TIMOR-LESTE GENDER AND SOCIAL INCLUSION ANALYSIS AND ACTION PLAN

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Local Health System Sustainability Project

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Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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ACRONYMS

ADS	Automated Directives System
ADTL	Association for Disability in Timor-Leste
CCT	Cooperative Cafe Timor
CODIVA	Coalition for Diversity and Action
CSO	civil society organization
DHS	Demographic Health Survey
FONGTIL	Forum of Non-Governmental Organizations of Timor-Leste
GBV	gender-based violence
GESI	gender equity and social inclusion
HAI	Health Alliance International
LGBTI	lesbian, gay, bisexual, transgender, and intersex
MSSI	Ministry of Social Solidarity and Inclusion
PRADET	Psychosocial Recovery and Development in East Timor
SEII	Secretary of State for the Gender Equality and Social Inclusion (*Sekretaria Estadu ba Igualdade no Inkluzaun*)
SEM	Secretary of State for the Support and Socio-Economical Promotion of Women
SSYS	Secretary of State for Youth and Sports
TLDHS	Timor-Leste Demographic and Health Survey
VPU	Vulnerable Persons Unit
WHO	World Health Organization

EXECUTIVE SUMMARY

The gender equity and social inclusion (GESI) analysis for Timor-Leste includes key findings related to each objective area, recommendations, stakeholder mapping, and an action plan to integrate GESI into work plan activities based on the findings. Several key points are summarized here.

KEY FINDINGS

Objective 1: Strengthen Health Governance and Financing

- Timor-Leste lacks capacity to generate, interpret, and use quality data on gender and other social vulnerabilities. While some improvements have been made in regard to disaggregation of data, the absence of reliable and regular disaggregated data (income, sex, age, migratory status, disability, social groupings and geographic location) is a key challenge for evidence-based policy making and planning. This stems from a lack of significant sex-disaggregated data use within the Ministry of Health on a routine basis.
- There is strong female leadership within the Ministry of Health, but capacity, resources, and priority for gender mainstreaming, or ensuring gender considerations are incorporated into programs, remain low. The Ministry of Health has a gender focal point to promote gender equity policy and gender in planning – including for accessibility, quality, and management of health care services – but as with other ministries, implementation is still far from reaching established goals. Despite gender equity goals, training is not available to all staff on key gender topics; it is usually provided by international organizations such as United Nations agencies and local and international NGOs.
- Gender-responsive budgeting remains a priority for the country's Inter-Ministerial Gender Working Group, with support from the Ministry of Finance and the secretary of state for the gender equality and social inclusion (*Sekretaria Estadu ba Igualdade no Inkluzaun*) (SEII), but the Ministry of Health has indicated they do not have experience with gender-responsive budgeting. Earlier in 2021, UN Women launched the Spotlight Initiative to engage NGOs in state- and gender-responsive budgeting.

Objective 2: Strengthen Health Sector Workforce Management

- In Timor-Leste, the health workforce is dominated by men; in 2007, for example, there were nearly twice as many men compared to women (1,420 to 753) in Ministry of Health establishment posts. Medical doctors have more gender balance, the majority of nurses are male, and midwives are almost exclusively female.
- At the leadership level, the current minister of health is a woman, and the director general is also a woman. Many leading civil society organizations' directors are also women. However, at a more local level, the majority of district health services are led by men.
- Several gender-related factors affect retention, including sexual harassment and lack of safe accommodation, particularly in remote or suco (village) areas in municipalities.
- The incidence of gender-based violence (GBV) is high, but the competence of the health workforce to address and respond to victims of GBV is low.
- Although training and professional development opportunities are available for both men and women, trainings are often offered in international locations or Dili, rather than at the municipality level, and require travel, which is typically harder for women to manage along with their domestic home and caregiving responsibilities.

Objective 3: Strengthen Existing Community Health Systems to Improve Healthy Behaviors

- There is an overwhelming perception that there will be negative consequences for women, including conflict and violence, if they seek family planning information or services without permission from their husbands. Likewise, there is a need for education and consciousness-raising, especially in remote areas, about family planning as a legacy of entrenched gender norms.
- There are a high number of pregnancies among adolescent girls in Timor-Leste. One of the main causes of adolescent pregnancies is lack of knowledge on reproductive health, lack of access to contraception, and limited agency in terms of decisions on whether or not to have sex. Unmarried pregnant adolescents may face social costs such as rejection by their families, the end of their education, and the threat of violence.
- There is a high level of GBV, with several key factors contributing, including: attitudes that accept violence; traditional beliefs and customs surrounding marriage and gender roles; informal and formal legal justice systems that do not protect against violence; and lack of awareness of legal rights and ability to access the criminal justice system.
- The Ministry of Health aims to have no discrimination in providing health care to all citizens, including people with disabilities, but little has been done to address the needs of people with disabilities. Most health facilities were not accommodating to people with disabilities.
- Individuals who identify as LGBTI face stigma and discrimination. Research found that 18 percent of men who have sex with men and 43 percent of transgender persons had been refused health services in Timor-Leste.

Objective 4: Improve Civic Engagement

- During interviews, civil society organizations identified priority issues for GESI and health. These include: greater attention on GBV, including training of health professionals; disability rights, including accessibility of infrastructure; education on reproductive health and family planning, particularly for men, to increase women's access; policies mandating inclusion being translated into languages (dialects) most people can understand rather than only Portuguese; and access to health services for women in rural areas, including timely access for pregnant women to high-quality, trusted and friendly health services.
- Civil society organizations also mentioned that one of the biggest challenges when working with the government is that the government is constantly changing or reforming. For example, one government was supportive of disability inclusion work, but a change in the government meant starting over.

STAKEHOLDERS

Aligned with the definitions of forms of exclusion and key themes from the findings, the GESI analysis includes an index of important stakeholders in GESI for the Health System Sustainability Activity in Timor-Leste. GESI is a cross-cutting issue, with stakeholders beyond those in the health sector specifically. This mapping will serve as the basis for coordination in integration of GESI considerations.

ACTION PLAN

Based on the findings of the GESI analysis, the Activity developed a GESI action plan for the Activity. The plan provides a set of specific and achievable recommendations to enable the project to mainstream a

gender and social inclusion lens across its activities. The Health System Sustainability Activity will prioritize consideration of these recommendations during its annual work planning and over the life of the project.

1. INTRODUCTION

1.1 BACKGROUND

The USAID Health System Sustainability Activity in Timor-Leste is part of USAID's Local Health System Sustainability project, a global initiative to help countries achieve sustainable, self-financed health systems and support access to universal health coverage and improve health and well-being. The Activity is implemented by Abt Associates with support from sub-implementing partners, including Banyan Global. The purpose of the Activity is to help ensure that more Timorese citizens can access affordable health services through a well-functioning national health system.

In support of this overarching purpose, the Health System Sustainability Activity in Timor-Leste focuses on four objectives:

1. Objective 1: Strengthen Health Governance and Financing
2. Objective 2: Strengthen Health Sector Workforce Management
3. Objective 3: Strengthen Existing Community Health Systems to Improve Healthy Behaviors
4. Objective 4: Improve Civic Engagement

A GESI strategy was developed within the framework of the global project. The strategy aims to integrate a gender equity approach into all project activities to maximize the effectiveness of project planning and empower the health systems with an inclusive perspective. The GESI strategy for the project is consistent with the USAID Gender Equality and Women's Empowerment Policy and other key Agency and U.S. government policies aimed at guiding project activities, such as the 205 Automated Directives System (USAID - ADS 205, 2017).

The GESI strategy for the global project has six strategic components, including: obtain a statement of commitment to GESI by its partner countries; conduct GESI analyses; focus on staff development (recruitment, training, GESI focus points, etc.); integrate GESI into planning and budgeting; include GESI in monitoring, evaluation, and knowledge management; and develop local capabilities. In line with the GESI strategy, this document is the GESI analysis for the Timor-Leste Activity.

1.2 METHODOLOGY

The analysis consisted of conceptualization, desk research, interviews with key stakeholders (primary data collection), and analysis of the gathered information.

From June through July 2021, as part of the desk research, the USAID Health System Sustainability Activity reviewed documents relevant to gender equality and social inclusion. Documents included government publications, academic articles, and research and reports conducted by local and international organizations related to the topical areas. From August through September 2021, they conducted 25 qualitative interviews with key stakeholders in Timor-Leste. These stakeholder informants represented a variety of government institutions and civil society organizations, which are listed in Annex 1: Organizations Interviewed.

Through these interviews, the Activity gained important insight into gaps in access to health care and how to improve access to and quality of health services for women, intersex or transgender people, and people with disabilities. The Activity will be able to draw on this information as it invests in capacity

development and supports activities related to gender equality and social inclusion.

The five domains of the Gender Analysis Framework included in USAID Automated Directives System 205 were considered in analyzing the data (USAID PPL, 2021). These are as follows:

- Institutional laws, policies, and practices: The laws include formal statutory laws and informal and customary legal systems. Policies and regulations include formal and informal rules and procedures adopted by public institutions to make decisions and launch public actions. Institutional practices may be formal or informal and include behavior or standards related to human resources (hiring and firing), professional conduct (workplace harassment), and the like.
- Cultural norms and beliefs: Every society has cultural norms and beliefs (often expressed as gender stereotypes) about what are the appropriate qualities, life goals, and aspirations of men and women. Gender norms and beliefs are influenced by perceptions of gender identity and expression and are often supported by and embedded in laws, policies, and institutional practices.
- Gender roles, responsibilities, and time use: The most fundamental division of labor within all societies is between productive (market) economic activity and reproductive (non-market) activity. This is the central social structure that characterizes male and female activity.
- Accessing and controlling assets and resources: Whether women and men or other socially defined groups own and/or have access to, and the capacity to use, productive resources: assets (land, housing); income; social benefits (social security, pensions); public services (health, water); technology; and necessary information to be a fully active and productive member of society.
- Power and decision-making patterns: Whether women and men or other socially defined groups are able to decide, influence, and exercise control over material, human, intellectual, and financial resources, in the family, the community, and the country. It also includes the ability to vote and run for public office at all levels of government.

While the team took steps to avoid or minimize potential limitations or challenges when conducting the GESI analysis, some limitations were beyond our control, and it is important to acknowledge their potential impacts on analysis methodology, findings, and recommendations:

- COVID-19-related travel restrictions and lockdowns in Dili affected the team's ability to schedule interviews. Many meetings were cancelled at the last minute and had to be rescheduled.
- Many interviews were conducted online because of the lockdowns, and for a few of these, poor internet connectivity was a problem.

2. FINDINGS

The Gender Development Index (GDI) is based on the sex-disaggregated Human Development Index (HDI). The HDI is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and have a decent standard of living. The GDI measures gender inequalities in achievement in three basic dimensions of human development: health (measured by female and male life expectancy at birth), education (measured by female and male expected years of schooling for children and mean years for adults aged 25 years and older) and command over economic resources (measured by female and male estimated GNI per capita). Timor-Leste ranks 141 on the HDI, out of 189 ranked countries (UNDP, 2020).

Table 1. Timor-Leste Human Development Indicators

Indicator	Timor-Leste
HDI value	0.606 (0.587 for females; 0.623 for males)
Life expectancy at birth	69.5 (71.6 for females; 67.5 for males)
Expected years of schooling	12.6
Mean years of schooling	4.8 (3.8 for females; 5.6 for males)
GDI	0.942
Gender Inequality Index (GII)	N/A

Source: UNDP, 2020

2.1 DEFINING FORMS OF EXCLUSION

It is important to define forms of exclusion and vulnerable groups as specifically as possible. An analysis of the impact of COVID-19 in Timor-Leste found systemic gender inequality and exclusion of marginalized groups from decision-making and services, which is likely to exacerbate the impact of the pandemic on vulnerable groups (Nguyen, 2020).

Women. 60 percent of women in Timor-Leste have reported problems in accessing health care. The maternal mortality during the 7-year period before the most recent 2016 TLDHS was estimated at 195 maternal deaths per 100,000 live births. Use of modern family planning methods is low; 16 percent of all women and 25 percent of currently married women are using modern contraception (GDS, 2018). The low use of modern contraceptive methods contributes to Timor-Leste's high fertility rate (4.2 births per woman (GDS, 2018)) and increasing the number of women at risk (Nguyen, 2020). Additionally, there is stigma associated with offering family planning methods to unmarried women.

Men. Although men traditionally hold power and access to resources relative to women, men can have trouble accessing and receiving health services, for various reasons.

Children. The median age of first marriage is 21.7 years among women aged 25-49 and 26.8 years among men aged 30-59 (GDS, 2018). An estimated 19 percent of girls in the country are married prior to the age of 18 (U.S. State Department, 2021). Teenage pregnancy is common, with 7 percent of women aged 15–19 having already started childbearing (GDS, 2018). The highest prevalence of early childbearing is among adolescents who are poor, uneducated, living in rural areas, and living in Oecussi, Liquicia, and Manufahi (GDS, 2018). Women aged 15–19 are five times more likely to experience violence during pregnancy (GDS, 2018), and these figures may be underestimates (Wild, 2020).

People living in remote or isolated areas. Around 70 percent of the population lives in rural areas and is largely dependent on subsistence agriculture or fishing (GDS, 2018). Midwives report that women who are socially or geographically isolated are more at risk of violence, and they are less likely to report violence (Wild, 2020). The government signed the Maubisse Declaration in 2015 and again in 2018, which outlines actions by ministries to improve service provision for and participation by women and people with disabilities in rural areas, but implementation progress has been slow (Wild, 2020). Employment has not increased significantly for rural women and there continues to be limited access to safety, protection, and opportunities for protection. People in rural and remote areas are less likely to have a radio, television, computer, cell phone, or their own transportation, which is important for improving healthy behaviors or accessing health services. To get to health facilities, patients or others

living in remote areas have to deal with long trips on bad roads with no public transportation available. Skilled assistance during delivery is much more common in urban areas (86 percent) than rural areas (86 percent) (GDS, 2018). 70.5 precent of rural women reported at least one problem accessing health care compared to 40.2 of urban women. In rural areas, the top reported reasons for problems in accessing health care among women aged 15-49 included distance to health facility, having to take transport, and not wanting to go alone. 80.6 percent of rural women also had at least one concern about the availability of care, compared to 67.6 percent of urban women (GDS, 2018).

Disability. According to the 2015 census, 49.1 percent of the population lives with a disability including walking, seeing, hearing, or intellectual/mental condition (GDS, 2016a). The Constitution grants equal rights to, and prohibits discrimination against, persons with disabilities, in addition to requiring the state to protect them. It says, "A disabled citizen shall enjoy the same rights and shall be subject to the same duties as all other citizens, except for the rights and duties which they are unable to exercise or fulfill due to their disability" (Constitution of the Democratic Republic of Timor-Leste, Article 21, 2002). Eighteen percent of the population five years old and older reported some level of difficulty in at least one domain of functioning, including seeing, hearing, communicating, remembering or concentrating, walking or climbing steps, or washing all over or dressing (GDS, 2018). Seventy-two percent of people with a disability have never attended school. The establishment of a national disability council by the Government of Timor-Leste, planned for several years, remains pending (Brown, 2020). Service providers note domestic violence and sexual assault against persons with disabilities ais a growing concern (U.S. State Department, 2021). The health system has few specialists in disability-inclusive health, although there has been progress with disability-inclusive health training in Baucau, Ermera, and Dili (Wild, 2020). With respect to social protection for people with disabilities, it is reported that 85 percent of people with a disability are not receiving Timor-Leste's disability pension (Asian Development Bank, 2014). No hospitals or health posts have a wheelchair access/ramp.

People who identify as LGBTI. People who identify as lesbian, gay, bisexual, transgender, or intersex (LGBTI) experience stigma, discrimination, and violence in Timor-Leste. Research by the women's organization Rede Feto found widespread rape, physical and psychological abuse, ostracism, discrimination, and marginalization of people who identify as lesbian, bisexual, or transgender (U.S. State Department, 2021). For example, 86 percent of respondents, who were lesbian, bisexual, and transgender women, reported both physical and psychological violence (Saeed, 2017). This extends to experiencing discrimination when accessing health services (Wild, 2020). In addition, most transgender people are asked to provide their assigned birth name or are discriminated against if they use their preferred name when accessing health services.

Language. Younger, Indonesian-and Tetum-speaking activists have found it difficult to engage with the government due to a perceived government preference for using Portuguese. Many government documents are produced only in Portuguese, not Tetum, making access more difficult for some people (Brown, 2020). Even though the official language is Portuguese and Tetum (the local language spoken by the vast majority of the population), few laws have been translated into Tetum. Where there is a conflict in translation between the Tetum and Portuguese, the Portuguese version is used. Only a small portion of the population are proficient in Portuguese; the most recent census reported Portuguese is the mother tongue for 0.12 percent of the population, a second language for 2.79 percent of the population, and a third language for 3.22 percent of the population (GDS, 2016b). The same census shows that the number of people speaking English and Indonesian in Timor-Leste far surpass those speaking Portuguese

even in those below age 20. Some people in rural areas understand only their own dialects, and this can be a challenge when disseminating information if proper translations are not available. For example, per the 2015 census, only four (4) people in Oecussi speak Portuguese.

2.2 LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

Gender equality is ingrained in government policy in Timor-Leste. Article 6 and Article 17 of the Constitution state that women and men "have the same rights and duties in all areas of political, family, economic, social, and cultural life," and a fundamental objective of the state is "to create, promote and guarantee the effective equality of opportunities between women and men" (Constitution of the Democratic Republic of Timor-Leste, Section 6 and 17, 2002). Timor-Leste has signed and ratified major gender-related conventions including The Convention on the Elimination of All Forms of Discrimination against Women**,** International Covenant on Civil and Political Rights, and International Covenant on Economic, Social and Cultural Rights, and has undertaken legal obligations to respect, protect, and fulfill the human rights of women in Timor-Leste. GoTL also committed to achieve SDG 5 and Timor-Leste submitted a Voluntary National Review on progress toward the SDGs.

In 2009 a law was enacted to include mistreatment of a spouse or child as a crime, which anyone can report, and the state is obliged to investigate and prosecute crimes. In 2010 the Law Against Domestic Violence was passed, providing protection to spouses, ex-spouses, families, and domestic workers from physical, sexual, psychological, and economic abuse including threats, intimidation, insults, bodily assault, coercion, harassment, and deprivation of liberty (Wild, 2020). In practice, implementation of the law is weak and typically thought of only for physical violence against women (Wild, 2020).

There are two articles in the Law Against Domestic Violence relevant to health workers. Article 22 states that health workers are required to provide medical care and follow-up, preserve of evidence, inform the victim of their rights, help report the facts of the case to the police, and refer the victim to a shelter or other services. Article 40 states that all staff are subject to professional confidentiality rules and should not reveal any facts they learned through providing care to victims of violence. Consent based on the free will of the victim should be obtained before sharing any of their information (Wild, 2020).

While Timor-Leste has made progress in developing a National Action Plan on Gender-Based Violence, including an emphasis on developing curricula and training responders, ensuring privacy and confidentiality in health facilities, and developing referral pathways, the top-down approach for the development rather than engaging with communities and civil society organizations limits the implementation in reality, especially in rural areas. Likewise, there is a lack of sustained government funding for services to address GBV (Wild, 2020). Funding to address gender-based violence GBV mostly comes mostly from United Nations agencies such as the United Nations Development Programme, UN Women, the United Nations Population Fund, and the Department of Foreign Affairs and Trade of the Government of Australia.

2.3 GENDER ROLES, RESPONSIBILITIES, AND TIME USE

Fertility is highly valued in Timor-Leste and there are expectations around having children as soon as possible after marriage (Wild, 2020). Timor-Leste has made progress in reducing its total fertility rate

from 5.7 in the 2009–2010 Timor-Leste Demographic and Health Survey (2009-10 TLDHS) to 4.2 in the 2016 Timor-Leste Demographic and Health Survey (2016 TLDHS) (GDS, 2018); however, family planning remains a challenge, with nearly a quarter of married women having unmet need (GDS, 2018).

The division of labor in Timor-Leste is governed by traditional patriarchal norms and practices, with women primarily responsible for domestic work and childcare (Wild, 2020). Even women with paid jobs outside the household are still responsible for household duties including cooking and childcare.

The employment rate is higher for men (72 percent) than women (34 percent) in Timor-Leste (GDS, 2018). Barriers to employment for women or for better pay include limited training and education, lack of access to opportunity, and domestic responsibilities. Women are more likely to work in the informal sector, performing jobs characterized by lack of wage protections, unsafe working conditions, inability to negotiate leave or working hours, and layoffs without notice or compensation (Wild, 2020). Most women are still excluded from the formal workforce and do not have the chance to have stable income; therefore, the majority of women remain economically dependent on their husband, partner, or families.

2.4 CULTURAL NORMS AND BELIEFS

Timorese society is primarily patriarchal and patrilineal, although certain ethno-linguistic groups are matrilineal, including Tetum-Terik, Bunaque, and Galoli (in some areas of Covalima, Bobonaro, Ainaro, Viqueque, Manatuto and Manufahi), representing about 13 percent of the population (Wild, 2020). Within the patriarchal society, men are still seen to be responsible for making decisions in the household, and act as the breadwinner of the family. Cultural values that Timorese society has reinforce male authority over women and limit the choices available for women.

Health seeking behavior is related to various factors including distance, economics, and perceived need for care; there are also gendered factors related to health seeking behavior (Zwi, 2009). The 2016 TLDHS asked women about both problems accessing health care and concerns about the availability of health care. In the 2016 TLDHS, more women reported concerns about the availability of health care than problems accessing health care. Seventy-six percent of women report at least 1 of the 5 concerns about the availability of care. The major concern is about availability of medicines (cited by 72% of women). Sixty percent of women say they are concerned about the quality of care, and the same proportion are concerned about the availability of any health provider. Fifty-two percent of women are concerned about the availability of a female health provider. Fifty-six percent of women say they have concerns about being treated respectfully (GDS, 2018). In addition, research from 2013 concluded midwives are not always trusted by the women in the communities they serve. One example is women are reluctant to seek care for fear of being reprimanded by a midwife for not presenting earlier or for not attending regular antenatal care (O'Dwyer, 2013).

Within problems of accessing health care, distance and transport are the leading issues in accessing health care, but cultural factors include not wanting to access care alone (41 percent and 3rd leading issue for accessing health care) and getting permission to go (35 percent and 5th leading issue) (GDS, 2018). Family members are very involved in both making and executing decisions about when and where to seek help. A husband's parents may be involved in decisions related to spacing children or using contraceptives (Zwi, 2009). Decisions to seek care during labor and birth are often made by the husband or the woman's mother-in-law (Wallace, 2016). Health care utilization in Timor-Leste is higher among the higher wealth quintiles. Immunizations, treatment of acute respiratory infections, and use of

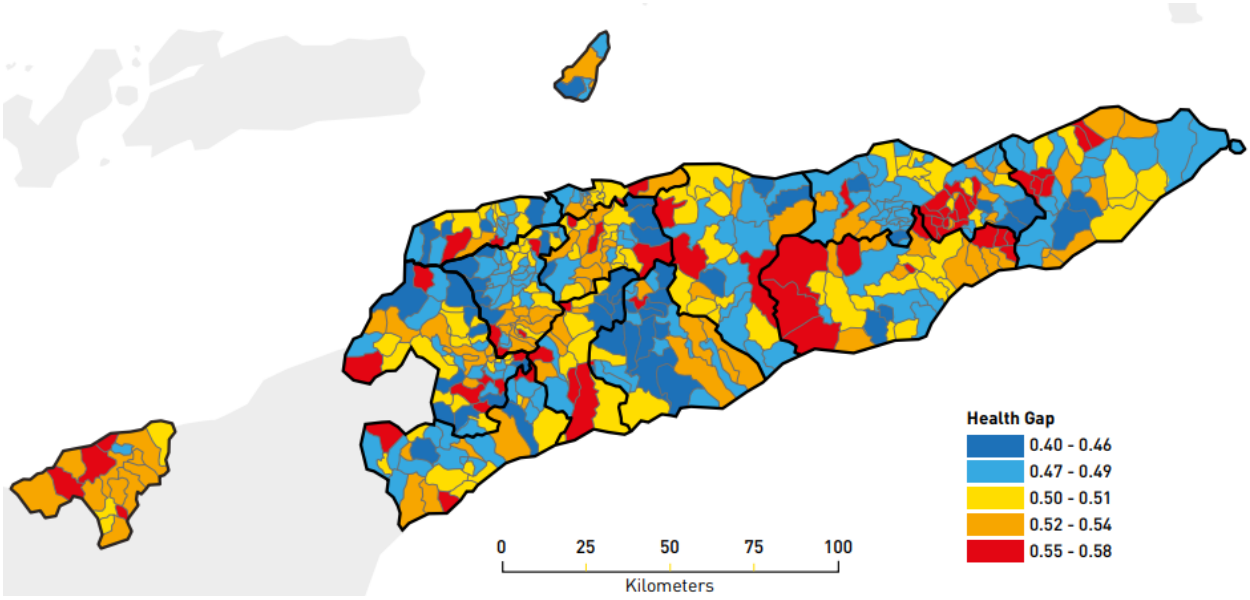
bed nets are higher among children from wealthier households. Skilled antenatal care and delivery, contraceptive prevalence and use of bed nets are also higher among women from wealthier households (World Bank, 2014).

In the most recent TLDHS, women (74 percent) were more likely than men (53 percent) to agree with at least one justification for a man beating his wife (GDS, 2018). The 2016 TLDHS also found that only 34 percent of women and 40 percent of men believe a woman is justified in refusing to have sex with her husband. Research from four municipalities (Ermera, Dili, Baucau, and Viqueque) found that both men and women use the term *obriga,* which means force in Tetun, to describe men's entitlement to sex and the likelihood of violence if a woman refuses (Wallace, 2020). Traditional attitudes, especially for people living outside Dili, encourage them to marry young.

2.5 ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

Research from the World Bank and General Directorate of Statistics on gender-disaggregated indicators at the *suco* level found there is no clear correlation between poverty and gender gaps in health.[1] But there are differences in gender health gaps between *sucos*. The research used data from the 2015 Population and Housing Census, the 2014 Survey of Living Standards, and the 2016 TLDHS.

Figure 1. Index of Gender Gaps in Health at Suco Level



Source: The World Bank and GDS, 2019

The average number of years of school completed in Timor-Leste is similar for men (7.5 years) and women (8 years), but varies considerably by municipalities; for example, in Ermera, men complete on average 5.3 years of school compared to women's 2.5 years (GDS, 2018). In a study on the primary

[1] The index of gender gaps in health is measured by the difference between female-male household members in the number of days spent being ill in the past 30 days or hospitalized in the past 12 months. The map presents the proportion of households with a female disadvantage in health.

health care system in Timor-Leste, midwives identified lack of education as perpetuating a lower status of women and contributing to domestic violence, because of the lack of knowledge that violence against women is wrong, and because of the inability of women to speak up (Wild, 2016). A highly patriarchal society contributes to the marginalization of women in land ownership or property. Generally, women can live on, use, and manage land, but they do not own the land they live on. Differences in land ownership rights between women and men contributes to structural inequality and to poverty for women in Timor-Leste.

2.6 PATTERNS OF POWER AND DECISION-MAKING

Under Article 12 (3) of the 2006 Law on the Elections of the National Parliament (as amended in 2011), on electoral lists, one out of every group of three candidates must be a woman. In Timor-Leste as of 2018, 25 of the 65 total seats in the National Parliament (38 percent) were held by women (International IDEA, n.d.). At the subnational level, men and women may be elected to Local Suco Councils. Under the electoral law, the Local Suco Councils must be composed of the local *suco* chief, the chiefs of all the villages that are included in the local districts, and, additionally, two women; two youth representatives, one of each sex; and one elder (International IDEA, nd). At the same time, the quota system leads to views of female representatives as tokens, and there are still problems with male-dominated politics and patriarchal norms prioritizing men's status and power (Niner, 2011).

Eighty-seven percent of women say they make decisions about household purchases, visiting family and relatives, and health care either by themselves or jointly with their husband (GDS, 2018). The proportion of currently married women aged 15-49 who participate in each of the 3 decisions asked about has increased since the 2009-10 TLDHS: participation in decisions about their own health care increased from 87% in 2009-10 to 93% in 2016; in the same period, participation in decisions about making major household purchases increased from 86% to 94% and in making decisions about visits to her family or relatives increased from 91% to 94% (GDS, 2018). However, levels of female decision-making may be lower across inland areas (Nguyen, 2020).

3. ANALYSIS PER TIMOR-LESTE OBJECTIVE AREA

The following is a synthesis of the findings from the five- domain GESI analysis and the interviews and consultations, organized by objective area.

3.1 OBJECTIVE 1: STRENGTHEN HEALTH SECTOR GOVERNANCE AND FINANCING

The Timor-Leste National Health Sector Strategic Plan 2011–2030 includes few gender-sensitive strategies. It notes the need to respond to "different situations and requirements of men and women," and commits to developing guidelines for mainstreaming gender issues in health sector planning. The plan mentions affirmative action to address the needs of vulnerable groups, including women, children, and people with a disability, but the specifics are not outlined. A recent gender and health assessment found that the health policy framework provides a strong foundation, but that "efforts to tackle inequalities have been inconsistent" (Asian Development Bank, 2014). Key issues for women, including maternal and child health, are top priorities for the Ministry of Health. Despite key metrics improving (proportion of women receiving antenatal care from a skilled provider, women delivering with assistance

from a skilled birth attendant, and number of antenatal visits), maternal and infant mortality remain among the highest in the world.

MoH Institutional Capacity to Generate, Interpret, and Use Quality Data to Inform Policy (Intervention 1.1 and 1.2)

Collecting and analyzing disaggregated data is a crucial first step for equitable resource optimization, but many government agencies, including the Ministry of Health, lack data and lack experience using disaggregated data to inform planning or policy. According to the United Nations Sustainable Development Cooperation Framework (United Nations Timor-Leste, 2020), "while some improvements have been made in regard to gender disaggregation of data, the absence of reliable and regular disaggregated data (income, sex, age, migratory status, disability, social groupings and geographic location) in certain national surveys and government administrative data is a key blockage to evidence-based policy making and establishing future projections necessary for government planning. While the data gaps are clearly recognized to hinder the progress of the country towards the SDGs, the technical and institutional capacities in ministries, government bodies and offices to plan, allocate resources and undertake data collection, data analysis, monitoring and reporting remain weak."

Lack of sex-disaggregated data. Sex-disaggregated data is essential for decision-making. Improving data collection and monitoring and evaluation is one of the priorities of the health sector strategic plan, but more rigorous efforts should be directed to collecting sex-disaggregated data that reflect women's health care needs, analyzing and disseminating such information, and regular monitoring to assess progress (Asian Development Bank, 2014). The UNSDCF 2021-2025 echoes this and suggests digital technologies and making disparate systems interoperable (District Health Information System-2, Human Resources Registration System, Logistics Management Information System, maternal health, ambulance system, quality control system and others) are needed to improve quality of data, including sex, age and disability disaggregated data, as well as specific data collection system targeting and involving participation of the marginalized groups (United Nations Timor-Leste, 2020). Through interviews, the Ministry of Health indicated they have sex-disaggregated data, but it is typically limited to workforce data and not used for decision-making. The ministry's Statistics Department compiles and collects data on health, including creating the Family Registration System, an online platform to register health information of Timor-Leste citizens. That system includes maternal and child health information, but not all of it is sex-disaggregated or disability- disaggregated. It is difficult to track gender inequality in health when sex-disaggregated data is difficult to obtain.

Limited resources and capacity in data management and analysis make it difficult for agencies to meet the requirements for gender-related monitoring and evaluation. There are long-recognized calls for ongoing capacity development to build the skills and systems to efficiently produce and use data for gender-related monitoring (Asian Development Bank, 2014). This includes developing practical guidance in local languages and data visualizations for policymakers to effectively mainstream GESI into their work.

Capacity for GESI issues. Starting in 2002, an Inter-Ministerial Working Group identified gender focal points in all ministries to help develop mainstreaming strategies starting in 2002 (Asian Development Bank, 2005). Appointing long-term gender advisers in key ministries had been a strategy for bringing in expertise, increasing gender awareness, and ensuring public administration is gender sensitive. These advisers brought experience in how to incorporate gender issues into planning, budgeting, and policy

and program development, addressing skills shortages in these areas and building the capacity of others. The mechanism was successful in that it supported some ministries to conduct gender assessments of their activities, elaborate gender strategies or policies and run internal gender trainings. However, the gender focal points faced challenges including lack of support from the ministries or secretaries of state, lack of experience and training on gender issues themselves and, crucially, an inability to influence planning or budgeting processes due to their lack of involvement in the planning stage of government activities and in budget setting (O'Dwyer, 2013). A 2009 assessment of gender mainstreaming in several ministries, including health, found progress, such as the appointment of focal points, drafting of gender strategies, and raising awareness and capacity of staff. However, most advisors were donor funded and the initiative was not sustained.

The gender focal point system was replaced with the Inter-Ministerial Gender Working Group mechanism, which aims to make coordination more effective, provide easier monitoring and better promote gender mainstreaming by integrating higher level personnel with greater influence into the group. The World Health Organization (WHO) supported the Ministry of Health in establishing the Gender Working Group to strengthen coordination among programs on gender equity. In collaboration with development partners, the WHO supported the development of the National Action Plan on Gender-Based Violence (WHO, 2016). A goal for the National Health Sector Strategic Plan 2011–2030 is to develop guidelines for mainstreaming gender issues in health sector planning, in line with National Gender Policy (WHO, 2016). The Inter-Ministerial Gender Working Group created combined reports on progress on the CEDAW with responses from 12 ministries, but the Ministry of Health was not one of them (O'Dwyer, 2013).

In the Ministry of Health there is no gender training available to all staff. Some specific departments have training on gender; for example, the epidemiology department received training on gender and sex disaggregation as related to COVID-19, but there is no uniform training available across the Ministry of Health. Training on gender is usually provided by international organizations, such as United Nations agencies, WHO, and local and international NGOs.

Improve Resource Optimization and Health Financing at the National and Subnational Levels Through Improved Data, More Efficient Budgeting Processes, and More Evidence-Based Advocacy (Intervention 1.3)

Gender-responsive budgeting. Gender-responsive budgeting seeks to improve gender equality, support long-term economic growth, increase transparency and accountability, improve operational efficiency, and strengthen data collection and indicators. The government officially introduced gender-responsive budgeting in 2009 through parliamentary resolution no.12/2010, but the process of gender-responsive budgeting started in 2003 during the administration of then Office of the Advisor on the Promotion of Equality (Department of Foreign Affairs and Trade, Australian Government, n.d.). Male members of Parliament at first resisted the effort, saying it could be construed as special treatment to women and therefore anti-gender equality (Costa, 2019). In the initial implementation, the gender budgeting initiatives focused on fiscal issues within the context of rights-based goals such as women's equality, women's economic empowerment, poverty reduction, eliminating GBV, and enhancing women's role in decision-making, education, and health (Christie, 2016). More recently, efforts at mainstreaming gender have focused on incorporating issues into the Annual Action Plans of each ministry and state institution with the aim of translating these ultimately into programming and budgets.

An analysis of gender-responsive budgeting in 24 countries, including 13 from the Caribbean and 11 from the Pacific Islands, found Timor-Leste was the only place with on-going significant gender budgeting initiatives. Most places did not carry initiatives beyond a pilot period (Tamoya, 2016). The sustained efforts are attributed to a strong legal framework and institutionalization. For example, integration of gender in Annual Action Plans can be regarded as the centerpiece of the gender budgeting framework in Timor-Leste (Tamoya, 2016). The number of ministries and state institutions that included provisions and actions related to gender equality in their Annual Action Plans doubled from 14 to 28 between 2013 and 2014 (Christie, 2016). While Annual Action Plans represent a potentially strategic entry point for gender budgeting, the current AAP format does not allow for in-depth analysis (Tamoya, 2016).

There are remaining challenges for gender-responsive budgeting in Timor-Leste. Some of the factors limiting gender-responsive budgeting include lack of data and limited transparency in tracking spending, (Johnston, 2018). Limited availability of sex disaggregated data makes it nearly impossible to track the implementation of programs mentioned in the Annual Action Plans (Tamoya, 2016).

While some may have thought that the adoption of a gender-responsive budgeting strategy was premature, Monica Costa, author of *Gender- Responsive Budgeting in Fragile States, The Case of Timor-Leste* argues that gender-responsive budgeting initiatives have contributed to budget accountability and transparency, and ultimately improved policy and budget processes and decisions (Costa, 2019). But efforts are largely donor-supported, and some see it as a formality or rubber-stamp rather than meaningful (Johnston, 2018).

Through interviews, Ministry of Health staff indicated they did not have experience with gender-responsive budgeting. However, the Inter-Ministerial Gender Working Group, across several ministries, has prioritized mainstreaming gender into the budgeting process. Some examples of the gender-related sections of Annual Action Plans include: the Secretary of State for Vocational Training and Employment identifying young people (male and female) for training in producing and sewing local products for the hospitality industry; the Ministry of Defense and Security planned workshops to raise awareness about mechanisms for defending rights, including the issue of women's access to justice and legal assistance with an emphasis on ensuring gender balance in attendees; and several ministries included specific gender targets for recruitment and training of staff.

The Ministry of Finance is taking part in the Inter-Ministerial Gender Working Group, where it plays an important role in mainstreaming gender into the budgeting processes, and also issues budget circulars to all government agencies to consider the gender dimension in their budget and annual work plans.

The SEII also promotes gender mainstreaming within public sector development planning and budgeting in Timor-Leste. In 2012, SEII's (then the Secretary of State for the Support and Socio-Economical Promotion of Women [SEM]) ability to advocate for gender budgeting was strengthened by its inclusion on the Budget Review Committee. The SEII is also assigned the task of promoting gender mainstreaming as a strategy to be applied in all development sectors and at all levels of operational activities, from the national to the grassroots level, including technical support and capacity-building to line ministries to facilitate mainstreaming of gender into planning and budgeting. In 2014, UN Women trained members of SEM, along with the Ministry of Finance and technical advisors were seconded to SEM and the Ministry of Finance (Darisuren, 2016). In 2016, UN Women recommended SEM strengthen the coordination functions across the ministries and convene regular exercises, including strengthening training for gender focal points in decentralized government units (Darisuren, 2016).

Earlier in 2021, UN Women launched the Spotlight Initiative to support transformative change on the ground to end violence against women and girls, including seeking NGOs to engage in capacity development with civil society on the state budgeting process and gender-responsive budgeting for addressing violence against women and girls. Planned activities include organizing the Gender-Responsive Budgeting Working group, building civil society organizations' capacities including for women with disabilities and members of the LGBTI community, facilitating capacity development sessions, and preparing briefs and consultations with oversight bodies including Parliament (UN Women, 2021).

GESI in health financing. The WHO describes user fees for health as "the most inequitable method for financing health care services," (WHO, 2008) given the differential effect on men and women from societal and household norms around control and distribution of resources. Global research indicates women individually or female-headed households are at greater risk of experiencing financial hardship from out-of-pocket health spending, suggesting a need to find innovative approaches that target women with policies that eliminate direct payments (WHO and World Bank, 2019). However, in Timor-Leste out-of-pocket spending as a share of total health expenditures is 7.8 percent (World Bank, 2018). Other social stratifications such as socio-economic status and age can constrain financial protection in health services, for example, women's health-specific services or access for older men or women, or for widows.

There are costs other than services associated with accessing health care. Despite public health care being free at the point of delivery in Timor-Leste, wealthier patients access hospital care at nearly twice the rate of poorer patients. Lack of patient transport is the critical cross-cutting issue preventing access to hospital care. Without it, many communities resort to carrying patients by porters or on horseback, walking or paying for (unaffordable) private arrangements to reach hospital, or opt for home-based care. Other significant out-of-pocket expenses for hospital visits were blood supplies from private suppliers; accommodation and food for the patient and family members; and repatriation of the deceased. Consequently, some people report they would never return to hospital, others delayed seeking treatment or interrupted their treatment to return home (Price, 2016).

A 2014 World Bank report concluded that the distribution of government spending on health was "pro-rich" (World Bank, 2014). Using data from two most recently available Living Standards Measurement Surveys for utilization of health services and government expenditure data at the hospital and district levels from the Ministry of Health and the Ministry of Finance, the report stated spending on hospitals is "pro-rich" whereas spending on district health services is "pro-poor" (World Bank, 2014). When it comes to lower-level health care services such as community health centers, health posts and mobile clinics, government spending is also "pro-poor" according to the World Bank. Taken together, total subsidies for health are found to be pro-rich and generally, government expenditure on health favors the better-off (World Bank, 2014). As an example of the impact, women in the highest wealth quintile are more likely to receive ANC from a skilled provider than women in the lowest quintile (95 percent versus 72 percent) (GDS, 2018).

Research shows that unless explicit attention is paid to gender and social inclusion factors, for example, poverty among women, unemployment among men, or female-headed households, movement toward increasing domestic resource mobilization and universal health coverage can fail to improve gender equality and can even exacerbate inequalities (Witter, 2017).The overall experience from both South America and Asia has been that demand-side financing, although primarily focused on maternal and child

health services, can be effective in reducing the financial barriers to access, and can increase use of prioritized health services, but fails to address underlying gender norms limiting ability to pay for and access services (Witter, 2017). Further, applying a gender-lens to resource allocation often simplifies thinking into women's services, leaving out key considerations for men and other groups.

To find efficiencies in health spending requires monitoring for gender bias in resource allocation. In reprioritizing resourcing for health services, maternal and child health services are typically protected, but certain reproductive health and family planning services can be left out, such as GBV services.

3.2 OBJECTIVE 2: STRENGTHEN HEALTH SECTOR WORKFORCE MANAGEMENT

Globally, women account for 70 percent of the health and social care workforce, but in Timor-Leste, the health workforce is dominated by men. In 2007, for example, there were nearly twice as many men compared to women (1,420 to 753) in Ministry of Health establishment posts. Table 2 shows the distribution of health workers in Timor-Leste in 2019, but only includes medical doctors and nursing personnel. Other sources indicate 39 percent of the health workforce is female, when including medical specialists, doctors, nurses, midwives, lab technicians, public health officers, and health managers and administrators (Asian Development Bank, 2014). There is little data available, but community health volunteers, or *Promotores Saude Familia*, are likely majority female.

Table 2. Distribution of Health Workers in Timor-Leste, by Sex

	Male, %	Female, %
Medical doctors	51.5	48.5
Nursing personnel	61.9	38.1

Source: Global Health Observatory data repository, 2019

At the leadership level, the current minister of health is a woman, and the director general is also a woman. In other relevant ministries, the minister and vice minister of social solidarity and inclusion are both women, as are the vice minister of finance and many leading civil society organizations' directors. However, at a more local level, the majority of Municipal Health Service (MHS) team are led by men (Asante, 2011).

Strengthen Government of Timor-Leste Systems to Recruit and Retain a Qualified and Competent Health Workforce, and Allocate that Workforce More Equitably Across the Country (Intervention 2.1)

Recruitment. Timor-Leste has had challenges with human resources for health recruitment over the last two decades. Historically, men have dominated health professions. When the Human Resources Department advertises a job vacancy it always encourages women to apply. In 2003, the government adopted a program to train medical doctors in Cuba, with the expectation that those trained returned to serve in Timor-Leste and were automatically absorbed in the public health sector. The program sought to have gender balance in the selection, as well as quotas based on the geographical origin of the candidates, with the intention that they would be deployed in their districts of origin ensuring an appropriate coverage across districts, increasing retention and health worker acceptability for local communities (Bertone, 2018). In 2017, the gender distribution of the medical workforce was almost

equal with a male to female (M:F) ratio of 1.01 although the balance was in favor of males at specialist level (M:F ratio of 2.6) (Bertone, 2018).

Most recently, in 2016, introduction of the "special regime" for access to higher education for families of military and police officers, diplomats, members of Parliament, journalists, elite athletes, and students from international secondary schools contributed to lack of equity in the recruitment system. Although only 10 percent of the annual intake should be recruited through this modality, in 2018 more than 65 percent of students enrolled in nursing studies, 60 percent of those in midwifery, and 35 percent in medicine went through the 'special regime' (Bertone, 2018). Because the selection in the 'special regime' includes many male dominated fields such as military and athletes, this may be one factor contributing to the lack of women or people from rural areas in health professions, particularly compared to global averages in a female-dominated industry.

Decent work. Female health workers face sexual and physical harassment, causing harm, ill health, attrition, low morale, and stress (WHO, 2019). There is not a specific law for sexual harassment although in 2012, Resolucao do Governo No. 21/2012 was approved to establish an inter-ministerial commission for supervision of the implementation of National Action Plan for GBV. Because of the absence of the law or reporting mechanisms, many sexual harassment cases go unreported or are not properly managed. The labor code prohibits sexual harassment in the workplace, but it is reportedly widespread. However, relevant authorities processed no cases during 2020, 2019, 2016, or 2015 (U.S. State Department, 2021). Within the Ministry of Health, when employees experience discrimination and sexual harassment, they can report it to their supervisor and bring it to the attention of the Public Service Commission. The Public Service Commission has a mandate to address disciplinary administrative process rules with sanctions that apply to public servants who violate disciplinary rules, including engaging in sexual harassment.

Retention. A 2015 discrete choice experiment on the preferences of health workers in Timor-Leste revealed different incentives for males and females. For example, more female health workers preferred working in a Community Health Center to males, having housing provided, having access to training opportunities, and having good or fair equipment. Male health workers valued wages and working in an urban setting more highly than other factors (World Bank and OPM, 2015). Many midwives and single female doctors are reluctant to live alone in what they feel is inappropriate or unsafe accommodation, particularly in remote areas (O'Dwyer, 2013). In a 2015 survey of health workers in Timor-Leste, 98 percent of facilities provided maternity leave for staff (World Bank and OPM, 2015).

According to the country's Human Resources Department there is no pay gap between male and female workers. There is a salary scale based on position and experience, which is shared, and the Human Resources Department maintains that each health worker is paid according to their role and level, and there is no challenge in retaining female and male workers.

Distribution. Some midwives, nurses, and doctors are reluctant to live alone in what they feel is inappropriate or unsafe accommodation, particularly in remote or *suco* areas in municipalities. The Midwifery Association mentioned that one of the biggest challenges facing health professionals is that there are not enough adequate accommodations for them.

Another important consideration in the distribution of the health workforce is community trust of providers. There are disincentives for health workers to work in their own rural or remote

communities because of access to certain allowances working in different areas, but one study found considerable distrust toward health providers from outside the clients' area, with implications for seeking care during pregnancy and birth (Wallace, 2016). Similarly, some people in rural areas understand only their own dialects, which creates communication challenges for health workers from different who do not speak the dialect to the area they are working.

Support the Government of Timor-Leste to Develop Health Workforce Competencies and Standards to Effectively Guide Regulatory and Quality Health Systems (Intervention 2.2)

Competencies for social determinants of health. Health workers do not have the competencies to address different needs of individuals including information on gender, youth, and disability. At the same time, health workers do not always have the competencies to offer high-quality, equitable services for women. For example, women seeking contraceptives are often asked, "Where is your husband?", denying female autonomy in decision-making. In some Timorese culture, contraception and family planning is still a taboo topic, and single mothers are often discriminated against; the unmet need for family planning is 25 percent (of married women) (GDS, 2018). Transgender people and men who have sex with men also experience stigma in health services. The difficulties to accessing health care in a safe and non-discriminatory manner discourages LGBTI people from accessing health care (OHCHR, 2016). There is also a lack of basic knowledge and skills on how to support people with disability amongst health care workers, at least in part a result of no modules during pre-service training on disability in healthcare (McCoy, 2013).

GBV competencies. Thirty-three percent of women in Timor-Leste aged 15-49 have experienced physical violence at some time in their lives; nearly as many (29 percent) have experienced physical violence in the 12 months (GDS, 2018). Research on midwives in Timor-Leste revealed that they about the health effects of violence but want to learn more skills to deal with cases of it. Midwives who had received training on addressing GBV noted that they could not put their skills into practice because of problems such as lack of privacy and time (Wild 2016). Psychosocial Recovery and Development in East Timor (PRADET), an NGO focused on psychosocial services including domestic violence, sees a lack of health professionals or medical providers who can manage the care of patients who have suffered domestic violence, and recommends more education and training for health professionals to address intimate partner violence. La Trobe University and the WHO piloted a curriculum in Tetum and English to better equip nurses, midwives and doctors to recognize and help survivors of domestic and sexual violence. The curriculum including a facilitator's manual, PowerPoint teaching slides, student guide, and video resources are available online.[2]

Improve Training and Professional Development Opportunities for the Health Workforce

According to the Human Resources Department and the Midwifery Association, there is no discrimination when it comes to professional development opportunities: both men and women are treated the same way and given the same opportunities. However, training is typically offered by external parties such as the United Nations Population Fund, WHO, or the Government of Australia, rather than the Ministry of Health. Some training is conducted overseas, and some conducted mostly in

[2] The pre-service training curriculum is available: https://www.latrobe.edu.au/jlc/research/reducing-violence/timor-leste

Dili, but it is not common to have training in the municipalities. Health workers have to travel to the capital to attend training, which means that they also have to leave some of their work and domestic care responsibilities behind, which is typically harder for women. NGOs like the Coalition for Diversity and Action (CODIVA), PRADET, Asosiasaun Maluk Timor, and the Association for Disability in Timor-Leste (ADTL) suggest that continuing professional development for health care professionals is vital and needs to be conducted to increase the ability to provide good and equitable health care services to communities.

3.3 OBJECTIVE 3: IMPROVE HEALTHY BEHAVIORS

This section focuses on the GESI considerations in the identification of social norms underpinning lack of healthy behaviors.

Increase Community Adoption of Healthy Behaviors and Influence Social Norms that Underpin those Behaviors (Intervention 3.1)

Reproductive health and family planning. Fertility is highly valued in Timor-Leste and there are expectations around having children as soon as possible after marriage (Wild, 2020). The total fertility rate in Timor-Leste is 4.2 children; the ideal family size for women is 3.7 children, while men want 3.3 children (GDS, 2018). Fertility patterns are closely associated with women's education and wealth quintiles. The fertility rate is substantially lower as women's educational attainment increases, from 6.1 births among women with no education to 2.9 births among women with more than secondary education. Similarly, fertility is also inversely associated with wealth. Women in the lowest wealth quintile have an average of 5.2 births, compared with only 3.4 births for women in the highest quintile (GDS, 2018).

Reproductive health decisions are perceived to be made mutually between husband and wife according to research done in October 2015 by Marie Stopes International in Timor-Leste with their clients, but there is an overwhelming perception that there will be negative consequences for women, including conflict and violence, if they seek family planning information or services without permission from their husband, or if they refuse to have sexual relations with their husbands (Wallace, 2016).

Several civil society organizations during the interviews noted a huge need for socialization around family planning, especially in remote areas. During the Indonesian occupation, in order to limit Timorese reproduction, women were forcibly sterilized or administered with long-acting contraceptives (Wild, 2020). Mass administration of prophylactics such as Depo Provera injections (Progestogen-only injectable) and masse dispersal of Microgynon tablets (oral contraceptive) were used for forced sterilization or forced contraception, despite telling women they were used to treat malaria, tuberculosis, increase vitamins, or assist with conception (Mason, 2005).

Adolescent girls. There are a high number of pregnancies among adolescent girls in Timor-Leste; 46.6 per 1,000 women (GDS, 2018). One of the main causes of adolescent pregnancies is lack of knowledge on reproductive health, lack of access to contraception, and limited agency in terms of decisions on whether or not to have sex. Unmarried pregnant adolescents may face social costs such as rejection by their families, the end of their education and the threat of violence. Data show a high correlation between adolescent pregnancy and early marriage, with around two-thirds of adolescent mothers in Timor-Leste being married. As it is socially unacceptable to be an unmarried mother, young pregnant women are often pushed into marrying the father of their child. In other cases, young women marry

early, sometimes even before the legal age of 17 (marriage at 16 is allowed with parental consent as per the civil code). Currently, 19% of young women are married by the time they turn 18. Adolescent mothers and their children face greater risks of difficult births and mortality, and neonatal complications. In Timor-Leste, adolescent mothers die nearly twice as often as mothers in their twenties and have the highest number of stillbirths and infant deaths in the first week of life, and less chance of the baby surviving to age five (Provedoria dos Direitos Humanos e Justiça – PDHJ and UNFPA, 2017).

Maternal mortality. High fertility underlies high maternal mortality. For Timorese women specifically, little is known about the causes of maternal mortality, but globally the main direct causes are severe bleeding (hemorrhage), infection, high blood pressure (eclampsia), unsafe abortion, and obstructed labor. There are many reasons why women may not seek health care during pregnancy and delivery including distance to a health facility (46 percent) and having to take transport (44 percent), followed by not wanting to go to access care alone (41 percent), getting money for treatment (38 percent), and getting permission to go (35 percent) (GDS, 2018).

One of the critical issues in Timor-Leste is also the lack of facilities and skilled birth attendants who can manage a delivery. Experiences with the health system also influence decisions to seek care. Most women aged 15–49 report having problems in accessing care when they are sick (96 percent), with the most common concern including "no drugs available" (87 percent identified this as a problem), or "no provider is available" (82 percent). Another often-cited reason relates to a lack of female health providers (63 percent) (Asian Development Bank, 2014). According to NGO Asosiasaun Maluk Timor, women in rural areas mostly give birth without attendance from a midwife or any other health professional and the government does not provide support to Community Birth Attendants.[3] The 2016 TLDHS reported 44.8 percent of women in rural areas delivered with a skilled provider (GDS, 2018).

Men often serve as gatekeepers to health services, either as primary decision-makers or as controllers of household financial decision-making, which can decrease women's access to health services. Husbands and a woman's mother-in-law are considered the key decision-makers in seeking care during labor and birth (Wallace, 2016). The USAID-funded Health Improvement Project supported a grant to the Cooperative Café Timor (CCT) described further in the Stakeholder Mapping Section) for a men's health program. Given the significant cultural tradition of men as the decision maker for household issues, including access to health services, the program aimed not only to improve men's own personal health but also to enable men to assume a positive facilitating role in their family's access to health services. The program also addressed GBV. In Between 2013–2014, CCT facilitated men's health groups, and trained groups using a seven- module Men's Health Manual (Timor-Leste Health Improvement Project, 2015).

GBV. Imbalance in the power held by women and men, along with an abuse of that power, has led to high levels of domestic violence. Much research has been conducted to provide insight into the underlying causes of GBV in Timor-Leste and the barriers to its eradication. The research points to the following key factors on the social norms side:

- Attitudes that accept and condone violence.

[3] Community birth attendants are a cadre first created in 2005 by clinic and NGO Bairo Pite Clinic. They have remained largely outside of the public sector system and receive training and support only from NGOs.

- Traditional beliefs and customs surrounding marriage and gender roles.
- Authority of informal and formal legal justice systems.
- Lack of awareness of legal rights and ability to access the criminal justice system (Asian Development Bank, 2014).

There is a distinction made between "big" and "small" cases of violence; only "big" cases, such as when blood is spilled, a weapon is used, or the violence is frequently repeated, are considered unacceptable and possibly a crime (Asian Development Bank, 2014). There is also a perception that such violence is a private matter that should not be discussed in public, and it will take time to change harmful gender norms. According to Health Alliance International (HAI), which works on GBV programs, certain stereotypes hinder women from accessing health services. Among them is that men are always in charge of making decisions, so it is difficult for women to decide to use contraception or other family planning. HAI recommends that the government create a better and more efficient system to register GBV cases as a starting point.

Accessibility. The Ministry of Health aims to have no discrimination in providing health care to all citizens, including people with disabilities, but so far little has been done to address the needs of people with disabilities. Policies are in place, but in the implementation, health facilities are not disability- friendly. There is minimal political will from the government to implement programs that can benefit and empower people with disabilities. Research from 2015 shows that most Community Health Centers and Health Posts were not accommodating for people with disabilities. For example, only 6 percent of facilities had handrails and 3 percent had signs for visually impaired patients (World Bank and OPM, 2015). According to the ADTL, Timor-Leste needs investment in social inclusion. Their suggestions to improve accessibility include: 1) all line ministries should allocate budget for social inclusion programs and activities; 2) improve accessibility of infrastructure to make health facilities easily to visit for by people with disabilities; and 3) address widespread discrimination and stigma received by people with disabilities, including using respectful language.

LGBTI discrimination. There are issues of stigma and discrimination for individuals who identify as LBGTI. In 2014, research found that 18 percent of men who have sex with men and 43 percent of transgender persons had been refused health services in Timor-Leste (Belun, 2018). According to CODIVA, an organization focused on the rights of LGBTI persons, many times transgender people face discrimination when at health posts/clinics or hospitals, including not being able to use their preferred name.

Health services for youth. By age 20, 33 percent of women in Timor-Leste have had sex, 31 percent are married, and 20 percent have given birth (JSI, 2020). But Timorese youth have limited knowledge and understanding of reproductive health and the health risks of teenage pregnancies. While the Ministry of Health has focused on universal access to sexual and reproductive health services, access to family planning services for young people, especially unmarried young people, remains extremely limited.

Strengthen Civil Society Organizations' Capacity to Fulfill their Roles in the Health System (Intervention 3.2)

Several of the civil society organizations working on GESI issues related to the health system in Timor-Leste are listed in the Civil Society portion the Stakeholder Mapping Section.

A consensus among many organizations interviewed for the GESI analysis was that funding for gender

equality comes from donors or international agencies. A current example provided was that during the COVID-19 pandemic and health requirements such as stay-at-home measures, domestic violence cases are increasing, and organizations like PRADET, Casa Vida, and the Forum Komunikasaun ba Feto Timor Lorosa'e (FOKUPERS) are overwhelmed and receiving only minimal government support for their work.

3.4 OBJECTIVE 4: IMPROVE CIVIC ENGAGEMENT AND ADVOCACY FOR HEALTH SYSTEM STRENGTHENING

Deepen Civil Society Engagement in Priority-setting, Monitoring, and Accountability for Essential Health Products and Services (Intervention 4.1)

Support to NGOs on GESI issues. The NGO Advocacy for Good Governance Activity found that donors have supported Timorese NGOs in their efforts to establish gender and anti-sexual harassment policies, attend related trainings, and integrate gender and inclusion in multi-year institutional strategies. For example, almost all NGOs interviewed for the GESI analysis had a written gender policy. However, lack of application, enforcement, and proper resourcing has stalled progress, as has lack of political will (Brown, 2020). When the NGO Advocacy for Good Governance Activity asked key informants for suggestions, NGOs suggested the need to support "sustainable, core financing so they can pursue new funding that aligns with their mandate while eliminating the time consuming 'shapeshifting' pursuits that do not meet their objectives" (Brown, 2020). Likewise, even with international donor focus and funding for GESI, many national NGOs have been unable to establish internal organizational policies related to safe workplace culture, including the prevention of and response to workplace sexual harassment violations. Many informants for the NGO Advocacy for Good Governance Activity also noted that Timorese men are not well represented in GESI activities as participants or champions, creating a dichotomy in which GESI is seen as a women's issue, and limiting influence and power.

Civil society organizations mentioned that one of the biggest challenges when working with the government is that government is constantly changing or reforming in Timor-Leste. One government comes with good policy or practice and suddenly the new one arrives and change everything. For example, ADTL shared that one government was supportive of disability inclusion work, but a change in the government meant starting over.

Key Government of Timor-Leste stakeholders understand perspectives and needs of clients and health workers (Intervention 4.2)

The NGO Advocacy for Good Governance Activity found a lack of resource-efficient ways to raise awareness of GESI issues with national Government of Timor-Leste officials (Brown, 2020). Likewise, while the primary literature shows that the government has made strides in mainstreaming gender in government policy and structure, the secondary data suggests implementation gaps due to insufficient budget appropriation.

Priority issues identified by civil society organizations. During interviews, civil society organization identified priority issues for GESI and health. These include:

- Greater attention on GBV including training of health professionals given the high incidence of GBV but reported low competencies by heath workers to address GBV.
- Disability rights including accessibility with infrastructure.
- Socialization around reproductive health and family planning, particularly with men, to increase women's access.

- Inclusion with language in documents such as policies translated into languages most people can understand including Tetum or specific dialects depending on the type of document and audience.
- Access to health services for women in rural areas, including timely access for pregnant women to high-quality, trusted health services.

The civil society organizations interviewed for the GESI analysis were often focused on these social justice and equity issues and may not represent the priorities of all civil society organizations in Timor-Leste.

4. STAKEHOLDER MAPPING

Aligned with the definitions of forms of exclusion and key themes from the findings, the following are important stakeholders in GESI for the Health System Sustainability Activity in Timor-Leste. GESI is a cross-cutting issue with stakeholders beyond those in the health sector specifically. This mapping will serve as the basis for coordination for integration of GESI considerations.

4.1 GOVERNMENT

Ministry of Health. The Ministry of Health has considered gender equality and social inclusion as part of their program and has written gender policy based on the Timor-Leste National Health Sector Strategic Plan 2011-2030. The Ministry of Health has a gender focal point to promote gender policy and gender development plans including for accessibility, quality, and management of health care services, but implementation is still far from reaching established goals. Despite gender goals, there is no gender training available to all staff. Some specific departments have training on gender; for example, the epidemiology department received training on gender and sex disaggregation as related to COVID-19, but there is no uniform training available across the Ministry of Health. Training on gender is usually provided by international organizations such as United Nations agencies and, local and international NGOs.

Since 2008 (to present day) the Ministry of Health has launched the Community Health Integrated Services (SISCa) to improve maternal and child health at the *suco* level and promote of births at health posts and family planning through community health volunteers. The community health volunteers in SISCa work in six areas: 1) population registration, 2) nutrition assistance, 3) maternal and child health, 4) personal hygiene and sanitation, 5) health care services, and 6) health education with the goal of increasing access to health assistance (Soares, 2011). The basic package of SISCa services includes antenatal care, family planning services, nutrition monitoring, immunization, Tuberculosis case-finding and referral, and Malaria testing and treatment (Timor-Leste National Health Sector Strategic Plan 2011–2030).

Ministry of Social Solidarity and Inclusion. The Ministry of Social Solidarity and Inclusion (MSSI) has a written gender policy and a unit to oversee gender and women's empowerment programs, including protection of women victims and vulnerable families, LGBTI, and people with disabilities. Part of the MSSI mission is to promote social integration including community reintegration, social security, and social assistance programs in order to guarantee social inclusion, promote gender equality, and empower women, girls, and people with disabilities.

The MSSI is trying to promote gender balance in leadership positions; more than 30 percent of its senior

leadership posts are occupied by women. Both the minister and the vice-minister are women. Formal protocols and reporting mechanisms allow staff to make complaints for redress of gender discrimination in the office, but there is no data available on whether the process is accessible and used by staff. Staff can file a formal complaint to a supervisor when they experience sexual harassment, and the complaint will be directed to the Public Service Commission. The Department of Ethics and Discipline of the Public Service Commission will then conduct an investigation and can initiate disciplinary procedures for such acts.

The MSSI does not have experience with gender-responsive budgeting, but according to the director general, the annual work plan always ensures that the program is gender-sensitive/responsive. When analyzing changes to policy or budgeting, the MSSI always considers gender and social inclusion. The MSSI ensures that all its programs have a gender component and include the most vulnerable in the country, including women, elderly, people with disabilities, and LGBTI people. During the COVID-19 lockdown in 2020, the MSSI provided cash transfers of USD 200.00 per household for more than 300,000 families in 13 municipalities. An analysis of initial impacts of the cash transfer program on gender dynamics found examples of increased agency and women's autonomy and payment spent in the interests of all. However, some of the limitations or areas for improvement in future cash transfer programs included that distribution tended to go to male heads of households, domestic violence was a barrier with women living in crisis accommodation excluded from the system, and some members of the household were excluded due to sexual or gender orientation (Leahy, 2020).

The MSSI also acts as the government agency that responsible for vulnerable people including people with disabilities. In the Constitution, people with disabilities have the same rights and no citizen can be discriminated against on the grounds of physical or mental condition, as provided in paragraph 1 of article 21 and paragraph 2 of article 16. In addition to subsidy to people with disabilities, MSSI has a conditional cash transfer program for vulnerable household called *Bolsa da Mae,* which was first created in 2008. This year MSSI has decided to reform *Bolsa da Mae* program to reduce poverty and improve maternal and child health and nutrition. This new *Bolsa da Mae* program provides cash to pregnant women and children under three years old. Children with disability allowance will receive $15 to $30 every month. *Bolsa da Mae* remained in operation during the COVID-19 state of emergency, although there were some interruptions in functions (UNDP, 2020).

SEII. The SEII plays an important role in advocating for gender equality and promoting gender mainstreaming within public sector development planning and budgeting in Timor-Leste, but also has limited capacity to support other ministries. The SEII is also assigned the task of promoting gender mainstreaming as a strategy to be applied in all development sectors and at all levels of operational activities from the national to grassroots levels, including technical support and capacity- building to line ministries to facilitate mainstreaming of gender into planning and budgeting.

The SEII promotes gender mainstreaming at the national level by advocating the appointment of gender focal points in government agencies and the establishment within these agencies of Inter-Ministerial Gender Working Groups. This Inter-Ministerial Gender Working Group is an intersectoral cooperation and coordination mechanism that includes line ministries such as the Ministry of Health, MSSI, and Ministry of Finance, to ensure that attention is given to gender issues, and to develop gender strategy and always ensure that gender components are included in their annual work plans, budget, policies, and program.

The SEII supports gender-responsive budgeting and has gender balance in its senior leadership posts. It has developed gender guidelines and shared these with line ministries in Timor-Leste on how to develop annual work plans based on gender perspective and ensure that program implementation is gender-sensitive. In addition, the SEII provides trainings for line ministries' gender focal points on gender–sensitive planning and budgeting and the use of gender markers.

Ministry of Finance. The Ministry of Finance has a written gender equality policy and uses gender guidelines developed and designed by the SEII. At the Ministry of Finance there is gender balance in senior leadership positions; women occupy, almost half of the high-level roles. The Ministry of Finance is taking part in the Inter-Ministerial Gender Working Group and plays an important role in mainstreaming gender into the budgeting processes. The Ministry of Finance also issues a budget circular to all government agencies encouraging them to consider gender in their budget and annual work plans, including by analyzing sex-, gender-, and age-disaggregated data when designing the project or program.

Ministry of State Administration. The Ministry of State and Administration is the government institution responsible for local and national administration, territorial management, and support to the election process in the country. This Ministry has a gender focal point and is also part of the Inter-Ministerial Gender Working Group led by the SEII. The Ministry of State Administration has a written gender equality policy, and there is gender balance among staff. Women occupy leadership positions. The Ministry of State Administration has experience with gender-responsive budgeting. For example, a Gender Guidelines tool was created by SEII in 2015 and piloted for ten different line ministries included the Ministry of State Administration (and Ministry of Health) (Department of Foreign Affairs and Trade, Australian Government, n.d.). Every year, the ministry allocates around $100,000 for its gender mainstreaming program. The ministry under Decree Law No. 3/2016 on Municipal Administration has the mandate to institutionalize gender mainstreaming at the municipal level in all territories of Timor-Leste.

Secretary of State for Youth and Sports. The Secretary of State for Youth and Sports (SSYS) works closely with young people, including girls and youth with disabilities, in the promotion of youth well-being and development. It has a written gender equality policy and applies it across SSYS activities and programs to ensure that the participation from girls should be at least 30 percent. The SSYS has a gender focal point and takes a part in a GBV prevention group led by the State Secretary for Gender Equality and Inclusion, which is responsible for sexual and reproductive health. The SSYS has been working closely with the United Nations Population Fund on sexual and reproductive health, particularly with a focus on keeping girls in schools rather than having them dropping out because of pregnancy.

Even though the SSYS does not work directly in the health sector, it promotes health among youth, and access to youth- friendly and quality health services. Other work that SSYS has been doing in the area of social inclusion is to increase employment of young women and youth with disabilities The SSYS also has the role of strengthening youth representation in village councils so that they can actively participate in the decision-making process in a way that will benefit young girls and boys, and youth with disabilities.

National Vulnerable Persons Unit. The Vulnerable Persons Unit (VPU) was established in 2000 under the National Police of Timor-Leste. Its mandate is to investigate domestic violence cases, sex crimes violation, child abuse, missing persons, human trafficking, and crimes committed upon people with disabilities or mental health issues. The National Police of Timor-Leste has a written gender equality policy, but senior leadership roles in this institution are still dominated by men. The VPU service is

available in all municipalities in Timor-Leste. The VPU works mostly in the area of domestic violence; it works closely with civil society organizations such as FOKUPER, PRADET, Casa Vida, and women's network organizations to respond to domestic violence and conduct legal procedures to support victims, including making it easier for victims of domestic violence to access hospitals. The VPU is also part of the Redi Referral Network, whose purpose is to increase collaboration and cooperation on issues related to domestic violence and vulnerable persons. The Network consists of women's organizations, health services, and government agencies such as the SSEI and MSSI.

4.2 CIVIL SOCIETY

ADTL. The Asosiasaun Defisiensia Timor-Leste is the umbrella body for disability organizations in Timor-Leste. It was established in 2014 from a working group of local disability organizations and was officially registered as a national association in 2015. The ADTL is a dues-paying, membership-based, umbrella organization representing over 18 Disabled People's Organizations, faith-based organizations, and non-government organizations that promote equal participation of people with disabilities in community life in Timor-Leste. The ADTL's vision is that people with disabilities should inspire society and lead social change.

Alola Foundation. Founded in 2001 by the then First Lady, Ms. Kirsty Sword Gusmão, the foundation operates to improve the lives of women and children by cultivating female leaders and advocating for women's rights. The foundation was originally created to raise awareness of the widespread sexual violence against women and girls in Timor-Leste during the militia attacks of September 1999. Its mission is to promote women's rights and increase women's leadership capacity, improve the health status of women and children, increase access to and quality of education for women and children, and strengthen women's small enterprises at the grassroots level. Program areas include women's economic empowerment, maternal and child health, education (scholarships for girls that support literacy, including teacher training), and advocacy support in women's and children's rights including programs to promote domestic violence laws and counter human trafficking. Alola aims to preserve traditional Timorese identity through programming focused on economic development, including through collaboration with the Ministry of Arts and Culture and the Ministry of Tourism. Alola also has its social enterprise called Alola Esperansa, which provides markets opportunities for women to produce and sell handcrafts and agricultural products.

One of the oldest NGOs in the country, Alola has received recognitions from international counterparts and from governments. The Ministry of Health and SEII are the two closest partners that always involve Alola in their work. Alola is working closely with the Ministry of Health on a national breastfeeding program. Alola is invited to provide technical inputs, feedback, interventions, and recommendations on health (especially women's and children's health) and gender equality to the two ministries. It works in both urban and rural areas.

Belun. Belun's mission is to serve society and prevent conflict. Some key work that Belun has been doing includes conflict resolution, community capacity development, research and advocacy, and political development.

Belun also currently works on the Women in Peace and Security Project in close collaborations with UN Women. This project aims to provide capacity-building trainings to women's groups and

community-based organization as well as local NGOs, develop gender policies, and facilitate training on small grants capital to women's groups in Baucau, Covalima, and Regiao Administrativa Especial Oe-Cusse Ambeno. Belun also has a mediation program under the United Nations Development Programme's Justice System Program, to increase women's participation in obtaining their rights of ownerships in land disputes. Belun has been working closely with the SEII and is a member of the gender referral network, which is a venue to discuss and share information on gender-based violence GBV and the national action plan for GBV and gender- responsive budgeting.

Casa Vida. A national NGO that opened in 2008, Casa Vida is a special support home providing assistance for young girls from birth to age 18 who come from a situation of sexual violence or other abuse and have been referred by the MSSI or a similar body. Casa Vida also provides training to these victims to help them become healthy, happy, well- adjusted, educated, and skilled. Casa Vida's general focus area is on women and children's rights, domestic violence, victim services, skill-building, and vocational training. The organization offers training programs to girls in crisis situations as a means of therapy. Skill-building focuses on sewing, jewelry-making, crafts, culinary arts, and restaurant/hospitality services. Casa Vida also helps facilitate the girls' return to their families and communities with restored self-confidence and self-esteem.

One of Casa Vida's other main activities is a socialization and advocacy program on gender equality and sexual violence prevention for women and children. This program is ongoing, in Dili and Baucau municipalities, with plans to expand it to two more municipalities: Viqueque and Manufahi.

CODIVA. CODIVA is focused on the rights of LGBTI persons. CODIVA conducted advocacy and training for health staff in Dili to offer respectful care for LGBTI persons. CODIVA is one the very few LGBTI organizations in Timor-Leste that also acts as a national network for LGBTI communities in the country. CODIVA work is to strengthen the LGBTI communities and advocate for their rights including access to health. The CODIVA program includes providing gender sensitization training to local authorities and institutions. CODIVA focuses on tackling stigma and discrimination toward the LGBTI community in Timor-Leste, and at the moment is working with the United Nations Spotlight Initiative to end GBV in the country. CODIVA also works closely with the Ministry of Health on HIV prevention program and on how the LGBTI community can have the same rights and access to health service as others. With the SEII, CODIVA has been asked to provide technical expertise, feedback, and recommendation, for any works that related to LGBTI issues.

Conselho Nacional Juventude Timor Lorosae (CNJTL). This is the umbrella organization for the youth civil society organizations of Timor-Leste. It works closely with youth, including youth with disabilities, and advocates for their rights.

Cooperativa Café Timor (CCT). A Timorese organic coffee producing and -processing cooperative, CCT provides health care 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, which also focused on male engagement spurred by a grant from the USAID-funded Health Improvement Project. CCT created its own health division in 1998, because health services were generally unavailable to its members. Its network of seven clinics and 24 mobile clinics in coffee-growing regions (Ainaro and Ermera municipalities) are available to anyone who comes in. Since independence, Timor-Leste has built a much larger health system, but public clinics still lack some features and may not always have medications available, so people continue to use the CCT clinic. The most common service the clinics

provide is pre/post-natal care. CCT recently began more work around gender and inclusion, including conducting a study of their health clinics in coffee-growing communities. CCT has a gender equality policy, and their health program has direct engagement with people at the village level. Their male engagement program in the health sector focuses on access to family planning.

Forum Komunikasaun ba Feto Timor Lorosa'e (FOKUPERS). FOKUPERS was established during the Indonesian occupation to address GBV and human rights violations against women and children. Four important program areas that FOKUPERS is working on right now are: women's rights advocacy, GBV victim assistance, community awareness and training, and early childhood quality education. In its victim assistance program, FOKUPERS supports victims of GBV in all 13 municipalities of Timor-Leste, providing legal support and trauma healing. FOKUPERS also has emergency assistance for victims 24/7 and provides shelter for victims of domestic violence. FOKUPERS partnered with the Ministry of Health on Mobile Clinics program in Liquica and Bobonaro. The mobile clinics allows health professionals to come to communities, because most of the time women have difficulty accessing transport to health posts simply because they do not have any money.

Forum of Non-Governmental Organizations Timor-Leste (FONGTIL). FONGTIL is a non-profit, non-sectarian, and non-partisan organization, and acts as the umbrella for local and international organizations in Timor-Leste. It is composed of 300 local, national, and international NGO members representing 13 municipalities. FONGTIL's mission is to work with and support its member organizations to promote the well-being and interests of all Timorese citizens; work toward ensuring that the people of Timor-Leste are free from all forms of injustice, including poverty, exploitation, and discrimination, and have the opportunity to participate openly and freely in the political and democratic decision-making process; and support and strengthen the NGO sector to be an effective voice for all Timorese citizens, especially the most vulnerable members of the Timorese community. FONGTIL is currently implementing the United Nations Spotlight Initiative to eliminate all forms of violence against women and girls, working with women in four municipalities: Aileu, Baucau, Liquica, Ermera, and Viqueque.

HAI. HAI's main area of work is health. In particular its work focuses on improving maternal and newborn health in Timor-Leste, and maternal and infant nutrition. Currently HAI is working on the GBV program, in close cooperation with the Ministry of Health, by providing training to health professionals on how to assess and identify victims of gender- based-violence, how to undertake proper registration, and how to use equipment to conduct observations. This program has been implemented in Ermera and Liquica municipalities. HAI is part of the National Plan Taskforce to prevent GBV, led by the Ministry of Interior. HAI's main work is in health. The program aims to end GBV by shifting cultural norms at the villages level and trying to introduce gender- sensitive health services in clinics across Timor-Leste.

Asosiasaun Maluk Timor. Asosiasaun Maluk Timor is an NGO that aims to transform health care in Timor-Leste's community health centers, so that people get high-quality care, when and where they need it. Asosiasaun Maluk Timor provides free and essential medical services to over 300 Timorese people every day. Care ranges from preventative vaccines and antenatal screening to emergency treatment for life-threatening conditions such as infection and trauma. It also provides support to rural areas through mobile outreach activities.

PRADET. PRADET works mainly on psychosocial services. It provides services to people who are experiencing trauma, mental illness, and other psychological problems. PRADET has a Fatin Hakmatek,

or Safe Room, program, where PRADET provides counseling, medical treatment, and forensic documentation of injuries for victims of domestic violence, sexual assault, and child abuse. PRADET also has a program to counter trafficking, where it provides temporary safe accommodation and, health and counseling to people who have been trafficked to Timor-Leste. PRADET works in 13 municipalities. It PRADET works closely with the Ministry of Health in so many areas. It also has a small branch office right inside the national hospital of Timor-Leste.

Rede Feto. Rede Feto is the umbrella organization for women's organizations in Timor-Leste. Its focus is on gender equality and women's empowerment. Its mission is to fight for and defend the interest of women, empower women in order to achieve equal rights, and contribute to the development and promotion of women's rights. Through a network of service providers who support and refer victims of GBV, including victims of domestic violence, sexual assault, and child abuse, Redo Feto advocates against GBV in all forms; monitors the protection of women, girls, and other at-risk groups; and ensures timely access to appropriate support and care services (legal, health, social, and psychosocial) for victims of violence. This year, Rede Feto is working closely with UN Women on its Spotlight Initiative to end GBV in Ermera, Bobonaro and Ainaro municipalities.

The Ministry of Health did not involve Rede Feto in the Timor-Leste National Health Sector Strategic Plan. The by State Secretary of Gender Equality and Inclusion did invite Rede Feto to provide technical expertise, input, feedback, and recommendations on gender policy. Rede Feto has been working closely with the Ministry of Health on a breast cancer awareness program, breastfeeding campaigns, an HIV program, and COVID-19.

St John of God International Health. This organization focuses on health care, particular in hospitals, specializing in leadership, quality standards, and clinical education and training, and has been working closely with the Ministry of Health. It sees that the biggest challenges that the government is facing right now are more pressing, such as managing the pandemic, but emphasizes that it still needs to be advocated on gender equity, gender diversity, disability inclusion, and LGBTI issues.

UNFPA. UNFPA has worked in Timor-Leste since 1999. In 2020, UNFPA focus was on integrated sexual and reproductive health services (56.5 percent of program expenses), analysis on population dynamics (22.5 percent), gender equality (19.2 percent), and adolescents and youth. UNFPA also focuses on national capacity for production and dissemination of quality disaggregated data on population and development issues, especially for mapping demographic disparities and socio-economic inequalities and using this data and evidence for decision-making.

UN Women. UN Women established a presence in Timor-Leste with an initial needs assessment in 2000 and opened a project office in 2001. Currently, UN Women works in the following areas: gender-responsive planning and budgeting, women in politics, Committee on the Elimination of Discrimination against Women implementation in Timor-Leste, and women, peace and security. In 2021, UN Women launched the Spotlight Initiative to engage NGOs in state- and gender-responsive budgeting.

5. GENDER EQUALITY AND SOCIAL INCLUSION ACTION PLAN

Based on the findings of the GESI analysis, the Activity developed a GESI action plan for the Activity. The purpose of the GESI action plan is to provide a set of specific and achievable recommendations for the project to mainstream gender and social inclusion across its activities. The Health System Sustainability Activity will consider these recommendations during its annual work planning over the project life.

Table 1. GESI Integration Action Plan Tasks

GESI Integration Action Plan Tasks	
Objective 1: Strengthen health sector governance	
Intervention 1.1: Generate Actionable Information on the GoTL's Capacity to Generate, Interpret, and Use Quality Data to Inform Policy Processes	
1	Provide technical assistance for disaggregated data including organizing them, determining appropriate indicators, developing systems for maintaining them, and creating data analytic tools and dashboards to analyze key indicators by sex and age.
Intervention 1.2: Enhance MOH Institutional Capacity to Generate, Interpret, and Use Quality Data to Inform Policy	
2	Co-develop a Ministry of Health training or a program to provide GESI orientation to government staff.
Intervention 1.3: Improve resource optimization and health financing at the national and subnational levels through improved data, more efficient budgeting processes, and more evidence-based advocacy	
3	Explore the SEII's experience with gender-responsive budgeting and coordinate between the SEII and the Ministry of Health to increase gender-responsive budgeting in health.
4	Support the Inter-Ministerial Gender Working Group and gender focal point at the Ministry of Health through collaboration with the Activity.
5	Conduct additional analysis on GESI factors in health financing, building off World Bank research showing government health spending is "pro-rich" and potentially spending more on hospitals for individual with more resources already than community health centers, health posts and mobile clinics, which serve more vulnerable populations.
Objective 2: Strengthen health sector workforce management	
Intervention 2.1 Strengthen GOTL systems to recruit and retain a qualified and competent health workforce, and allocate that workforce more equitably across the country	
6	Examine recruitment systems and introduce or reintroduce human resource policies, systems and procedures for ensuring equal opportunities in the employment, career development and promotion of men, women and people with disabilities.
7	Provide training or enforce code of conduct to eliminate sexual harassment or gender-based discrimination in the workplace as a retention mechanism, together with health professional boards.
8	Examine varied incentives and retention mechanisms by gender, such as access to safe housing, with a focus on promoting recruitment and retention of health workers within their own communities and increasing number of women health workers, especially in rural and remote areas.

GESI Integration Action Plan Tasks	
Intervention 2.2 Support the GOTL to Develop Health Workforce Competencies and Standards to Effectively Guide Regulatory and Quality Health Systems	
9	Organize training for health care professionals on national laws and international conventions related to GBV and referral services.
10	Improve the competencies of health care professionals to treat patients with disabilities and LGBTI persons with respect and provide high-quality services.
Intervention 2.3 Improve Training and Professional Development Opportunities for the Health Workforce	
11	Advocate for in-service training at the municipal level or virtually to be more accessible to women.
Objective 3: Improve healthy behaviors	
Intervention 3.1: Increase community adoption of healthy behaviors and influence social norms that underpin those behaviors	
12	Increase awareness of and use of health services especially for women living in rural areas, using various forms of communication, especially on reproductive health and family planning.
13	Design social and behavior change strategies with best practices for engaging males.
14	Integrate GBV into all levels of programming to improve healthy behaviors.
Intervention 3.2: Strengthen civil society organizations' capacity to fulfill their roles in the health system	
15	Engage civil society organizations with ability to deploy male engagement strategies.
16	Provide outreach services together with civil society organizations to increase women's access to reproductive health services, and the ability of LGBTI people and people with disabilities to access health care.
Objective 4: Improve civic engagement and advocacy for health system strengthening	
Intervention 4.1 Deepen civil society engagement in priority setting, monitoring, and accountability for essential health products and services	
17	Facilitate collaborations and partnership between the Ministry of Health and civil society organizations that work in the areas of gender equality, social inclusion and health as part of the grants program.
Intervention 4.2 Key GOTL stakeholders, such as the MOH, INS, and Ministry of Social Solidarity and Inclusion, better understand the perspectives and needs of both their clients and health workers who provide services	
18	Advocate for continuity of programs and initiatives related to GESI across changing government administrations or personnel.
Cross-cutting for MEL and sustainability and transition	
19	Validate the GESI Stakeholder Mapping and explore potential for expanded partnerships or grants, particularly under Objective 3.
20	Continue to disaggregate where possible in MEL.
21	Provide practical guidance and Activity documents in local languages to effectively reach diverse audiences.

ANNEX 1: ORGANIZATIONS INTERVIEWED

From August through September 2021, the Activity conducted 25 qualitative interviews with key stakeholders in Timor-Leste to inform the GESI analysis and action plan.

Number	Organization	Title of Individual Interviewed
1	ALOLA Foundation	Economic Empowerment Program Manager
2	Association for Disability in Timor-Leste (ADTL)	Executive Director
3	Belun	Executive Director
4	Casa Vida	Director
5	Coalition for Diversity and Action (CODIVA)	Executive Director
6	Conselho Nacional Juventude Timor Lorosae (CNJTL)	President
7	Cooperativa Café Timor (CCT)	Quality Control and Health Development Manager
8	FOKUPERS (Forum Komunikasaun ba Feto Timor Lorosa'e)	Awareness Coordinator
9	Forum ONG Timor-Leste (FONGTIL)	Program Manager
10	Health Alliance International (HAI)	Project Performance Manager
11	Asosiasaun Maluk Timor	Human Resources Director
12	Midwifery Association	Coordinator (also former Vice Minister of Health)
13	Ministry of Finance	Director, Development Partnership Management Unit
14	Ministry of Health	Head of Environmental Health Department
15		Head of Surveillance Epidemiology Department
16		Director of Health Municipality Office (Ermera)
17		Head of Human Resources
18	Ministry of Social Solidarity and Inclusion	Director General
19	Ministry of State and Administration	Human Resources
20	National Vulnerable Persons Unit	Acting Director
21	Psychosocial Recovery and Development in East Timor (PRADET)	Executive Director
22	Rede Feto	Advocacy Officer
23	Secretary of State for the Gender Equality and Social Inclusion	Head Department of Training
24	Secretary of State for Youth and Sports	Director General
25	St John of God International Health (SJGIH)	Director

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