

July 2013

FAMILY PLANNING AND MATERNAL, NEONATAL, AND CHILD HEALTH IN TIMOR-LESTE



*Assessing Gender
Constraints and
Opportunities,
Improving Outcomes*

This publication was prepared by Sara Pappa, Elisabeth Rottach, and Haleh Vaziri (consultant) for the Health Policy Project.

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Suggested citation: Pappa, S., E. Rottach, and H. Vaziri. 2013. *Family Planning and Maternal, Neonatal, and Child Health in Timor-Leste: Assessing Gender Constraints and Opportunities, Improving Outcomes*. Washington, DC: Futures Group, Health Policy Project.

The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. It is implemented by Futures Group, in collaboration with CEDPA (a part of Plan International USA), Futures Institute, Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

Family Planning and Maternal, Neonatal, and Child Health in Timor-Leste: Assessing Gender Constraints and Opportunities, Improving Outcomes

JULY 2013

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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
BMI	body mass index
CHC	community health center
EBF	exclusive breastfeeding
FP	family planning
FALINTIL	Armed Forces for the National Liberation of East Timor
FRETILIN	Revolutionary Front for an Independent East Timor
GBV	gender-based violence
GPM	Gender, Policy, and Measurement program
HDI	Human Development Index
HIV	human immunodeficiency virus
HPP	Health Policy Project
IDP	internally displaced person
INTERFET	International Force for East Timor
IUD	intrauterine device
MFI	microfinance institution
MMR	maternal mortality ratio
MNCH	maternal, neonatal and child health
MOH	Ministry of Health
NGO	nongovernmental organization
NHPF	National Health Policy Framework
NHPS	National Health Promotion Strategy
NRHS	National Reproductive Health Strategy
RDT	rapid diagnostic test
SRH	sexual and reproductive health
STI	sexually transmitted infection
TFR	total fertility rate
UDT	Timorese Democratic Union
UNTAET	United Nations Transitional Administration in East Timor
USAID	U.S. Agency for International Development
VAD	vitamin A deficiency
WHO	World Health Organization

INTRODUCTION

International health programs and donors in Timor-Leste and throughout the world increasingly recognize the importance of incorporating strategies to address gender inequality into programs to improve health outcomes for women, men, and children. To strengthen gender integration efforts in Timor-Leste, the Gender, Policy, and Measurement (GPM) program, a USAID-funded program implemented by the Health Policy Project (HPP) and MEASURE Evaluation, undertook this gender assessment. The assessment aims to discover the normative, socioeconomic, and political variables and power dynamics that impede and/or facilitate access to and utilization of health services in Timor-Leste. These spheres may overlap, but drawing distinctions brings clarity to an analysis of the relationship between gender and family planning and maternal, neonatal and child health (FP/MNCH) outcomes. This analysis will help donors and implementing organizations to incorporate gender interventions in the formulation, implementation, and evaluation of their FP/MNCH family planning and maternal, neonatal and child health programs. It will also assist scholars and policymakers focused on women's rights and healthcare issues to understand how a gender assessment is conducted and used to provide actionable intelligence.

Conducting a Gender Assessment—Methodology and Objectives

To inform FP/MNCH programming efforts in Timor-Leste, HPP has engaged in a gender assessment based on the methodology and concepts elaborated in *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action*, developed for the Interagency Gender Working Group. Identifying gender inequities in Timor-Leste and elucidating their consequences for FP/MNCH outcomes, this assessment seeks to:

- Explain the roles, responsibilities, norms, behaviors, participation, and vulnerabilities of women and men in Timor-Leste;
- Ascertain gender constraints that result in low access to and use of FP/MNCH services;
- Highlight those projects and organizations explicitly addressing gender in their programs;
- Discover information gaps related to gender that may warrant further research and data collection; and
- Recommend strategies to overcome gender barriers to the use of FP/MNCH services.

HPP has reviewed the published and unpublished, or “grey,” literature pertaining to access to and utilization of FP/MNCH services in Timor-Leste to identify consistent and/or dominant trends related to gender. The review focused on six broad themes: basic gender norms, practices, and roles; traditional beliefs and practices; gender-specific service barriers; access to resources; male-female power dynamics; and political engagement. Also relevant to this assessment is information about organizations in Timor-Leste that work on gender issues. Gleaned during an initial site visit to Dili and surrounding districts in March 2012, as well as through internet searches and a review of unpublished materials, information regarding specific projects, activities, and initiatives undertaken by local Timorese organizations illustrates how Timorese civil society addresses gender.

The effort to understand the gender-specific context for access to and utilization of vital health services in Timor-Leste is challenging due to the relative paucity of research on FP/MNCH in the country. Therefore, this assessment draws on literature about global trends in the developing world, with special emphasis on studies of neighboring countries in South and Southeast Asia, to discern factors that are likely to influence the availability and use of FP/MNCH in Timor-Leste. This comparative approach is likely to generate

hypotheses about Timor-Leste and neighboring countries that merit further investigation. The sources reviewed for this assessment include:

- Documents from the websites of United Nations agencies, the World Health Organization (WHO), the International Center for Research on Women (ICRW), the Cochrane Collaboration, Health Alliance International (HAI), the World Bank, the Asian Development Bank (ADB), Demographic and Health Survey–Timor-Leste (DHS), etc.;
- Government documents from Timor-Leste and the United States;
- Official documents, workplans or final reports of any existing or prior development programs in Timor-Leste; and
- Published articles dated from 1990 to 2013, with a focus on those from 2005 to 2013, found in MEDLINE and POPLINE searches using the search terms “gender,” “women’s empowerment,” “male involvement,” “decision making,” “gender-based violence,” leadership roles,” and “Timor-Leste/East Timor” combined with “family planning,” “contraceptives,” “maternal health,” “neonatal health,” and “child health”; including any additional topics¹ for which gender norms may be formulated and the final gender analysis may further inform FP/MNCH outcomes in Timor-Leste.

¹ Additional topics include, water sanitation, nutrition, immunizations, prevention of other disease/sickness among women of reproductive age and infants/young children: malaria, tuberculosis, diarrhea, HIV/STI prevention, sexual and reproductive health, access to health services, availability of skilled birth attendants, etc.

TIMOR-LESTE'S LEGACY OF COLONIALISM AND CONFLICT

A Brief History

Although an exposition of Timor-Leste's history is beyond the scope of this analysis, brief consideration of its legacy of colonialism and conflict is vital to understanding the gender constraints and opportunities that shape FP/MNCH outcomes in the country. A review of watershed events in Timor-Leste's contemporary history underscores the physical insecurity, political instability, socioeconomic destruction, and cultural disruption resulting from occupation and strife—effects which in turn aggravate existing gender inequities and cause women to suffer disproportionately.



- Europeans began exploring the island of Timor during the early 16th century, with Portuguese missionaries and traders reaching its coast in 1515. Portugal's hold on the island was geographically uneven, but it ruled the eastern portion of Timor for 460 years.
- Timor-Leste experienced decolonization in 1975, a year after Portugal's democratic revolution. As liberation groups emerged, civil war erupted between the social democratic Revolutionary Front for an Independent East Timor (FRETILIN) and the conservative Timorese Democratic Union (UDT) when the UDT attempted a coup and FRETILIN resisted, with the help of the local Portuguese military.
- FRETILIN unilaterally declared independence in November 1975, and Indonesia worried about the creation of a communist state next door. In December, Indonesia invaded Timor-Leste. In July 1976, Indonesia declared Timor-Leste as its 27th province, despite the UN Security Council's opposition.
- Facing resistance by the Armed Forces for the National Liberation of East Timor (FALINTIL), Indonesia occupied the country for roughly 25 years, during which at least 100,000 lives were lost.
- In August 1999, the Timorese voted for independence in a UN-sponsored referendum. The pro-Indonesia militias responded by launching a campaign of terror that killed thousands of people, displaced some 300,000, and destroyed much of the country's infrastructure. Australian-led peacekeepers the International Force for East Timor (INTERFET) and the United Nations Transitional Administration in East Timor (UNTAET) worked to restore order during the rest of 1999.
- INTERFET's deployment ended in February 2000 with the military command's transfer to the UN. Over the next two years, more than 200,000 refugees returned to Timor-Leste. In May 2002, the country's independence became official with Xanana Gusmão sworn in as the first president.
- During the lead-up to the May 2007 presidential election, Timor-Leste saw renewed civil strife, and some 15 percent of the population fled their homes. The UN sent peacekeeping forces in 2006 to reinstate order. The UN peacekeeping mission ended on December 31, 2012, after a gradual hand-off of control over the police force to the Timorese authorities.

Effects on Institutions and Women's Lives

As the Timorese have struggled against foreign occupation and domestic factionalism to build a fragile democracy, they must still contend with inter-related challenges: rampant poverty, high unemployment, and some of the world's worst maternal mortality rates (International Crisis Group [ICG], 2012; Thompson and Mercer, 2010). Mixed international-civil war has weakened legal institutions, healthcare delivery structures, the educational system, and social services, leaving women and girls disproportionately affected (Marsh, Purdin and Navani, 2006).

Certain prevailing patriarchal cultural norms and practices have become more entrenched since independence as once-dependable social networks and community safeguards have collapsed, increasing Timorese women's and girls' vulnerability to exploitation and violence (Marsh et al., 2006). In the years immediately before and after the 1999 UN-sponsored referendum, roughly one in four women indicated experiencing violence by someone outside their family. Almost half reported suffering some form of intimate partner violence (Hynes, Robertson, Ward and Crouse, 2004). Testimonies from the Indonesian occupation revealed frequent instances of gender discrimination, rape, and sexual slavery perpetrated by Indonesia's military (Allden, 2007). Besides heightened exposure to gender-based violence, women in war-affected societies are more likely to marry at a young age, have early pregnancies, and suffer miscarriages. The relative lack of access to quality reproductive healthcare makes mortality and morbidity all the more probable (Chynoweth, 2008; Kottegoda, Samuel and Emmanuel, 2008).

While conflict reinforces aspects of patriarchy, it disrupts livelihoods and the socioeconomic roles of women and men. For example, during the Indonesian Occupation, Timorese women assumed many of the predominately male responsibilities within households as fathers, sons, and husbands disappeared or were killed. Moreover, participation in the resistance to occupation politicized women who were at the forefront of the battle against the "Indonesianisation" of Timor-Leste. Timorese women sought to socialize their children and communities to traditions and customs unique to the Timorese people. Following independence in 1999, and UN recognition of statehood in 2002, these women became activists for gender equality in the process of nation-building (Corcoran-Nantes, 2009; Wandita, Campbell-Nelson and Leong Pereira, 2006). Yet women's contributions to the resistance and nation-building did not necessarily lead to improvements in status as patriarchal attitudes and practices persisted (Corcoran-Nantes, 2009).

In short, the effects of colonialism and mixed international-civil war on women's lives must be kept in mind when identifying gender-specific obstacles to FP/MNCH service access and utilization. Additionally, an examination of demand- and supply-side barriers to health services is necessary to inform an assessment of gender norms, roles, and practices, as well as an analysis of how access to resources and legal rights, in addition to existing power dynamics, influence the status of women in Timorese society.

DEMAND- AND SUPPLY-SIDE BARRIERS TO HEALTH SERVICE ACCESS AND USE

Use of health services in Timor-Leste is low, which affects the health outcomes of men, women, and children (Zwi et al., 2009). Women and men confront barriers that limit the demand for and supply of services (Paruzzolo, Mehra, Kes and Ashbaugh, 2010). Costs associated with seeking healthcare such as service fees, transportation expenses, and opportunity costs are common demand-side factors impeding access to and use of services; location of facilities and quality of care are typical supply-side barriers (Paruzzolo et al., 2010).

A study in Timor-Leste found that in certain instances, various costs associated with seeking care prevent access and utilization. Traditional providers may demand payment when a positive outcome is achieved. Although government healthcare providers typically do not charge fees, when services are received privately or after hours, patients may have to pay. Costs may also arise when patients obtain medications or seek referral to another healthcare facility (Zwi et al., 2009).

Research has shown that the cost of FP/MNCH services is a critical barrier to access and utilization (Paruzzolo et al., 2010). Studies in Nepal, India, Indonesia, Vietnam, Laos, and Cambodia highlighted household wealth and cost of health services as significant predictors of service use (Agus and Horiuchi, 2012; Goland, Hoa and Malqvist, 2012; Matsuoka, Aiga, Rasmey, Rathavy and Okitsu, 2010; Namasivayam, Osuorah, Syed and Antai, 2012; Sagna and Sunil, 2012; Singh, Rai, Alagarajan and Singh, 2012; Tran, Gottvall, Nguyen, Ascher and Petzold, 2012; Ye, Yoshida, Harun-Or-Rashid and Sakamoto, 2010). Similar research in the Republic of Vanuatu found that household wealth inequality is a risk factor for poor reproductive health service utilization (Rahman, Haque, Mostofa, Tarivonda and Shuaib, 2011).

Moreover, understanding service fees and insurance plans may place women at a disadvantage in seeking health services to ensure positive health outcomes. A study in rural Indonesia revealed that a misunderstanding of the government's insurance scheme dissuaded women from taking advantage of free health services, including antenatal, delivery, and postnatal care (Titaley, Hunter, Heywood and Dibley, 2010). Service costs may have an impact on child health outcomes as well. Research in urban India found a much higher prevalence of underweight and stunted children among the poor due to inadequate infant feeding practices, insufficient dietary intake, and frequent infections, as compared to those in higher economic standing (Agarwal and Srivastava, 2009).

Opportunity costs may be another concern for health service users. A woman seeking healthcare for herself or her child may have difficulty taking time off from her daily work or paying someone else to assume her responsibilities (Paruzzolo et al., 2010). A study in Cambodia found that high opportunity costs are a significant barrier to utilization of maternal health services, especially during specific times of the year, such as harvest season, when women are expected to contribute to the workload (Matsuoka et al., 2010). Similar studies in Indonesia and Laos found that having the ability to continue caring for children and doing housework, even in the time surrounding childbirth, adds to the appeal and convenience of delivering at home versus in a healthcare facility (Sychareun et al., 2012; Titaley et al., 2010).

Health Alliance International (HAI) supports the placement and training of **Maternal and Child Health (MCH) District Program Officers** as members of the District Health Management Team in four districts of Timor-Leste. This initiative aids in capacity development for maternal and child health at the district level (Health Alliance International [HAI], 2012; Tuba Rai Metin, 2012).

Taking time off from work and/or daily chores is especially complicated when healthcare facilities are practically inaccessible due to distance and lack of transportation. In Timor-Leste, long distances to healthcare facilities are a critical concern for rural dwellers who do not have means of transportation (Zwi et al., 2009), creating one of the most significant barriers to FP/MNCH service access and utilization (Ensor and Cooper, 2004). Several studies have documented the impact of distance on healthcare use. Women in rural Cambodia have cited distance and poor road conditions as reasons for not utilizing government-provided maternal health services (Matsuoka et al., 2010), just as women in Bangladesh, Indonesia, Vietnam, Laos, India, and Nepal have pointed to long travel times, poor roads, and high transportation costs as impediments to seeking care (Agus and Horiuchi, 2012; Haque, Rahman, Mostofa and Zahan, 2012; Malqvist, Sohel, Do, Eriksson and Persson, 2010; Namasivayam et al., 2012; Sagna and Sunil, 2012; Shrestha et al., 2012; Singh et al., 2012; Titaley et al., 2010; Tran et al., 2012; Ye et al., 2010).

Research has also demonstrated the impact of distance on actual health outcomes. Two studies in Vietnam found lower birth weights and slower growth rates among children in rural areas as compared to their urban counterparts (Nguyen et al., 2012; Vaktskjold, Van Tri, Phi and Sandanger, 2010). A third study in Vietnam showed an increased risk of neonatal death for mothers in rural areas where healthcare facilities are far from their homes (Malqvist et al., 2010). Taking into account the barriers of distance and cost is vital to ensuring women have access to FP/MNCH services. With low usage of important services such as antenatal care and facility-based delivery, women in rural areas are at an extreme disadvantage when it comes to ensuring positive health outcomes for themselves and their children.

Health Alliance International (HAI), an international NGO working to bolster health systems and provide healthcare for all, strives to strengthen the Ministry of Health's maternal and child health and child survival services through integration into primary healthcare in Timor-Leste (Health Alliance International (HAI), 2013).

Quality of care is an additional obstacle to health service utilization. In Timor-Leste, the factors influencing healthcare-seeking behavior include positive user-provider interactions; availability and accessibility of facilities that are well-equipped with basic medical supplies and equipment, and staffed with qualified, well-trained providers; as well as access to medications and treatments when needed (Zwi et al., 2009). These factors are particularly important in the case of home-based deliveries, because close to 80 percent of births in Timor-Leste occur at home, and 70 percent of these are not attended by a skilled provider (National Statistics Directorate [NSD] [Timor-Leste], Ministry of Finance [Timor-Leste] and ICF Macro, 2010). The poor condition of facilities, negative staff attributes, and unfavorable healthcare facility policies and protocols

often deter Timorese women from seeking facility-based deliveries (Wild, Barclay, Kelly and Martins, 2010).

The impact of quality of care on FP/MNCH service access and use is seen in a number of other studies. In Cambodia, research found that women's choices to deliver in a healthcare facility were heavily influenced by perceptions of safety and staff attributes, causing many women to elect a home birth out of comfort (Ith, Dawson and Homer, 2012). A similar study in Laos indicated that rural women often chose to give birth at home due to unfavorable aspects of hospital-based deliveries such as episiotomies, exposure of their genitals to strangers, and the presence of male birth attendants (Sychareun et al., 2012).

Perceptions surrounding quality of care and their impact on utilization of essential FP/MNCH services, especially institutional delivery, exemplify how various barriers to health service access are interconnected. The situation in which a woman chooses to deliver her baby at home, even in the absence of a skilled attendant, sheds light on the need to ensure that FP/MNCH services are adequate and accessible and underscores the general lack of health knowledge. This in turn raises questions about women's place of residence or low educational attainment as barriers to achieving positive health

outcomes. As research in Indonesia and Laos has shown, improving women's health knowledge may aid in achieving positive health outcomes such as higher rates of antenatal care utilization, use of trained delivery attendants, and protective behaviors to decrease instances of childhood anemia in rural households (Agus and Horiuchi, 2012; Souganidis et al., 2012; Titaley et al., 2010; Ye et al., 2010).

While demand- and supply-side barriers obstruct access to care, deeply entrenched gender inequalities have a significant impact on a woman's overall health status, as well as the health of her children. Even when services are available, women's lower social status may continue to undermine their ability to gain access to care (Paruzzolo et al., 2010). Because a fragile healthcare infrastructure exists alongside stagnant patriarchal beliefs, norms, and practices in Timor-Leste, a gender assessment is critically important to investigate how women are impeded from receiving vital health services such as antenatal care, safe delivery services, and emergency obstetric care, and how various gender-specific barriers manifest themselves.

THE STATE OF WOMEN AND CHILDREN'S HEALTH AND THE SUPPORTING POLICY FRAMEWORK

Maternal, Neonatal, and Child Health—Critical Needs Unmet

Priority needs in maternal, neonatal, and child health remain unmet in Timor-Leste. The country's maternal and child health indicators are among the worst in Southeast Asia (Thompson and Mercer, 2010). The maternal mortality ratio (MMR) is 557 deaths per 100,000 live births, child mortality is 64 deaths per 1,000 live births, and one in 16 children dies before their fifth birthday. Seventy percent of deaths among children under age five occur during the first year of life. Infant mortality is 45 deaths per 1,000 live births, and neonatal mortality is 22 deaths per 1,000 live births (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

Under-five mortality rates in Timor-Leste are relatively high, with malaria, diarrhea, and respiratory infections taking a heavy toll. Contaminated drinking water, inadequate sanitation, and poor nutrition exacerbate health risks. Malnutrition remains a major public health problem: 27 percent of women and 58 percent of children are chronically malnourished. While progress on micronutrient supplementation is laudable, vitamin A deficiency (VAD) among children is high, poor breastfeeding practices are widespread, and iron supplementation for pregnant and postnatal women is inadequate (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010). Routine immunization coverage remains low; just over half of children ages 12–23 months, 53 percent, are fully vaccinated, and 23 percent have received no vaccinations at all (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

The utilization of FP/MNCH services is quite rare. The majority of Timorese live in rural areas, so gaining access to health services, including birthing facilities, can be challenging because most facilities are in urban areas (Ministry of Health [MoH], 2009). Human resources for maternal health are also limited, with only 0.1 physicians and 2.19 nurses and midwives per 1,000 people (World Bank, 2011). Consequently, 78 percent of deliveries take place at home, and 70 percent of births are not attended by a skilled provider (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010). Hemorrhage, obstructed labor, sepsis, unsafe abortions, and eclampsia are more likely when access to emergency obstetric care is poor (Wild et al., 2010).

Family Planning—Low Contraception Use

At 5.7 births per woman, the total fertility rate (TFR) in Timor-Leste is one of the highest in Southeast Asia (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010). Contraceptive use is low, with 21 percent of currently married women and 13 percent of all women using a modern method (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010); 31 percent of women report an unmet need for family planning (World Bank, 2011). Among those without access to family planning counseling and service delivery, 21 percent have an unmet need for birth spacing, 10 percent for limiting future child-bearing, and 35 percent do not want more children (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010). Consequently, 14 percent of women give birth by age 18, nearly half by age 22, and two-thirds by age 25 (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010). The median birth interval is 29 months, varying with age from a low of 25.5 months among mothers age 15 to 19 to a high of 33.9 months among mothers age 40 to 49 (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

The low rate of contraceptive use is due in part to the lack of exposure to family planning messages, counseling, and service delivery. Eighty-six percent of Timorese women and 59 percent of men have never received relevant information on family planning and contraceptive use (National Statistics

Directorate [NSD] [Timor-Leste] et al., 2010). Couples in rural areas are at a particular disadvantage in this regard. Seventy-four percent of rural women know of a modern family planning method as compared to 88 percent of those in urban areas, and current use of family planning methods is greater among urban women—28 percent versus 19 percent for those in rural areas (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010). The government is a major source of contraceptives, serving 87 percent of users. Community health centers supply 45 percent, health posts 20 percent, government and referral hospitals 17 percent, periodic community-based health service delivery events, 3 percent, and mobile clinics 2 percent (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

Health Policies and Programs—Expanding Access to Improve Outcomes

Shortly after gaining independence, the Ministry of Health established the first National Health Policy Framework (NHPF) for 2000–2012. The NHPF serves as the basis for the formulation of the National Health Promotion Strategy (NHPS) and the National Reproductive Health Strategy (NRHS) (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010). The primary objectives of the NRHS are to:

- Increase the general population's knowledge of issues related to sexuality and reproductive health;
- Promote family planning to help stabilize the population growth rate and reduce the incidence of unintended, unwanted, and mistimed pregnancies;
- Ensure that all women and men have access to basic reproductive health services, as well as access to health promotion initiatives and information on issues related to reproductive health;
- Reduce maternal mortality and morbidity;
- Lessen the burden of HIV/STIs;
- Improve the health status of people of reproductive age; and
- Meet changing reproductive health needs over the life cycle (Ministry of Health [MoH], 2004).

Family planning is a major component in Timor-Leste's *First Development Plan, 2002–2007*. The Family Planning and Maternal and Child Health project began in 2002 and has since gradually involved all 13 districts in the country. Endorsed by the MOH in 2004, the project addresses population growth and offers guidance on the development and execution of family planning programs. Over time, family planning has become an integral part of government health services. Modern family planning methods (male condoms, contraceptive pills, and injectables) are regularly provided through national, regional, zonal, and district hospitals; primary healthcare centers; and health posts and sub-health posts, which offer the most basic services at the village-level. Services such as implant and intrauterine device (IUD) insertions are available, but only at a limited number of hospitals, health centers, and selected health posts staffed with trained personnel. Depending on the district, sterilization services are offered through “seasonal” or mobile outreach services (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

The MOH delivers medical services through the national hospital in Dili, five district referral hospitals, 67 community health centers (CHCs), and 172 health posts. Staffed by a resident midwife, nurse, or assistant nurse, health posts deliver primary health services and serve as an extension of CHCs in some villages, also referred to as *sucos*. In 2008, the MOH developed a new program called *Servisus Integrado Saude Comunitaire* (SISCa), which means “Integrated Health Services at the Community Level” in the Tetum language. The program seeks to extend the reach of primary health services at the community and household levels and is being implemented in 13 districts, 65 sub-districts, and 442 villages and hamlets, with a total of 602 SISCa posts (Ministry of Health [MoH], 2012).

Occurring on a monthly basis, SISCa events connect the government healthcare system with rural communities. SISCa events revolve around a “Six Table Assistance System” composed of population registration, nutrition assistance, maternal and child health, personal hygiene and sanitation, health services, and health education. Families have the opportunity to visit each station where they receive care, ask questions of the staff and obtain information in a familiar setting (Health Alliance International [HAI], 2012). The SISCa program’s full potential has not yet been realized, however. For example, the Timorese still rely heavily on government facilities as a major source of contraceptives, even though SISCa posts offer family planning services and outnumber all regular facilities combined (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

Consideration of Gender within the Health Policy Framework—Uneven Government Attention and Efforts

Although a relatively strong foundation exists to address gender inequities in the healthcare system through Timor-Leste’s health policy framework, the government’s attention to relevant issues and efforts to tackle the inequalities have been inconsistent. The NRHS identifies approaches to remedy gender disparities, prevent gender-based violence (GBV), and improve gender-sensitive services in FP, reproductive health, maternal health as well as sexual and reproductive health for young people. Timor-Leste’s Health Sector Strategic Plan names gender equity as one of 17 cross-cutting strategies forming the core focus for action by the MOH and its partners. The plan aims to achieve women’s representation in decision-making posts at all levels of the

healthcare system through such measures as gender mainstreaming in the MOH, enhancing awareness of gender issues among healthcare professionals, providing affirmative action for women, and increasing access to gender-sensitive health services. The National Health Promotion Strategy points to gender mainstreaming in health promotion interventions as a means to improve equality in broader power

Cooperativa Café Timor (CCT), a Timorese organic coffee-producing and -processing cooperative, provides healthcare services to rural areas by establishing health clinics, mobile clinic teams and community extension teams in five districts in Timor-Leste under its **Clinic Café Timor** initiative (USAID, 2012a).

Rede Feto, a national network of 23 women’s organizations, works to strengthen members’ capacities for administration and advocacy. The network seeks to ensure a measurable impact in advancing women’s status and each member organization’s participation in the national development process (Rede Feto, 2012).

relations between women and men. The Secretariat of State for the Promotion of Equality was created in 2008 to ensure gender mainstreaming in government policies. The Council of Ministers established Gender Focal Points in all departments to support gender mainstreaming in their respective agencies.

These strategies are effective in explicitly addressing gender-related issues, but other policies and plans fail to mainstream gender sufficiently. The National Policy for Family Planning refers only briefly to the importance of equality in services for men and women. The Health Workforce Plan notes the imbalance

in the ratio of male-to-female healthcare workers, but does not analyze its causes or propose remedies. The guidelines for implementing SISCAs—often the only health services available to rural communities—do not adequately consider such barriers to improved health outcomes as discrimination and violence against women.

ASSESSMENT OF GENDER'S ROLE IN SEEKING HEALTH SERVICES AND ENSURING POSITIVE OUTCOMES

An assessment of gender's role in the access to and use of FP/MNCH services is instructive in light of the poor state of women's and children's health in Timor-Leste, the government's efforts to develop a widely available, cost-effective healthcare delivery system, and the unevenness of gender mainstreaming throughout the health policy framework.

Normative Factors Shaping Access to and Use of FP/MNCH Services

In the normative realm, factors that affect access to and utilization of FP/MNCH services and subsequent health outcomes include the construction of gender itself, traditional beliefs and practices, customs surrounding marriage and dowry, as well as the assumption of reproductive and economic and/or productive roles related to employment and income generation and/or household responsibilities.

The construction of gender

Every society considers particular attributes, behaviors, roles, and responsibilities to be suitable for men or women. These socially constructed gender identities influence men's and women's preferences, decisions, and behaviors in seeking reproductive healthcare and play a significant role in the access to care. Recognizing the various dimensions of inequality that result from the construction of gender may aid in determining barriers to health services and improving access (Baral, Lyons, Skinner and van Teijlingen, 2010; Furuta and Salway, 2006; Namasivayam et al., 2012).

Considering gender norms, roles, and practices is vital when designing and implementing health programs that serve women, men, and children effectively and equally. In Timor-Leste, gender norms are reinforced from an early age, shaping girls', boys', women's, and men's beliefs and perceptions of appropriate ways to act. Traditionally, men are the heads of families, as well as leaders and decisionmakers in the community at large (Gajewski, Ihara and Tornier, 2007; National Statistics Directorate [NSD] [Timor-Leste] et al., 2010). Timorese men are active in the public domain, with access to social, economic, and political spaces, while women are relegated mainly to the domestic sphere (Myrntinen, 2009). Men are thus afforded greater freedom and more opportunities to accrue wealth and status, leading to significant inequality between women and men (Allden, 2007). Moreover, rigid norms surrounding masculinity legitimize inequitable manifestations of manhood, such as the use of violence and other controlling behaviors, and constrain men from behaving in "un-masculine" ways (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

Timorese women, by contrast, are assumed by Timorese society to be passive supporters and followers. They are expected to be submissive, and must obey their husbands, parents, in-laws, and community leaders. These norms of female subservience limit freedoms and opportunities, leaving women with little decision-making power even when their own health is at stake, including decisions to use contraceptives or give birth at a health facility (Myrntinen, 2009; National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

Traditional beliefs and practices

A society's gender identities are often constructed using traditional beliefs and practices. In Timor-Leste, these beliefs and practices shape decisions to seek healthcare and to use FP/MNCH services in particular. Family members (including in-laws), neighbors, and local authorities may become involved in decisions about when and where to seek medical help and in choices regarding child spacing and contraceptive use (Zwi et al., 2009). Studies in Timor-Leste have elucidated the influence of traditional family practices on

delivery at home versus in a healthcare facility (Wild et al., 2010; Wild, Barclay, Kelly and Martins, 2012).

Extensive literature on neighboring countries in South Asia documents the impact of traditional beliefs and practices on healthcare choices. For example, in rural Cambodia, women practice “roasting”—a traditional postnatal activity in which they spend a minimum of three days lying beside a fire or hot coals to regain strength and replace any heat that is thought to be lost during childbirth (Matsuoka et al., 2010). Practices surrounding heat are also followed among Timorese women (Wild et al., 2010), as well as by the Chinese, Malays, and Indians in Singapore (Naser et al., 2012). Confinement practices may be observed across cultures (Naser et al., 2012), as may customs surrounding food and eating (Wulandari and Klinken Whelan, 2011).

Traditional beliefs and practices can be harmful when they obstruct access to and utilization of maternal health services. Research in Cambodia found that cultural themes and practices likely affect a woman’s decision to initiate and continue exclusive breastfeeding. Because “roasting” interferes with breastfeeding, mothers often delay nourishing their babies until the minimum-three-day practice has ended (Wren and Chambers, 2011). Similar research in Laos showed that women with superstitious beliefs have poor knowledge of antenatal care, proper nutrition during pregnancy, and symptoms of obstetric complications (Phoxay, Okumura, Nakamura and Wakai, 2001).

The role of mothers and mothers-in-law may also be a significant determinant of FP/MNCH service access and use. According to one study on birth choices in Timor-Leste, intergenerational continuity is a strong predictor of place of delivery (Wild et al., 2010). Studies in Nepal, India, Singapore, and Pakistan reached similar conclusions and more strongly emphasized the influence of mothers-in-law on contraceptive uptake or use of antenatal care (Char, Saavala and Kulmala, 2010; Kadir, Fikree, Khan and Sajan, 2003; Naser et al., 2012; Shrestha et al., 2012; Simkhada, Porter and van Teijlingen, 2010). Although mothers and mothers-in-law may play a positive role as a support system to women during pregnancy and childbirth, they and other family members may have a negative impact on certain healthcare choices, actions, and outcomes. In such instances, traditional beliefs and practices become significant barriers to FP/MNCH access and use.

Customs surrounding marriage and dowry

In Timor-Leste, marriage and dowries are firmly entrenched traditions. Marriage is “not only the alliance between two individuals, but seals an intricate set of relationships, obligations and reciprocity between the bride’s and groom’s extended families and their social networks (NGOs Working Group on CEDAW, 2009), (p.17). As marriage occurs early for Timorese women, they rarely have much say over when and who they marry. Almost a quarter of Timorese women marry before age 18, compared to only five percent of men, with urban dwellers tending to marry later (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010). Divorce is a sensitive issue and is generally socially unacceptable. Women find asking for a divorce very difficult even in cases of domestic violence (NGOs Working Group on CEDAW, 2009).

Early marriage may be extremely detrimental to young women’s health, status, power, and autonomy within the household (Jensen and Thornton, 2003). Newly married young women or girls are often pressured to begin childbearing right away. If their bodies are not ready, early childbirth can be dangerous for the mothers and babies. Moreover, early marriage and childbearing deny young women and girls opportunities for education, which in turn, may have implications for their health status (Jensen and Thornton, 2003; Ryan, 2012). Research in Nepal, India, Cambodia, and Laos found that women who married at a younger age were less likely to take advantage of access to skilled antenatal care and institutional delivery and were more likely to experience high fertility rates (Adhikari, 2010; Manithip, Sihavong, Edin, Wahlstrom and Wessel, 2011; Namasivayam et al., 2012; Sagna and Sunil, 2012).

Besides the early age of marriage, the dowry system in Timor-Leste may have deleterious effects on women's and girls' social status. Referred to as the *barlaque*, the dowry system is still practiced in many parts of the country (Allden, 2007). While the practice of dowry varies among districts, it generally consists of livestock (cows, buffalos, or goats), money, or alcohol (ProQuest LLC and Brigham Young University [BYU], 2011). Paid to the wife's family as part of the marriage exchange, the dowry often reinforces patriarchal norms and power imbalances by implying that women are "purchased," resulting in men treating their wives as property rather than partners. Women may thus be expected to fulfill such obligations as childbearing, leaving little room to negotiate healthy spacing and timing of pregnancies (Wild et al., 2010). The dowry system's impact on women's status may also be seen in Uganda and India where culturally specific practices result in worsened gender relations and are connected to adverse health outcomes such as poor contraceptive use, high fertility rates, unwanted pregnancies, and unsafe abortions (Diamond-Smith, Luke and McGarvey, 2008; Kaye, Mirembe, Ekstrom, Kyomuhendo and Johansson, 2005).

Feto iha Kbiit Servisu

Hamutuk (FKSH) is a local NGO that works with rural women to develop their leadership skills. FKSH also trains them in small business development and basic life skills (Feto iha Kbiit Servisu Hamutuk [FKSH], 2012).

Reproductive and productive roles

In Timor-Leste, women's fundamental roles at home and in society revolve around bearing and raising children, as well as ensuring that the household runs smoothly. Carrying a heavy workload, they are primarily responsible for chores such as cooking, cleaning, raising children, and managing the family's finances. Women in rural areas also tend crops, feed livestock, and collect firewood and water. Women working outside the home is far more common in urban areas (ProQuest LLC and Brigham Young University [BYU], 2011). Men in Timor-Leste are the main "breadwinners" and gain prestige through wage labor in the formal economy (Myrntinen, 2009). Seventy-seven percent of men participate in the labor force compared to 48 percent of women (Ministry of Economy and Development, 2008).

In terms of assumed reproductive roles, one study revealed that the Timorese recognize the value of birth spacing in relation to the household economy, the mother's and child's health and, notably, women's ability to fulfill their roles in childcare and household management. This finding stands in contrast to Timor-Leste's high fertility rate. The advantages resulting from birth spacing include enabling women to attend to each child's needs while maintaining the household, allowing mothers to seek older children's help in caring for younger siblings and in performing household chores, affording women opportunities to take on income-generating tasks such as picking coffee, and helping couples to educate each of their children (Zwi et al., 2009).

Timorese women are more likely to use a family planning method than men, who receive family planning information from their wives. When the man does not want to use contraceptives, however, the typical outcome is that family planning methods are abandoned. In a 2009 study in Timor-Leste, most participants asserted that husbands and wives should come to agreement on contraceptive use. Yet they also believed that when spouses disagree, a wife should follow her husband's position. Participants also noted that women's acquiescence could lead to underlying tension. Moreover, the study found that adolescent men tend to be more open to birth spacing than married men, which could be an important entry point for family planning programs (Zwi et al., 2009).

Fertility and birth spacing are important predictors of health service utilization and outcomes. Research in rural Indonesia showed that fertility rates are a main factor influencing the number of antenatal care visits among pregnant women (Agus and Horiuchi, 2012). According to a similar study in Cambodia, higher parity women were also less likely to utilize maternal health services (Sagna and Sunil, 2012). Another study in Indonesia revealed that the likelihood of child anemia increases in families with more children

(Souganidis et al., 2012). Similarly, research in Nepal indicated that women with more children and shorter spacing between births experienced higher child mortality (Adhikari, 2010).

In assessing gender barriers to FP/MNCH service access and utilization, it is critical to consider interrelated normative factors that may place women and young girls at a disadvantage. Gender identities, the persistence of traditions—particularly customs surrounding marriage and dowry—as well as the assignment of reproductive and productive roles are elements that merit further investigation in the context of efforts to improve FP/MNCH in Timor-Leste.

Socioeconomic Factors Shaping Access to and Use of FP/MNCH Services

In terms of access to resources, disparities between Timorese women and men exist in educational attainment, employment, and income—key socioeconomic factors that may restrict or enhance health service access and use, especially with regard to FP/MNCH.

Educational attainment

In Timor-Leste, as in other societies in the developing world, education is an essential tool for achieving equality between women and men (NGOs Working Group on CEDAW, 2009). Access to education for girls and women contributes to greater civic participation and helps to combat poverty, youth violence, sexual harassment, and human trafficking. Higher educational attainment may lead to long-term health benefits, including prevention of HIV/AIDS, delayed marriage, reduced domestic violence, lower fertility rates, decreased infant mortality, and improved child nutrition (UNICEF, 2011).

Timorese girls face various challenges in attaining and completing their education. Girls' education is not highly valued, with many families choosing to send their sons to school rather than their daughters. Parents may prioritize other household costs over girls' education and regard their sons as future providers for the family. Girls who do attend school must balance both their education and household obligations. Many women in Timor-Leste perform poorly or abandon school because of domestic responsibilities. Early marriage and pregnancy also contribute to high drop-out rates (NGOs Working Group on CEDAW, 2009), and parents in rural areas may accept early marriage because the dowry is higher for girls than for women (Japan International Cooperation Agency [JICA], 2011). Many girls in rural areas live far from their schools, making attendance difficult. Parents may hesitate to educate their daughters due to fear that they will be sexually abused while traveling to and from school if the distance from home is long (NGOs Working Group on CEDAW, 2009).

Alola Foundation's Education and Literacy Program expands opportunities for women through the growth in access to and quality of education for women and children in Timor-Leste (Alola Foundation, 2012).

The impact of educational attainment on health outcomes is evident in Timor-Leste and other countries. Among women with lower educational attainment, instances of maternal and child mortality, disease, and malnutrition are more common (NGOs Working Group on CEDAW, 2009). Studies in Indonesia, the Republic of Vanuatu, Nepal, Vietnam, India, Cambodia, Laos, and the Philippines concluded that women's education is a significant predictor and determinant of access to and use of maternal and child health services (Agarwal and Srivastava, 2009; Agus and Horiuchi, 2012; Becker, Peters, Gray, Gultiano and Black, 1993; Furuta and Salway, 2006; Goland et al., 2012; Malqvist et al., 2010; Manithip et al., 2011; Namasivayam et al., 2012; Rahman et al., 2011; Sagna and Sunil, 2012; Singh et al., 2012; Vikram, Vanneman and Desai, 2012; Ye et al., 2010). Education empowers women and exposes them to the information and skills necessary to take control of their personal health and their children's health (Adhikari and Podhisita, 2010). Moreover, as research in India indicates, educated women are more likely

to receive necessary immunizations, take prescribed medications and supplements during pregnancy, and make the appropriate number of antenatal care visits (Sarma and Rempel, 2007).

Education is strongly correlated to healthcare access and utilization as well as to health outcomes (UNICEF, 2011). Affording women and girls the knowledge to ensure positive health outcomes for themselves and their children, educational attainment should be emphasized as vital to any policies and programs that purport to encourage use of FP/MNCH services and make healthcare more widely available in Timor-Leste.

Employment and income

As with educational attainment, earning money and controlling how it is spent are key components of women's empowerment. Women who are employed have more control over income, are able to accumulate assets, are less dependent on their husbands or other family members, and are thus more likely to make their own healthcare decisions (Paruzzolo et al., 2010). Yet because women's main role as caregivers in the home is a major constraint to seeking and keeping a job, women have higher unemployment rates and lower labor force participation rates than men in Timor-Leste (Asian Development Bank (ADB) and UNIFEM, 2005). While both men and women work in the informal sector, women tend to engage in lower income-generating tasks. Sixty-seven percent of employed women perform agricultural jobs and 22 percent work in sales and service (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

Moris Rasik and Tuba Rai Metin are two of Timor-Leste's main microfinance institutions (MFI). Both organizations provide vital financial services to the poor in order to improve the livelihood of families and empower women (Moris Rasik, 2012).

Most Timorese women do not earn income for the work they do. Only 19 percent of employed women are paid cash. Less than 1 percent collect both cash and payment in-kind, and 1 percent receive only in-kind payment. Four in five employed women do not receive any form of payment for their work. They are involved mainly in the agricultural sector and usually work for a family member or are self-employed (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

In addition to having access to employment opportunities and income, an added marker of empowerment is that women must have control over their earnings. Thirty-six percent of married Timorese women who receive cash earnings reported that they alone choose how their earnings are used, while 58 percent decide with their husbands. Younger women are less likely to be involved in decisions about how their earnings are used. Forty-two percent of women in urban areas decide independently how to spend their earnings, compared to 31 percent of those in rural areas. Rural-dwelling women are more likely than their urban counterparts to decide with their husbands how their earnings are spent—62 versus 54 percent, respectively (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

Studies in the Philippines and India showed that employed women enjoy greater financial autonomy and are more likely to utilize vital health services such as family planning, antenatal care, and child health services (Agarwal and Srivastava, 2009; Miles-Doan and Brewster, 1998). As noted earlier, the financial autonomy and control over monetary resources derived from employment may lead to increased utilization of FP/MNCH services, whereas in lower income households, healthcare access and use are limited due to unexpected costs.

Factors Related to Power Dynamics that Shape Access to and Use of FP/MNCH Services

The decision about how to spend one's earnings illustrates that the power dynamics between women and men within their households may affect access to and use of healthcare as well as outcomes in FP/MNCH. Power dynamics are reflected in the level of control over decision-making which typically entails some indirect or direct negotiations between women and men, and in the perpetration of GBV, involves the use of force by men against women.

Decision-making authority

Timorese women are often engaged in the decision-making process within the household. Yet the strength of their role varies with the type of decision, and they rarely make decisions on their own. Decision making about healthcare is frequently negotiated with the husband and other family members. Neighbors and community members may impose their opinions on these decisions. A woman's in-laws may insert themselves in decisions about family planning and using contraceptives; their involvement is largely an outcome of practicing dowry (Zwi et al., 2009).

Even so, 63 percent of married women make the final decision about daily household purchases on their own (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010). This authority may be attributed to the fact that Timorese women are primarily responsible for managing household finances (ProQuest LLC and Brigham Young University [BYU], 2011). With respect to decision making about other issues such as one's own healthcare, major household purchases, and visits to family or relatives, women are more likely to decide with their husbands (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

Research in the region has highlighted decision-making authority as a determinant of health service access and utilization. According to studies in Nepal, India, and Bangladesh, more decision-making power and autonomy among women translates into greater use of maternal and child health services and positive health outcomes (Allendorf, 2007; Haque et al., 2012; Shroff et al., 2011). Additional studies examining power dynamics within the household found that gender dynamics may be a strong determinant of health choices and outcomes. In Laos, for example, research indicated that household gender dynamics are critical to decisions about where to give birth (Sychareun et al., 2012), and mothers in Nepal's female-headed households are less likely to experience a child's death than their counterparts in male-headed households (Adhikari and Podhisita, 2010). Similar research in Indonesia deemed household power dynamics extremely influential in determining utilization of prenatal and delivery care services (Beegle, Frankenberg and Thomas, 2001).

Gender-based violence

Whereas decision-making authority is negotiated at least to some extent, GBV is a manifestation of brute force and compulsion. Stemming from established gender norms, roles, and inequality in society, such violence involves women, men, and children. GBV is further based on a man or woman's biological sex, gender identity, and/or adherence to social norms defining masculinity and femininity (Interagency Gender Working Group [IGWG], 2012).

GBV is widespread in Timor-Leste with domestic violence its most common form. Domestic violence is considered a private, family matter (UN Women, 2012). Reporting is rare and seeking a remedy through traditional justice systems is not a common practice (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

Alola Foundation, an NGO operating in Timor-Leste, was originally established in 2001 to raise awareness about GBV. The organization has now expanded its mission to include activities in the areas of advocacy, economic empowerment, education and literacy, maternal and child health, and humanitarian assistance (Alola Foundation, 2012)

The dowry system fosters the notion that women are their husbands' property and men may thus rule over their wives as they please (Japan International Cooperation Agency [JICA], 2011). In cases of GBV, the perpetrator's family often gives animals (water buffalos, goats, or pigs) to the victim's family in exchange for reconciliation and conflict resolution. These gestures conclude with a ceremony, usually a feast, to demonstrate forgiveness (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

Nearly 40 percent of Timorese women over age 15 have experienced some form of physical violence, while 34 percent of those who have been married report suffering abuse from their husbands (UN Women, 2012). Eighty-six percent of women believe that a husband is justified in beating his wife for at

Victim Support Services (VSS), falling under the **Judicial System Monitoring Programme (JSMP)** promotes women's access to formal justice structures and mechanisms and encourages utilization in relation to violence against women in Timor-Leste. Similar organizations supporting women through the formal legal process include **Forum Komunikasi untuk Perempuan Timor Lorosa'a (FOKUPERS)** and **Psychological Recovery and Development Timor-Leste (PRADET)** (Trembath, Grenfell and Moniz Noronha, 2010)

least one of the following reasons: burning food, arguing with him, leaving the house without telling him, neglecting the children, and/or refusing sexual intercourse. The most widely accepted reason for wife-beating is neglecting the children, according to 76 percent of women, followed by leaving the home without permission (72 percent), and arguing with the husband (64 percent). Four in five men agree with at least one of these reasons for wife-beating. Similar to attitudes among women, 71 percent of men justify wife-beating if she neglects the children (National Statistics Directorate [NSD] [Timor-Leste] et al., 2010).

GBV is a significant deterrent to women seeking much-needed healthcare, as numerous studies have concluded. One study in Bangladesh found intimate partner violence to be associated with low use of reproductive health services among women, including antenatal care and safe delivery facilities (Rahman,

Nakamura, Seino and Kizuki, 2012). Another study in Bangladesh revealed that instances of intimate partner violence are connected to an increased risk of having stunted or underweight children (Rahman, Poudel, et al., 2012). Research in India has shown that infants and young children are at a greater risk of death in families where mothers experience spousal violence (Silverman et al., 2011).

Political Factors Shaping Access to and Use of FP/MNCH Services

In examining power dynamics between women and men, the focus is the household, whereas political factors affecting access to and use of FP/MNCH services are manifested more publicly at the community and national levels.

Customary laws and practices

Recent legal frameworks in Timor-Leste reflect growing recognition of and commitment to gender equality. In 2006, the Electoral Law established quotas for women's participation in Parliament, resulting in increased female representation. In 2010, following remarkable changes to the penal code that made domestic violence a punishable crime, the Law Against Domestic Violence was passed. Moreover, segments of civil society are undertaking efforts to create gender equality as NGOs mobilize to garner support for increased female representation in Parliament and highlight such issues as education, healthcare, the economy, justice, and security in Timor-Leste (UN Women, 2012).

Despite some progress in formulating laws to advance gender equality and increased efforts by civil society to further this goal, land rights remain a major issue for women in Timor-Leste. Especially in rural areas, land is the primary asset and is typically passed down through the male line. Women may acquire land only through marriage and do not have property rights (Asian Development Bank (ADB) and UNIFEM, 2005). Similarly, daughters do not have inheritance rights due to the assumption that they will

leave the family after marriage, subsequently acquiring access to their husbands' inheritance (NGOs Working Group on CEDAW, 2009). Gender disparities in land access exist throughout Southeast Asia, and even when women do own land, they tend to have smaller holdings and poorer access to productive inputs and support services than their male counterparts (World Bank, 2012).

Lack of land and inheritance rights severely restricts women's autonomy, creates significant gendered power imbalances, and reinforces women's dependence on marriage as a survival mechanism. Timor-Leste's legal framework has not yet addressed customary, informal laws regarding land ownership. Ensuring women's rights to own and inherit land and resources will reduce their economic vulnerability, empower them and, in turn, enhance their ability to seek FP/MNCH services and produce positive health outcomes (Grown, Gupta and Pande, 2005).

Political participation and leadership

The political process in Timor-Leste generally does not promote or accommodate women's interests. Women who wish to become involved in politics contend with a range of institutional constraints. Of the women in political parties, only a few hold leadership roles and engage in the party's decision-making process (NGOs Working Group on CEDAW, 2009). Cultural constraints impede women from pursuing political activities as well. The patriarchal mentality is a major obstacle to women's political participation. Community traditions, interpretation of religious texts and values, as well as public policies reinforce the view that women are not equal to men. Internalizing this message, women come to lack confidence in their abilities to have an impact on the political process (NGOs Working Group on CEDAW, 2009).

At the regional level, there are no female governors in any of the 13 provinces and only one in the 65 districts (Japan International Cooperation Agency [JICA], 2011). Women enjoy more opportunities at the village level. The law for *suco* (village) elections stipulates that three seats in each village council must be reserved for women (NGOs Working Group on CEDAW, 2009). During the 2009 *suco* elections, UN Women organized transformative leadership trainings for potential candidates, 627 women and 232 men, in four districts. As a result, 20 percent of women running for the position of *chefe de suco* (village chief) and 57 percent of candidates for *chefe de aldeia* (hamlet chief) won elections in ten percent of the *sucos* in the target districts. Despite these successes, however, women confront challenges once elected to the village councils, whose members invest minimal effort in cultivating women's skills to perform their political duties effectively. The perception persists that Timorese women are not suited to be community leaders and their place remains at home (NGOs Working Group on CEDAW, 2009).

The impact of women rising to political positions on FP/MNCH service access and use cannot be underestimated. As more women take office, they tend to articulate once underemphasized policy concerns, advance new priorities, transform the nature of the debate, and promote the interests of previously neglected constituencies. Women and children usually benefit from an increased female presence in politics. Women office holders are more likely to formulate policies that seek to achieve gender equality, meet children's basic needs, and create family-friendly societies.

RECOMMENDATIONS—A HOLISTIC APPROACH TO EXPANDING FP/MNCH SERVICE ACCESS AND USE IN TIMOR-LESTE

This gender assessment of family planning and maternal, neonatal, and child health in Timor-Leste illuminates the normative, socioeconomic, and political variables, as well as existing power dynamics, that hinder or facilitate access and use of essential services. The analysis reveals that Timorese women confront significant obstacles in seeking FP/MNCH care, including longstanding patriarchal norms, insufficient access to vital resources such as education and employment, a lack of decision-making authority, GBV, an inconsistent and sometimes ineffective policy environment, a discriminatory legal framework, and inadequate female presence in political positions. These barriers exist amidst the historical legacy of colonialism and mixed international-civil war, which aggravated gender disparities and virtually destroyed the healthcare delivery system, along with much of the country's infrastructure.

This assessment leads to recommendations to assist donors and implementing organizations in eliminating gender-related barriers to seeking healthcare. These five recommendations reflect a holistic approach to expanding FP/MNCH access and use:

- Consider the impact of conflict and political instability on healthcare infrastructure, availability and accessibility of vital health services, gender norms and relations, and gender-specific barriers to health service access and use (Chynoweth, 2008; Kottegoda et al., 2008)
- Break down demand- and supply-side barriers to seeking healthcare by expanding coverage to poor and rural communities, including affordable care options that will not impede access and utilization (Paruzzolo et al., 2010)
- Improve healthcare quality and ensure that a wide range of services is available: counseling on family planning, contraception, antenatal care, and safe delivery services as well as comprehensive child health and nutrition services (Paruzzolo et al., 2010; USAID, 2011, 2012b)
- Empower women by increasing access to educational, employment, and leadership opportunities (Paruzzolo et al., 2010; USAID, 2012b)
- Target gender norms and practices that undermine women's and girls' ability to seek vital FP/MNCH services by engaging government institutions and civil society to develop policies and undertake initiatives aimed at improving women's status in society (Paruzzolo et al., 2010; UN Women, 2012; World Bank, 2012)

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