municipalities of Timor-Leste.

The training focused on the following aspects:

1. *Questionnaire training:* A total of 96 participants were trained on survey content by the INETL and MoH technical team, which had previously participated in the training of trainers (ToT) and the pretest. The training topics included key concepts of the survey, interviewing procedures, identification of selected households, and detailed content of the Household Questionnaire, Woman's Questionnaire, and Man's Questionnaire. The training was conducted in Tetum, and the trainees practiced mock interviews to review the comprehension and translation of the questionnaires. Quizzes were given throughout the training to evaluate the trainees' comprehension and to evaluate differences in comprehension and interviewing skills among the different classrooms. The participants alternated between different classes to maintain uniformity among the classes.

2. *CAPI training:* As the main training was conducted within a gap of 2 days after the pretest, the training modality had to be changed from the pretest training whereby training on questionnaire content was completed first, followed by CAPI training. CAPI training was conducted by five trainers who had received additional training before the main training session. Twenty-four teams were created, comprising a team supervisor, two female interviewers, and a male interviewer. The teams first practiced assigning households. They then entered data through the mock interviews, moving section by section. Trainees were taught about all data transfer types from the interviewer's menu and the supervisor's menu system: receiving household assignments, sending data to supervisors daily, sharing household data, and sending data to the central office via CSWeb.

   Supervisors received additional training to practice receiving system upgrades from the central office via CSWeb and transferring these upgrades to the interviewers via Bluetooth.

   In addition, participants learned to complete biomarker forms based on eligible children and women in the household schedule. Later, they received completed biomarker forms from the biomarker specialists and entered them into CAPI. The supervisors also learned how to select children for anthropometry revisits and how to complete the identification panel of revisit questionnaires, enter the revisit questionnaire, and identify cases for referral for malnutrition.

3. *Biomarker training:* The biomarker specialists completed an intense training session led by the ICF trainer and the trainers from MoH who had undergone the ToT and pretest training.

   The training included:

   - *Anthropometry training:* Training in anthropometry started with theoretical training and continued with practical sessions. Biomarker specialists practiced measuring each other and received hands-on experience with children recruited for the practice. At the end of the training, the anthropometry standardization exercise was conducted. Because not all of the participants passed the standardization exercise, retraining and restandardization were carried out to ensure that only those who met the threshold were selected for data collection. INETL recruited 60 children age 0–4 for the standardization and restandardization, with 10 children per shift. Six shifts were carried out, for a total of 26 biomarker specialists for this exercise.

   - *Anemia testing:* Biomarker specialists were trained on identification of women eligible for anemia testing in a subsample of households, informed consent procedures, completion of the Biomarker Questionnaire, infection prevention procedures, and management of biohazardous waste. Participants were trained in venous blood collection for anemia testing as per the 2024 WHO guidelines (WHO 2024). In addition, they were trained on HemoCue 201+ testing for anemia at

the point of care. Practical sessions followed the theoretical sessions, with interviewers volunteering to be tested by biomarker specialists.

4. *Field practice:* INETL selected 24 non-sample localities for the field practice, with one team assigned to each cluster. Convenience sampling was adopted to allow capture of households and individuals with different characteristics. This allowed for practicing different sections of the questionnaires. Field practice was carried out from September 23 to September 25, 2025. Data from 12 households per cluster could be captured in CAPI. Trainers from INETL, MoH, and ICF were assigned to the teams to observe the interviews and biomarker measurements, providing feedback and support as needed. A review session was held on September 26 during which the teams could share their experience and clarify any concerns.

2.6 FIELDWORK

Data collection was carried out from September 29, 2025, to January 31, 2026, by 24 teams, each composed of six members: one supervisor, one male interviewer, two female interviewers, one biomarker specialist, and one driver. Fieldwork monitoring was a crucial part of the 2025–26 TLDHS. INETL and MoH assured quality control through supervision and monitoring of teams during fieldwork. The primary monitoring was carried out by the team supervisors, who were responsible for the performance of their teams. They held sessions daily with each team to reinforce the training received, clarify any concerns, and provide feedback. They maintained high morale among the teams, who had to work under harsh field conditions.

INETL organized additional layers of fieldwork monitoring throughout data collection, such as the following:

1. *Monitors from INETL and MoH:* Twenty monitors (nine from INETL and 11 from MoH) assigned to specific municipalities and teams were in the field throughout the data collection period. They were responsible for supervising their teams' movement, monitoring data quality using field-check tables, ensuring that teams had proper coordination, and resolving any issues that arose.

2. *Biomarker quality control:* Five biomarker quality control staff who participated in the ToT and pretest were assigned to work alongside the monitors and visit the teams for monitoring. The quality control staff observed biomarker specialists' consent and testing procedures using the technical checklists provided. They also kept track of field supplies for the teams and refilled the items required. They worked in close coordination with the INETL project management staff.

3. *Information technology (IT) staff:* Five IT staff members from INETL were deployed as needed to resolve CAPI-related issues.

4. Senior technical staff from INETL and MoH regularly visited the teams to review their work and monitor data quality.

Additionally, a staff member from The DHS Program and consultant from UNFPA independently visited the teams to monitor data and biomarker collection. During the field visits, monitors provided critical feedback to improve team performance. They used the field-check tables, based on data from completed clusters, to highlight specific issues for each team and observe interviews. Weekly meetings were held with the monitors to discuss the results of the field-check tables so that all teams would receive uniform feedback immediately. The technical committee members and representatives from UNFPA and UNICEF also monitored the fieldwork on different occasions.

2.7 DATA PROCESSING

The survey data were collected using tablet computers running the Android operating system and Census and Survey Processing System (CSPro) software, jointly developed by the United States Census Bureau, ICF, and Serpro S.A.

The CAPI program was used for data collection. The program accepted only valid responses, automatically performed checks on ranges of values, skipped to the appropriate question based on the responses given, and checked the consistency of the data collected. Answers to the survey questions were entered into the tablets by each interviewer. Supervisors downloaded interview data from interviewers' tablets to their tablet via Bluetooth, checked the data for completeness, and monitored fieldwork progress. Each day, after the completion of interviews, supervisors sent data to the central server. Data were sent to the central office via secure internet data transfer. The data processing monitors monitored the quality of the data received and downloaded data files for completed clusters into the system.

3 KEY FINDINGS

3.1 RESPONSE RATES

Table 1 presents the response rates for the 2025–26 TLDHS. A total of 12,880 households were selected for the TLDHS sample, of which 12,473 were found to be occupied. Of the occupied households, 12,259 were successfully interviewed, yielding a response rate of 98%. In the interviewed households, 13,875 women age 15–49 were identified as eligible for individual interviews. Interviews were completed with 12,961 women, yielding a response rate of 93%. In the subsample of households selected for the male survey, 7,631 men age 15–59 were identified as eligible for individual interviews and 6,879 were successfully interviewed, yielding a response rate of 90%.

Table 1 Results of the household and individual interviews

Number of households, number of interviews, and response rates, according to residence (unweighted), Timor-Leste DHS 2025–26

	Residence		
Result	Urban	Rural	Total
Household interviews			
Households selected	3,472	9,408	12,880
Households occupied	3,356	9,117	12,473
Households interviewed	3,271	8,988	12,259
Household response rate[1]	97.5	98.6	98.3
Interviews with women age 15–49			
Number of eligible women	4,517	9,358	13,875
Number of eligible women interviewed	4,088	8,873	12,961
Eligible women response rate[2]	90.5	94.8	93.4
Household interviews in subsample			
Households selected	1,737	4,716	6,453
Households occupied	1,676	4,561	6,237
Households interviewed	1,632	4,491	6,123
Household response rate in subsample[1]	97.4	98.5	98.2
Interviews with men age 15–59			
Number of eligible men	2,333	5,298	7,631
Number of eligible men interviewed	2,052	4,827	6,879
Eligible men response rate[2]	88.0	91.1	90.1

[1] Households interviewed/households occupied
[2] Respondents interviewed/eligible respondents

3.2 CHARACTERISTICS OF RESPONDENTS

Table 2 presents the weighted and unweighted numbers and percent distributions of women and men interviewed in the 2025–26 TLDHS by selected background characteristics. The results presented in this report are based on weighted data that are representative of the country as a whole, urban and rural areas separately, and each of the country's 14 municipalities.

- Fifty-one percent of women and 37% of men age 15–49 perceive their health status as good, while 44% of women and 59% of men perceive their health status as very good.
- Thirty-eight percent of women and 51% of men have never been married. Women are more often married or living with a partner (i.e., in union) than men (60% and 48%, respectively). Women are slightly more likely than men to report that they are divorced, separated, or widowed (3% and 1%, respectively).
- The large majority of respondents live in rural areas (64% of women and 67% of men). A majority of respondents (32% of women and 30% of men) live in Dili.

- Twelve percent of women and 11% of men have no education. Most of the respondents (61% of women and 59% of men) have a secondary education, while 18% of women and 16% of men have more than a secondary education.

Table 2 Background characteristics of respondents

Percent distribution of women and men age 15–49 by selected background characteristics, Timor-Leste DHS 2025–26

	Women			Men		
Background characteristic	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15–19	20.4	2,650	2,750	22.0	1,293	1,339
20–24	18.0	2,330	2,138	19.0	1,121	1,059
25–29	15.2	1,970	1,921	14.2	838	796
30–34	14.7	1,909	1,916	12.9	757	753
35–39	13.5	1,753	1,784	12.0	708	714
40–44	11.4	1,474	1,527	12.2	715	705
45–49	6.7	874	925	7.7	452	474
Self-reported health status						
Very good	43.6	5,654	5,659	58.8	3,458	3,433
Good	51.2	6,630	6,587	36.8	2,168	2,170
Moderate	4.7	612	653	4.0	235	217
Bad	0.5	59	58	0.4	21	19
Very bad	0.0	5	4	0.0	2	1
Religion						
Roman Catholic	97.5	12,642	12,329	98.0	5,767	5,627
Muslim	0.2	29	26	0.2	11	10
Protestant	2.0	256	578	1.6	95	192
Hindu	0.0	1	2	0.0	0	0
Other	0.3	33	26	0.2	12	11
Marital status						
Never married	37.5	4,865	4,589	50.5	2,973	2,909
Married	51.2	6,633	6,954	41.9	2,465	2,498
Living together	8.5	1,104	1,058	6.5	385	378
Divorced/separated	1.9	244	244	0.9	50	41
Widowed	0.9	115	116	0.2	12	14
Residence						
Urban	35.6	4,613	4,088	33.2	1,951	1,763
Rural	64.4	8,348	8,873	66.8	3,933	4,077
Municipality						
Aileu	4.2	550	978	4.7	279	488
Ainaro	4.5	586	840	4.6	273	398
Atauro	0.6	83	544	0.6	33	206
Baucau	8.6	1,119	934	8.7	511	385
Bobonaro	6.7	870	860	6.5	384	355
Covalima	5.4	706	861	5.8	342	391
Dili	31.7	4,102	1,858	29.9	1,761	814
Ermera	9.4	1,219	1,050	9.4	550	482
Lautem	5.0	646	822	4.9	286	356
Liquica	6.0	777	1,018	6.5	381	481
Manatuto	3.1	407	784	3.3	193	361
Manufahi	3.5	460	728	4.0	234	382
Oecusse	5.8	748	837	5.4	318	350
Viqueque	5.3	687	847	5.7	338	391
Education						
No education	11.8	1,531	1,606	10.5	617	632
Primary	9.9	1,289	1,404	14.0	822	862
Secondary	60.6	7,850	8,085	59.3	3,491	3,513
More than secondary	17.7	2,290	1,866	16.2	955	833
Wealth quintile						
Lowest	16.6	2,155	2,324	16.8	990	1,034
Second	17.9	2,320	2,632	19.1	1,122	1,258
Middle	19.8	2,572	2,879	21.0	1,238	1,326
Fourth	21.7	2,809	2,789	21.2	1,245	1,238
Highest	24.0	3,105	2,337	21.9	1,290	984
Total 15–49	100.0	12,961	12,961	100.0	5,885	5,840
50–59	na	na	na	na	994	1,039
Total 15–59	na	na	na	na	6,879	6,879

Note: Education categories refer to the highest level of education attended, whether or not that level was completed.
na = Not applicable

3.3 FERTILITY

Table 3 shows the total fertility rate (TFR) and age-specific fertility rates (ASFRs) among women by 5-year age groups for the 3-year period preceding the survey.

Total fertility rate

The average number of children a woman would have by the end of her childbearing years if she bore children at the current age-specific fertility rates. Age-specific fertility rates are calculated for the 3 years before the survey, based on detailed pregnancy histories provided by women.

Sample: Women age 15–49

- If fertility were to remain constant at current levels, a woman in Timor-Leste would bear an average of 3.4 children in her lifetime.
- Fertility is low among adolescents (34 births per 1,000 women age 15–19), peaks at 178 births per 1,000 among women age 30–34, and then decreases thereafter. In rural areas, fertility peaks at 195 births per 1,000 among women age 25–29 before subsequently declining.
- Fertility is higher in rural areas than in urban areas; on average, rural women give birth to 3.8 children in their lifetime, as compared with 2.7 children among urban women.

Table 3 Current fertility

Age-specific and total fertility rates, the general fertility rate, and the crude birth rate for the 3 years preceding the survey, according to residence, Timor-Leste DHS 2025–26

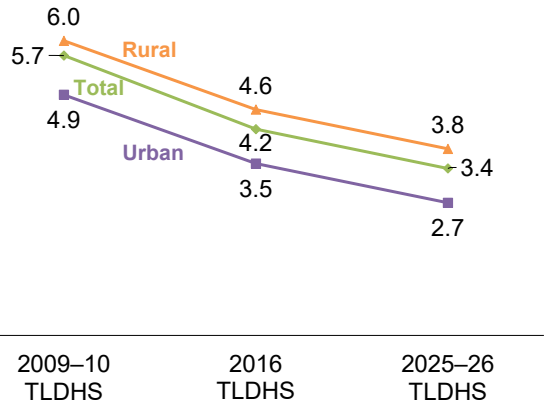
	Residence		
Age group	Urban	Rural	Total
10–14	[0]	[0]	[0]
15–19	22	41	34
20–24	72	164	127
25–29	132	195	173
30–34	181	177	178
35–39	96	124	115
40–44	33	54	47
45–49	[0]	[7]	[5]
TFR (15–49)	2.7	3.8	3.4
GFR	85	128	112
CBR	22.8	24.8	24.3

Note: Age-specific fertility rates are per 1,000 women. Estimates in brackets are truncated. Rates are for the period 1–36 months preceding the interview. Rates for the 10–14 age group are based on retrospective data from women age 15–17.
TFR: Total fertility rate, expressed per woman
GFR: General fertility rate, expressed per 1,000 women age 15–44
CBR: Crude birth rate, expressed per 1,000 population

Trends: As shown in **Figure 1**, the TFR declined from 5.7 children per woman in the 2009–10 TLDHS to 3.4 in the 2025–26 TLDHS. The TFR among women in rural areas decreased from 6.0 in the 2009–10 TLDHS to 3.8 in the 2025–26 TLDHS. Among women in urban areas, the TFR decreased from 4.9 in the 2009–10 TLDHS to 2.7 in the 2025–26 TLDHS.

Figure 1 **Trends in fertility by residence**

TFR for the 3 years before each survey



3.4 TEENAGE FERTILITY

Teenage pregnancy
Percentage of women age 15–19 who have ever been pregnant.
Sample: Women age 15–19

Table 4 shows the percentage of women age 15–19 who have had a live birth, who have ever had a pregnancy loss, who are currently pregnant, and who have ever been pregnant according to background characteristics.

- Seven percent of women age 15–19 have ever been pregnant.
- Five percent of young women have had a live birth.
- Less than 1% of young women have had a pregnancy loss.
- Two percent of young women are currently pregnant.

Table 4 Teenage pregnancy

Percentage of women age 15–19 who have ever had a live birth, percentage who have ever had a pregnancy loss, percentage who are currently pregnant, and percentage who have ever been pregnant, according to background characteristics, Timor-Leste DHS 2025–26

Background characteristic	Percentage of women age 15–19 who: Have ever had a live birth	Have ever had a pregnancy loss[1]	Are currently pregnant	Have ever been pregnant	Number of women
Age					
15	0.0	0.2	0.2	0.3	570
16	0.8	0.2	1.0	2.1	488
17	3.1	0.1	2.6	5.7	570
18	7.8	0.6	2.9	10.6	480
19	12.7	0.4	3.0	15.0	543
Residence					
Urban	3.1	0.1	0.7	3.8	949
Rural	5.8	0.4	2.6	8.3	1,701
Municipality					
Aileu	3.8	0.0	1.1	4.9	118
Ainaro	4.1	0.6	3.8	7.4	140
Atauro	1.8	0.0	2.4	4.2	15
Baucau	6.2	0.0	2.3	7.9	243
Bobonaro	3.4	0.0	1.6	4.3	176
Covalima	6.5	0.0	3.1	9.7	135

Continued…

Table 4—*Continued*

Background characteristic	Percentage of women age 15–19 who: Have ever had a live birth	Have ever had a pregnancy loss[1]	Are currently pregnant	Have ever been pregnant	Number of women
Dili	3.5	0.0	0.9	4.3	765
Ermera	4.9	0.5	1.8	7.2	256
Lautem	2.7	0.5	1.1	3.7	160
Liquica	5.4	1.8	2.4	8.3	147
Manatuto	6.9	0.8	0.8	7.7	77
Manufahi	5.5	0.6	3.5	8.6	111
Oecusse	7.9	0.3	2.3	10.2	181
Viqueque	8.1	0.0	5.4	12.8	126
Education					
No education	11.3	0.0	2.4	13.7	65
Primary	12.5	1.9	4.0	16.5	138
Secondary	4.2	0.2	1.9	6.0	2,336
More than secondary	3.5	0.0	0.0	3.5	111
Wealth quintile					
Lowest	4.3	0.0	4.0	7.9	419
Second	7.3	0.2	2.0	9.2	478
Middle	5.7	1.0	2.3	8.5	539
Fourth	4.6	0.3	1.7	6.1	565
Highest	2.7	0.0	0.4	3.0	649
Total	4.8	0.3	1.9	6.7	2,650

[1] Stillbirth, miscarriage, or abortion

3.5 FERTILITY PREFERENCES

Desire for another child

Women were asked whether they wanted more children and, if so, how long they would prefer to wait before the birth of the next child. Women who are sterilized are assumed not to want any more children.

Sample: Currently married women age 15–49

Table 5 shows fertility preferences among currently married women age 15–49 by number of living children.

- Nine percent of women want another child soon (within the next 2 years), 23% want to have another child later (in 2 or more years,) and 1% want another child but have not decided when.
- Fifteen percent of women want no more children, 2% are sterilized (or their partner has been sterilized), and 3% say they are infecund.
- The percentage of women who want no more children increases with the number of living children they have, from 4% among those with one child to 36% among those with six or more children.

Table 5 Fertility preferences by number of living children

Percent distribution of currently married women age 15–49 by desire for children, according to number of living children, Timor-Leste DHS 2025–26

	Number of living children[1]							
Desire for children	0	1	2	3	4	5	6+	Total
Have another soon[2]	34.8	12.3	10.1	8.8	4.9	3.2	1.0	8.8
Have another later[3]	9.0	37.4	31.2	27.1	19.4	10.5	5.6	23.3
Have another, undecided when	1.3	1.3	1.5	0.8	0.9	0.7	0.1	1.0
Undecided	46.2	43.4	47.8	47.0	45.5	47.1	46.0	46.1
Want no more	4.5	3.6	6.2	11.9	23.5	28.9	36.1	15.4
Sterilized[4]	0.3	0.4	1.2	2.1	2.3	3.8	4.2	2.0
Declared infecund	3.9	1.5	2.1	2.4	3.4	5.8	6.9	3.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	375	1,377	1,560	1,461	1,231	792	941	7,737

[1] The number of living children includes a woman's current pregnancy.
[2] Wants next birth within 2 years
[3] Wants to delay next birth for 2 or more years
[4] Includes both female and male sterilization

3.6 FAMILY PLANNING

3.6.1 Contraceptive Use

Contraceptive prevalence

Percentage of women who use any contraceptive method.

Sample: Currently married women age 15–49 and sexually active unmarried women age 15–49

Modern methods

Include male and female sterilization, injectables, intrauterine devices (IUDs), contraceptive pills, implants, female and male condoms, emergency contraception, the standard days method, the Billings method, and the lactational amenorrhea method.

Table 6 presents data on contraceptive use among currently married women and sexually active unmarried women.

- Thirty-nine percent of currently married women are using a contraceptive method, with 34% using a modern method and 5% using a traditional method. Sixty-one percent of currently married women are not using any contraceptive method.
- The most used contraceptive methods among currently married women are implants (25%), withdrawal (5%), and injectables (4%).
- Twenty-one percent of sexually active unmarried women are using a contraceptive method; 13% are using a modern method, and 8% are using a traditional method.

Trends: Use of contraceptives among currently married women increased from 22% in the 2009–10 TLDHS to 39% in the 2025–26 TLDHS. Over the same period, use of modern contraceptives increased from 21% to 34%.

Table 6 Current use of contraception according to background characteristics

Percent distribution of currently married women and sexually active unmarried women age 15–49 by contraceptive method currently used, according to background characteristics, Timor-Leste DHS 2025–26

Background characteristic	Any method	Any modern method	Modern method											Any traditional method	Traditional method			Not currently using	Total	Number of women
			Female sterilization	IUD	Injectables	Implants	Pill	Male condom	Emergency contraception	SDM	Billings method	LAM	Other		Rhythm	Withdrawal	Other			
	CURRENTLY MARRIED WOMEN																			
Number of living children																				
0	3.7	1.1	0.2	0.0	0.5	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.0	2.5	0.0	2.5	0.0	96.3	100.0	569
1–2	35.2	29.3	0.8	1.4	2.1	23.5	0.3	0.2	0.0	0.2	0.0	0.7	0.0	5.9	0.2	5.8	0.0	64.8	100.0	2,859
3–4	45.7	40.4	2.3	2.3	4.9	29.1	0.7	0.2	0.0	0.4	0.0	0.4	0.1	5.3	0.4	4.7	0.1	54.3	100.0	2,612
5+	47.6	43.8	4.1	4.2	4.5	29.9	0.5	0.1	0.0	0.2	0.1	0.2	0.0	3.8	0.1	3.4	0.3	52.4	100.0	1,698
Age																				
15–19	29.8	26.0	1.2	0.0	1.5	22.8	0.0	0.0	0.0	0.0	0.0	0.5	0.0	3.8	0.0	3.8	0.0	70.2	100.0	189
20–24	34.7	29.8	0.3	1.1	2.6	25.3	0.1	0.1	0.0	0.0	0.0	0.3	0.0	4.9	0.0	4.9	0.0	65.3	100.0	869
25–29	38.3	32.9	0.4	1.2	3.0	26.5	0.4	0.7	0.0	0.0	0.1	0.6	0.0	5.4	0.1	5.4	0.0	61.7	100.0	1,306
30–34	41.6	36.2	0.9	1.3	4.2	28.6	0.3	0.1	0.0	0.0	0.0	0.8	0.0	5.4	0.1	5.3	0.0	58.4	100.0	1,692
35–39	44.1	38.6	2.2	2.9	4.3	26.6	0.9	0.1	0.0	0.9	0.0	0.6	0.0	5.5	0.4	4.9	0.2	55.9	100.0	1,605
40–44	41.4	36.8	4.4	4.1	3.9	23.4	0.6	0.1	0.0	0.3	0.0	0.0	0.0	4.6	0.5	3.8	0.3	58.6	100.0	1,333
45–49	27.7	24.4	4.8	2.9	1.8	14.3	0.1	0.0	0.0	0.1	0.1	0.0	0.3	3.3	0.4	2.7	0.3	72.3	100.0	743
Residence																				
Urban	36.1	28.9	3.4	2.5	1.7	18.7	0.7	0.4	0.0	0.8	0.0	0.6	0.1	7.2	0.3	6.7	0.2	63.9	100.0	2,301
Rural	40.4	36.4	1.4	2.1	4.2	27.8	0.4	0.1	0.0	0.0	0.0	0.4	0.0	4.0	0.2	3.8	0.1	59.6	100.0	5,437
Municipality																				
Aileu	24.2	23.7	0.9	1.0	2.0	19.2	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.5	0.0	75.8	100.0	342
Ainaro	27.9	26.3	1.2	1.4	2.4	21.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.6	0.0	1.6	0.0	72.1	100.0	359
Atauro	29.6	27.3	1.1	0.0	4.3	20.7	1.2	0.0	0.0	0.0	0.0	0.0	0.0	2.2	0.0	2.2	0.0	70.4	100.0	51
Baucau	43.4	30.5	2.5	4.9	0.4	22.6	0.0	0.0	0.0	0.0	0.0	0.2	0.0	12.9	0.0	12.9	0.0	56.6	100.0	750
Bobonaro	42.6	42.0	2.8	0.5	5.5	32.7	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.6	0.0	57.4	100.0	555
Covalima	38.9	37.2	2.7	0.2	10.4	23.8	0.2	0.0	0.0	0.0	0.0	0.0	0.0	1.7	0.0	1.7	0.0	61.1	100.0	472
Dili	35.5	28.1	2.5	2.9	1.3	18.3	0.8	0.6	0.0	0.9	0.0	0.7	0.1	7.4	0.4	6.8	0.2	64.5	100.0	1,966
Ermera	44.5	43.1	0.9	1.7	3.9	35.9	0.5	0.0	0.0	0.1	0.0	0.2	0.0	1.3	0.0	1.1	0.2	55.5	100.0	788
Lautem	30.7	20.5	0.7	2.0	0.4	16.1	0.4	0.2	0.0	0.0	0.4	0.2	0.0	10.2	0.9	8.7	0.6	69.3	100.0	394
Liquica	45.6	42.2	0.2	2.3	4.7	30.4	1.0	0.3	0.1	0.1	0.0	3.2	0.0	3.4	0.0	3.2	0.2	54.4	100.0	519
Manatuto	54.6	50.0	3.0	2.1	6.1	37.8	0.3	0.0	0.0	0.4	0.0	0.2	0.0	4.7	0.9	3.7	0.0	45.4	100.0	279
Manufahi	59.9	53.2	1.6	1.2	7.5	42.4	0.2	0.2	0.0	0.0	0.0	0.0	0.0	6.7	1.0	5.7	0.0	40.1	100.0	294
Oecusse	32.2	30.1	3.3	1.5	9.2	16.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.2	0.0	2.2	0.0	67.8	100.0	492
Viqueque	40.2	37.7	2.0	3.0	0.8	31.6	0.2	0.0	0.0	0.0	0.0	0.0	0.0	2.5	0.0	2.5	0.0	59.8	100.0	476
Education																				
No education	41.1	38.0	1.1	2.0	4.0	30.4	0.4	0.0	0.0	0.0	0.0	0.1	0.0	3.1	0.0	2.9	0.2	58.9	100.0	1,280
Primary	40.6	37.8	2.8	2.0	4.8	27.7	0.3	0.0	0.0	0.0	0.1	0.1	0.0	2.8	0.0	2.8	0.0	59.4	100.0	1,013
Secondary	39.8	34.8	2.1	2.3	3.4	25.6	0.4	0.2	0.0	0.2	0.0	0.6	0.1	5.0	0.3	4.6	0.2	60.2	100.0	4,278
More than secondary	33.3	24.3	2.0	2.1	2.2	15.2	0.7	0.6	0.0	1.0	0.1	0.4	0.0	8.9	0.4	8.5	0.0	66.7	100.0	1,165

Continued…

Table 6—Continued

Background characteristic	Any method	Any modern method	Modern method: Female sterilization	IUD	Injectables	Implants	Pill	Male condom	Emergency contraception	SDM	Billings method	LAM	Other	Any traditional method	Traditional method: Rhythm	Withdrawal	Other	Not currently using	Total	Number of women
Wealth quintile																				
Lowest	41.7	38.5	1.1	2.0	4.8	30.3	0.2	0.0	0.0	0.0	0.0	0.1	0.0	3.3	0.0	3.2	0.1	58.3	100.0	1,481
Second	41.4	37.6	1.0	2.0	4.2	29.6	0.3	0.1	0.0	0.0	0.0	0.3	0.0	3.8	0.2	3.5	0.1	58.6	100.0	1,507
Middle	39.9	35.0	1.8	2.0	3.9	26.2	0.5	0.0	0.0	0.1	0.1	0.4	0.0	4.9	0.2	4.7	0.0	60.1	100.0	1,584
Fourth	39.3	33.2	2.5	2.5	3.2	23.0	0.3	0.4	0.0	0.2	0.0	1.0	0.0	6.2	0.3	5.7	0.2	60.7	100.0	1,629
Highest	33.5	26.8	3.5	2.6	1.3	16.6	0.9	0.4	0.0	0.9	0.0	0.3	0.1	6.7	0.5	6.0	0.2	66.5	100.0	1,537
Total	39.1	34.1	2.0	2.2	3.5	25.1	0.5	0.2	0.0	0.3	0.0	0.4	0.0	5.0	0.2	4.6	0.1	60.9	100.0	7,737
SEXUALLY ACTIVE UNMARRIED WOMEN[1]																				
Residence																				
Urban	30.2	17.8	0.0	0.0	0.0	3.2	0.0	14.6	0.0	0.0	0.0	0.0	0.0	12.5	0.0	12.5	0.0	69.8	100.0	92
Rural	9.3	6.6	0.0	0.0	0.0	6.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.7	0.0	2.7	0.0	90.7	100.0	68
Total	21.3	13.0	0.0	0.0	0.0	4.6	0.0	8.4	0.0	0.0	0.0	0.0	0.0	8.3	0.0	8.3	0.0	78.7	100.0	160

Note: If more than one method is used, only the most effective method is considered in this tabulation.
SDM = Standard days method
LAM = Lactational amenorrhea method
[1] Women who have had sexual intercourse within 30 days preceding the survey

3.6.2 Need and Demand for Family Planning

Table 7 presents data on unmet need, met need, and total demand for family planning among currently married and sexually active unmarried women. These indicators help evaluate the extent to which family planning programs in Timor-Leste are meeting the demand for services.

Unmet need for family planning

Percentage of women who (1) are not pregnant and not postpartum amenorrheic and are considered fecund and want to postpone their next birth for 2 or more years or stop childbearing altogether but are not using a contraceptive method, or (2) have a mistimed or unwanted current pregnancy, or (3) are postpartum amenorrheic and their most recent birth in the last 2 years was mistimed or unwanted.

Met need for family planning

Current contraceptive use (any method).

Sample: Currently married women age 15–49 and sexually active unmarried women age 15–49

Demand for family planning:	Unmet need for family planning + met need (current contraceptive use [any method])
Proportion of demand satisfied:	Current contraceptive use (any method) / Unmet need + current contraceptive use (any method)
Proportion of demand satisfied by modern methods:	Current contraceptive use (any modern method) / Unmet need + current contraceptive use (any method)

- In Timor-Leste, 23% of currently married women have an unmet need for family planning.
- Sixty-two percent of currently married women have a demand for family planning. Sixty-three percent of this demand is satisfied, and 55% is satisfied by modern methods.
- Seventy-three percent of sexually active unmarried women have an unmet need for family planning.
- Ninety-four percent of sexually active unmarried women have a demand for family planning. Twenty-three percent of this demand is satisfied, and 14% is satisfied by modern methods.

Table 7 Need and demand for family planning among currently married women and sexually active unmarried women

Percentage of currently married women and sexually active unmarried women age 15–49 with unmet need for family planning, percentage with met need for family planning, percentage with met need for family planning who are using modern methods, percentage with demand for family planning, percentage of the demand for family planning that is satisfied, and percentage of the demand for family planning that is satisfied with modern methods, according to background characteristics, Timor-Leste DHS 2025–26

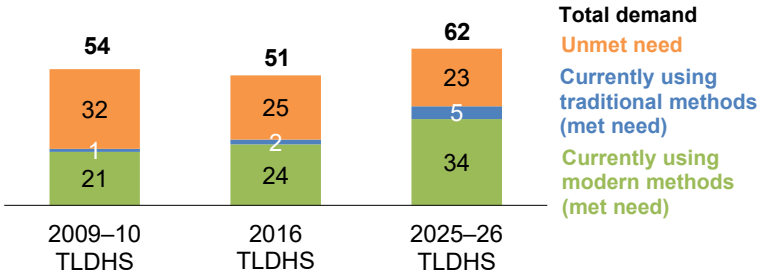
Background characteristic	Unmet need for family planning	Met need for family planning (currently using)		Total demand for family planning[3]	Number of women	Percentage of demand satisfied[1]	
		All methods	Modern methods[2]			All methods	Modern methods[2]
CURRENTLY MARRIED WOMEN							
Age							
15–19	26.8	29.8	26.0	56.6	189	52.7	45.9
20–24	28.5	34.7	29.8	63.2	869	54.9	47.1
25–29	26.7	38.3	32.9	65.0	1,306	58.9	50.5
30–34	24.3	41.6	36.2	65.9	1,692	63.2	55.0
35–39	23.4	44.1	38.6	67.6	1,605	65.3	57.2
40–44	19.1	41.4	36.8	60.4	1,333	68.5	60.9
45–49	10.3	27.7	24.4	38.0	743	72.9	64.2
Residence							
Urban	25.9	36.1	28.9	61.9	2,301	58.2	46.6
Rural	21.5	40.4	36.4	61.9	5,437	65.3	58.7
Municipality							
Aileu	31.5	24.2	23.7	55.8	342	43.5	42.6
Ainaro	25.4	27.9	26.3	53.3	359	52.3	49.3
Atauro	29.1	29.6	27.3	58.7	51	50.4	46.6
Baucau	21.0	43.4	30.5	64.3	750	67.4	47.4
Bobonaro	22.1	42.6	42.0	64.7	555	65.8	64.9
Covalima	23.9	38.9	37.2	62.9	472	61.9	59.2
Dili	26.7	35.5	28.1	62.2	1,966	57.0	45.1
Ermera	20.0	44.5	43.1	64.4	788	69.0	66.9
Lautem	27.5	30.7	20.5	58.2	394	52.8	35.2
Liquica	15.3	45.6	42.2	61.0	519	74.8	69.3
Manatuto	15.6	54.6	50.0	70.3	279	77.8	71.1
Manufahi	13.0	59.9	53.2	72.8	294	82.2	73.0
Oecusse	24.9	32.2	30.1	57.2	492	56.4	52.5
Viqueque	17.3	40.2	37.7	57.5	476	70.0	65.6
Education							
No education	19.8	41.1	38.0	60.9	1,280	67.5	62.4
Primary	20.0	40.6	37.8	60.5	1,013	67.0	62.5
Secondary	23.2	39.8	34.8	63.0	4,278	63.2	55.2
More than secondary	27.1	33.3	24.3	60.4	1,165	55.1	40.3
Wealth quintile							
Lowest	21.5	41.7	38.5	63.2	1,481	66.0	60.9
Second	21.3	41.4	37.6	62.7	1,507	66.0	60.0
Middle	21.4	39.9	35.0	61.3	1,584	65.1	57.1
Fourth	24.2	39.3	33.2	63.5	1,629	62.0	52.3
Highest	25.5	33.5	26.8	59.0	1,537	56.7	45.3
Total	22.8	39.1	34.1	61.9	7,737	63.2	55.1
SEXUALLY ACTIVE UNMARRIED WOMEN[4]							
Residence							
Urban	64.3	30.2	17.8	94.6	92	32.0	18.8
Rural	84.0	9.3	6.6	93.3	68	9.9	7.1
Total	72.7	21.3	13.0	94.0	160	22.7	13.9

Note: Numbers in this table correspond to the revised definition of unmet need described in Bradley et al. 2012.
[1] Percentage of demand satisfied is met need divided by total demand.
[2] Modern methods include female sterilization, male sterilization, IUD, injectables, implants, pill, male condom, emergency contraception, standard days method (SDM), lactational amenorrhea method (LAM), Billings method, and other modern methods.
[3] Total demand is the sum of unmet need and met need.
[4] Women who have had sexual intercourse within 30 days preceding the survey

Trends: Total demand for family planning among currently married women decreased from 54% in the 2009–10 TLDHS to 51% in the 2016 TLDHS before increasing to 62% in the 2025–26 TLDHS. Over the same period, unmet need decreased from 32% to 23% (**Figure 2**).

Figure 2 **Trends in use of, need for, and demand for family planning**

Percentage of currently married women age 15–49



3.7 EARLY CHILDHOOD MORTALITY

Neonatal mortality: The probability of dying within the first month of life.

Postneonatal mortality: The probability of dying between the first month of life and the first birthday (computed as the difference between infant and neonatal mortality).

Infant mortality: The probability of dying between birth and the first birthday.

Child mortality: The probability of dying between the first and the fifth birthday.

Under-5 mortality: The probability of dying between birth and the fifth birthday.

Table 8 presents estimates of childhood mortality for three successive 5-year periods prior to the 2025–26 TLDHS. The rates were estimated directly from information collected as part of a retrospective pregnancy history in which female respondents listed all of the children to whom they have given birth, along with each child's date of birth, survivorship status, and current age or age at death.

- During the 5 years immediately preceding the survey, the neonatal mortality rate was 16 deaths per 1,000 live births.
- The infant mortality rate was 32 deaths per 1,000 live births.
- The child mortality rate was 9 deaths per 1,000 children surviving to age 12 months, while the overall under-5 mortality rate was 41 deaths per 1,000 live births.

Table 8 Early childhood mortality rates

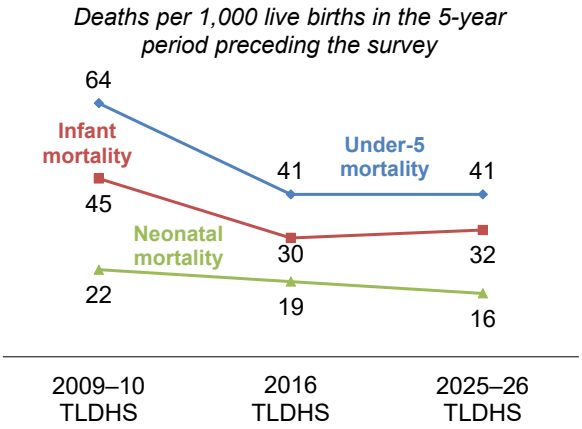
Neonatal, postneonatal, infant, child, and under-5 mortality rates for 5-year periods preceding the survey, Timor-Leste DHS 2025–26

Years preceding the survey	Neonatal mortality (NN)	Post-neonatal mortality (PNN)[1]	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-5 mortality ($_5q_0$)
0–4	16	17	32	9	41
5–9	16	19	35	6	41
10–14	19	17	35	5	40

[1] Computed as the difference between the infant and neonatal mortality rates

Trends: Neonatal mortality decreased from 22 deaths per 1,000 live births in the 5 years preceding the 2009–10 survey to 16 deaths per 1,000 live births in the 5 years preceding the 2025–26 survey. The infant mortality rate declined from 45 deaths per 1,000 live births in the 5 years preceding the 2009–10 survey to 30 deaths per 1,000 live births in the 5 years preceding the 2016 survey before increasing slightly to 32 deaths per 1,000 live births in the 5 years preceding the 2025–26 survey. The under-5 mortality rate dropped substantially from 64 deaths per 1,000 live births in the 5 years preceding the 2009–10 survey to 41 deaths per 1,000 live births in the 5 years preceding the 2016 survey but has since remained unchanged (**Figure 3**).

Figure 3 **Trends in early childhood mortality rates**



3.8 MATERNAL CARE

Proper care during pregnancy and delivery is important for the health of both the mother and the baby. **Table 9** presents key indicators related to maternal care.

3.8.1 Antenatal Care

Antenatal care from a skilled provider

Pregnancy care received from skilled providers, such as doctors, nurses, and midwives.

Sample: Women age 15–49 who had a live birth or stillbirth in the 2 years before the survey

Antenatal care (ANC) from a skilled provider is important to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, at delivery, and during the postnatal period.

- Eighty-eight percent (88%) of women reported receiving antenatal care from a skilled provider for their most recent live birth in the 2-year period preceding the survey.
- Seventy-one percent of women had at least four ANC visits for their most recent live birth.
- Overall, 82% of women took iron-containing supplements during their most recent pregnancy.

Trends: The proportion of women with a live birth in the 2 years preceding the survey who received antenatal care from a skilled provider during the pregnancy for their most recent live birth has remained relatively stable over time (86% in 2009–10, 85% in 2016, and 88% in 2025–26).

3.8.2 Tetanus Toxoid

Protection against neonatal tetanus

The number of tetanus toxoid injections needed to protect a baby from neonatal tetanus depends on the mother's vaccinations. A birth is protected against neonatal tetanus if the mother has received any of the following:

- Two tetanus toxoid injections during the pregnancy
- Two or more injections, the last one within 3 years of the birth
- Three or more injections, the last one within 5 years of the birth
- Four or more injections, the last one within 10 years of the birth
- Five or more injections at any time prior to the birth

Sample: Women age 15–49 with a live birth in the 2 years before the survey

Tetanus toxoid injections are given during pregnancy to prevent neonatal tetanus, a major cause of early infant death in many countries. Neonatal tetanus is often caused by failure to observe hygienic procedures during delivery.

- Overall, 60% of women with a live birth in the 2 years preceding the survey received sufficient tetanus toxoid injections to protect their baby against neonatal tetanus.

Trends: The percentage of women whose most recent live birth was protected against neonatal tetanus decreased from 78% in 2009–10 to 71% in 2016 and 60% in 2025–26.

Table 9 Maternal care indicators

Among women age 15–49 who had a live birth and/or a stillbirth in the 2 years preceding the survey, percentage who received antenatal care (ANC) from a skilled provider for the most recent live birth or stillbirth, percentage with four or more ANC visits for the most recent live birth or stillbirth, percentage who took any iron-containing supplements during pregnancy, and percentage whose most recent live birth was protected against neonatal tetanus; among all live births and stillbirths in the 2 years before the survey, percentage delivered by a skilled provider and percentage delivered in a health facility; and among women age 15–49 with a live birth or stillbirth in the 2 years preceding the survey, percentage who received a postnatal check during the first 2 days after giving birth, according to background characteristics, Timor-Leste DHS 2025–26

	Women who had a live birth and/or a stillbirth in the 2 years preceding the survey					Live births and stillbirths in the 2 years preceding the survey			Women who had a live birth and/or a stillbirth in the 2 years preceding the survey	
Background characteristic	Percentage receiving antenatal care from a skilled provider[1]	Percentage with 4+ ANC visits	Percentage who took any iron-containing supplements during pregnancy[2]	Percentage whose most recent live birth was protected against neonatal tetanus[3]	Number of women	Percentage delivered by a skilled provider[1]	Percentage delivered in a health facility	Number of births	Percentage with a postnatal check during the first 2 days after birth[4]	Number of women
					LIVE BIRTHS					
Mother's age at birth										
<20	90.3	74.1	89.6	63.1	178	83.8	78.1	183	61.4	178
20–34	88.0	71.5	82.6	60.3	1,824	78.1	71.4	1,909	55.4	1,824
35–49	88.6	67.8	79.3	57.2	525	76.9	70.0	539	57.2	525
Residence										
Urban	93.4	79.9	85.5	63.7	673	94.9	91.8	705	66.3	673
Rural	86.4	67.7	81.3	58.5	1,854	72.2	64.2	1,927	52.5	1,854
Municipality										
Aileu	99.4	75.5	90.2	57.9	114	97.9	89.7	120	49.3	114
Ainaro	84.8	29.2	57.9	57.3	109	71.2	65.7	113	44.3	109
Atauro	95.3	90.0	85.8	71.9	14	91.3	86.3	14	39.8	14
Baucau	55.7	52.1	91.9	60.4	263	79.7	73.7	273	67.2	263
Bobonaro	88.9	67.6	86.6	48.6	202	61.0	52.1	213	51.3	202
Covalima	98.1	72.1	94.9	59.7	147	86.7	82.4	150	76.6	147
Dili	91.7	76.9	84.8	65.9	582	97.1	94.1	605	65.5	582
Ermera	96.1	66.3	75.6	55.6	309	57.7	44.9	326	42.0	309
Lautem	96.8	92.2	83.3	51.6	135	78.4	76.6	143	78.8	135
Liquica	84.6	74.5	66.6	71.9	168	77.2	71.6	171	54.2	168

Continued…

Table 9—*Continued*

Background characteristic	Women who had a live birth and/or a stillbirth in the 2 years preceding the survey					Live births and stillbirths in the 2 years preceding the survey			Women who had a live birth and/or a stillbirth in the 2 years preceding the survey	
	Percentage receiving antenatal care from a skilled provider[1]	Percentage with 4+ ANC visits	Percentage who took any iron-containing supplements during pregnancy[2]	Percentage whose most recent live birth was protected against neonatal tetanus[3]	Number of women	Percentage delivered by a skilled provider[1]	Percentage delivered in a health facility	Number of births	Percentage with a postnatal check during the first 2 days after birth[4]	Number of women
Manatuto	98.6	83.4	94.3	76.8	85	76.7	69.2	89	67.7	85
Manufahi	99.2	86.1	71.5	73.9	87	76.8	65.1	89	62.5	87
Oecusse	83.5	72.7	85.0	48.8	152	57.6	48.9	160	24.6	152
Viqueque	88.3	77.7	78.1	49.5	159	74.5	65.3	164	36.4	159
Mother's education										
No education	84.4	65.0	77.7	56.8	329	57.1	48.3	344	38.6	329
Primary	86.5	67.4	80.1	57.4	317	65.8	55.8	332	47.0	317
Secondary	87.5	70.6	83.3	59.2	1,482	81.3	74.5	1,539	58.3	1,482
More than secondary	95.8	80.1	85.1	66.8	399	94.5	92.5	416	69.9	399
Wealth quintile										
Lowest	83.4	59.5	76.7	56.2	543	54.0	45.4	561	35.2	543
Second	88.2	69.6	82.1	57.1	530	70.2	59.9	559	49.9	530
Middle	88.0	70.7	83.6	61.2	525	82.4	74.5	544	58.6	525
Fourth	88.8	77.4	85.0	61.3	539	93.6	89.6	551	71.2	539
Highest	94.9	80.1	85.7	64.8	391	96.1	94.7	417	69.8	391
Total	88.3	70.9	82.4	59.9	2,527	78.3	71.6	2,632	56.2	2,527
STILLBIRTHS										
Total	*	*	*	na	17	*	*	17	*	17
LIVE BIRTHS AND STILLBIRTHS[5]										
Total	88.4	71.0	82.5	na	2,544	78.4	71.7	2,649	56.4	2,544

Note: If more than one source of assistance was mentioned, only the provider with the highest qualifications is considered in this tabulation. Stillbirths are fetal deaths in pregnancies lasting 28 or more weeks. When pregnancy duration is reported in months, stillbirths are fetal deaths in pregnancies lasting 7 or more months. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
na = Not applicable
[1] Skilled provider includes doctor, nurse, and midwife.
[2] Iron tablets
[3] Includes mothers with two injections during the pregnancy of their most recent live birth, or two or more injections (the last within 3 years of the most recent live birth), or three or more injections (the last within 5 years of the most recent live birth), or four or more injections (the last within 10 years of the most recent live birth), or five or more injections at any time prior to the last live birth
[4] Includes women who received a check from a doctor, midwife, nurse, community health worker, or traditional birth attendant
[5] For women who had both a live birth and a stillbirth in the 2 years preceding the survey, data on antenatal care and postnatal checks are tabulated for the most recent birth only.

3.8.3 Delivery Care

Institutional deliveries

Deliveries that occur in a health facility.

Sample: All live births and/or stillbirths in the 2 years before the survey

Skilled assistance during delivery

Births delivered with the assistance of doctors, nurses, and midwives.

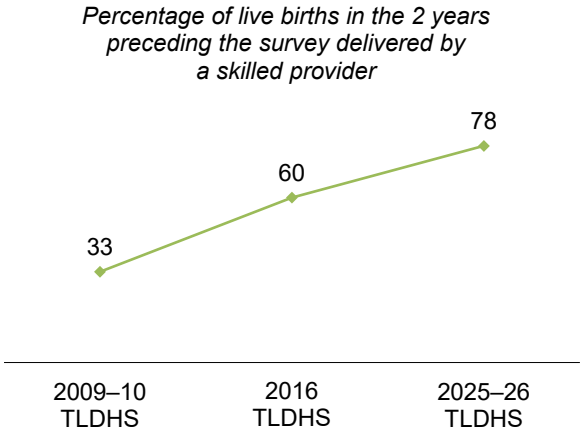
Sample: All live births and/or stillbirths in the 2 years before the survey

Access to proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that could lead to death or serious illness for the mother, baby, or both (Van Lerberghe and De Brouwere 2001; WHO 2006a).

- Seventy-two percent of live births in the 2 years preceding the survey were delivered in a health facility.
- Seventy-eight percent of live births were delivered with assistance from a skilled provider.

Trends: The percentage of live births with skilled assistance during delivery increased from 33% in 2009–10 to 60% in 2016 and 78% in 2025–26 (**Figure 4**).

***Figure 4* Trends in delivery assistance**



3.8.4 Postnatal Care for the Mother

A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Thus, prompt postnatal care (PNC) for both the mother and the child is important to treat any complications arising from the delivery, as well as to provide the mother with important information on how to care for herself and her child. Safe motherhood programs recommend that all women receive a check of their health during the first 2 days after delivery.

- Overall, 56% of women with a live birth in the 2 years preceding the survey received a postnatal check within 2 days after delivery.

3.9 VACCINATION COVERAGE

Universal immunization of children against common vaccine-preventable diseases is crucial in reducing infant and child morbidity and mortality. In Timor-Leste, routine childhood vaccines include bacille Calmette-Guérin (BCG) (tuberculosis), HepB (hepatitis B), oral polio vaccine (OPV) or inactivated polio vaccine (IPV), pentavalent or DPT-HepB-Hib (diphtheria, pertussis, and tetanus; hepatitis B; and *Haemophilus influenzae* type b), pneumococcal conjugate vaccine (PCV), rotavirus vaccine (RV), and measles-rubella. A booster dose of DPT is also included.

Information on vaccination coverage was obtained in two ways in the 2025–26 TLDHS: from written vaccination records, including the Mother and Child Health Booklet (*Livrinho Saude Inan ho Oan* [LISIO]), and from verbal reports.

3.9.1 Basic Antigen Coverage

Fully vaccinated: basic antigens

Percentage of children who received specific vaccines at any time before the survey (according to LISIO, a vaccination card, or the mother's report). To have received all basic antigens, a child must receive at least:

- One dose of BCG vaccine, which protects against tuberculosis
- Three doses of polio vaccine given as oral polio vaccine (OPV), inactivated polio vaccine (IPV), or a combination of OPV and IPV
- Three doses of DPT-containing vaccine, which protects against diphtheria, pertussis (whooping cough), and tetanus
- One dose of measles-containing vaccine given as measles-rubella (MR)

Sample: Children age 12–23 months

Historically, an important measure of vaccination coverage has been the proportion of children receiving all "basic" antigens. Children are considered fully vaccinated against all basic antigens if they have

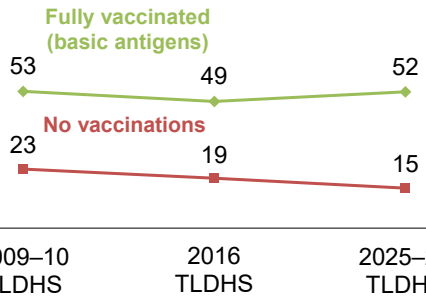
received the BCG vaccine, three doses each of polio vaccine and DPT-containing vaccine, and a single dose of measles-containing vaccine. In Timor-Leste, the BCG vaccine is usually given at birth or at first clinic contact, while the polio and DPT-containing vaccines are given at approximately age 6, 10, and 14 weeks. A first measles-containing vaccination should be given at or soon after age 9 months.

- Eighty-four percent of children age 12–23 months received the BCG vaccine, 68% received the third dose of DPT-HepB-Hib, and 64% received the first dose of measles vaccine (**Table 10**).
- Overall, 52% of children age 12–23 months are fully vaccinated with basic antigens, and 15% have received no vaccinations.

Trends: There has been no substantial progress over time in the percentage of children age 12–23 months who are fully vaccinated (received all of the basic antigens). The percentage dropped from 53% in 2009–10 to 49% in 2016 and has since exhibited a slight increase (52% in 2025–26). The percentage of children receiving no vaccinations decreased from 23% in 2009–10 to 15% in 2025–26 (**Figure 5**).

***Figure 5* Trends in childhood vaccinations**

Percentage of children age 12–23 months



3.9.2 Vaccination Coverage according to National Schedule

A second measure of vaccination coverage is the percentage of children age 12–23 months and 24–35 months who are fully vaccinated according to the national schedule. In this report, a child age 12–23 months is considered to be fully vaccinated according to the national schedule if the child has received all basic antigens as well as a birth dose of OPV, a birth dose of HepB vaccine, one dose of IPV, three doses of HepB and Hib (given as part of DPT-containing vaccine), three doses of the pneumococcal vaccine, and three doses of rotavirus vaccine. Children age 24–35 months are considered fully vaccinated according to the national schedule if they receive a second dose of the measles vaccine and the fourth dose of the DPT booster vaccine in addition to all of the vaccinations relevant for a child age 12–23 months.

Table 10 shows that 35% of children age 12–23 months are fully vaccinated according to the national schedule. Among children age 24–35 months, 24% are fully vaccinated according to the national schedule.

- Sixty percent of children age 12–23 months received the third dose of PCV, and 62% received the third dose of rotavirus vaccine.
- Among children age 24–35 months, 46% received a second dose of measles-rubella vaccine and 48% received the fourth dose of DPT.

Table 10 Vaccinations by background characteristics

Percentage of children age 12–23 months and children age 24–35 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), percentage fully vaccinated (basic antigens), percentage fully vaccinated according to the national schedule, and percentage who received no vaccinations, according to background characteristics, Timor-Leste DHS 2025–26

	Children age 12–23 months																				Children age 24–35 months			
			DPT-HepB-Hib			OPV[2]					Pneumococcal			Rotavirus										
Background characteristic	BCG	HepB (birth dose)[1]	1	2	3	0 (birth dose)	1	2	3	IPV	1	2	3	1	2	3	Measles-rubella 1	Fully vaccinated (basic antigens)[3]	Fully vaccinated according to national schedule[4]	No vaccinations	Number of children	Measles-rubella 2	DPT 4	Fully vaccinated according to national schedule[5]	Number of children
Sex																									
Male	83.4	74.3	78.4	74.4	66.4	68.0	77.7	71.5	59.7	70.5	75.1	69.9	57.3	76.0	70.4	59.8	63.4	51.4	34.0	15.7	666	47.8	49.5	23.9	600
Female	84.3	73.9	81.3	77.9	70.0	68.9	81.2	74.8	60.6	72.9	78.5	74.3	62.7	78.2	73.4	64.4	64.5	53.3	36.7	15.1	638	43.7	47.2	24.8	587
Birth order																									
1	83.0	75.2	79.7	75.8	69.1	70.1	78.4	74.3	61.5	71.3	77.1	72.4	62.9	77.8	72.9	65.6	66.1	53.4	38.1	16.1	339	52.4	57.5	26.8	305
2–3	85.8	74.1	80.6	77.3	67.4	68.1	80.6	74.4	59.7	74.4	77.6	73.0	59.1	78.1	72.7	60.0	63.2	51.8	35.4	13.5	545	43.9	45.5	26.4	465
4–5	86.3	78.8	83.6	80.5	73.6	73.3	84.7	75.8	63.5	75.0	80.0	76.6	62.1	80.5	75.4	65.8	67.0	56.6	36.8	12.7	295	46.4	50.0	23.9	275
6+	71.2	60.0	67.9	61.5	56.2	54.1	64.8	57.8	50.6	53.3	64.5	56.0	50.5	63.0	57.1	52.5	53.6	42.0	24.2	27.6	125	36.5	34.8	12.9	142
Vaccination card[6]																									
Seen	97.9	85.5	97.2	95.3	88.2	82.6	97.2	94.1	83.4	85.0	93.2	89.7	77.9	93.2	90.6	80.1	78.7	73.5	49.9	1.1	916	61.6	62.1	36.2	789
Not seen or no longer has	71.8	68.1	55.5	45.2	29.9	48.7	52.0	32.5	7.7	56.9	52.4	41.9	24.6	54.2	38.2	27.5	40.0	3.1	0.7	27.5	234	20.5	31.7	0.9	240
Never had	18.1	15.5	12.9	8.9	7.0	14.1	15.2	9.8	1.3	15.0	15.9	12.5	6.5	15.9	11.8	6.7	12.1	1.3	1.3	81.9	154	4.9	4.9	0.4	157
Residence																									
Urban	84.4	80.6	78.7	75.9	67.3	72.4	78.4	73.7	58.3	70.6	77.2	74.3	60.8	77.6	73.9	66.6	61.7	49.2	39.9	15.4	348	45.2	50.2	30.0	333
Rural	83.6	71.7	80.2	76.2	68.5	67.0	79.8	72.9	60.8	72.1	76.7	71.2	59.6	76.9	71.1	60.4	64.7	53.5	33.7	15.4	956	46.0	47.6	22.1	854
Municipality																									
Aileu	86.3	83.2	79.0	77.9	75.2	83.6	82.1	75.8	65.0	80.0	70.3	68.2	64.4	76.6	74.5	71.0	79.1	63.4	53.3	13.7	61	64.8	62.4	36.2	53
Ainaro	81.3	72.8	79.9	75.9	69.6	65.8	77.3	71.0	65.6	75.1	77.1	71.6	67.6	77.1	70.2	64.8	66.0	57.9	39.0	17.3	59	39.4	43.2	14.2	55
Atauro	96.2	90.8	96.2	96.2	86.7	87.0	88.7	88.7	72.9	82.7	94.5	92.3	80.1	96.2	96.2	83.6	89.2	71.8	46.9	3.8	7	58.4	52.2	30.7	8
Baucau	79.1	71.6	77.6	70.1	65.9	71.6	72.5	68.7	62.2	72.1	64.5	56.1	45.8	63.6	55.6	49.1	64.0	54.7	29.9	20.0	147	45.3	52.3	12.8	119
Bobonaro	79.0	53.0	76.1	68.7	55.9	51.2	76.6	65.0	50.9	61.5	73.6	67.5	48.4	74.8	68.7	49.7	42.4	36.2	12.1	21.0	95	27.0	27.5	11.1	100
Covalima	91.8	88.9	92.9	90.0	85.9	86.0	91.8	86.5	78.9	77.8	88.8	85.9	77.1	90.6	85.3	77.8	80.6	71.9	56.1	6.4	80	60.8	58.3	36.2	74
Dili	83.2	79.6	76.0	72.5	63.8	71.6	76.7	71.7	56.5	68.8	76.7	73.9	60.1	76.7	71.8	65.3	61.6	49.2	42.0	16.8	304	46.3	52.8	33.9	267
Ermera	84.6	65.5	79.8	77.3	68.7	49.4	80.6	71.2	58.1	73.7	78.1	70.7	56.7	79.0	72.8	62.2	56.6	46.3	20.2	14.6	161	34.4	37.0	13.4	145
Lautem	95.0	85.3	89.9	86.2	78.6	81.9	87.4	80.3	57.8	79.8	88.7	84.0	73.4	89.1	85.3	71.5	81.5	56.2	39.2	3.8	68	59.7	53.0	25.1	72
Liquica	92.1	81.0	91.0	88.9	72.8	78.1	90.0	82.8	59.5	76.0	92.1	88.9	69.2	92.1	88.9	71.0	71.0	55.2	38.0	7.9	81	48.1	50.4	27.7	75
Manatuto	82.1	71.7	80.6	78.5	74.1	67.2	83.6	80.6	66.6	73.2	74.1	68.1	62.1	70.2	68.7	63.0	73.4	63.0	46.6	13.4	41	65.5	68.3	33.7	39
Manufahi	95.0	86.7	90.0	85.0	75.0	83.4	91.7	80.0	67.5	80.0	90.0	85.0	75.8	86.7	83.3	75.8	76.7	60.9	41.7	5.0	43	48.3	44.9	23.3	43
Oecusse	65.4	59.7	64.0	62.2	54.0	52.2	65.4	61.4	48.5	59.1	63.7	62.0	51.4	64.0	58.0	45.1	49.1	40.8	28.6	30.3	73	41.3	46.4	24.2	73
Viqueque	83.3	69.2	77.4	75.2	69.2	66.7	76.3	71.8	63.3	69.2	72.6	67.0	54.8	72.6	67.0	52.3	60.8	51.8	31.1	16.7	84	43.1	46.0	25.9	65
Mother's education																									
No education	74.1	59.7	70.2	68.9	55.7	53.7	69.6	64.7	49.4	62.0	65.6	64.0	48.1	67.0	64.1	49.1	50.2	42.1	22.9	24.6	184	39.1	39.3	17.1	177
Primary	81.1	66.3	77.0	73.0	64.5	64.3	80.0	72.8	59.7	63.4	73.5	67.2	59.0	73.2	68.1	57.5	60.5	51.1	27.1	17.3	156	40.1	43.6	19.3	154
Secondary	87.2	77.9	83.2	78.4	71.6	72.3	81.7	75.6	62.9	74.7	80.3	74.4	62.3	80.8	74.2	65.1	67.7	55.1	38.1	12.1	776	46.1	49.4	24.5	681
More than secondary	81.5	78.9	77.6	76.4	69.2	70.5	79.1	71.5	59.6	75.3	76.2	73.9	62.6	75.0	72.9	65.9	64.7	51.9	42.7	18.2	189	56.4	57.6	35.6	174

Continued…

Table 10—*Continued*

Background characteristic	Children age 12–23 months																				Children age 24–35 months			
			DPT-HepB-Hib			OPV[2]					Pneumococcal			Rotavirus										
	BCG	HepB (birth dose)[1]	1	2	3	0 (birth dose)	1	2	3	IPV	1	2	3	1	2	3	Measles-rubella 1	Fully vaccinated (basic antigens)[3]	Fully vaccinated according to national schedule[4]	No vaccinations	Number of children	Measles-rubella 2	DPT 4	Fully vaccinated according to national schedule[5]	Number of children
Wealth quintile																									
Lowest	75.1	59.8	73.2	68.9	60.5	54.8	72.1	67.0	54.1	66.4	68.7	63.4	49.4	70.0	63.3	51.1	58.4	46.6	24.7	22.2	280	42.4	44.9	14.6	253
Second	87.2	72.3	82.8	78.8	71.1	67.5	84.5	76.4	62.1	73.0	80.7	74.3	64.5	80.4	75.2	64.7	65.3	55.6	34.1	12.2	280	43.4	46.6	23.1	277
Middle	85.6	76.4	82.4	78.6	71.6	72.9	81.7	74.2	65.0	74.0	77.1	72.0	61.1	77.2	72.8	63.2	65.2	55.4	39.8	13.7	263	44.6	47.4	22.1	230
Fourth	85.6	80.4	81.0	77.6	69.3	75.3	81.2	76.1	63.3	72.0	79.0	74.5	62.0	78.3	73.8	64.2	65.0	55.4	41.0	14.4	272	49.0	49.8	29.2	224
Highest	86.2	84.5	79.8	77.1	68.5	73.4	77.2	71.6	55.3	73.7	79.1	77.4	63.9	80.5	75.3	68.9	66.5	48.0	38.2	13.8	209	51.0	54.5	35.3	204
Total	83.8	74.1	79.8	76.1	68.2	68.4	79.4	73.1	60.1	71.7	76.8	72.0	59.9	77.1	71.9	62.0	63.9	52.3	35.3	15.4	1,304	45.8	48.4	24.3	1,187

Note: Children are considered to have received the vaccine if it was either written on the child's vaccination card (LISIO) or reported by the mother. For children whose vaccination information is based on the mother's report, date of vaccination is not collected. The proportions of vaccinations given during the first and second years of life are assumed to be the same as for children with a written record of vaccination.
BCG = Bacille Calmette-Guérin
DPT = Diphtheria-pertussis-tetanus
HepB = Hepatitis B
Hib = *Haemophilus influenzae* type b
OPV = Oral polio vaccine
IPV = Inactivated polio vaccine
[1] Children are considered to have received HepB (birth dose) if it was recorded on their card or reported by their mother, regardless of timing.
[2] OPV 0 is the polio vaccination given at birth.
[3] BCG, three doses of DPT-HepB-Hib (pentavalent), three doses of polio vaccine (excluding polio vaccine given at birth), and one dose of measles-rubella vaccine
[4] BCG, HepB (birth dose), three doses of DPT-HepB-Hib (pentavalent), four doses of OPV, one dose of IPV, three doses of pneumococcal vaccine, three doses of rotavirus vaccine, and one dose of measles-rubella vaccine
[5] BCG, HepB (birth dose), three doses of DPT-HepB-Hib (pentavalent), four doses of OPV, one dose of IPV, three doses of pneumococcal vaccine, three doses of rotavirus vaccine, fourth dose of DPT, and two doses of measles-rubella vaccine
[6] Vaccination card (LISIO), booklet, or other home-based record

3.10 CARE SEEKING FOR AND TREATMENT OF CHILD ILLNESS

Acute respiratory infection (ARI), fever, and dehydration from diarrhea are important contributing causes of childhood morbidity and mortality in developing countries (WHO 2003). Prompt medical attention when a child has the symptoms of these illnesses is, therefore, crucial in reducing child deaths. **Table 11** presents information on care seeking for ill children in Timor-Leste. Overall, 1% of children under age 5 showed symptoms of an ARI, 22% had a fever, and 14% experienced diarrhea in the 2 weeks preceding the survey (data not shown).

- Advice or treatment was sought for 76% of children with symptoms of ARI in the 2 weeks before the survey.
- Advice or treatment was sought for 65% of children with a fever in the 2 weeks before the survey.
- Advice or treatment was sought for 62% of children with diarrhea in the 2 weeks before the survey.
- Fifty-seven percent of children with diarrhea received oral rehydration salts (ORS), 49% received zinc supplements, 39% received ORS and zinc supplements, and 27% received ORS, zinc supplements, and continued feeding.

Table 11 Treatment for acute respiratory infection, fever, and diarrhea

Among children under age 5 who had symptoms of acute respiratory infection (ARI) or had a fever during the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, and among children under age 5 who had diarrhea during the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, percentage given a fluid made from oral rehydration salt (ORS) packets, percentage given zinc, percentage given ORS and zinc, and percentage given ORS, zinc, and continued feeding, according to background characteristics, Timor-Leste DHS 2025–26

	Children with symptoms of ARI[1]		Children with fever		Children with diarrhea					
Background characteristic	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Percentage given fluid from ORS packet	Percentage given zinc	Percentage given ORS and zinc	Percentage given ORS, zinc, and continued feeding[3]	Number of children
Age in months										
<6	*	2	50.5	72	(48.4)	(32.9)	(35.7)	(23.6)	(15.0)	38
6–11	*	13	69.9	191	68.7	61.3	56.4	51.1	35.6	97
12–23	*	26	66.4	356	62.8	60.4	52.9	43.1	29.5	269
24–35	*	16	65.0	272	61.7	51.7	44.4	32.7	21.4	204
36–47	*	10	60.5	247	55.8	56.2	44.3	36.0	27.9	160
48–59	*	11	67.2	204	68.8	63.6	53.1	42.6	26.6	101
Sex										
Male	(70.3)	39	62.7	707	61.7	53.3	48.5	37.3	26.9	471
Female	(81.4)	38	67.1	635	62.3	61.1	49.6	41.8	27.2	397
Residence										
Urban	*	30	62.2	394	63.1	64.4	55.7	46.8	30.7	242
Rural	(70.7)	48	65.9	949	61.5	53.9	46.4	36.4	25.6	626
Municipality										
Aileu	*	0	76.5	50	(77.6)	(91.7)	(19.9)	(19.9)	(3.2)	25
Ainaro	*	4	59.4	65	58.8	44.7	37.4	31.5	18.2	40
Atauro	*	0	(58.7)	6	*	*	*	*	*	3
Baucau	*	4	52.3	78	(43.9)	(28.2)	(24.9)	(19.2)	(15.8)	61
Bobonaro	*	4	66.7	103	68.6	49.6	52.2	34.7	29.4	67
Covalima	*	5	82.9	71	74.8	59.5	55.8	39.0	35.1	61
Dili	*	29	62.2	358	59.9	60.0	54.0	44.3	27.5	225
Ermera	*	11	61.7	226	56.3	56.1	45.1	36.5	25.2	156
Lautem	*	1	50.5	89	54.3	52.9	37.4	32.7	27.9	79
Liquica	*	9	69.2	99	75.7	61.4	68.1	51.4	33.3	61
Manatuto	*	0	77.2	40	*	*	*	*	*	11
Manufahi	*	3	72.2	42	(78.9)	(74.4)	(77.8)	(67.8)	(32.3)	32
Oecusse	*	3	80.8	58	*	*	*	*	*	22
Viqueque	*	4	65.0	57	(64.1)	(59.0)	(62.9)	(51.3)	(39.8)	24
Mother's education										
No education	*	10	61.9	186	62.8	55.2	48.9	36.6	28.7	126
Primary	*	9	67.8	188	70.5	61.7	51.2	43.5	29.5	101
Secondary	(76.3)	49	63.8	770	61.5	55.8	46.4	38.2	25.4	530
More than secondary	*	10	68.6	199	55.7	59.5	59.6	44.1	30.3	111

Continued…

Table 11—*Continued*

Background characteristic	Children with symptoms of ARI[1]		Children with fever		Children with diarrhea					
	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Percentage given fluid from ORS packet	Percentage given zinc	Percentage given ORS and zinc	Percentage given ORS, zinc, and continued feeding[3]	Number of children
Wealth quintile										
Lowest	*	11	59.9	285	57.5	49.8	42.8	32.3	18.8	199
Second	*	13	73.4	287	63.2	54.4	46.0	34.6	26.1	204
Middle	*	26	64.2	275	61.5	62.9	50.6	44.8	29.4	154
Fourth	*	10	61.5	260	67.1	56.8	48.1	39.4	30.0	165
Highest	*	17	64.6	235	61.2	63.5	60.8	49.6	33.4	147
Total	75.8	77	64.8	1,343	62.0	56.9	49.0	39.3	27.0	868

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Symptoms of ARI include short, rapid breathing that is chest-related and/or difficult breathing that is chest-related.
[2] Includes advice or treatment from the following sources: public sector, private medical sector, nongovernmental organization (NGO) medical sector, shop, and market. Excludes advice or treatment from a traditional practitioner.
[3] Continued feeding includes children who were given more, the same as usual, or somewhat less food during the diarrhea episode.

3.11 CHILD NUTRITIONAL STATUS

Anthropometry is commonly used to measure child nutritional status. Anthropometric measurements are used to report on child growth indicators. The distribution of height and weight for children under age 5 was compared with the WHO Child Growth Standards reference population (WHO 2006b). The distribution of a well-nourished population will be similar to that of the reference population, while the distribution of a poorly nourished population will not. The indices height-for-age, weight-for-height, and weight-for-age can be expressed in standard deviation units (*z* scores) from the median of the reference population. Values that are greater than two standard deviations below the median of the WHO Child Growth Standards are used to define malnutrition.

Stunting (assessed via height-for-age)

Height-for-age is a measure of growth faltering. Children whose height-for-age *z* score is below minus two standard deviations (−2 SD) from the median of the reference population are considered short for their age (stunted). Children whose *z* score is below minus three standard deviations (−3 SD) from the median are considered severely stunted.

Sample: Children under age 5

Wasting (assessed via weight-for-height)

The weight-for-height index measures body mass in relation to body height or length and describes acute undernutrition. Children whose weight-for-height *z* score is below minus two standard deviations (−2 SD) from the median of the reference population are considered thin (wasted). Children whose *z* score is below minus three standard deviations (−3 SD) from the median are considered severely wasted.

Sample: Children under age 5

Underweight (assessed via weight-for-age)

Weight-for-age is a composite index of height-for-age and weight-for-height that takes into account both wasting and stunting. Children whose weight-for-age *z* score is below minus two standard deviations (−2 SD) from the median of the reference population are classified as underweight. Children whose *z* score is below minus three standard deviations (−3 SD) from the median are considered severely underweight.

Sample: Children under age 5

Overweight (assessed via weight-for-height)

Children whose weight-for-height *z* score is more than two standard deviations (+2 SD) above the median of the reference population are considered overweight.

Sample: Children under age 5

The 2025–26 TLDHS identified a total of 3,587 children under age 5 who were eligible for height and weight measurements. The percentages with valid data for height-for-age, weight-for-height, and weight-for-age were 94%, 95%, and 95%, respectively (data not shown).

- Overall, 45% of children under age 5 are stunted (short for their age), and 17% are severely stunted (**Table 12**).
- Nineteen percent of children under age 5 are wasted (thin for their height), 4% are severely wasted, and 2% are overweight.
- Forty-one percent of children under age 5 are underweight (small for their age), and 12% are severely underweight.

Table 12 Nutritional status of children

Percentage of children under age 5 classified as malnourished according to three anthropometric indices of child growth: height-for-age, weight-for-height, and weight-for-age, according to background characteristics, Timor-Leste DHS 2025–26

	Height-for-age[1]				Weight-for-height					Weight-for-age			
Background characteristic	Percent-age below −3 SD	Percent-age below −2 SD[2]	Mean *z* score (SD)	Number of children	Percent-age below −3 SD	Percent-age below −2 SD[2]	Percent-age above +2 SD	Mean *z* score (SD)	Number of children	Percent-age below −3 SD	Percent-age below −2 SD[2]	Mean *z* score (SD)	Number of children
Age in months													
<6	7.9	18.6	−0.9	339	6.2	16.8	8.8	−0.5	337	6.2	18.4	−1.0	349
6–11	7.0	21.6	−0.9	369	3.8	19.3	1.5	−1.0	370	7.4	29.3	−1.4	375
12–23	17.0	49.0	−1.9	711	5.1	20.6	0.6	−1.2	710	12.3	43.3	−1.8	716
24–35	24.4	55.5	−2.1	634	4.5	16.1	1.1	−1.0	639	14.3	44.7	−1.9	641
36–47	20.6	53.0	−2.0	724	3.5	18.7	0.2	−1.1	727	13.4	48.3	−1.9	726
48–59	13.7	47.8	−1.9	684	3.8	18.6	1.7	−1.2	687	11.4	47.4	−2.0	690
0–23	12.2	34.6	−1.4	1,418	5.0	19.3	2.8	−1.0	1,418	9.5	33.6	−1.5	1,440
24–59	19.5	52.0	−2.0	2,042	3.9	17.9	1.0	−1.1	2,053	13.0	46.9	−1.9	2,058
Sex													
Male	19.1	47.8	−1.8	1,799	4.6	20.3	1.7	−1.1	1,802	13.5	43.8	−1.8	1,815
Female	13.7	41.8	−1.6	1,662	4.1	16.5	1.7	−1.0	1,669	9.5	38.8	−1.7	1,683
Mother's interview status													
Interviewed	16.1	44.8	−1.7	3,159	4.4	18.7	1.8	−1.0	3,151	11.8	41.1	−1.7	3,191
Not interviewed but in household	20.9	46.8	−1.9	82	6.1	18.2	1.1	−1.0	80	12.7	51.2	−1.9	83
Not interviewed, not in household[3]	20.8	45.7	−1.8	219	3.6	15.2	1.2	−1.0	240	8.2	42.1	−1.7	224
Residence													
Urban	11.5	36.7	−1.5	850	4.1	18.5	1.8	−1.0	850	10.2	35.2	−1.5	852
Rural	18.1	47.6	−1.8	2,611	4.4	18.5	1.7	−1.1	2,621	12.0	43.4	−1.8	2,645

Continued…

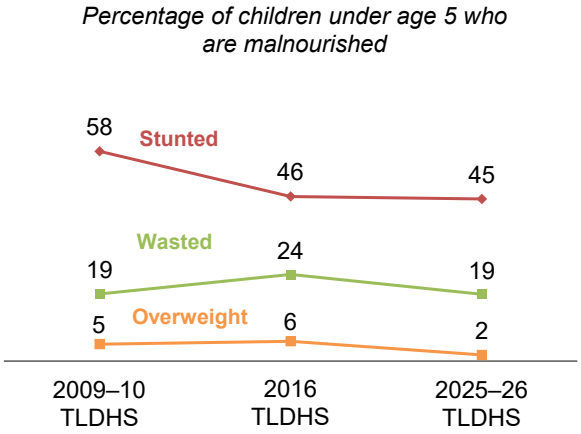
Table 12—*Continued*

Background characteristic	Height-for-age[1]				Weight-for-height					Weight-for-age			
	Percent-age below −3 SD	Percent-age below −2 SD[2]	Mean *z* score (SD)	Number of children	Percent-age below −3 SD	Percent-age below −2 SD[2]	Percent-age above +2 SD	Mean *z* score (SD)	Number of children	Percent-age below −3 SD	Percent-age below −2 SD[2]	Mean *z* score (SD)	Number of children
Municipality													
Aileu	15.2	46.1	−1.7	171	5.3	17.0	0.4	−1.0	172	7.7	34.8	−1.6	173
Ainaro	24.2	52.3	−1.8	152	11.4	25.8	2.3	−1.2	149	15.0	51.7	−1.9	156
Atauro	29.9	52.2	−1.9	21	19.8	41.5	0.8	−1.8	21	27.7	63.4	−2.4	22
Baucau	16.1	42.8	−1.8	361	1.1	14.1	1.0	−0.9	367	9.6	37.3	−1.7	365
Bobonaro	14.4	49.5	−1.8	282	7.1	24.7	3.5	−1.2	279	14.4	50.5	−1.9	290
Covalima	13.0	39.4	−1.6	204	1.9	26.0	0.7	−1.3	206	9.3	47.2	−1.8	205
Dili	10.8	34.9	−1.4	740	4.3	18.8	1.5	−1.1	742	10.7	34.8	−1.6	742
Ermera	30.2	57.4	−2.1	452	4.2	14.2	2.4	−0.8	448	15.0	45.1	−1.8	458
Lautem	6.6	36.9	−1.6	207	4.9	20.1	1.3	−1.1	206	8.3	35.8	−1.7	207
Liquica	14.6	46.6	−1.8	217	2.8	14.7	0.6	−1.0	227	9.8	42.5	−1.7	220
Manatuto	13.2	34.9	−1.5	114	1.7	14.4	1.4	−1.0	113	4.1	34.4	−1.5	116
Manufahi	12.7	37.1	−1.5	136	3.9	13.1	2.8	−0.8	138	3.7	28.1	−1.4	136
Oecusse	25.9	56.9	−2.2	196	6.3	24.5	2.8	−1.3	196	20.9	55.5	−2.2	197
Viqueque	15.8	54.7	−2.0	206	2.9	14.3	2.0	−1.1	208	13.6	45.0	−1.9	211
Mother's education[4]													
No education	25.9	57.6	−2.0	487	5.8	21.6	1.4	−1.1	482	17.4	51.8	−2.0	494
Primary	21.0	48.7	−1.9	413	4.4	18.2	0.8	−1.1	409	11.8	48.0	−1.9	418
Secondary	14.4	43.5	−1.7	1,838	4.0	18.3	2.1	−1.0	1,837	11.0	39.5	−1.7	1,857
More than secondary	9.7	34.4	−1.5	503	4.6	17.7	1.6	−0.9	502	9.3	32.5	−1.5	504
Wealth quintile													
Lowest	25.0	56.5	−2.0	764	5.8	21.6	1.6	−1.1	765	16.3	53.2	−2.0	779
Second	19.5	49.2	−1.9	748	4.9	19.9	2.1	−1.1	754	14.0	44.3	−1.8	758
Middle	15.2	45.0	−1.8	748	3.1	15.1	1.3	−1.0	753	8.7	38.5	−1.7	756
Fourth	10.3	37.0	−1.5	637	2.5	16.1	1.7	−1.0	633	6.7	35.8	−1.6	637
Highest	9.9	32.3	−1.4	563	5.3	19.4	2.0	−1.0	566	11.3	31.7	−1.5	568
Total	16.5	44.9	−1.7	3,461	4.4	18.5	1.7	−1.0	3,471	11.6	41.4	−1.7	3,498

Note: Each of the indices is expressed in standard deviation units (SD) from the median of the WHO Child Growth Standards.
[1] Recumbent length is measured for children under age 2; standing height is measured for all other children.
[2] Includes children who are below −3 SD from the WHO Child Growth Standards population median
[3] Includes children whose mothers are deceased
[4] For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.

Trends: The percentage of children under age 5 who are stunted decreased from 58% in 2009–10 to 46% in 2016 and has since remained stable (**Figure 6**). After increasing from 19% in 2009–10 to 24% in 2016, the percentage of children who are wasted dropped to 19% in 2025–26. The percentage of children who are overweight has declined slightly over time, from 6% in 2016 to 2% in 2025–26.

Figure 6 **Trends in nutritional status of children**



3.12 INFANT AND YOUNG CHILD FEEDING

Optimal infant and young child feeding (IYCF) practices are critical to the health and survival of young children. Recommended IYCF practices include early initiation of breastfeeding (within the first hour of life), exclusive breastfeeding for the first 6 months of life, and feeding children a diet that meets a minimum diversity standard (WHO and UNICEF 2021).

Early initiation of breastfeeding

Percentage of children born in the last 2 years who were put to the breast within 1 hour of birth.

Sample: Children born in the last 2 years

Exclusive breastfeeding under 6 months

Percentage of children age 0–5 months who were fed exclusively with breast milk during the previous day.

Sample: Youngest children age 0–5 months living with their mother

Minimum dietary diversity

Percentage of children age 6–23 months who were fed a minimum of five out of eight defined food groups during the previous day. The eight food groups are as follows: breast milk; grains, roots, and tubers; legumes and nuts; dairy products (milk, yogurt, and cheese); flesh foods (meat, fish, poultry, and organ meat); eggs; vitamin A-rich fruits and vegetables; and other fruits and vegetables.

Sample: Youngest children age 6–23 months living with their mother

Key IYCF indicators are presented in **Table 13**.

- Fifty-nine percent of children born in the last 2 years were breastfed within 1 hour of birth.
- Fifty-five percent of children under age 6 months are exclusively breastfed.
- Nineteen percent of children age 6–23 months are fed with a minimum dietary diversity.

Table 13 Infant and young child feeding (IYCF) indicators

Percentage of children fed according to various IYCF practices, Timor-Leste DHS 2025–26

Indicator	Indicator numerator and denominator	Value
Early initiation of breastfeeding[1]	Percentage of children born in the last 2 years who were put to the breast within 1 hour of birth	59.4
	Number of children born in the last 2 years	2,632
Exclusive breastfeeding under 6 months	Percentage of children age 0–5 months who were fed exclusively with breast milk during the previous day	54.8
	Number of youngest children age 0–5 months living with their mother	619
Minimum dietary diversity 6–23 months	Percentage of children age 6–23 months who were fed foods and beverages from at least 5 out of 8 defined food groups during the previous day	19.1
	Number of youngest children age 6–23 months living with their mother	1,829
Sweet beverage consumption 6–23 months	Percentage of children age 6–23 months who were given a sweet beverage during the previous day	19.4
	Number of youngest children age 6–23 months living with their mother	1,829
Unhealthy food consumption 6–23 months	Percentage of children age 6–23 months fed unhealthy foods during the previous day	27.7
	Number of youngest children age 6–23 months living with their mother	1,829

[1] Includes children born in the 2 years preceding the survey regardless of whether the children were living or dead at the time of the interview

Unhealthy infant and young child feeding practices should be avoided because they can promote unhealthy weight gain and replace nutritious foods that provide important nutrients for children. For infants and young children, consumption of sweet foods and beverages increases the risk of dental caries and childhood obesity. The indicator definition below for unhealthy food consumption describes sentinel unhealthy foods, foods high in sugar, salt, or unhealthy fats that are commonly consumed by infants and young children (WHO and UNICEF 2021).

Sweet beverage consumption

Percentage of children age 6–23 months who were given a sweet beverage during the previous day.

Unhealthy food consumption

Percentage of children age 6–23 months who were fed sentinel unhealthy foods during the previous day.

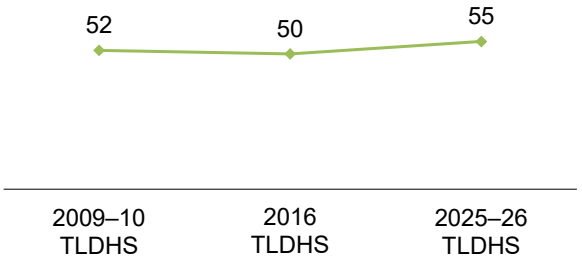
Sample: Youngest children age 6–23 months living with their mother

- Nineteen percent of children age 6–23 months were fed a sweet beverage during the previous day.
- Twenty-eight percent of children age 6–23 months consumed unhealthy foods during the previous day.

Trends: There has been little change over time in the percentage of children age 0–5 months who are exclusively breastfed (52% in 2009–10, 50% in 2016, and 55% in 2025–26) (**Figure 7**).

Figure 7 **Trends in exclusive breastfeeding**

Percentage of children age 0–5 months



3.13 ANEMIA IN WOMEN

Anemia in adults can cause fatigue, lethargy, reduced physical productivity, and poor work performance (Chaparro and Suchdev 2019). Anemia is a major concern among pregnant women because it can lead to increased maternal mortality and poor birth outcomes (Haider et al. 2013).

Anemia in women

	Hemoglobin level in grams/deciliter*			
	Nonpregnant women age 15–49	Pregnant women age 15–49		
Anemia status		First trimester	Second trimester	Third trimester
Anemic	<12.0	<11.0	<10.5	<11.0
Mildly anemic	11.0–11.9	10.0–10.9	9.5–10.4	10.0–10.9
Moderately anemic	8.0–10.9	7.0–9.9	7.0–9.4	7.0–9.9
Severely anemic	<8.0	<7.0	<7.0	<7.0
Not anemic	≥12.0	≥11.0	≥10.5	≥11.0

*Hemoglobin levels are adjusted for cigarette smoking and for altitude according to WHO 2024.

Sample: Women age 15–49

In 2024, WHO released new guidelines on the preferred blood source for measuring hemoglobin, the methodology for adjusting hemoglobin levels for altitude and cigarette smoking, and the hemoglobin cutoffs used to define anemia (WHO 2024). Under this new guidance, the cutoffs to define anemia among pregnant women have changed.

The results for women presented in this report use the new cutoffs to define anemia and have been adjusted for altitude and cigarette smoking according to the latest WHO guidelines. This survey used venous blood to measure hemoglobin as recommended in the new guidelines. It is not advisable to examine trends in anemia prevalence estimates derived using different blood testing methods, adjustment factors, or hemoglobin cutoffs. Therefore, trends from past TLDHS surveys are not presented.

- Overall, 30% of women age 15–49 are anemic; 20% are mildly anemic, 10% are moderately anemic, and 1% are severely anemic.
- Forty-two percent of pregnant women are anemic, with 25% mildly anemic, 15% moderately anemic, and 2% severely anemic.
- Mean hemoglobin levels are 12.3 g/dl among women overall and 11.0 g/dl among pregnant women.

Table 14 Prevalence of anemia in women

Percentage of women age 15–49 classified as having anemia, and mean hemoglobin level, according to background characteristics, Timor-Leste DHS 2025–26

Background characteristic		Anemia status by hemoglobin level				Mean hemoglobin level (g/dl)	Number of women
		Any	Mild	Moderate	Severe		
	Not pregnant	<12.0 g/dl	11.0–11.9 g/dl	8.0–10.9 g/dl	<8.0 g/dl		
	Pregnant trimester 1	<11.0 g/dl	10.0–10.9 g/dl	7.0–9.9 g/dl	<7.0 g/dl		
	Pregnant trimester 2	<10.5 g/dl	9.5–10.4 g/dl	7.0–9.4 g/dl	<7.0 g/dl		
	Pregnant trimester 3	<11.0 g/dl	10.0–10.9 g/dl	7.0–9.9 g/dl	<7.0 g/dl		
Age							
15–19		29.8	21.0	8.5	0.4	12.3	765
20–29		31.8	20.4	10.7	0.7	12.2	1,289
30–39		30.0	19.1	9.6	1.3	12.3	1,148
40–49		28.2	18.7	8.4	1.1	12.4	680
Number of children ever born							
0		30.2	22.4	7.4	0.4	12.3	1,500
1		33.6	18.2	14.0	1.5	12.0	450
2–3		28.1	16.2	10.5	1.4	12.3	905
4–5		28.9	18.5	9.4	1.0	12.4	652
6+		34.0	22.7	10.7	0.6	12.3	373
Maternity status							
Pregnant		41.7	25.3	14.6	1.8	11.0	212
Not pregnant[1]		29.6	19.5	9.3	0.8	12.4	3,669
Residence							
Urban		28.8	19.4	8.4	1.1	12.3	1,269
Rural		31.0	20.0	10.1	0.8	12.3	2,612
Municipality							
Aileu		36.7	28.1	8.6	0.1	12.3	168
Ainaro		29.8	22.4	7.0	0.4	12.3	191
Atauro		16.4	13.2	2.7	0.5	12.8	29
Baucau		35.1	20.2	13.3	1.7	12.1	332
Bobonaro		38.7	22.3	15.0	1.4	12.1	251
Covalima		25.4	17.6	7.6	0.2	12.5	246
Dili		29.7	19.9	8.8	1.0	12.3	1,103
Ermera		28.7	19.4	8.7	0.6	12.4	418
Lautem		24.8	16.9	7.4	0.4	12.5	206
Liquica		30.7	22.7	7.3	0.7	12.3	242
Manatuto		30.7	21.3	9.5	0.0	12.3	133
Manufahi		22.9	14.5	8.3	0.0	12.4	149
Oecusse		32.8	17.9	13.7	1.2	12.2	186
Viqueque		29.2	16.1	10.9	2.2	12.4	227
Education							
No education		36.3	24.4	10.6	1.3	12.2	453
Primary		31.9	17.6	13.7	0.6	12.3	401
Secondary		29.0	19.2	9.1	0.7	12.3	2,335
More than secondary		29.7	20.4	7.9	1.4	12.3	692

Continued…

Table 14—*Continued*

Background characteristic		Anemia status by hemoglobin level				Mean hemoglobin level (g/dl)	Number of women
		Any	Mild	Moderate	Severe		
	Not pregnant	<12.0 g/dl	11.0–11.9 g/dl	8.0–10.9 g/dl	<8.0 g/dl		
	Pregnant trimester 1	<11.0 g/dl	10.0–10.9 g/dl	7.0–9.9 g/dl	<7.0 g/dl		
	Pregnant trimester 2	<10.5 g/dl	9.5–10.4 g/dl	7.0–9.4 g/dl	<7.0 g/dl		
	Pregnant trimester 3	<11.0 g/dl	10.0–10.9 g/dl	7.0–9.9 g/dl	<7.0 g/dl		
Wealth quintile							
Lowest		36.8	23.0	13.1	0.8	12.2	649
Second		30.8	19.9	10.2	0.8	12.3	716
Middle		30.5	20.5	8.1	1.8	12.3	788
Fourth		26.8	17.4	9.0	0.4	12.4	830
Highest		28.1	19.1	8.3	0.7	12.4	898
Total		30.3	19.8	9.6	0.9	12.3	3,881

Note: Anemia classifications are based on cutoffs applied to hemoglobin levels that have been adjusted for altitude and cigarette smoking (WHO 2024). Hemoglobin is measured in grams per deciliter (g/dl) using the HemoCue 201+ device.
[1] Includes women who do not know if they are pregnant

3.14 MALARIA

3.14.1 Ownership and Use of Insecticide-treated Nets

Insecticide-treated nets (ITNs) repel and kill mosquitoes, thus providing protection against mosquito bites and reducing the transmission of malaria parasites. When high coverage of ITNs is achieved, ITNs help decrease malaria risk at the individual level as well as at the community level by reducing the vector population. The distribution and use of ITNs is one of the core interventions for preventing malaria infection in Timor-Leste.

Ownership of insecticide-treated nets

Households that have at least one insecticide-treated net (ITN). An ITN is a factory-treated net that does not require any further treatment.

Sample: Households

Full household ITN coverage

Percentage of households with at least one ITN for every two people.

Sample: Households (with at least one person who stayed in the household the night before the survey)

Table 15 presents information on household ownership of ITNs.

- Forty-two percent of households own at least one ITN.
- Twenty percent of households have full ITN coverage.

Table 15 Household possession of insecticide-treated nets

Percentage of households with at least one insecticide-treated net (ITN), average number of ITNs per household, and percentage of households with at least one ITN per two persons who stayed in the household last night, according to background characteristics, Timor-Leste DHS 2025–26

Background characteristic	Percentage of households with at least one ITN[1]	Average number of ITNs[1] per household	Number of households	Percentage of households with at least one ITN[1] for every two persons who stayed in the household last night[2]	Number of households with at least one person who stayed in the household last night
Residence					
Urban	32.2	0.6	3,398	12.3	3,397
Rural	46.2	1.0	8,861	22.5	8,853
Municipality					
Aileu	45.3	0.9	462	10.7	462
Ainaro	30.2	0.6	598	11.6	598
Atauro	53.4	1.2	106	34.9	104
Baucau	45.7	1.0	1,188	22.9	1,187
Bobonaro	52.8	1.2	972	28.1	972
Covalima	47.5	1.0	787	26.4	786
Dili	25.3	0.5	2,838	7.6	2,838
Ermera	36.0	0.7	1,270	14.3	1,270
Lautem	50.9	1.1	645	22.1	645
Liquica	35.9	0.7	735	12.3	732
Manatuto	47.1	1.0	438	22.4	438
Manufahi	36.0	0.7	545	17.9	545
Oecusse	77.9	1.6	848	45.4	848
Viqueque	58.0	1.4	827	35.2	826
Wealth quintile					
Lowest	43.8	0.8	2,821	20.5	2,819
Second	48.1	1.0	2,517	23.3	2,516
Middle	47.1	1.1	2,405	22.5	2,401
Fourth	43.1	1.0	2,321	19.2	2,321
Highest	27.6	0.6	2,195	11.8	2,194
Total	42.3	0.9	12,259	19.7	12,250

[1] An insecticide-treated net (ITN) is a factory-treated net that does not require any further treatment.
[2] De facto household members

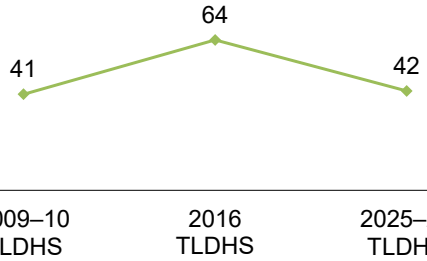
Trends: The percentage of households that own at least one ITN increased from 41% in 2009–10 to 64% in 2016 before decreasing to 42% in 2025–26 (**Figure 8**).

ITNs act as both a physical and a chemical barrier against mosquitoes. By reducing the vector population, ITNs can help reduce malaria risk at the community level as well as among individuals who use them. **Table 16** presents data on use of ITNs by children under age 5 and pregnant women.

- Forty percent of children under age 5 slept under an ITN the night before the survey.
- Thirty-eight percent of pregnant women age 15–49 slept under an ITN the night before the survey.

***Figure 8* Trends in household ownership of insecticide-treated nets**

Percentage of households owning at least one insecticide-treated net (ITN)



Note: An insecticide-treated net (ITN) is a factory-treated net that does not require any further treatment.

Table 16 Use of insecticide-treated nets by children and pregnant women

Percentage of children under age 5 who slept under an insecticide-treated net (ITN) the night before the survey; among children under age 5 in households with at least one ITN, percentage who slept under an ITN the night before the survey; percentage of pregnant women age 15–49 who slept under an ITN the night before the survey; and among pregnant women age 15–49 in households with at least one ITN, percentage who slept under an ITN the night before the survey, according to background characteristics, Timor-Leste DHS 2025–26

	Children under age 5 in all households		Children under age 5 in households with at least one ITN[1]		Pregnant women age 15–49 in all households		Pregnant women age 15–49 in households with at least one ITN[1]	
Background characteristic	Percentage who slept under an ITN[1] last night	Number of children	Percentage who slept under an ITN[1] last night	Number of children	Percentage who slept under an ITN[1] last night	Number of pregnant women	Percentage who slept under an ITN[1] last night	Number of pregnant women
Residence								
Urban	32.3	1,872	79.3	763	30.5	145	78.8	56
Rural	43.1	5,211	83.6	2,686	39.4	551	81.9	266
Municipality								
Aileu	48.5	316	85.2	180	(23.2)	24	*	9
Ainaro	33.5	333	87.0	128	(33.2)	28	*	11
Atauro	52.4	43	81.9	28	*	4	*	3
Baucau	41.8	736	81.8	377	38.8	72	(75.4)	37
Bobonaro	52.9	571	87.4	345	44.2	57	(83.4)	30
Covalima	36.4	384	77.5	180	(36.4)	41	(68.1)	22
Dili	25.8	1,591	76.4	538	20.0	129	*	36
Ermera	37.3	881	84.3	390	42.9	86	(92.7)	40
Lautem	39.7	415	76.2	216	39.4	45	(72.3)	24
Liquica	33.0	460	75.1	202	25.5	63	*	21
Manatuto	42.6	243	81.0	128	(40.8)	22	*	9
Manufahi	39.5	252	87.4	114	(37.0)	25	*	10
Oecusse	75.7	411	90.3	345	(68.9)	40	(92.5)	30
Viqueque	54.0	447	86.7	279	55.8	61	(88.5)	38
Wealth quintile								
Lowest	43.3	1,547	84.8	791	44.3	139	91.7	67
Second	44.5	1,531	85.6	795	43.6	134	86.7	67
Middle	44.5	1,412	83.9	749	41.4	167	79.9	86
Fourth	40.7	1,371	83.7	666	37.3	143	77.1	69
Highest	25.5	1,221	69.5	448	17.1	114	(61.2)	32
Total	40.2	7,082	82.6	3,449	37.6	696	81.3	322

Note: Table is based on children and pregnant women who stayed in the household the night before the interview. Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] An insecticide-treated net (ITN) is a factory-treated net that does not require any further treatment.

3.14.2 Case Management of Fever in Children

Care seeking for children under age 5 with a fever

Percentage of children under age 5 with a fever in the 2 weeks before the survey for whom advice or treatment was sought from a health provider, a health facility, or a pharmacy.

Sample: Children under age 5 with a fever in the 2 weeks before the survey

- Twenty-two percent of children under age 5 had a fever in the 2 weeks before the survey.
- Sixty-five percent of children who had a fever in the 2 weeks before the survey were taken for advice or treatment.

Table 17 Children with fever and treatment of fever

Percentage of children under age 5 with a fever in the 2 weeks preceding the survey, and among children under age 5 with fever, percentage for whom advice or treatment was sought, according to background characteristics, Timor-Leste DHS 2025–26

	Children under age 5		Children under age 5 with fever	
Background characteristic	Percentage with a fever in the 2 weeks preceding the survey	Number of children	Percentage for whom advice or treatment was sought[1]	Number of children
Residence				
Urban	22.8	1,729	62.2	394
Rural	21.3	4,449	65.9	949
Municipality				
Aileu	18.0	279	76.5	50
Ainaro	23.8	274	59.4	65
Atauro	15.2	37	(58.7)	6
Baucau	12.5	623	52.3	78
Bobonaro	21.0	491	66.7	103
Covalima	20.9	339	82.9	71
Dili	24.2	1,481	62.2	358
Ermera	30.0	756	61.7	226
Lautem	24.9	357	50.5	89
Liquica	25.4	391	69.2	99
Manatuto	19.2	210	77.2	40
Manufahi	19.6	216	72.2	42
Oecusse	16.5	353	80.8	58
Viqueque	15.3	371	65.0	57
Wealth quintile				
Lowest	21.4	1,337	59.9	285
Second	22.2	1,293	73.4	287
Middle	22.2	1,237	64.2	275
Fourth	21.0	1,239	61.5	260
Highest	21.9	1,072	64.6	235
Total	21.7	6,178	64.8	1,343

Note: Figures in parentheses are based on 25–49 unweighted cases.
[1] Includes advice or treatment from the following sources: public sector, private sector, nongovernmental organization (NGO) medical sector, shop, and market. Excludes advice or treatment from a traditional practitioner.

3.15 HIV

3.15.1 Prevention Knowledge among Young People

Knowledge about HIV prevention

Knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chances of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting two major misconceptions about HIV transmission: HIV can be transmitted by mosquito bites and a person can become infected by sharing food with a person who has HIV.

Sample: Women and men age 15–24

Knowledge of how HIV is transmitted is crucial in enabling people to avoid HIV infection, and this is especially true for young people, who are often at greater risk because they may have shorter relationships with more partners or engage in other risky behaviors.

- Overall, 6% of young women and 10% of young men age 15–24 have knowledge of HIV prevention (**Table 18**).
- Knowledge about HIV prevention is higher among both young women (14%) and young men (15%) who have more than a secondary education than among those with no education (2% and 6%, respectively).

Table 18 Knowledge about HIV prevention methods among young people

Percentage of young women and young men age 15–24 with knowledge about HIV prevention, according to background characteristics, Timor-Leste DHS 2025–26

Background characteristic	Women age 15–24		Men age 15–24	
	Percentage with knowledge about HIV prevention[1]	Number of women	Percentage with knowledge about HIV prevention[1]	Number of men
Age				
15–19	4.7	2,650	6.8	1,293
15–17	3.8	1,627	5.1	788
18–19	6.1	1,023	9.4	505
20–24	7.5	2,330	12.9	1,121
20–22	6.3	1,436	13.2	716
23–24	9.4	894	12.2	405
Marital status				
Never married	6.3	3,885	9.6	2,214
Ever had sex	8.7	203	13.6	964
Never had sex	6.2	3,682	6.4	1,250
Ever married	5.0	1,096	10.1	200
Residence				
Urban	7.7	1,934	9.8	839
Rural	4.9	3,047	9.5	1,575
Municipality				
Aileu	4.9	220	29.4	117
Ainaro	5.0	227	3.3	112
Atauro	0.8	27	6.9	11
Baucau	4.9	395	3.4	207
Bobonaro	4.8	308	13.0	151
Covalima	1.0	235	8.4	139
Dili	8.6	1,738	10.8	757
Ermera	2.9	451	11.7	212
Lautem	6.2	256	6.9	139
Liquica	8.5	285	13.3	149
Manatuto	10.6	145	17.8	78
Manufahi	5.0	173	4.3	91
Oecusse	0.6	294	0.5	117
Viqueque	5.0	227	0.0	134
Education				
No education	1.6	144	5.9	119
Primary	1.8	267	5.5	255
Secondary	5.1	3,891	9.9	1,853
More than secondary	14.0	679	14.7	187
Wealth quintile				
Lowest	2.1	745	5.3	376
Second	2.5	859	8.4	478
Middle	6.1	992	8.6	499
Fourth	8.4	1,125	10.8	534
Highest	8.6	1,260	13.5	526
Total	6.0	4,981	9.6	2,414

[1] Knowledge about HIV prevention means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting two common misconceptions about transmission or prevention of HIV: HIV can be transmitted by mosquito bites and a person can become infected by sharing food with a person who has HIV.

3.15.2 Sexual Behavior

Information on sexual behavior is important in designing and monitoring intervention programs to control the spread of HIV.

- Less than 1% of women and 10% of men age 15–49 reported having two or more sexual partners during the 12 months prior to the survey (**Table 19.1** and **Table 19.2**).

- Three percent of women and 26% of men reported having sexual intercourse with a person who neither was their spouse nor lived with them. Among these respondents, 30% of men reported using a condom during their most recent sexual intercourse with such a partner (data are not shown for women because there was only one case).

- Among women who have ever had sexual intercourse, the mean number of lifetime sexual partners is 1.2; among men, the mean is 4.0.

Table 19.1 Multiple sexual partners and higher-risk sexual intercourse in the last 12 months: Women

Among all women age 15–49, percentage who had sexual intercourse with more than one sexual partner in the last 12 months and percentage who had intercourse in the last 12 months with a person who neither was their husband nor lived with them; among women who had sexual intercourse in the last 12 months with a person who neither was their husband nor lived with them, percentage who used a condom during last sexual intercourse with such a partner; and among women who ever had sexual intercourse, mean number of sexual partners during their lifetime, according to background characteristics, Timor-Leste DHS 2025–26

	All women			Women who had intercourse in the last 12 months with a person who neither was their husband nor lived with them		Women who ever had sexual intercourse[1]	
Background characteristic	Percentage who had 2+ partners in the last 12 months	Percentage who had inter-course in the last 12 months with a person who neither was their husband nor lived with them	Number of women	Percentage who reported using a condom during last sexual intercourse with such a partner	Number of women	Mean number of sexual partners in lifetime	Number of women
Age							
15–24	0.1	3.0	4,981	20.9	147	1.5	1,288
15–19	0.1	1.8	2,650	(9.3)	48	2.5	262
20–24	0.0	4.3	2,330	26.5	99	1.2	1,026
25–29	0.3	4.7	1,970	27.3	92	1.1	1,487
30–39	0.1	1.7	3,662	(5.0)	64	1.2	3,478
40–49	0.1	0.7	2,348	*	17	1.1	2,262
Marital status							
Never married	0.1	5.6	4,864	20.4	274	2.6	440
Married/living together	0.1	0.4	7,737	(7.3)	31	1.1	7,716
Divorced/separated/ widowed	0.2	4.3	359	*	16	1.1	359
Residence							
Urban	0.2	4.4	4,612	22.5	204	1.2	2,687
Rural	0.1	1.4	8,349	11.4	116	1.2	5,828
Municipality							
Aileu	0.1	3.6	550	(9.7)	20	1.1	372
Ainaro	0.0	1.3	586	*	8	1.1	379
Atauro	0.4	1.1	83	*	1	1.1	57
Baucau	0.1	0.2	1,119	*	3	1.1	789
Bobonaro	0.5	3.0	870	(6.5)	26	1.2	611
Covalima	0.1	0.8	706	*	6	1.1	512
Dili	0.2	5.3	4,102	23.2	219	1.5	2,355
Ermera	0.0	0.1	1,219	*	1	1.0	812
Lautem	0.3	0.4	646	*	3	1.1	421
Liquica	0.0	2.1	777	*	17	1.0	564
Manatuto	0.0	1.3	407	*	5	1.1	293
Manufahi	0.0	0.5	460	*	2	1.1	311
Oecusse	0.0	0.5	748	*	4	1.3	528
Viqueque	0.1	0.8	687	*	6	1.0	513
Education							
No education	0.1	0.7	1,531	*	11	1.1	1,379
Primary	0.1	0.3	1,289	*	5	1.1	1,080
Secondary	0.2	2.2	7,850	11.0	170	1.3	4,660
More than secondary	0.0	5.9	2,290	30.1	134	1.1	1,396
Wealth quintile							
Lowest	0.2	1.0	2,155	(0.0)	22	1.1	1,573
Second	0.0	1.1	2,320	(11.0)	25	1.2	1,624
Middle	0.2	2.4	2,572	17.3	61	1.3	1,733
Fourth	0.2	2.8	2,809	14.6	78	1.3	1,805
Highest	0.0	4.3	3,105	25.6	135	1.1	1,780
Total	0.1	2.5	12,961	18.5	320	1.2	8,515

Note: Information on women with 2+ partners in the last 12 months who reported using a condom during last sexual intercourse is not presented because there was only one such case. Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

[1] Means are calculated excluding respondents who gave non-numeric responses.

Table 19.2 Multiple sexual partners and higher-risk sexual intercourse in the last 12 months: Men

Among all men age 15–49, percentage who had sexual intercourse with more than one sexual partner in the last 12 months and percentage who had intercourse in the last 12 months with a person who neither was their wife nor lived with them; among men having more than one partner in the last 12 months, percentage reporting that a condom was used during last intercourse; among men who had sexual intercourse in the last 12 months with a person who neither was their wife nor lived with them, percentage who used a condom during last sexual intercourse with such a partner; and among men who ever had sexual intercourse, mean number of sexual partners during their lifetime, according to background characteristics, Timor-Leste DHS 2025–26

	All men			Men who had 2+ partners in the last 12 months		Men who had intercourse in the last 12 months with a person who neither was their wife nor lived with them		Men who ever had sexual intercourse[1]	
Background characteristic	Percentage who had 2+ partners in the last 12 months	Percentage who had intercourse in the last 12 months with a person who neither was their wife nor lived with them	Number of men	Percentage who reported using a condom during last sexual intercourse	Number of men	Percentage who reported using a condom during last sexual intercourse with such a partner	Number of men	Mean number of sexual partners in lifetime	Number of men
Age									
15–24	10.4	33.9	2,414	23.4	251	24.4	818	3.9	1,130
15–19	5.5	20.7	1,293	22.5	72	22.7	268	2.7	326
20–24	16.0	49.0	1,121	23.7	179	25.3	550	4.3	804
25–29	13.6	39.9	838	31.0	114	32.1	334	4.1	747
30–39	9.5	18.7	1,465	24.2	139	39.5	274	4.4	1,355
40–49	5.6	8.0	1,167	15.5	65	35.4	93	3.5	1,084
Marital status									
Never married	13.1	43.8	2,973	31.7	390	26.9	1,303	3.9	1,562
Married/living together	5.8	6.4	2,849	6.1	166	50.6	183	3.9	2,697
Divorced/separated/ widowed	20.8	52.0	63	*	13	(13.1)	33	8.7	57
Type of union									
In polygynous union	(20.8)	(18.7)	48	*	10	*	9	(4.3)	47
Not in polygynous union	5.6	6.2	2,801	6.1	156	51.1	174	3.9	2,650
Not currently in union	13.3	44.0	3,035	31.6	403	26.6	1,336	4.1	1,619
Residence									
Urban	13.7	34.6	1,951	27.6	267	36.6	676	4.7	1,444
Rural	7.7	21.4	3,933	21.2	302	23.8	843	3.6	2,872
Municipality									
Aileu	6.1	20.6	279	(71.8)	17	50.6	57	2.9	223
Ainaro	7.0	30.4	273	(1.9)	19	20.3	83	2.0	209
Atauro	1.3	3.9	33	*	0	*	1	1.7	18
Baucau	4.5	16.5	511	*	23	24.4	84	2.5	370
Bobonaro	7.5	23.0	384	(16.4)	29	16.7	88	3.0	267
Covalima	4.3	11.5	342	*	15	(13.8)	39	4.4	224
Dili	14.2	37.3	1,761	27.8	250	35.7	656	4.6	1,328
Ermera	14.2	31.2	550	8.3	78	13.5	172	3.9	457
Lautem	8.1	16.2	286	(38.7)	23	32.6	46	4.2	185
Liquica	7.4	20.4	381	(27.1)	28	21.8	78	2.9	289
Manatuto	18.4	31.8	193	36.5	36	46.7	61	4.0	151
Manufahi	9.2	26.2	234	(9.8)	22	12.7	61	2.6	160
Oecusse	3.9	13.0	318	*	12	(35.3)	41	2.6	208
Viqueque	5.2	14.3	338	*	17	42.1	48	10.0	227
Education									
No education	4.9	12.1	617	(22.5)	30	24.9	75	3.4	503
Primary	5.8	16.4	822	19.5	47	25.7	135	3.5	635
Secondary	9.9	28.6	3,491	22.4	346	27.3	998	4.2	2,349
More than secondary	15.3	32.6	955	30.3	146	39.1	311	4.2	829
Wealth quintile									
Lowest	4.7	15.8	990	(5.6)	46	16.6	156	3.2	716
Second	8.1	23.1	1,122	17.5	90	20.9	259	3.3	804
Middle	8.0	22.6	1,238	20.3	99	24.2	280	4.2	908
Fourth	11.7	28.7	1,245	25.4	146	34.6	357	4.9	891
Highest	14.6	36.2	1,290	33.1	188	37.8	468	4.0	997
Total 15–49	9.7	25.8	5,885	24.2	569	29.5	1,519	4.0	4,316
50–59	4.3	5.7	994	(25.4)	43	43.6	57	3.3	936
Total 15–59	8.9	22.9	6,879	24.3	612	30.0	1,575	3.9	5,251

Note: Figures in parentheses are based on 25–49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

[1] Means are calculated excluding respondents who gave non-numeric responses.

3.15.3 Prior HIV Testing

HIV testing programs diagnose people living with HIV so that they can be linked to care and access antiretroviral therapy (ART). Knowledge of HIV status helps HIV-negative individuals reduce risk and remain negative.

- Five percent of women and 3% of men age 15–49 have ever been tested for HIV and received the results; 2% of women and less than 1% of men have been tested and did not receive the results (**Table 20.1** and **Table 20.2**).
- Ninety-four percent of women and 97% of men have never been tested for HIV.
- One percent each of women and men were tested for HIV in the last 12 months and received the results of the most recent test.

Table 20.1 Coverage of prior HIV testing: Women

Percent distribution of women age 15–49 by HIV testing status and by whether they received the results of the last test, percentage of women ever tested, and percentage of women who were tested in the last 12 months and received the results of the last test, according to background characteristics, Timor-Leste DHS 2025–26

Background characteristic	Percent distribution of women by testing status and by whether they received the results of the last test			Total	Percentage ever tested	Percentage who have been tested for HIV in the last 12 months and received the results of the last test	Number of women
	Ever tested and received results	Ever tested, did not receive results	Never tested[1]				
Age							
15–24	1.9	1.1	97.0	100.0	3.0	0.7	4,981
15–19	0.6	0.5	98.8	100.0	1.2	0.4	2,650
20–24	3.4	1.7	94.9	100.0	5.1	1.2	2,330
25–29	7.0	2.6	90.4	100.0	9.6	1.9	1,970
30–39	6.2	2.9	90.9	100.0	9.1	1.2	3,662
40–49	5.4	1.7	92.9	100.0	7.1	0.6	2,348
Marital status							
Never married	1.4	0.8	97.9	100.0	2.1	0.6	4,865
Ever had sex	2.2	3.9	93.9	100.0	6.1	1.0	449
Never had sex	1.3	0.5	98.3	100.0	1.7	0.6	4,415
Married or living together	6.5	2.7	90.8	100.0	9.2	1.3	7,737
Divorced/separated/ widowed	4.7	1.0	94.3	100.0	5.7	0.6	359
Residence							
Urban	6.4	1.3	92.3	100.0	7.7	1.5	4,612
Rural	3.5	2.3	94.2	100.0	5.8	0.8	8,349
Municipality							
Aileu	2.6	0.3	97.1	100.0	2.9	0.7	550
Ainaro	3.6	0.8	95.6	100.0	4.4	0.9	586
Atauro	1.2	0.9	97.9	100.0	2.1	0.1	83
Baucau	2.6	11.6	85.8	100.0	14.2	0.6	1,119
Bobonaro	2.1	2.5	95.5	100.0	4.5	0.3	870
Covalima	1.7	0.3	98.0	100.0	2.0	0.8	706
Dili	6.7	1.5	91.8	100.0	8.2	1.6	4,102
Ermera	0.8	0.9	98.4	100.0	1.6	0.2	1,219
Lautem	8.7	0.3	91.0	100.0	9.0	0.4	646
Liquica	6.8	0.8	92.4	100.0	7.6	2.0	777
Manatuto	5.7	0.8	93.5	100.0	6.5	2.2	407
Manufahi	5.8	0.2	94.0	100.0	6.0	1.2	460
Oecusse	0.8	0.6	98.6	100.0	1.4	0.1	748
Viqueque	6.1	0.3	93.6	100.0	6.4	1.6	687
Education							
No education	1.2	1.7	97.1	100.0	2.9	0.2	1,531
Primary	2.4	1.3	96.3	100.0	3.7	0.3	1,289
Secondary	3.8	1.8	94.4	100.0	5.6	0.8	7,850
More than secondary	10.6	2.8	86.6	100.0	13.4	3.0	2,290

Continued…

Table 20.1—*Continued*

Background characteristic	Percent distribution of women by testing status and by whether they received the results of the last test: Ever tested and received results	Ever tested, did not receive results	Never tested[1]	Total	Percentage ever tested	Percentage who have been tested for HIV in the last 12 months and received the results of the last test	Number of women
Wealth quintile							
Lowest	1.4	1.3	97.3	100.0	2.7	0.0	2,155
Second	2.4	2.1	95.5	100.0	4.5	0.5	2,320
Middle	4.0	1.9	94.2	100.0	5.8	0.9	2,572
Fourth	5.9	2.5	91.6	100.0	8.4	1.3	2,809
Highest	7.7	1.7	90.6	100.0	9.4	1.9	3,105
Total	4.5	1.9	93.5	100.0	6.5	1.0	12,961

[1] Includes respondents who have not heard of HIV or who refused to answer questions on testing

Table 20.2 Coverage of prior HIV testing: Men

Percent distribution of men age 15–49 by HIV testing status and by whether they received the results of the last test, percentage of men ever tested, and percentage of men who were tested in the last 12 months and received the results of the last test, according to background characteristics, Timor-Leste DHS 2025–26

Background characteristic	Percent distribution of men by testing status and by whether they received the results of the last test: Ever tested and received results	Ever tested, did not receive results	Never tested[1]	Total	Percentage ever tested	Percentage who have been tested for HIV in the last 12 months and received the results of the last test	Number of men
Age							
15–24	1.1	0.2	98.7	100.0	1.3	0.5	2,414
15–19	0.2	0.0	99.7	100.0	0.3	0.2	1,293
20–24	2.0	0.4	97.5	100.0	2.5	0.8	1,121
25–29	3.0	0.8	96.2	100.0	3.8	1.2	838
30–39	4.8	0.8	94.5	100.0	5.5	1.0	1,465
40–49	3.4	0.6	96.0	100.0	4.0	0.8	1,167
Marital status							
Never married	1.9	0.2	97.8	100.0	2.2	0.7	2,973
Ever had sex	3.3	0.4	96.3	100.0	3.7	1.1	1,612
Never had sex	0.4	0.0	99.6	100.0	0.4	0.3	1,360
Married or living together	3.5	0.8	95.7	100.0	4.3	0.8	2,849
Divorced/separated/ widowed	4.7	0.0	95.3	100.0	4.7	1.0	63
Residence							
Urban	3.8	0.5	95.7	100.0	4.3	1.0	1,951
Rural	2.2	0.5	97.3	100.0	2.7	0.7	3,933
Municipality							
Aileu	0.5	0.3	99.2	100.0	0.8	0.3	279
Ainaro	0.9	0.1	99.0	100.0	1.0	0.6	273
Atauro	1.0	0.3	98.6	100.0	1.4	0.0	33
Baucau	5.6	1.6	92.8	100.0	7.2	1.6	511
Bobonaro	3.4	0.1	96.4	100.0	3.6	1.2	384
Covalima	1.9	0.0	98.1	100.0	1.9	0.9	342
Dili	2.8	0.4	96.8	100.0	3.2	0.7	1,761
Ermera	2.5	0.2	97.3	100.0	2.7	0.2	550
Lautem	2.3	0.3	97.4	100.0	2.6	1.1	286
Liquica	2.9	1.7	95.4	100.0	4.6	1.1	381
Manatuto	2.1	0.0	97.9	100.0	2.1	0.3	193
Manufahi	1.2	0.0	98.8	100.0	1.2	0.6	234
Oecusse	5.2	1.1	93.7	100.0	6.3	0.9	318
Viqueque	1.1	0.5	98.4	100.0	1.6	0.0	338

Continued…

Table 20.2—*Continued*

Background characteristic	Percent distribution of men by testing status and by whether they received the results of the last test: Ever tested and received results	Ever tested, did not receive results	Never tested[1]	Total	Percent-age ever tested	Percent-age who have been tested for HIV in the last 12 months and received the results of the last test	Number of men
Education							
No education	1.0	0.4	98.7	100.0	1.3	0.4	617
Primary	1.5	0.5	98.0	100.0	2.0	0.3	822
Secondary	2.2	0.3	97.5	100.0	2.5	0.6	3,491
More than secondary	6.9	1.5	91.6	100.0	8.4	2.0	955
Wealth quintile							
Lowest	0.4	0.2	99.5	100.0	0.5	0.1	990
Second	1.3	0.3	98.4	100.0	1.6	0.5	1,122
Middle	3.0	0.5	96.5	100.0	3.5	0.6	1,238
Fourth	3.3	0.7	96.0	100.0	4.0	1.1	1,245
Highest	4.9	0.8	94.3	100.0	5.7	1.4	1,290
Total 15–49	2.7	0.5	96.8	100.0	3.2	0.8	5,885
50–59	2.7	0.1	97.2	100.0	2.8	0.7	994
Total 15–59	2.7	0.5	96.8	100.0	3.2	0.8	6,879

[1] Includes respondents who have not heard of HIV or who refused to answer questions on testing

3.16 CHILDHOOD DEVELOPMENT

3.16.1 Children's Living Arrangements and Parental Survival

Orphan
A child with one or both parents who are dead.
Sample: Children under age 18

- Three in four (75%) de jure children under age 18 live with both of their parents; 10% are not living with their biological parents. Six percent of children under age 18 are orphans, with one or both parents dead (**Table 21**).
- Orphanhood is highest among children age 15–17 (11%) and lowest among those under age 2 (2%).

Trends: The proportion of children under age 18 who do not live with a biological parent has remained the same since 2016 (10%), as has the proportion of children with one or both parents dead (6%).

Table 21 Children's living arrangements and orphanhood

Percent distribution of de jure children under age 18 by living arrangements and survival status of parents, percentage of children not living with a biological parent, and percentage of children with one or both parents dead, according to background characteristics, Timor-Leste DHS 2025–26

Background characteristic	Living with both parents	Living with mother but not with father		Living with father but not with mother		Not living with either parent					Total	Percentage not living with a biological parent	Percentage with one or both parents dead[1]	Number of children
		Father alive	Father dead	Mother alive	Mother dead	Both alive	Only mother alive	Only father alive	Both dead	Missing information on father/ mother				
Age														
0–4	78.4	13.1	1.4	0.9	0.2	5.0	0.2	0.2	0.2	0.4	100.0	5.6	2.1	7,029
<2	80.6	13.9	1.2	0.5	0.1	3.1	0.1	0.1	0.1	0.3	100.0	3.5	1.6	2,810
2–4	77.0	12.6	1.5	1.2	0.2	6.2	0.2	0.3	0.2	0.5	100.0	7.0	2.5	4,219
5–9	75.9	9.3	2.4	1.7	0.9	8.3	0.4	0.4	0.3	0.4	100.0	9.4	4.4	7,941
10–14	74.4	6.5	3.9	2.4	1.6	9.3	0.5	0.6	0.4	0.3	100.0	10.8	7.0	7,418
15–17	65.6	5.5	5.6	2.9	2.3	14.2	1.2	1.2	1.0	0.5	100.0	17.6	11.3	3,724
Sex														
Male	75.0	8.9	2.9	1.9	1.2	8.4	0.5	0.5	0.4	0.4	100.0	9.7	5.5	13,501
Female	74.4	9.1	3.2	1.8	1.0	8.7	0.5	0.5	0.4	0.4	100.0	10.1	5.6	12,611
Residence														
Urban	74.7	9.5	3.4	2.4	0.9	7.2	0.3	0.5	0.4	0.7	100.0	8.5	5.5	7,064
Rural	74.7	8.8	2.9	1.7	1.2	9.0	0.5	0.5	0.4	0.3	100.0	10.5	5.5	19,048
Municipality														
Aileu	79.3	6.4	2.4	1.1	0.7	8.2	0.4	0.9	0.2	0.5	100.0	9.6	4.5	1,196
Ainaro	74.1	7.5	3.5	2.8	0.8	8.4	0.6	0.3	1.7	0.3	100.0	11.1	6.9	1,364
Atauro	69.6	13.0	3.7	1.9	0.8	8.4	0.5	0.4	0.2	1.4	100.0	9.5	5.6	162
Baucau	64.7	13.6	2.1	1.9	0.6	15.8	0.4	0.7	0.1	0.2	100.0	16.9	3.9	2,660
Bobonaro	76.8	7.7	4.3	0.8	1.0	7.8	0.4	0.4	0.3	0.6	100.0	8.9	6.3	2,039
Covalima	77.5	7.4	4.3	0.3	0.9	6.7	0.9	0.4	1.0	0.7	100.0	9.0	7.5	1,468
Dili	76.5	8.6	3.6	2.2	1.0	6.2	0.4	0.5	0.4	0.6	100.0	7.5	5.9	5,750
Ermera	79.6	7.6	2.3	2.6	1.9	5.3	0.2	0.1	0.3	0.2	100.0	5.9	4.8	3,046
Lautem	65.9	16.1	2.9	2.6	1.0	10.3	0.7	0.2	0.2	0.2	100.0	11.4	5.1	1,601
Liquica	76.0	8.3	2.2	1.9	0.9	9.4	0.5	0.3	0.3	0.2	100.0	10.5	4.2	1,616
Manatuto	71.5	10.3	2.4	1.4	2.3	10.0	0.7	0.5	0.4	0.3	100.0	11.6	6.4	915
Manufahi	78.3	6.8	2.0	1.4	1.0	9.3	0.2	0.9	0.2	0.0	100.0	10.6	4.2	1,011
Oecusse	79.3	5.6	4.1	1.1	1.3	6.5	0.8	1.0	0.3	0.1	100.0	8.5	7.4	1,593
Viqueque	70.6	8.7	2.0	2.4	1.2	11.8	0.6	1.0	0.5	1.1	100.0	13.9	5.3	1,692
Wealth quintile														
Lowest	77.9	6.9	3.5	1.4	1.1	7.6	0.4	0.4	0.5	0.2	100.0	8.9	6.0	5,651
Second	75.4	7.7	3.0	1.7	1.3	8.8	0.6	0.7	0.4	0.5	100.0	10.5	6.0	5,403
Middle	74.0	9.0	3.1	2.2	1.1	8.7	0.6	0.6	0.4	0.3	100.0	10.3	5.7	5,204
Fourth	73.4	10.1	2.4	1.8	1.2	9.5	0.4	0.3	0.3	0.5	100.0	10.5	4.6	5,204
Highest	72.3	11.6	3.1	2.2	0.7	8.2	0.3	0.6	0.4	0.6	100.0	9.5	5.2	4,650
Total <15	76.2	9.6	2.6	1.7	0.9	7.6	0.4	0.4	0.3	0.4	100.0	8.7	4.6	22,388
Total <18	74.7	9.0	3.0	1.9	1.1	8.5	0.5	0.5	0.4	0.4	100.0	9.9	5.5	26,112

Note: Table is based on de jure members, i.e., usual residents.
[1] Includes children with father dead, mother dead, both dead, and one parent dead but missing information on survival status of the other parent

3.16.2 Birth Registration

Registered birth

Child has a birth certificate or child does not have a birth certificate, but the birth is registered with the civil authorities.

Sample: De jure children under age 5

Birth registration in Timor-Leste is conducted under the National Directorate of Civil Registration and Notary in the Ministry of Justice. Universal birth registration is recommended according to the National Action Plan for Children 2016–2020 (GDS, UNICEF, and UNFPA 2019).

- At the time of the survey, 61% of children under age 5 were registered with the civil authorities (38% of children under age 1 and 67% of children between age 1 and age 4). Thirty-five percent of children had birth certificates (**Table 22**).

Table 22 Birth registration of children under age 5

Percentage of de jure children under age 5 whose births are registered with the civil authorities, according to background characteristics, Timor-Leste DHS 2025–26

Background characteristic	Percentage of children whose births are registered and who: Had a birth certificate	Did not have birth certificate	Total percentage of children whose births are registered	Number of children
Age				
<1	11.2	26.8	38.0	1,344
1–4	40.0	26.8	66.8	5,685
Sex				
Male	34.0	26.5	60.5	3,664
Female	35.0	27.2	62.3	3,365
Residence				
Urban	42.7	21.2	63.9	1,866
Rural	31.5	28.9	60.4	5,163
Municipality				
Aileu	18.5	42.8	61.3	314
Ainaro	30.7	25.0	55.7	332
Atauro	52.0	30.4	82.4	43
Baucau	37.7	35.3	73.0	725
Bobonaro	32.8	18.9	51.7	569
Covalima	35.9	20.4	56.4	382
Dili	41.3	23.7	65.0	1,591
Ermera	35.0	15.3	50.2	875
Lautem	35.1	33.9	69.0	407
Liquica	30.3	41.3	71.6	461
Manatuto	36.5	22.2	58.7	240
Manufahi	22.7	51.4	74.1	250
Oecusse	24.5	28.8	53.3	404
Viqueque	36.0	17.3	53.3	437
Wealth quintile				
Lowest	26.7	28.7	55.4	1,537
Second	29.7	27.5	57.2	1,517
Middle	33.6	30.5	64.0	1,387
Fourth	36.9	25.7	62.6	1,381
Highest	48.8	20.7	69.5	1,207
Total	34.5	26.8	61.3	7,029

Trends: Birth registration of children under age 5 increased slightly from 55% in 2009–10 to 60% in 2016 and remained stable at 61% in 2025–26. The proportion of children with a birth certificate has not improved over time.

3.16.3 Child Discipline

Nonviolent disciplinary approaches

Include one or more of the following: (1) taking away privileges, forbidding something the child liked, or not allowing the child to leave the house; (2) explaining that the child's behavior was wrong; or (3) giving the child something else to do.

Sample: De jure children age 1–14

Psychological aggression

Includes one or both of the following: (1) shouting, yelling, or screaming at the child or (2) calling the child dumb, lazy, or a similar term.

Sample: De jure children age 1–14

Physical punishment

Includes one or more of the following: (1) shaking the child; (2) spanking, hitting, or slapping the child on the bottom with a bare hand; (3) hitting the child on the bottom or other part of the body with a belt, hairbrush, stick, or other similar hard object; or (4) hitting the child on the hand, arm, or leg.

Sample: De jure children age 1–14

Severe physical punishment

Includes one or both of the following: (1) hitting or slapping the child on the face, head, or ears or (2) beating the child up, that is, hitting the child over and over as hard as one can.

Sample: De jure children age 1–14

The way parents and caretakers discipline children can have long-term consequences for their physical and psychological development and well-being. The 2025–26 TLDHS Household Questionnaire included questions from the UNICEF Multiple Indicator Cluster Survey (MICS) module on how children in the household are usually disciplined. The questions were asked about one randomly selected child age 1–14 in each household in the subsample of households not included in the men's survey. The respondent to the Household Questionnaire (the household head or other household member) was asked a series of separate questions about disciplinary practices that may have been used with the child during the month before the survey.

Table 23 groups different forms of disciplinary practices into four subclasses.

- Eleven percent of children age 1–14 experienced only nonviolent discipline, 67% experienced psychological aggression, 53% experienced physical punishment, and 23% experienced severe physical punishment.
- Overall, 74% of children experienced at least one form of violent discipline.

Table 23 Child discipline

Percentage of de jure children age 1–14 by child disciplining methods experienced during the month preceding the survey, according to background characteristics, Timor-Leste DHS 2025–26

Background characteristic	Percentage of children age 1–14 who experienced:					Number of children age 1–14
	Only nonviolent discipline	Psychological aggression	Any physical punishment	Severe physical punishment[1]	Any violent discipline method	
Age						
1–2	16.8	50.1	35.5	12.0	56.4	652
3–4	10.9	65.7	54.3	19.9	74.7	569
5–9	9.2	70.7	59.1	25.9	77.0	1,519
10–14	10.6	72.2	53.7	25.0	77.6	1,497
Sex						
Male	10.7	69.3	54.6	23.6	75.5	2,224
Female	11.5	65.3	51.1	21.5	71.9	2,013
Residence						
Urban	10.9	67.2	49.7	19.5	73.1	1,183
Rural	11.2	67.5	54.2	23.8	74.0	3,053
Municipality						
Aileu	8.0	67.1	66.7	40.8	76.7	175
Ainaro	17.6	57.3	52.7	30.6	62.5	207
Atauro	8.8	46.2	39.1	13.8	52.6	29
Baucau	11.6	68.9	46.3	16.8	73.0	417
Bobonaro	21.0	53.0	53.0	13.6	70.7	340
Covalima	11.6	73.2	37.9	19.5	75.4	267
Dili	9.9	68.4	50.8	21.9	74.3	954
Ermera	7.7	72.2	62.5	28.0	76.6	468
Lautem	10.9	69.5	58.6	30.1	76.3	235
Liquica	5.2	79.5	58.8	26.5	81.4	274
Manatuto	9.0	70.5	60.3	20.8	79.0	151
Manufahi	9.3	71.5	61.5	19.3	75.7	173
Oecusse	14.7	58.0	33.8	8.6	63.3	275
Viqueque	9.3	67.0	60.5	29.4	76.0	270

Continued…

Table 23—*Continued*

Background characteristic	Percentage of children age 1–14 who experienced:					Number of children age 1–14
	Only nonviolent discipline	Psychological aggression	Any physical punishment	Severe physical punishment[1]	Any violent discipline method	
Mother's education						
No education	11.1	66.0	50.8	21.8	71.3	502
Primary	14.3	63.0	52.9	23.1	71.6	457
Secondary	11.1	68.2	53.5	23.3	74.3	2,580
More than secondary	8.6	68.3	52.9	19.6	74.7	652
Wealth quintile						
Lowest	10.2	64.9	54.4	23.6	72.5	901
Second	11.6	68.5	56.1	25.6	75.5	876
Middle	10.1	72.1	54.8	24.0	77.0	811
Fourth	13.2	66.5	51.9	21.3	72.7	885
Highest	10.1	65.1	46.8	18.0	71.0	763
Total	11.1	67.4	52.9	22.6	73.8	4,237

Note: Experience of child disciplining methods includes only disciplining experienced from adult members of the household; disciplining experienced from other people (e.g., family members not living in the household) is excluded.
[1] Includes one or both of the following: (1) hit or slapped the child on the face, head, or ears or (2) beat the child up, that is, hit the child over and over as hard as one could

3.16.4 Early Childhood Development Index 2030

Early childhood development is a multidimensional process that involves an ordered progression of motor, cognitive, language, socioemotional, and regulatory skills and capacities across the first few years of life (UNICEF 2016). While these are distinct domains of early childhood development, they are interconnected. Nurturing and supporting all of these dimensions in a holistic manner is key to ensuring that children have the best chance to reach their full potential. Physical growth, literacy and numeracy skills, socioemotional development, and learning readiness set the trajectory for lifelong health, learning, and well-being (Shonkoff and Philips 2000). In 2015, early childhood development became part of the Sustainable Development Goals (SDG indicator 4.2.1). These global goals include a commitment to ensure that, by the year 2030, all children will have equitable access to quality early childhood development and early learning opportunities.

Early Childhood Development Index 2030 (ECDI2030)

The ECDI2030 comprises 20 items organized according to the three general domains of health, learning, and psychosocial well-being. Each of the three general domains is composed of a set of core subdomains:

- Health subdomains: gross motor development, fine motor development, and self-care.
- Learning subdomains: expressive language, literacy, numeracy, prewriting, and executive functioning.
- Psychosocial well-being subdomains: emotional skills, social skills, internalizing behavior, and externalizing behavior.

The ECDI2030 module is not designed to report on individual domains separately. Rather, it is meant to produce a single summary score that captures the interlinked development concepts embedded in the three domains mentioned in SDG 4.2.1.

The 2025–26 TLDHS asked mothers 20 questions about the way their children behave in certain everyday situations and the skills and knowledge they have acquired. The Early Childhood Development Index 2030 (ECDI2030) captured the proportion of children age 24–59 months who are developmentally on track in health, learning, and psychosocial well-being.

Children developmentally on track according to the Early Childhood Development Index 2030 (ECDI2030)

Percentage of children who have achieved the minimum number of ECDI2030 milestones expected for their age group as follows:

- 24–29 months: at least 7 milestones
- 30–35 months: at least 9 milestones
- 36–41 months: at least 11 milestones
- 42–47 months: at least 13 milestones
- 48–59 months: at least 15 milestones

Sample: Children age 24–59 months living with their biological mother

According to the ECDI2030, 50% of children age 24–59 months living with their biological mother are on track in terms of health, learning, and psychosocial well-being (**Table 24**).

Table 24 Early Childhood Development Index 2030 (ECDI2030)

Percentage of children age 24–59 months who are developmentally on track in health, learning, and psychosocial well-being, Timor-Leste DHS 2025–26

Background characteristic	Early Childhood Development Index 2030[1]	Number of children age 24–59 months
Age in months		
24–35	55.6	554
36–47	47.5	542
48–59	45.1	544
Sex		
Male	46.6	844
Female	52.5	796
Residence		
Urban	57.9	462
Rural	46.2	1,178
Municipality		
Aileu	39.0	74
Ainaro	44.7	74
Atauro	68.3	10
Baucau	33.1	165
Bobonaro	58.7	120
Covalima	46.7	92
Dili	56.1	363
Ermera	51.1	210
Lautem	57.3	108
Liquica	51.3	104
Manatuto	56.2	56
Manufahi	55.6	57
Oecusse	40.4	98
Viqueque	41.8	109
Mother's education		
No education	46.0	278
Primary	38.2	213
Secondary	50.3	932
More than secondary	61.7	217
Wealth quintile		
Lowest	41.4	359
Second	46.7	376
Middle	49.4	291
Fourth	54.3	337
Highest	58.0	276
Total	49.5	1,640

[1] MICS indicator TC.53; SDG indicator 4.2.1

3.16.5 Child Functioning

Functional domains: children age 2–4

Seeing, hearing, walking, fine motor, communication, learning, playing, and controlling behavior.

Children age 2–4 with functional difficulties

Functional difficulty in the functional domains of seeing, hearing, walking, fine motor, communication, learning, playing, and controlling behavior is defined as responses of "a lot of difficulty" or "cannot do at all." For the functional domain of behavior control, "a lot more" is considered functional difficulty.

Sample: Children age 2–4 living with their biological mother

Functional domains: children age 5–17

Seeing, hearing, walking, self-care, communication, learning, remembering or concentrating, accepting change, controlling behavior, making friends, anxiety, and depression.

Children age 5–17 with functional difficulties

Functional difficulty in the functional domains of seeing, hearing, walking, self-care, communication, learning, remembering, concentrating, accepting change, controlling behavior, and making friends is defined as responses of "a lot of difficulty" or "cannot do at all." Functional difficulty in the functional domains of anxiety and depression is defined as a response of "daily."

Sample: Children age 5–17 living with their biological mother

The Convention on the Rights of the Child (UN 1989) and the Convention on the Rights of Persons with Disabilities promote equal rights for all children, recognizing the rights of children with disabilities. However, children with disabilities tend to face various types of discrimination in social and economic settings. Information on functional difficulties among children age 2–17 was collected in the 2025–26 TLDHS based on reports from mothers.

Table 25 shows that, overall, 10% of children age 2–17 have functional difficulty in at least one domain. Less than 1% of children age 2–4 have functional difficulty in at least one domain, as compared with 12% of children age 5–17.

Table 25 Child functioning: Children age 2–17

Percentage of children age 2–17 with functional difficulty in at least one domain, Timor-Leste DHS 2025–26

Background characteristic	Percentage of children age 2–4 with functional difficulty in at least one domain	Number of children age 2–4	Percentage of children age 5–17 with functional difficulty in at least one domain	Number of children age 5–17	Percentage of children age 2–17 with functional difficulty in at least one domain	Number of children age 2–17
Age						
2–4	0.3	1,560	na	na	0.3	1,560
5–9	na	na	12.6	2,704	12.6	2,704
10–14	na	na	11.6	2,069	11.6	2,069
15–17	na	na	12.8	802	12.8	802
Sex						
Male	0.4	795	12.8	2,851	10.1	3,646
Female	0.3	764	11.7	2,724	9.2	3,488
Residence						
Urban	0.6	405	14.1	1,416	11.1	1,821
Rural	0.3	1,154	11.6	4,159	9.1	5,314
Municipality						
Aileu	0.0	74	5.2	281	4.1	355
Ainaro	0.0	73	17.5	293	14.0	366
Atauro	0.0	10	16.1	38	12.7	48
Baucau	0.8	164	13.1	551	10.3	715
Bobonaro	0.0	114	5.4	428	4.2	542
Covalima	0.0	92	6.7	347	5.3	438
Dili	0.8	296	18.0	1,077	14.3	1,374
Ermera	0.0	210	6.1	673	4.7	883
Lautem	0.8	108	5.4	346	4.3	455
Liquica	0.0	104	16.7	352	12.9	456
Manatuto	0.0	56	8.4	216	6.7	272
Manufahi	0.0	57	16.6	235	13.4	292
Oecusse	0.0	97	23.1	389	18.5	486
Viqueque	0.9	104	9.6	349	7.6	453
Mother's education						
No education	0.8	274	11.9	1,300	10.0	1,575
Primary	1.1	206	13.5	915	11.3	1,120
Secondary	0.1	886	11.7	2,854	8.9	3,740
More than secondary	0.0	194	14.0	506	10.1	700
Wealth quintile						
Lowest	0.3	356	14.1	1,197	10.9	1,552
Second	0.0	370	10.7	1,214	8.2	1,584
Middle	0.5	283	11.4	1,117	9.2	1,400
Fourth	0.3	317	11.8	1,158	9.3	1,475
Highest	1.0	234	13.4	890	10.8	1,124
Total	0.3	1,560	12.2	5,575	9.6	7,135

Note: Functional difficulty for children age 2–4 is defined as responses of "a lot of difficulty" or "cannot do at all" for all domains with the exception of controlling behavior, for which the response "a lot more" is considered functional difficulty. Functional difficulty for children age 5–17 is defined as responses of "a lot of difficulty" or "cannot do at all" for all domains with the exception of anxiety and depression, for which the response "daily" is considered functional difficulty.
na = Not applicable

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