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.
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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