Gender Blind:

Rebuilding Health Systems in Conflict-Affected States - Timor-Leste

This case study on Timor-Leste is part of the *Building Back Better* research initiative undertaken by the Stockholm International Peace Research Institute (SIPRI) working group on gender and the ReBUILD consortium. The team conducted four case studies of countries affected by conflict - Mozambique, Timor-Leste, Sierra Leone and northern Uganda - to examine whether health system reconstruction has promoted equality and created a health system that is gender equitable.

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CONTEXT AND CONFLICT

Gender equality: The Indonesian invasion of Timor-Leste began in 1975 and lasted for 24 years. Although brutal in many ways, the Indonesian government introduced an education system which meant that more boys and girls in rural areas could go to school. Literacy among 18 to 24-year-olds rose from 50% in 2001 to 85% in 2007. The effect of gender norms can be seen in the high levels of malnutrition, particularly affecting women and children: a survey from 2009-2010 found that 29% of women were malnourished, and there is evidence that women and girls have to eat after men and boys in rural areas. Significant disparities in wealth exist between urban and rural populations.

Health equity: During the occupation, gender-based violence, including rape, sexual torture and sexual slavery was common. Domestic violence remains a significant problem, affecting more than a third of women. The number of women dying in childbirth and pregnancy is still too high, at 557 maternal deaths per 100,000 live births. The Catholic Church exerts influence over sexual and reproductive health, discouraging use of contraception and restricting access to abortion.

Impact of conflict on gender roles: The Indonesian invasion profoundly influenced gender roles and relationships. Men's identities were shaped by whether they took part in the resistance movement or not. Violence permeated everyday life; gangs and martial art clubs became popular and remain so today. Women were also actively involved in the resistance movement. Women were raped and forced to marry Indonesian soldiers, prompting the creation of women's groups in the 1990s. Just under half of women lost their husbands during the occupation, leading to an increase in the number of households headed by women, heightening their financial insecurity.

INTERNATIONAL HEALTH ENGAGEMENT AND GENDER

Humanitarian: Many donors funded initiatives to tackle gender-based violence just after independence. Collaboration between humanitarian agencies and national organisations remains fruitful, for instance UNFPA supports SEPI, the Secretariat of State for the Promotion of Equality, which was set up in 2007. With donor support, the government has increased human resources working on gender-based violence both in the police force and serious crimes unit.

Health system: Incorporating gender equity concerns into the post-conflict health system has not been without its challenges. Ministry of Health officials have struggled to see the relevance of gender and been reluctant to work closely with SEPI or to address gender-based violence. In the last few years, Ministry of Health staff have, however, been trained in gender analysis.

General gender programming: The government introduced a new law to combat domestic violence in 2010. Following ratification of the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) in 2002, the government has advanced equal rights for women and men, including in the Constitution. SEPI has set up gender focal points in four ministries, including health.

IS THE HEALTH SYSTEM IN TIMOR LESTE GENDER EQUITABLE?

The health system was measured against WHO's six health system building blocks:

Health service delivery: 77% of the rural population has access to health clinics, an improvement in recent years. However, challenges remain. Despite government commitment to safe motherhood, a study found that the health sector has not consistently led on other key sexual and reproductive health elements such as STIs and HIV/AIDS. According to a study in 2007, just under half of women with little or no education received no antenatal care. Gender disparities are evident in the treatment of malaria in children: only 18% of girls under five are likely to receive medicine before being taken to a clinic compared to 32% of boys.

Health workforce: No data is available to assess whether the health workforce is sensitive to gender equity concerns. The Ministry of Health has, however, built the capacity of health workers on maternal health issues.

Health information systems: UNDP noted in its 2011 report that the Ministry of Health was separating out health data by sex to track gender differences in access, mortality and illness.

Health system financing: Although the government is committed to free health care, poor people living in remote areas struggle to pay for travel to health facilities: a barrier to equitable access.

Medical products and technologies: In towns and cities, just 26% of girls under two are likely to be fully immunised, compared to 40% of boys. What's more, women in remote areas are obliged to travel long distances to access reproductive technologies when local midwives have not been trained to deliver a range of modern contraceptives.

Leadership and governance: Women hold just under 30% of seats in Parliament – a relatively high proportion - including important positions such as vice-minister of health. Nevertheless, there has been a lack of leadership from the health sector in collaborating with agencies active in gender-based violence.

DISCUSSION

In spite of challenges facing the government in integrating gender equity concerns into the health system, overall the reform of the health system since conflict ended has benefited women's health. In some areas, Timor-Leste has achieved some key targets, for example the proportion of births attended by a skilled health worker and contraceptive use. However, too many women and girls are still dying in pregnancy and childbirth and knowledge of HIV/AIDS is low. Poor people in remote areas face barriers in accessing health services, mainly due to the cost of travel. This has a particular impact on women.

ABOUT THIS BRIEF

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