UNDERSTANDING FAMILY PLANNING AND CONTRACEPTIVE CHOICES IN TIMOR-LESTE – AN EXPLORATION OF PERCEPTIONS, MISCONCEPTIONS AND REALITIES.

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ABSTRACT

Timor-Leste has made progress over the past decade in reducing maternal deaths, however the Maternal Mortality Ratio (MMR) remains one of the highest in South-East Asia, at 557 maternal deaths per 100 000 livebirths. Research from other parts of the world demonstrates that maternal deaths may be reduced by 29% by ensuring access to quality family planning measures.

Many women in Timor-Leste report an unmet need for family planning, and report that they want no more children or wish to delay their next child by two years or more. Despite this, over 50% of married Timorese women not using modern methods of contraception for family planning report that they do not intend to use these methods in the future. This qualitative research project was designed using feminist theory and de-colonising methodology, to explore some of the perceptions women of reproductive age have surrounding family planning and contraception in two districts of Timor-Leste. Eight focus group discussions and body mapping exercises enabled the researchers to hear the voices of 52 Timorese women, gain insight and understanding into their thoughts and beliefs surrounding family planning and contraception, and identify potential myths or barriers that exist in this domain.

Findings from this project demonstrate that the choice to access contraception is not one women make independently. Rather, their choices are influenced by their worldview, where family, community and tradition may take priority over individual desire or need. Women are constrained by culture, tradition, religion and colonisation, and barriers to accessing contraception include status, level of education, geographical location, cultural practices and familial obligations. Husbands, parents-in-law, barlake, the Catholic church, reproductive health literacy and financial circumstances all impact on women’s engagement with and perceptions of contraception.

The insights provided by this research may enable reproductive health providers to tailor their programs and services to women and areas of need, with the aim to improve women’s reproductive health and decrease maternal mortality.
DEDICATION

I dedicate this work to the women of Timor-Leste. Every woman counts.
I was truly humbled by the commitment and generosity of the people in Timor-Leste who contributed to the success of this project and helped make it a reality.

Firstly, to the women who gave of themselves and their time to participate so willingly and openly in the focus group discussions and body mapping exercises – I sincerely thank you. Please know that your words and your voices have been heard by many in both Timor-Leste and Australia, so we have had the opportunity to learn what matters to you.

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Except where noted, all the work was done by the candidate.
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DNSRMNCAH</td>
<td>Draft National Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health</td>
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<tr>
<td>FG</td>
<td>Focus Group</td>
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<tr>
<td>HAI</td>
<td>Health Alliance International</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IUD</td>
<td>Intra uterine device</td>
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<tr>
<td>KB</td>
<td><em>Keluarga Berencana</em> (Indonesian)</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MMC</td>
<td>Modern Methods of Contraception</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MOF</td>
<td>Ministry of Finance (Timor-Leste)</td>
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<td>MOH</td>
<td>Ministry of Health (Timor-Leste)</td>
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<td>MSI</td>
<td>Marie Stopes International</td>
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<td>MSITL</td>
<td>Marie Stopes International Timor-Leste</td>
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<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
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<td>NRHS</td>
<td>National Reproductive Health Strategy</td>
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<td>OCP</td>
<td>Oral Contraceptive Pill</td>
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<tr>
<td>RAP</td>
<td>Rapid Assessment Procedures</td>
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<tr>
<td>TCHR</td>
<td>Technical Commission of Human Research</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNTL</td>
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<td>World Health Organization</td>
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CHAPTER 1 – INTRODUCTION

Aims and significance

Fertility control and regulation is a contentious issue, with a rich history of practices, philosophies and influences which impact significantly on women’s health. Maternal health is a priority research area for Timor-Leste (Deen et al, 2013). This study was partially funded by Marie Stopes International Timor-Leste (MSITL). It aimed to gain insight and understanding into women’s knowledge of family planning using modern methods of contraception (MMC), as well as identify potential barriers to these family planning methods. In doing so, this study aimed to provide the background necessary for the tailoring and improvement of culturally appropriate family planning services, access and resources, both at MSITL and in government and non-government health care providers, ultimately improving maternal health and contributing to decreasing maternal mortality. This study will build upon research already conducted in Timor-Leste in the area of women’s health (see Bernardo, 2005; Niner, 2011; Belton, Whittaker & Barclay, 2009b; Richards, 2010a; Van Shoor, 2003 and Wild, 2009), as well as complement knowledge gained through the Demographic and Health Survey Timor-Leste 2010 (DHS, 2010) and recent studies by ‘Care’ (Dawson & Waters, 2013), and Health Alliance International (HAI, Berthiaume et al, 2011).

Background

Timor-Leste’s Maternal Mortality Ratio (MMR) is one of the highest in South East Asia, at 557 maternal deaths per 100,000 livebirths (Demographic and Health Survey, DHS 2010). Reducing this ratio was the motivation for this research. From a pragmatic, public health perspective, to decrease the number of women who die during or after pregnancy, the most straightforward approach is to prevent or delay pregnancy, by ensuring adequate and appropriate access to MMC (Diamond-Smith & Potts, 2011). Winikoff and Sullivan (1987, p.129) stated that “the risk of dying from pregnancy related complications in the population overall can be reduced if there are fewer pregnancies in the relevant group of women…[t]hus any intervention, such as family planning, which lowers fertility, will automatically decrease maternal deaths and lives will be saved”.

1
Timor-Leste’s fertility rate is high and the use and knowledge of contraception is low - factors which both significantly contribute to the high MMR (DHS, 2010). Insight into women’s beliefs which influence engagement with MMC in Timor-Leste, requires an understanding of perspectives, behaviours and cultural mores associated with fertility, birth and motherhood. Also required is an understanding of how historical, religious, traditional and cultural aspects of Timor-Leste impact on women’s reproductive health.

**History.** Timor-Leste is a new nation, gaining independence and sovereignty in 2002 (Kingsbury, 2012b; Leach, 2012). For four hundred years, until the early 1970s, Timor-Leste was a colony of Portugal (Molnar, 2010). Following a brief civil war and declaration of independence in 1975, Timor-Leste experienced invasion, occupation and oppression at the hands of Indonesia for the next twenty five years (Molnar, 2010). McWilliam (2008,p.219) argued that “under Indonesian rule [the] regulation, surveillance and control of bodies, both personal and collective, was severe”. The consequences from this oppressive legacy are still very much a part of life for thousands of Timorese, and affect their interaction, perceptions and willingness to engage with and trust people and institutions of apparent authority (Saikia, Dasvarma & Wells-Brown, 2009; Nixon, 2003).

After great resilience, determination and sacrifice by the people of Timor-Leste, a referendum for independence was held in 1999, resulting in 78% of people voting for independence (Kingsbury, 2012b). The transition to independence and withdrawal of Indonesian troops was anything but peaceful, and the Timorese were again subjected to extreme violence and persecution (Nevins, 2005). McWilliams (2008,p.218) argued that, “[t]he withdrawal of the Indonesia government, welcome though it was for the most part, took with it substantial financial subsidies and the organizational infrastructure that supported the regional economy”. Additionally, the departure of the Indonesians was characterised by immense loss of life, displacement of persons, and loss of resources (Molnar, 2010). The impact on the provision of health care was significant, and “[d]uring the violence of 1999, over 75% of all health facilities were destroyed, fixed consumables, equipment and records lost and 130 of the nation’s 160 doctors fled the country” (Saikia et al, 2009,p.14).

Timor-Leste now faces the challenge of building a united nation from its linguistically diverse population, and providing peace, prosperity and stability for the 1.2 million people who call Timor-Leste home (Molner, 2010; Sword Gusmao, 2003; Leach, 2012). The economic challenge is significant – Timor-Leste has one of the most fragile economies in the
The world, with half of the population living below the national poverty line, and many commentators have expressed concern with regard to the sustainability of revenue for Timor-Leste into the future (Shoesmith, 2011; Saikia & Hosglen, 2010).

**Geography and culture.** Timor-Leste is a small, mountainous country; a half an island that is part of the Malay Archipelago, approximately 500km north west of Australia (DHS, 2010; Martinkus, 2001). Timor-Leste comprises of 13 districts divided into 65 subdistricts which are made up of local indigenous communities known as ‘sucos’, or villages, of which there are 442 (DHS, 2010). These in turn are divided into 2225 aldeias, or hamlets (DHS, 2010). The majority of the population, approximately 70%, live in rural areas (DHS, 2010). Wayte et al (2008, p.84) described the Timorese as “a young, mainly conservative Catholic population with high fertility, high maternal mortality and widespread gender-based violence”.

The Timorese “are largely subsistence farmers, live in sub-tropical savannah and mountainous villages, organised along kinship and linguistic divisions” (Belton, Whittaker, Fonseca, Wells-Brown & Pais, 2009a,p.55). Divisions have also existed between those who identified with the ‘east’ compared with those who identified with the ‘west’ (Leach, 2012). Simplistically, those who identify with the ‘east’ believe easterners provided the strongest resistance to Indonesia, while those who identify with the ‘west’ believe westerners bore the brunt of the Indonesian invasion (Kingsbury, 2012a). Kingsbury (2012a,p.133) argued that “Viqueque is perhaps Timor-Leste’s least externally exposed and hence more ‘traditional’ district, and that which….was most identified with the ‘eastern’ cause”.

Each suco is ruled by a liurai - a traditional ruler or suco chief (Hicks, 2007). The liurais are believed to have powerful, deific characteristics and are seen as the “human embodiments of ancestral order” (Hicks, 2007,p.14). Since independence, many Timorese have returned to their sucos, and have resumed what is known as adat, defined by Hicks (2007,p.13) as “‘tradition’, ‘custom’, ‘way of the ancestors’, ‘customary law’”. Adat practices were severely hampered during the Indonesian occupation, in part due to the uncompromising security practices of the Indonesian government and its agents, as well as the displacement and dislocation of thousands of people from their homes and communities (McWilliam, 2008). The resurgence of adat following independence has been viewed by many as a celebration and affirmation of the traditional, indigenous Timorese way of life (Hicks, 2007; Niner, 2011;McWilliam, 2008). In contemporary Timor-Leste, despite
supporters of Western values and the somewhat aggressive encouragement of such values into the lives of the Timorese, for example, gender equality and democracy, adherence to and influence from *adat* remains strong, and the preferred authority for many Timorese (Hicks, 2007).

The rebirth of *adat*, has resulted in a redefining of gender roles, often to the detriment of Timorese women (Niner, 2011). Henfry (2004) argued that Timor-Leste ranks amongst the worst in the world in terms of gender equality development. However, the indicator for Millennium Development Goal (MDG) 3, ‘Promote gender equality and empowerment’, reports Timor-Leste ‘on track’ to meet their target for this goal by 2015 (Ministry of Finance, MOF, Timor-Leste, 2014). Despite this, Timorese society, in general, is patriarchal and conservative, with the customary, traditional laws favouring men over women, and women have a much lower social status compared with men (Bye, 2005; Khan & Hyati, 2012). In general, the men are the decision makers, education for sons is given more priority than education for daughters, and food, health care and other resources are distributed unequally between the sexes, with males favoured over females (Henfry, 2004; Hicks, 2004; Niner, 2011).

**Religion, spirits and healing.** The Timorese have a history of animistic beliefs and practices (Molnar, 2010). The spirits, the ancestors, the sacred objects, houses and places are the focus of rituals, myths, legends and customs which guide the lives of many Timorese (Molnar, 2010; Hicks, 2004). The relationship with the spirits and ancestors, as well as the alliances with kin, greatly impact on the way the Timorese perceive health and healing (McWilliam, 2008). Wild et al (2009,p.2) argue that “[t]he ghosts of the ancestors (*matebian*) are important for maintaining health and fertility. Failure to place offerings, neglect of kinship duties and customs (*adat*) or acting immorally may incur sanctions such as sickness and sterility”. Engagement with traditional healing is significant for many, and may involve herbal remedies for consumption or application; chants, mantras and spells embodied in rituals appealing to ghosts, spirits or ancestors; and practices of divination and animal sacrifice performed by appropriate healers (Hicks, 2004; Wild,2009; McWilliam,2008). These animistic philosophies and practices exist concurrently with the Catholicism practiced by many Timorese (Molnar, 2010; Kingsbury, 2012a).

**Catholicism.** The Catholic church has a long and significant history in Timor-Leste (Lyon, 2011; Bye, 2005). Catholicism has been a part of Timor-Leste since the sixteenth
century, however it was during the decades of Indonesian occupation that saw the most rapid conversion to Catholicism by the Timorese people (Molnar, 2010). Today, over 95% of the population has been baptised as Catholic, and the Catholic church is said to be “an institution which not only wields political power but is also generally viewed as having the longest arm in relation to its reach into communities across Timor-Leste” (Richards, 2010a,p.132). Van Schoor (2003,p.56), in her discussion regarding Timorese ritual, argued that “[t]oday, the most significant event for the child is considered baptism at the Catholic Church”.

Historically, the Portuguese Catholic influence on Timor-Leste resulted in the adoption and affirmation of conservative, patriarchal ways of life (Niner, 2011). During the twentieth century, prior to the Indonesian occupation, the establishment of Catholic schools throughout Timor-Leste not only prepared students for baptism, but promoted and reinforced “cultural perceptions of gender roles which laid emphasis on women’s value as mothers and home-makers” (Richards, 2010a,p.95). Niner (2011) argued that through both colonialism and the establishment of the Catholic church, the power and influence of Timorese women in Indigenous society was eroded and diminished, replaced with gender roles steeped in conservative, subservient sentiments and values. The Catholic church did not overtly seek to stamp out certain animistic beliefs or adat rituals and customs, in part because the patriarchal and hierarchal structure of indigenous Timorese society were complementary to the patriarchal and hierarchal practices and philosophies of the Catholic church (Rimmer (2007; Niner, 2011).

During the Indonesian occupation, the Catholic church provided aid, refuge and protection for the Timorese people (Van Schoor, 2003). Additionally, the Catholic church was able, through its networks, to provide information to the rest of the world as to the atrocities and injustices occurring inside Timor-Leste (Lyon, 2011). Molnar (2010,p.20) argued that “[t]he Catholic Church became the protector of the masses, providing physical refuge and moral support against the brutality of the occupation, and thereby becoming a rallying point for resistance”.

Richards (2010a) and Lyon (2011) have argued that as a result of the Catholic church’s support for the Timorese and their quest for independence, contemporary Timor-Leste feels an obligation to consider and collaborate at a national, political level with the Catholic church. This perceived ‘indebtedness’ and subsequent incorporation of conservative Catholic values into national policy, has greatly impacted on the lives of women in Timor-
Leste, with values such as ‘maternalism’ and ‘sexual purity’ emphasised, and ‘wife’ and ‘mother’ roles for women encouraged and reinforced (Niner, 2011; Richards, 2010a). Areas such as divorce, access to abortion, domestic violence legislation and access to family planning are scrutinised and influenced at a policy level by conservative, powerful, patriarchal and hierarchal Catholic values (Niner, 2011; Belton et al, 2009a; Richards, 2010a). Gabrielson (in Rimmer, 2007, p.340) argued that “[t]he Catholic faith is indeed deeply ingrained in the culture of East Timor. This makes the Church and its leaders, if not the strongest political entity, certainly the strongest moral authority in the land”. It is essential to have insight into the role the Catholic church plays with regard to policy areas that impact upon women, and recognise that women’s lives and wellbeing are shaped and determined by this influence (Belton et al, 2009a; Richards, 2010b).

Transitions: Country, culture, gender roles and church. Timor-Leste has undergone a rapid nation-building and development process since gaining independence (Hicks, 2007; Kingsbury, 2012a). The country, culture, gender roles and even the Catholic church, have all been exposed to outside influences that could potentially change life forever for the Timorese (Hicks, 2007; Richards, 2010a). It is likely this development and transition will continue, and the challenge for the Timorese will be to create a Timor-Leste that celebrates freedom and independence for all, incorporates the traditional with the contemporary, and forges a future with a population that is healthy, empowered and prosperous (Molnar, 2010). Mercer, Thomson and de Araujo (2014) argued that the voices of the Timorese were not considered during the early nation building process following independence – processes which set the agenda and direction for this new nation. It is therefore important for the future of Timor-Leste, that the voices of the Timorese people are heard and considered (Mercer et al, 2014). Kingsbury (2012a, p.157) argued that “in the short 10 years since the vote for independence, Timor-Leste had begun to rediscover, develop and invent a unity that many older, more established states still struggled to achieve”. Even so, the challenges ahead, particularly in the area of maternal health, are immense, with Molnar (2010, p.154) likening the situation to that of a “baby in the ICU”. The unity of Timor-Leste which was vitally important in resisting Indonesia, and later the persuasive Western fundamentals associated with the United Nations (UN), is at risk of disintegrating into historical ‘East-West’ divisions, while the divide between ‘urban’ and ‘rural’, as well as linguistic division remains significant (Hicks, 2007; Molnar, 2010; Leach, 2012; Kingsbury, 2012a).
Reproductive Health Care provision in Timor-Leste. The Ministry of Health (MOH) is responsible for the co-ordination and provision of health care services and resources throughout Timor-Leste (Ekpo et al, 2008). There has been a concerted effort since independence to rebuild health infrastructure and resources, and a great focus of the MOH has been the development of a health system based on primary health care principles (National Reproductive Health Strategy (NRHS) 2004-2015). Each of the thirteen districts of Timor-Leste has a District Health Service, which administers a number of Community Health Centres (CHC), Health Posts that provide a basic level of service, SISCAs (integrated community health services) and a number of mobile clinics in an attempt to provide as much of the population with accessible health care as possible (Ekpo et al, 2008). The delivery and provision of adequate health care, and specifically reproductive health care, remains an immense, multifactorial challenge for Timor-Leste (Soares, 2013; Richards, 2010a; Ekpo et al, 2008). There are many religious-affiliated, international aid and non-government organisations (NGOs) working in Timor-Leste, collaborating with the MOH to provide health services on the MOH’s behalf or complementing existing services (NRHS, 2004-2015). One such organisation is Marie Stopes International Timor-Leste.

Marie Stopes International Timor-Leste (MSITL). MSI is a non-government organisation which has provided sexual and reproductive health care for more than thirty years in over forty countries worldwide (MSI, 2014). MSI targets areas of need and provides services accordingly, positively impacting on the health and wellbeing of millions of people every year, and significantly decreasing maternal mortality and morbidity (MSI, 2014). Hartmann (1995) argued that care must be taken by NGOs such as MSI, to ensure that their services remain community and client centred, so as to decrease the risks of target-driven approaches and coercive practices.

Marie Stopes International Timor-Leste (MSITL) has been in Timor-Leste since 2007 (MSI, 2014). They offer specialist sexual and reproductive health care through clinics and outreach services in eight of Timor-Leste’s thirteen districts, as well as providing information and counselling via telephone (MSI, 2014). The outreach services provided are free of charge, and the MSITL teams use hiking, motorbikes, cars and boats to reach remote areas of Timor-Leste (MSI, 2014). Through the services and information provided, it is estimated that MSITL were effective in 2012 at averting over 5000 unintended pregnancies in Timor-Leste, averting over 800 unsafe abortions, and preventing 7 maternal deaths (MSI, 2014).
MSITL works in close partnership with the MOH, providing services and information at government health facilities, and ensuring a collaborative approach aimed at supporting the MOH to attain their national maternal health goals (MSI, 2014). This collaborative approach, whereby MSITL complements rather than competes with the MOH’s system, is an integral component of the sustainability of MSITL’s services within Timor-Leste (Mercer et al, 2014). MSITL’s philosophy of listening to the needs of a community before attempting to provide information or services, ensures that culturally appropriate and sustainable services are specifically targeted for a community’s needs (MSI, 2014). This approach is fundamental to the success of reproductive health services, and Hartmann (1995,p.64) has argued that often, “the donor-imposed model of family planning neglects, and sometimes outright disrespects, local culture”, alienating local communities and failing to meet their reproductive health needs. In contrast, MSITL’s approach not only supports and encourages empowerment of local communities, but ensures that sexual and reproductive health services have the best chance of having a positive impact, thus improving the lives of the women, men and children of Timor-Leste (MSI, 2014). MSI emphasises that “[t]o reach our FP [Family Planning] 2020 goals, we must understand more about who our clients – and our potential clients – are, and what tools and approaches work best to deliver a full range of modern family planning choices and services to them” (Hayes, Fry & Weinberger, 2013,p.11). This research project was well aligned with the MSITL philosophy of listening to the women, gaining insight into their beliefs and perceived needs, through a woman-centred approach.

This chapter has provided the aims and significance of this study, as well as introduced some of the historical, cultural, spiritual, social, political and geographical aspects of Timor-Leste. The following chapter will discuss maternal mortality, fertility control and regulation, potential barriers to such practices, and the relevance of these issues to Timor-Leste.
CHAPTER 2 – LITERATURE REVIEW

Maternal mortality

Maternal mortality remains a significant global public health issue, and 99% of these deaths occur in developing nations (World Health Organization, WHO, 2012). Of all the Millennium Development Goals (MDGs) due for realisation in 2015, it is towards MDG 5 - the improvement of maternal health - that progress has been slowest (World Bank, 2011). It has also been one of the most contested MDGs (Crossette, 2004; Hulme, 2009). MDG 5 incorporates two targets, the first: reducing the MMR by three quarters by the year 2015, and the second: universal access to reproductive health (UN, 2013). Timor-Leste’s MMR is one of the highest in the South East Asian region at 557 maternal deaths per 100,000 livebirths, and maternal deaths account for 42% of all deaths in women aged 15-49 (DHS, 2010). In contrast, many other 'lower middle-income' South East Asian countries (World Bank 2012) report much lower MMRs, for example, the Philippines at 99 per 100,000 and Vietnam at 59 per 100,000 (UN, 2013). The ‘Millennium Development Goal Monitor’ (UN, 2007), reported that Timor-Leste could possibly realise MDG 5 if some changes were made. The Ministry of Finance (MOF, Timor-Leste, 2014), however, reported that while some of the indicators are ‘on track’ for meeting the proposed 2015 targets, reducing maternal mortality remains ‘off track’. Appropriate and accessible family planning is recognised as crucial to meeting the MDGs (Williamson et al, 2009).

Specific causes of maternal mortality are not available for Timor-Leste (Belton et al, 2009b). However the WHO (2012) reported that maternal mortality in developing nations is caused by haemorrhage (24%), infection (15%), unsafe abortion (13%), eclampsia (12%), obstructed labour (8%) and other, including consequences of HIV, malaria and tuberculosis (28%). Specifically for Asia, 17 000 maternal deaths in this region during 2008 occurred due to unsafe abortion, accounting for 12% of maternal mortality (WHO,2011). Pine (1993,p.77) argued that “[f]amily planning initiatives result in increased contraceptive use which, in turn, reduces the incidence of unwanted pregnancy – and thus abortion”. This has been reflected throughout the world, where a number of initiatives have demonstrated positive contributions to the reduction in maternal mortality (WHO, 2012; Stover & Ross, 2010). One such initiative is the ‘Safe Motherhood Initiative’, composed of four inter-related areas including access to skilled care during pregnancy, labour and the postnatal period, timely access to
emergency obstetric care including availability and access to safe abortion, and access to relevant and appropriate family planning services (WHO, 2012).

While such initiatives have demonstrated some success in decreasing maternal mortality, there are still millions of unintended pregnancies every year, and an unmet need for access to family planning services for millions of women (UNFPA, 2012). As with maternal deaths, the majority of these women live in the developing world (Alkema, Kantorova, Menozzi & Biddlecom, 2013). It is estimated that this ‘unmet need’ will increase over the next 15 years by 40% (UNFPA, 2012). Research suggests that ensuring access to quality family planning services would decrease maternal deaths by 29% (Ahmed, Li, Liu & Tsui, 2012). This translates to preventing a quarter of a million maternal deaths – “[i]n 2008, use of contraceptive methods prevented over 250 000 maternal deaths through reducing unintended pregnancies” (Najafi-Sharjabad et al, 2013,p.181).

The health benefits for women through access to family planning services are well documented (UNFPA, 2012; WHO, 2013; Kavanaugh & Anderson, 2013; Ekpo et al, 2008). Being able to space and limit pregnancies reduces maternal morbidity and mortality (UNFPA, 2012; Mwaikambo et al, 2011). Furthermore, this positively influences the outcome for children and decreases neonatal morbidity and mortality – healthy women are able to nurture, provide care, continue breastfeeding and raise their children, ensuring access to food, education and health care (Kavanaugh & Anderson, 2013; Ekpo et al, 2008). Reduced maternal morbidity and mortality also results in women being able to contribute economically and socially to their families, communities and culture (Ekpo et al, 2008; Hardee et al, 2012).

From a national perspective, the benefits of decreasing maternal morbidity and mortality through access to family planning are extensive (Ekpo et al, 2008; UNFPA, 2012; Kavanaugh & Anderson, 2013). The UNFPA (2013,p.1) argued that “[i]nvesting in family planning enables faster economic growth in nations by changing the age structure and dependency ration of a given population. Depending on what services are offered, each dollar spend of family planning can save governments $4 in spending on health, housing, water, sewage and other public services”. This is a significant consideration for a country such as Timor-Leste which has a fragile and emerging economy (Shoesmith, 2011; Saikia, Hosgelen & Chalmers, 2011).
Fertility control and regulation

A brief historical overview. McLaren (1990,p.2) argued that “[t]hose who ask when fertility first came to be ‘controlled’ consciously or unconsciously avoid contemplating the possibility that perhaps it was always controlled”. People have regulated their fertility for millennia in response to social factors, economic factors and available resources (Correa, 1994; McLaren, 1990). Attempts to control fertility have employed a variety of practices and ingredients such as crocodile dung and cats’ testicles, magic and charms, herbs and potions, infanticide and abandonment, abortion, abstinence, withdrawal (coitus interruptus) and extended breastfeeding (Kochman, Sciaky-Tamir & Hurwitz, 2005; Jauniaux, 2000; Caldwell, 2004; Kumar, Kumar & Prakash, 2012; McLaren, 1990). Ancient societies were not opposed to contraception, but were perhaps constrained by its limited effectiveness, and Parkin (in Caldwell, 2004,p.7) argued that “the main factor against the demographic significance of contraception in the ancient world was not its unacceptability but its ineffectiveness, combined perhaps with a general lack of male interest”.

Kochman et al (2000,p.7) argued that “[i]n ancient times, women practiced birth control with little interference from religious or civil authorities”. As the centuries progressed, this changed, with records demonstrating an increasing influence from church and state, with both condoning or restricting dissemination of information, or support of practices, that controlled fertility (Connell, 1999; McLaren, 1990).

In the 19th Century, due to the Industrial Revolution, changing economic and employment circumstances and increased technological advances in modes of contraception, a ‘fertility transition’ occurred across Europe, resulting in the significant decline in fertility rates (Saito, 2006; Caldwell, 2004). Geographical and economic diversity was noted, with urban women’s fertility declining faster than rural women’s, and upper class women’s fertility declining faster than that of the lower class (McLaren, 1990).

At the beginning of the 20th Century, Sanger and Stopes advocated for the provision of information about, and access to, contraception for poorer women in lower classes in the United States and the United Kingdom (Connell, 1999; McLaren, 1990). These motivations
were tangled, with concern regarding infant and maternal mortality on one hand, and on the other neo-Malthusian and eugenic ideas of raising the fertility of the upper class while decreasing that of the lower class (McLaren, 1990).

Following the Second World War, when many women had been employed in munitions factories and had their children cared for while they worked, governments from Western countries supported a return to pre-war, ‘traditional’ values, where by women were placed firmly back in the realm of domesticity with earlier marriages and large numbers of children (McLaren, 1990). The ensuing post-war ‘baby-boom’ was evident not only in Western countries, but in the developing world as well, and suddenly, there was a significant increase in the number of people concerned with effective measure of fertility regulation and contraception (Cleland, 2009; McLaren, 1990).

The 1960s was a decade that could be described as a ‘perfect storm’ in terms of the focus, promotion and availability of contraception (Cleland, 2009; McLaren, 1990). Firstly, there was the availability of new MMC (for example, the oral contraceptive pill and the intrauterine device), backed by commercial interests as much as scientific or rights paradigms; secondly, the feminist movement gained momentum during this decade; and thirdly the xenophobic concerns of the West in terms of the perceived uncontrolled population growth in developing countries were significant (Cleland, 2009). The lines between family planning, population control and development became increasingly blurred, exacerbated perhaps by the 1960s being declared the ‘decade of development’ by the UN (UN, 2003). MMC, perhaps due to their potential to curb rapid population growth in the developing world, suddenly had new high profile, powerful supporters in the form of the President of the United States and the Head of the World Bank; the UN established the UN Fund for Population Activities (UNFPA), tactically appointed a Roman Catholic as the first director of this fund, and the contraception revolution was underway (Cleland, 2009).

Research supported by the UN began to investigate the relationship between economic development, social development and population growth (UN, 2003). Malthusian principles resurgned, however major international strategies instigated by the UN, maintained that their focus was on development, as opposed to population control (UN, 2003). Also emphasised was that individual countries could seek the support of the UN from a demographic research perspective with regard to measures of population control, but that ultimately policies regarding these issues needed to be driven by the individual countries in
question (UN, 2003). Many developing countries required the support of donor countries and organisations to establish population policies and conduct family planning programs (Cleland, 2009). Although sovereignty of individual countries was the official doctrine with regard to the instigation of population policy programs, there are suggestions that donor funds and World Bank loans were dependent on the local promotion and extensive establishment of such programs, thus clandestinely addressing the fears of the West of a population explosion within the developing world (Cleland, 2009; Kane, 2000).

The population programmes of the 1980s are criticised for being driven by demographics, at the expense of women’s rights (Kane, 2000). Kane (2000, p.435) argued that “[t]he international women’s movement pointed out that women had not been significantly involved in establishing policies relating to fertility regulation, and had little or no hand in the design and introduction of modern birth control methods”. The International Conference on Population and Development (ICPD) in Cairo in 1994, saw the transition of the reproductive health dialogue from one of a demographic and development focus, to a dialogue incorporating and focusing on objectives concerning ‘rights’ (Petchesky in Obermeyer, 2001).

This broadening of perspective acknowledged that “[w]omen’s education, equality and empowerment were recognised as paramount, and the importance of providing family planning within the context of full sexual and reproductive health care was stressed” (Simelela, 2006, p.294). It was hoped that these sentiments would be echoed in the Millennium Development Goals (MDG), which were created as a “framework for addressing the world’s health needs” (Mattson, 2010, p.573). However, fertility regulation and the provision of sexual and reproductive health resources have long been political areas of contention (Simelela, 2006; Richards, 2010a). There are many examples throughout history where women’s reproductive health rights have been sacrificed to the detriment of women (Simelela, 2006). One of the most striking examples of this is with regard to the development of MDG 5. In the original iteration of the MDGs, there was an absence of any reference to family planning, contraception or care for women during the antenatal period (Crossette, 2004). Hulme (2009) claimed that this exclusion was due to the lobbying and influence of the Holy See – “[t]hese complex and multi-layered institutional interactions, often conducted in secret, permitted a group of less than 1000 celibate, elderly males (the official residents of the Vatican) to reduce the access of 3 billion women to reproductive health services!” (Hulme, 2009, p.9). Reassuringly, this exclusion was somewhat addressed in 2008, with the
adoption of Target 5B – “Achieve, by 2015, universal access to reproductive health” (UN, 2008).

**An Asian perspective.** Saito (2006) writes that fertility transition occurred in Asia firstly in Japan in the early part of the 20th Century, and subsequently in many other parts of Asia in the latter part of the century, following the Second World War. Jones and Leete (2002,p.116) argued that, “[b]y the mid-1980s, several East and Southeast Asian countries had, or had nearly, completed the transition from high to low fertility. Fertility decline transcended political, economic, cultural and religious boundaries. It occurred in poor agricultural settings at lower levels of development and, more predictably, in the newly industrialized nations”. The warnings from the UNFPA regarding predictions of uncontrollable population growth, plus the success of public health programs at national levels resulting in the postponement of death and the improvement of health, emphasised the need for Asian countries to establish family planning programs (Jones & Leete, 2002; Cleland, 2009).

Correa (1994,p.25) states that “[a]ll Southern regions have been touched by fertility control strategies since the 1960s. However, full implementation of state-led population control policies is, in many senses, a characteristically Asian phenomenon”. Success stories, from a demographic perspective, include China, Indonesia, India and Bangladesh, although from a feminist perspective Correa (1994) argued that such programs have often been coercive, dismissive of women’s rights and inflexible with regard to method. While across much of Asia fertility rates have declined, Jones and Leete (2002) argued that two exceptions are Pakistan and Nepal. This is attributed predominantly to three factors, including the generally lower social status of women in these countries, the decreased opportunity for females to participate in education, and a reported large unmet need for reproductive health services (Jones & Leete, 2002).

**Fertility control and regulation in Timor-Leste**

Fertility regulation and control for women in Timor-Leste have been shaped by recent and past historical occurrences, cultural, and traditional practices, as well as global and religious influences.
Indigenous influence. Indigenous methods of contraception in Timor-Leste are based on behaviour, and include the withdrawal method and fertility awareness methods/periodic abstinence methods, traditional medicines and ritual/custom based methods (WHO, 2013). Fertility is highly valued and immensely important in traditional, indigenous Timorese society (Hicks, 2004; Niner, 2011; Nixon, 2003), and “an important part of Timorese survival and prosperity” (Wild et al, 2009, p.1). There are many aspects of fertility that are interwoven with both animistic and adat beliefs, philosophies and practices with strong pro-natalist ideology, as well as aspects which are concerned with Catholic values (Wild et al, 2009; Molnar, 2010). During marriage rituals, ceremonies and practices occur in order to encourage the ancestors to bless the bride and groom with fertility (Hicks, 2004). Marriage is important in indigenous Timorese society, as it is how kinship and alliance systems are maintained (Niner, 2011). Niner (2011, p.417) explained that “[m]arriage is bound by the lore of barlake (simplified in Western translations to dowry or brideprice), which is part of a wider, complex system of social action and ritual exchange aimed at creating social and spiritual harmony”. It is important to recognise that barlake involves much more than the provision of material gifts, and that it consists of life-long alliances, ceremonies and exchanges between the families of the wife-giver and wife-taker (Hicks, 2012; Khan & Hyati, 2012).

Traditionally barlake was important in protecting and valuing women, and emphasised the importance of women and their fertility (Khan & Hyati, 2012; Hicks, 2012). The process of women marrying, becoming a wife and creating procreation potential, has been coined the “flow of life”, and was extremely valued in traditional indigenous Timorese society (Niner, 2012, p.139). In contemporary times, the issue of barlake, like many of the traditional rituals and practices, is a contested one (Hicks, 2007; Niner, 2011). On one hand barlake again provides a framework of meaning, perceived to protect and value women in a way that is fundamental in traditional Timorese society, with women’s proven fertility leading to improved social status (Khan & Hyati, 2012; Bye, 2005; Wild et al, 2009). On the other hand is the opposing view that barlake has no place in contemporary Timorese society, and that the practice of barlake degrades and oppresses women, and puts them at increased risk from domestic violence (Richards, 2010a). Niner (2011) argued that there is a risk that barlake results in women and their fertility being viewed as a commodity, and something that is ‘bought’ by the husband and his family. This results in increased pressure on the women to produce many children, contributing to Timor-Leste’s very high birth rate and subsequent
high maternal mortality (Niner, 2011). Barlake remains a significant and influential practice, with approximately half of all contemporary marriages engaging with this practice (Bye, 2005; Niner, 2012). Richards (2010a,p.120) argued that within the Catholic church, “traditional practices such as barlake – the Timorese form of bride-price – are acceptable when they coincide with Catholic beliefs”.

The influence of the Catholic church. Simelela (2006,p.296) stated that “[t]he attitude of the Roman Catholic church has been the most important obstacle to the under use of contraception worldwide; indeed, no other religion has the same dogmatic opposition to contraception”. The Catholic church teaches that God, after he created man and woman, proclaimed “[b]e fertile and multiply; fill the earth and subdue it” (Sauders, 2003). Fertility, as perceived by the Catholic church, is one of the three most important components of marriage, along with indissolubility and faithfulness (Saunders, 2003). Children are seen as gifts from God, and many Timorese attribute children to the divine will of God, subsequently accepting that their fertility is beyond their control (Richards, 2010a). The Catholic church teaches that as long as they are being employed for moral reasons, as opposed to selfish motivations, practices to regulate fertility known as ‘natural family planning’ methods based on an understanding of a woman’s fertile period are permissible, while employing contraceptive drugs or devices, is evil and a sin (Catholic Church, 2014). The Catholic church differentiates family planning methods using the terms ‘natural’ as opposed to ‘artificial’ (Bernado, 2005). Bernado (2005,p.8) argued that “the implementation of family planning programs especially artificial methods cannot be implemented smoothly in East Timor because of the influential role of the Catholic Church”.

The Indonesian influence. It is believed that family planning practices during the Indonesian occupation of Timor-Leste, were forced upon women, resulting in long lasting mistrust of the country’s health system and services (Henfry, 2004; Bye, 2005). The National Reproductive Health Strategy (NRHS,2004,p.20) stated that “during the Indonesian occupation the community experienced a family planning program that was felt by the general community to be co-ercive and politically motivated”. Mercer et al (2014) argued that there has been an effort in Timor-Leste amongst supporters of family planning to present the services as “birth spacing” initiatives, rather than the fertility limitation practices associated with the Indonesian program known as KB (Keluarga Berencana). KB was based on 3 monthly contraceptive hormonal injections, delivered in a coercive manner during the Indonesian occupation, without adequate informed consent (Sissons, 1997; Richards, 2010a).
It is believed by many to have been an aggressive form of population control, designed to limit East Timorese family size to two to three children (Sissons, 1997; Richards, 2010a).

**The influence of the United Nations (UN).** The ICPD (in Simelela, 2006,p.292) declared that “[a]ll countries should take steps to meet the family planning needs of their population as soon as possible, and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and to related reproductive health services which are not against the law”. Timor-Leste is signatory to a number of conventions stipulating a variety of reproductive health care rights, including number and spacing of children (Belton et al, 2009b). Additionally, the government of Timor-Leste has recognised the need for making family planning programs a priority, in an attempt to realise its goals of decreasing poverty, improving women’s health, decreasing maternal and infant mortality and slowing population growth. A number of strategies exist at the national level to provide the framework in which to offer reproductive health care, for example, the ‘National Family Planning Policy’ (MOH, 2004) and the NRHS (MOH, 2004). A national conference, ‘Reproductive Health, Family Planning and Sex Education’, was convened in Dili in 2010, resulting in the declaration for affirmative action to “reduce maternal and child death, birth rate and teenage pregnancy in Timor-Leste” (Ruest-Archambault, 2010,p.7). However despite these numerous health policies and declarations, as well as the increased presence of donors and providers, “[f]amily planning…remains a great concern in Timor-Leste” (Soares in Ruest-Archambault, 2010,p.6). Additionally, Richards (2010b) and Belton et al (2009a) argued that strategies and policies such as these, which concern ‘sensitive’ issues, are first vetted and sanctioned by the Catholic church prior to publication and implementation.

**Barriers to fertility regulation and family planning**

Women’s human right to choose and access family planning services, “is limited by several factors, including economic, social and cultural barriers and unequal power relations which underline all aspects of women’s lives. Alongside these, there are strong moral opinions, religious beliefs, political and legal constraints limiting access” (Simelela, 2006,p.295). Additionally, “lack of knowledge of methods and reproduction, socio-demographic factors, and health service barriers are the main obstacles to modern
contraceptive practice among Asian women” (Najafi-Sharjabad et al, 2013,p.181). Access and opportunity with regard to education in general is also a significant factor, and Hartmann (1995,p.49) argued that “[t]he education level of women is the single most consistent predictor of fertility and contraceptive use”. Low educational achievement results in low health literacy (Mattson, 2010), which in turn impacts on a woman’s confidence to access and use contraception effectively – “[i]n order for women to feel confident about contraception and use it effectively, they need to understand how the reproductive system works” (Hartmann, 1995,p.52).

Many of these barriers are significant considerations for the women of Timor-Leste (Ruest-Archambault, 2010). Culture may act as a barrier in a variety of ways, and “[w]here the status of women is low, social barriers to accessing family planning methods can be more formidable than financial costs” (Campbell, Hodoglugil & Potts,2006,p.89). Consideration of religion in also important, and Richards (2010a,p.ii) argued that Timor-Leste’s “high rates of fertility, low rates of contraceptive prevalence and high levels of maternal mortality, demonstrate the importance of exploring perceptions, policies and practices around fertility and reproduction, particularly in the light of the Church’s influential opposition in this area”. Historical events impact also, with Timor-Leste’s post-conflict baby boom illustrating reproductive choices shaped through a “perceived post-genocidal psychology among the male members who believe that they have lost so many members of their families during the conflict and who must be replaced” (Saikia et al, 2009,p.1). A similar scenario occurred in Cambodia when following the genocide experienced by that country in the 1970s, the fertility rate rose significantly (Kiernan, 2008). Insight into cultural, religious and historical influences on women’s choices regarding MMC, and how these may act as barriers, is essential for stakeholders in Timor-Leste to enable the provision of culturally appropriate services, and Najafi-Sharjabad et al (2013,p.181) argued that “just making contraceptives available does not guarantee that women will use them”. Broom and Germov (in Germov, 2009,p.80) argued that “without an understanding of cultural and social processes, we will never be able to support the amelioration of health problems in poorer countries successfully”.

The MOH has nominated a contraceptive prevalence rate of 40% to be achieved in Timor-Leste by the end of 2015 (NRHS, 2004). In addition to those barriers discussed above, a number of potential health system barriers to achieving this target have been identified,
including lack of human resources and health care providers, lack of physical resources, facilities and supply chain issues, and inappropriate or inadequate education and information dissemination (Ekpo et al, 2008; Zwi et al, 2009; Siakia et al, 2009). Logistical challenges such as distance to a health facility or the conditions of the roads, also contribute to the challenge of meeting this target, and the provision of reproductive health care in general (Zwi et al, 2009).

Almost 35% of married women in Timor-Leste report that they want no more children, while another 35% report that they wish to delay the next birth by two or more years (DHS, 2010). Paradoxically, despite these desires, 54% of currently married women not using family planning methods state that they do not intend to use such methods in the future (DHS, 2010). The most cited reason for this non intention, is opposition to use (55%), with the majority of this opposition being ‘personal opposition’ from the woman herself (DHS, 2010). Additionally, a further 21% of women state that their non-intended use of family planning methods is due to concerns regarding the method itself, including fear of side effects and interference with the body’s normal processes (DHS, 2010).

A number of qualitative studies from around the world have demonstrated that misconceptions and myths regarding potential side effects from MMC often exist among women, influencing their decision to use such methods (Samandari & O’Connell, 2011; Zwi et al, 2009). Cambell et al (2006) argued that in some cases, due to misconceptions, women may perceive contraceptive methods as more harmful to their health than pregnancy. A recent report published by Marie Stopes International (Reiss, Nantayi, Odong & Ngo, 2012), recommended qualitative research exploring the myths surrounding MMC, in order to gain insight into misconceptions that may be acting as barriers. There is limited published information regarding these specific factors in Timor-Leste, although Richards (2010a) has suggested that sometimes these myths are perpetuated by those providing reproductive health care. Understanding and identifying these existing or potential barriers is crucial in order to provide appropriate and necessary sexual and reproductive health services, and thus help women to regulate, if they choose, their fertility (Cambell et al, 2006).

As it stands: Timor-Leste’s fertility

Although latest trends in the total fertility rate in Timor-Leste show a decline since they were last assessed, the total fertility rate (TFR) for women in Timor-Leste remains high
at 5.7 nationally, with rural women having a higher TFR than urban women, as demonstrated in the following Table 2.1:

Table 2.1: Total Fertility Rate (TFR) Timor-Leste 2010 and 2003:

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
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<tbody>
<tr>
<td>Total Fertility Rate per woman</td>
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</tr>
<tr>
<td>(15-49 years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>7.4</td>
<td>7.8</td>
<td>7.7</td>
</tr>
<tr>
<td>Total Fertility Rate per woman</td>
<td></td>
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<tr>
<td>(15-49 years)</td>
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<td></td>
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<tr>
<td>2010</td>
<td>4.9</td>
<td>6.0</td>
<td>5.7</td>
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</tbody>
</table>


Within Timor-Leste, knowledge and use of family planning methods have increased over the past decade, as illustrated in Table 2.2, with 19.7% of ever-married women reporting knowledge of any method of contraception in 2003 (DHS, 2003), increasing to 78.4% of currently married women in 2010 (DHS, 2010); and 10% of currently married women of reproductive age reporting current use of contraception in 2003 (DHS, 2003) increasing to 22.3% in 2010 (DHS, 2010). Despite this increase, a third of currently married women in 2010 reported an unmet need for family planning (DHS, 2010).
Table 2.2: Knowledge of Contraceptive Methods & Current Use of Contraceptive Methods, expressed as percentages, 2003 and 2010:

<table>
<thead>
<tr>
<th>METHOD/YEAR</th>
<th>Knowledge of contraceptive methods</th>
<th>Current use of contraceptive methods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2003</td>
<td>2010</td>
</tr>
<tr>
<td>Any method</td>
<td>19.7</td>
<td>78.1</td>
</tr>
<tr>
<td>Any modern method</td>
<td>-</td>
<td>77.7</td>
</tr>
<tr>
<td>Female sterilisation</td>
<td>1.3</td>
<td>23.9</td>
</tr>
<tr>
<td>Male sterilisation</td>
<td>0.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Pill</td>
<td>10.9</td>
<td>57.6</td>
</tr>
<tr>
<td>IUD</td>
<td>2.8</td>
<td>35.9</td>
</tr>
<tr>
<td>Injectable</td>
<td>19.2</td>
<td>70.3</td>
</tr>
<tr>
<td>Implants</td>
<td>5.0</td>
<td>40.0</td>
</tr>
<tr>
<td>Male condom</td>
<td>3.3</td>
<td>26.2</td>
</tr>
<tr>
<td>Female condom</td>
<td>-</td>
<td>10.1</td>
</tr>
<tr>
<td>Lactational amenorrhea</td>
<td>3.0</td>
<td>9.5</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>-</td>
<td>4.0</td>
</tr>
<tr>
<td>Standard days method</td>
<td>-</td>
<td>16.8</td>
</tr>
<tr>
<td>Any traditional method</td>
<td>-</td>
<td>21.7</td>
</tr>
<tr>
<td>Rhythm</td>
<td>3.2</td>
<td>17.0</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>1.0</td>
<td>10.2</td>
</tr>
<tr>
<td>Folk method</td>
<td>-</td>
<td>3.8</td>
</tr>
<tr>
<td>Mean number of methods known by respondents</td>
<td>0.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Not currently using</td>
<td>90.0</td>
<td>77.7</td>
</tr>
</tbody>
</table>

Number of respondents:
- 4177 ever married women
- 7906 currently married women
- 4070 currently married women
- 7906 currently married women


Table 2.2 demonstrates that injectable contraceptives remain most widely known and used contraceptive method reported by women in Timor-Leste, with only a small percentage of women reporting knowledge or use of long term methods such as IUDs or implants (DHS, 2003; DHS, 2010). Of note is the large discrepancy in the most recent survey between traditional and modern methods in both knowledge and use, with 71% of women reporting knowledge of any MMC compared with 17% of women reporting knowledge of any traditional method, and similarly 12.8% of women reporting use of any MMC as opposed to 0.7% of women reporting use of any traditional method (DHS, 2010). Hartmann (1995)
warned that in a circumstance such as this, it is important that the western MMC are provided in a sustainable manner, to ensure that a gap does not emerge if such services were to suddenly cease, resulting in women having few measures of fertility regulation due to the erosion of traditional knowledge.

Discrepancies exist also when considering fertility regulation across districts, or when comparing urban settings with rural settings. The following table based on DHS (2010,p.67) data demonstrates this urban/rural difference:

**Table 2.3: Current use of contraception: Percent distribution of currently married women, urban and rural, aged 15-49 by contraceptive method currently used:**

![Graph showing percent distribution of contraception use](image)

Source: DHS 2010.

Internal data from MSITL based on more recent data from the MOH show difference across districts with regard to contraceptive prevalence rates (CPR), and highlights the districts which are on track for Timor-Leste’s target of a CPR of 40% by 2015, and those districts which are struggling to attain that target, as illustrated in the following Table 2.4:
Table 2.4: Contraceptive Prevalence Rates (CPR) by District:

<table>
<thead>
<tr>
<th>District</th>
<th>Estimated Population of Women aged 15-49 years</th>
<th>Contraceptive Prevalence Rate CPR*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ainaro</td>
<td>12 387</td>
<td>39.3</td>
</tr>
<tr>
<td>Ermera</td>
<td>26 946</td>
<td>37.4</td>
</tr>
<tr>
<td>Liquica</td>
<td>14 959</td>
<td>36.7</td>
</tr>
<tr>
<td>Baucau</td>
<td>24 130</td>
<td>31.4</td>
</tr>
<tr>
<td>Oecussi</td>
<td>14 909</td>
<td>31.1</td>
</tr>
<tr>
<td>Aileu</td>
<td>10 168</td>
<td>31.0</td>
</tr>
<tr>
<td>Manatuto</td>
<td>9 060</td>
<td>28.6</td>
</tr>
<tr>
<td>Covalima</td>
<td>13 889</td>
<td>24.9</td>
</tr>
<tr>
<td>Bobonaro</td>
<td>20 520</td>
<td>24.8</td>
</tr>
<tr>
<td>Manufahi</td>
<td>10 613</td>
<td>23.1</td>
</tr>
<tr>
<td>Dili</td>
<td>69 745</td>
<td>17.8</td>
</tr>
<tr>
<td>Viqueque</td>
<td>14 615</td>
<td>16.6</td>
</tr>
<tr>
<td>Lautem</td>
<td>12 668</td>
<td>12.8</td>
</tr>
</tbody>
</table>

Source: Internal data from MSITL based on data from the ‘Statistics Department, Ministry of Health, Cabinet of the Health Information & Epidemiological Vigilance, Jan – Dec 2012’:

*Methods counted = oral contraceptive pills, injections, implants, IUDs, condom, vasectomy and tubectomy.

Table 2.4 illustrates that Ainaro, Ermera and Liquica have the highest CPR, while Viqueque and Dili’s CPR are much lower than other districts in Timor-Leste. Maternal mortality reported by district is not publicly available, and thus any correlation is not known. Identifying and exploring the factors that impact on women’s contraceptive choices in districts with low CPRs is an important ‘next step’ in the provision of services and resources that contribute to lowering maternal mortality.

This chapter has discussed maternal mortality, the issue and history of fertility control and regulation, barriers that exist in this domain and how this relates and features in Timor-Leste. The following chapter describes the methodology behind this study, designed to give a voice to the women of Timor-Leste and hear first hand from them their beliefs and perceptions with regard to family planning and contraception.
CHAPTER 3 - METHODOLOGY

This qualitative research aimed: to give a voice to the women of Timor-Leste regarding family planning using MMC; to determine what women perceive as barriers to family planning; and to gain insight into why women choose not to use MMC. These emic insights can focus resources and services to ensure family planning programs are culturally appropriate, target areas of need, and therefore contribute to decreasing maternal deaths in Timor-Leste.

The four research questions this study sought to answer were:

1. Why do women choose not to use MMC, long or short acting, to delay or cease having children?
2. What are the perceptions the women of Timor-Leste have regarding family planning using MMC?
3. What do the women of Timor-Leste perceive as barriers or disadvantages of family planning using MMC?
4. What are the areas of need with regard to access to information, services and resources concerning MMC in Timor-Leste?

Qualitative research

Qualitative research allows the exploration and understanding of the world around us (Liamputtong, 2009). It allows the voices of the respondents to be heard, and their stories to be told (Creswell, 2009). It helps to explain data from quantitative studies by gaining understanding into why participants responded as they did. Qualitative research is concerned with essence, meaning, quiddity, context and empowerment, and is ideally suited to this study due to the desire to explore and understand a sensitive topic within a culturally specific context (Liamputtong, 2010; Liamputtong, 2009).

Feminist theory. A feminist theoretical approach empowers the participants, gives them a voice and tells their stories (Liamputtong, 2009; Hesse-Biber, 2011). Feminist theory is concerned with the voices of women being acknowledged as sources of truth (Hesse-Biber, 2011). The overall goal of feminist research is to “capture women’s lived experiences in a respectful manner that legitimizes women’s voices as sources of knowledge” (Campbell &
Feminist research is concerned with concepts such as oppression, marginalisation and inequality, and employs a variety of methodologies and methods to “apply multiple lenses that heighten our awareness of sexist, racist, homophobic, and colonialist ideologies and practices” (Brooks & Hesse-Biber in Hesse-Biber & Leary, 2007, p.4). Mosse (in Bye, 2005) described the concept of ‘global feminism’, which recognises that although an universal description of the position of women does not exist, there are similarities that may be applied globally. Bye (2005) employed this position when analysing gender in Timor-Leste, adopting the paradigm that “women are oppressed not only by their gender but also by their class, race, caste, and colour, sharing these oppressions with men from similar social groupings, but the women are also oppressed by those men” (Bye, 2005, p.10). This study sought to capture the perceptions of Timorese women, and in doing so create awareness of their knowledge and their philosophies. For this, feminist research is well suited, and is not only about the women but ultimately for the benefit of women (Liamputtong, 2013).

**De-colonising methodology.** De-colonising methodology aims to decrease the risk of research being ethnocentric or disrespectful towards and biased against indigenous people, when such people are being “researched” by westerners. De-colonising methodologies require the research to be beneficial to those participating, and that the process contributes towards self-determination and development for those indigenous people involved (Smith in Liamputtong, 2010). This study employed a de-colonising methodology during the majority of phases of this research. This ensured that the study design was culturally considerate, and that the insights the participants provided were viewed and analysed in a culturally appropriate way, as well as respecting and recognising indigenous Timorese knowledge and beliefs. Table 3.1 demonstrates the collaboration and validation that took place throughout this study to ensure a de-colonising methodological approach, whereby each phase of the research was designed to involve and incorporate Timorese perspectives and philosophies:
Table 3.1: Collaboration & validation throughout the research project:

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Process</th>
<th>Personnel</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 2013</td>
<td>Timor-Leste (TL)</td>
<td>Initial consultation with MSITL to discuss areas of need, lines of enquiry, priority targets</td>
<td>H.Wallace, Dr Belton, N.Morgan, M.Kearney, A.Leite, Dr Soares</td>
<td>Menzies, Aus, Menzies, Aus, MSITL, TL, MOH, TL, MOH, TL</td>
</tr>
<tr>
<td>Aug 2013</td>
<td>Australia (Aus)</td>
<td>Literature Review, Development of research questions &amp; Study design.</td>
<td>H.Wallace, Dr Belton, Dr Soares</td>
<td>Menzies, Aus, Menzies, Aus, MOH, TL</td>
</tr>
<tr>
<td>Aug 2013</td>
<td>Timor-Leste</td>
<td>Confirmation of research questions, study design &amp; teams with MSITL &amp; University National Timor-Leste (UNTL) teams</td>
<td>N.Morgan, M.Kearney, Dr Soares, Dr Martins, N.Pereira</td>
<td>Menzies, TL, MSITL, MOH, TL, UNTL, UNTL</td>
</tr>
<tr>
<td>Sep 2013</td>
<td>Australia</td>
<td>Application to the Human Research Ethics Committee of NT &amp; the Technical Commission of Human Research (TCHR), MOH, TL</td>
<td>H.Wallace, Dr Belton, Dr Soares, N.Pereira, M.Kearney</td>
<td>Menzies, Aus, Menzies, Aus, MOH, TL, UNTL, MSITL</td>
</tr>
<tr>
<td>Oct 2013</td>
<td>Australia</td>
<td>Preparation of research proposal presentation for TCHR &amp; qualitative research training workshop</td>
<td>H.Wallace, Dr Belton, Dr Soares</td>
<td>Menzies, Aus, Menzies, Aus, MOH, TL</td>
</tr>
<tr>
<td>Nov 2013</td>
<td>Timor-Leste</td>
<td>Presentation of research proposal to TCHR</td>
<td>Dr Soares, M.Kearney, N.Pereira</td>
<td>MOH, TL, MSITL, UNTL</td>
</tr>
<tr>
<td>Nov 2013</td>
<td>Timor-Leste</td>
<td>Qualitative research workshop &amp; training, MSITL team; permission, recruitment and confirmation of research sites</td>
<td>Dr Soares, M.Kearney, N.Pereira, A.Miranda, E.da Costa</td>
<td>MOH, TL, MSITL, UNTL, MSITL, UNTL</td>
</tr>
<tr>
<td>Nov 2013</td>
<td>Timor-Leste</td>
<td>Field work: data collection: • 5 x Focus Group Discussion (FGD) &amp; Body Mapping (BM) Viqueque • 3 x FGD &amp; BM Dili Validation &amp; clarification at conclusion of each session</td>
<td>N.Pereira, A.Miranda, H.Wallace, M.Kearney, E.da Costa</td>
<td>MSITL, Menzies, Aus, MSITL, MOH, TL</td>
</tr>
<tr>
<td>Nov 2013</td>
<td>Timor-Leste</td>
<td>Translation &amp; Transcription First phases of analysis</td>
<td>H.Wallace, E Costa</td>
<td>Menzies, Aus, MSITL</td>
</tr>
<tr>
<td>Nov 2013</td>
<td>Timor-Leste</td>
<td>Validation of first phase analysis with MSI team members &amp; local experts – ‘de-colonising’ meeting at MSI, Dili; incorporation of feedback into second phase of analysis</td>
<td>H.Wallace, N.Pereira, Dr Soares, A.Miranda, M.Kearney, M.Pinto</td>
<td>Menzies, Aus, UNTL, MOH, TL, MSITL, MSITL, UNTL, MSITL</td>
</tr>
<tr>
<td>Jan 2014</td>
<td>Australia</td>
<td>Second phase of analysis; preparation of presentation of preliminary findings</td>
<td>H.Wallace, Dr Belton</td>
<td>Menzies, Aus, Menzies, Aus</td>
</tr>
<tr>
<td>Feb 2014</td>
<td>Timor-Leste</td>
<td>Validation with MSI team members &amp; local experts; preliminary findings</td>
<td>N.Morgan, Dr Soares</td>
<td>MSITL, MOH, TL</td>
</tr>
<tr>
<td>May 2014</td>
<td>Timor-Leste</td>
<td>Presentation of preliminary findings to TCHR, MOH</td>
<td>N.Morgan, Dr Soares</td>
<td>MSITL, MOH, TL</td>
</tr>
<tr>
<td>Jun 2014</td>
<td>Timor-Leste</td>
<td>Presentation of findings to MSITL, TCHR, MOH &amp; other stakeholders; collaboration &amp; validation from stakeholders &amp; local experts</td>
<td>H.Wallace, N.Morgan</td>
<td>Menzies, Aus, MSITL</td>
</tr>
<tr>
<td>Jul 2014</td>
<td>Australia</td>
<td>Incorporation of above feedback into third phase analysis; final report; treatise</td>
<td>H.Wallace</td>
<td>Menzies, Aus</td>
</tr>
<tr>
<td>Sep 2014</td>
<td>Timor-Leste</td>
<td>Feedback to villages &amp; Timorese community</td>
<td>N.Morgan, MSITL team</td>
<td>MSITL</td>
</tr>
</tbody>
</table>

(Names in **bold** denote a Timorese citizen).
Rapid Assessment Procedures (RAP) for ethnographic studies. This study used Rapid Assessment Procedures (RAP) methodology to gather emic data regarding women’s perceptions regarding MMC. RAP is a genre of qualitative research which provides relatively fast and focused data collection in the field, employing a variety of qualitative research methods (Utarini, Winkvist & Pelto, 2001; Holly & Shoobridge, 2004). RAP encourages and embraces iteration and opportunism, with flexibility and continual researcher reflection crucial to the study design (Chambers in Scrimshaw & Gleason, 1992).

This method of focused data collection was necessary in this study, due to logistical and cross-cultural challenges, and limited amount of time available to spend in the field. Also, it was an appropriate research design as it suited the goal of producing something that was ‘useful’ — “RAP efforts are intended to obtain useful data for the purposes of social action” (Utarini et al, 2001). RAP provided an appropriate tool to give a voice to numerous women from a variety of locations, age groups and educational backgrounds, allowing the researchers to gain cultural perspective, insight and understanding (Manderson & Aaby, 1992).

Definitions

Family planning, defined by the WHO (1982,p.3) is:
practices that help individuals or couples to attain certain objectives: to avoid unwanted births; to bring about wanted births; to regulate the intervals between pregnancies; to control the time at which births occur in relation to the ages of the parents; and to determine the number of children in the family. (WHO, 1982, p.3).

‘Traditional’ methods of contraception include the withdrawal method and fertility awareness methods/periodic abstinence methods, while ‘modern’ methods of contraception include oral hormonal pills, hormonal implants, hormonal injections, intrauterine devices, male and female condoms and male and female sterilisation (WHO, 2013). Additionally, Richards (2010a, p.182) identified that within Timor-Leste, the Indonesian term KB (keluarga berencana) is a common, everyday term used amongst the Timorese to describe family planning, although often refers only to the hormonal injection form of contraception. The term KB was used occasionally during this study to provide an everyday translation of the subject of investigation. Additionally, in discussions with the MSITL staff, they reported that often the terms “family planning” and “contraception” are used interchangeably in Timor-Leste.

The standard definition of women of reproductive age are females aged between 15-49 years (Weinberger, 2013). However as this was a student project from a novice researcher, I did not want to be working with children, so for this study, only women 18 years and above were included. Urban, peri-urban and rural areas were delineated according to classifications made by the Direccao Nacional de Estatistica, Timor-Leste.

**Literature Review**

Data was obtained through a literature review, a review of Marie Stopes International Timor-Leste internal data, and demographic health survey data from Timor-Leste. The iterative nature of qualitative research and underlying principles of RAP resulted in numerous returns to the literature (Liamputtong, 2013; Chambers in Scrimshaw & Gleason, 1992). The literature review search strategy involved the data bases ‘CINAHL’, ‘PubMed’ and ‘Biomed Central’, employing Boolean phrases and MESH headings where applicable, with key words including Timor-Leste OR East Timor, Family Planning OR Contraception, AND Maternal Mortality, for the time frame 2000 – 2014. These key words were also used within the search engines of ‘Google Scholar’, ‘Google’ and ‘ Summon’, to capture grey literature published in the form of reports, such as those from the WHO, UNFPA and MSI.
Sampling

The geographic locations from where the women were drawn – the districts of Dili and Viqueque - were identified during the literature review as locations with low CPRs (see Table 2.4, p.23). Also, Viqueque is recognised as being a more ‘traditional’, unexposed district of Timor-Leste, as opposed to Dili (Kingsbury, 2012a). After gaining permission from the village leaders, the MSITL team, either directly or through significant village women, verbally invited local women of reproductive age to take part in the study. The women did not need to be clients of MSITL. The women were provided with a plain language information page in Tetum, and this was read aloud to them prior to consent being sought. (See Appendix 6 for consent form and Appendix 7 for plain language information page). The data collection phase occurred during the latter half of November, 2013.1

Focus Group Discussions

Focus groups are an appropriate method of gathering data in a variety of circumstances, and are particularly useful in cross-cultural research due to their sensitivity to cultural variables and applicability in “studying dominant cultural values” (Kitzinger, 1995, p.300). They are a recognised method of data collection in research employing RAP research design (Utarini et al, 2001). Focus groups may lessen the feeling of intimidation for participants and do not require participants to be literate (Kitzinger, 1995).

Data was collected from eight focus group discussions comprising 4-11 women of reproductive age, held in five locations within the districts of Dili and Viqueque. The following Table 3.2 illustrates the characteristics of each focus group:

---

1 As similar research was being conducted by ‘Care’ (Dawson & Waters, 2013) just prior to this project, the locations for this study were chosen with reference to the ‘Care’ research, to ensure we conducted our project in different districts from ‘Care’, thus enabling insight into other districts of Timor-Leste.
Table 3.2: Characteristics of Focus Groups

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Location</th>
<th>No. of participants</th>
<th>Age Range</th>
<th>Marital status</th>
<th>Range No. of previous pregnancies</th>
<th>Range No. of living children</th>
<th>Vignette numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rural, Viqueque</td>
<td>4</td>
<td>18-25</td>
<td>All married</td>
<td>1-4</td>
<td>1-4</td>
<td>1 &amp; 3</td>
</tr>
<tr>
<td>2</td>
<td>Rural, Viqueque</td>
<td>4</td>
<td>25-37</td>
<td>All married</td>
<td>3-9</td>
<td>3-8</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Rural, Viqueque</td>
<td>9</td>
<td>25-45</td>
<td>All married</td>
<td>2-10</td>
<td>2-10</td>
<td>1 &amp; 2</td>
</tr>
<tr>
<td>4</td>
<td>Rural, Viqueque</td>
<td>11</td>
<td>20-37</td>
<td>All married</td>
<td>1-8</td>
<td>1-7</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Rural, Viqueque</td>
<td>7</td>
<td>18-35</td>
<td>All married</td>
<td>0-4</td>
<td>0-3</td>
<td>1 &amp; 3</td>
</tr>
<tr>
<td>6</td>
<td>Peri-urban, Dili</td>
<td>6</td>
<td>25-52</td>
<td>All married</td>
<td>1-6</td>
<td>0-5</td>
<td>2 &amp; 3</td>
</tr>
<tr>
<td>7</td>
<td>Urban, Dili</td>
<td>7</td>
<td>18-42</td>
<td>6/7 married</td>
<td>0-10</td>
<td>0-8</td>
<td>2 &amp; 3</td>
</tr>
<tr>
<td>8</td>
<td>Urban, Dili</td>
<td>4</td>
<td>19-38</td>
<td>All married</td>
<td>1-4</td>
<td>1-4</td>
<td>1,2 &amp; 3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>52</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The focus group discussions, all of which I was present for, were led by a Timorese female moderator, midwife and university lecturer, who had received training in focus group discussion techniques from a Timorese, Australian-educated Qualitative researcher (Liamputtong, 2013).

(Focus group discussion on a veranda, source:H.Wallace).
Vignettes

The use of a vignette within focus group discussions, particularly when the topic is of a sensitive nature, is less intimidating as the participants are able to talk in the ‘hypothetical’ rather than the direct personal (Braun and Clark, 2013). Chenhall et al (2013,p.127) argued that “[t]he use of scenarios has been demonstrated as an effective way of exploring sensitive information, while protecting individuals from revealing any information about themselves”.

Talking about family planning and contraception in Timor-Leste is perceived as sensitive, and sometimes taboo (Ruest-Archambault, 2010). Therefore, the moderator used culturally appropriate vignettes, that described the lives and circumstances of fictitious Timorese couples, rather than ask for direct, first-person accounts (Braun & Clark, 2013). The focus groups were asked to discuss the content of the vignettes and if necessary, respond to a number of questions regarding the story. The focus group discussions were audio recorded, and notes were taken by myself and a Timorese female MSITL reproductive health worker during the conversation. (See Appendix 1 for vignettes and questions).

Body Mapping to obtain insight into ethnophysiology and ethnoanatomy

The body mapping ethnophysiology exercise employed in this study, was based on previous research conducted by MacCormack (1985) and Belton et al (2009b). The women worked individually, allowing insight into the women’s personal beliefs and perceptions surrounding ethnoanatomy and ethnophysiology, that is, an understanding of anatomy and physiology from an emic perspective (Gittelsohn et al, 1998). This method was chosen to complement the data gained from the focus group discussions, and to give women the opportunity to share information in a ‘less public’ forum if they so desired (Chenhall et al, 2013). The body mapping exercise took place immediately after the focus group discussions.

Using a piece of paper on which an outline of a woman’s body had been printed, this exercise involved inviting all of the women to draw their visual representation of the female reproductive system, and then use these drawings to explain how they believed the female reproductive system functions. They were also asked for their thoughts on how different MMC work within the body. These sessions were audio recorded, notes were made by the researchers, and the participants asked to give their drawings to the researchers or allow the researchers to make a copy of their drawings for future analysis.
Analysis

All but one of the focus group discussions were conducted in Tetum by the moderator who is a native Tetum speaker, and notes were also taken in Tetum (the exception was one focus group that was conducted in a local dialect but translated into Tetum). At the conclusion of each discussion group, the moderator summarised back to the women, clarifying their perceptions (Bender & Ewbank, 1994). The audio recordings and notes from these discussions were later translated into English by a professional translator employed by MSITL. This translation occurred in the presence of myself, so I was able to ask for clarification or cultural interpretation when necessary (Liamputtong, 2013). The translation of the body map descriptions happened in real time – I sat with each woman and a female Timorese member of the research team, who translated the women’s explanations of their drawing from Tetum to English. This allowed for clarification or explanation, with the understanding that the participant could share as much or as little as they desired (Chenhall et al, 2013). This translation was also audio recorded.

Each focus group and body map discussion was transcribed (Kitzinger, 1995). Field notes and reflections following the completion of each group were made, which is important for validation (Liamputtong, 2013). From the translation and transcription process, I formed impressions on themes and issues I was hearing from the women (Kitzinger, 1995). Meeting with my Timorese colleagues at the conclusion of the data collection phase, I discussed, clarified and verified that what I was hearing and understanding was an accurate representation of the sentiments expressed by the women (Liamputtong, 2013). I also gained further cultural clarification and contextualisation during this decolonising methodology process (Smith, 1999).

Once reassured that the transcripts I had were an accurate reflection of the women’s beliefs, I went through each, highlighting certain words or phrases and making notes in the margins (Liamputtong, 2013). I revised each transcript, determining whether these words or phrases could be placed under a more concise category, and made a free-hand list of all these words, phrases and categories (Kitzinger, 1995). Borrowing from Richards’ (2010a) research, I used the research questions as the framework to structure the themes which emerged from the data, determining which categories belonged with which theme (Powell & Single, 1996). As I worked through each transcription, I was relaxed about the shuffling or consolidating that happened as part of the iterative analysis process (Powell & Single, 1996).
For the body map analysis, I created a table with a number of codes and analysed each picture using the table as a ‘checklist’ as to what had been drawn or explained, as well as noting the demographic data pertaining to each woman and any significant features of the body map. (See Table 3.3 in Appendix 2). This allowed me to obtain both a visual and verbal representation of each woman’s ethnoanatomy and ethnophysiology pertaining to reproductive health (Gittelsohn et al, 1998).

The discussion was framed through a feminist lens, engaging the “sociological imagination” (Mills in Germov, 2009), which promotes the consideration of multiple factors, encouraging exploration of these factors across time and space (Brannen & Nilsen, 2005; Crouch & McKenzie, 2006). Employing the framework devised by Willis and based on Mills’ concept of the “sociological imagination” (Germov, 2009), the four inter-related components of historical factors, cultural factors, structural factors and critical factors were used to explore how these factors impact on Timorese women’s perceptions, choices and realities with regard to family planning. Employing the sociological imagination, lessens the chance of our exploration “constrain[ing] intellectual curiosity and creativity, blind[ing] researchers to aspects of social phenomena, or even new phenomena and theories” (Feilzer, 2010,p.7). The feminist lens ensured the Timorese women were at the centre of this enquiry, and relationships, constructs or institutions which empower or disempower the women were explored (Hesse-Biber, 2011).

**Strategies for validating findings**

Triangulation was used to determine concordance or discordance between the data obtained through the focus group discussions and the insights obtained through the body mapping exercise (Utarini et al, 2001). Respondent validation was also sought at the conclusion of each focus group discussion and body mapping exercise (Liamputtong, 2013). Validation was also sought during the analysis stage, whereby analysis and reflection on the data occurred with Timorese colleagues in Dili (Utarini et al 2001).

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2 Due to the potential influence from the local midwife assisting with the body map exercise for Focus Group 4, that set of drawings was excluded from analysis.
Thick, rich descriptions of the findings were included in order to provide a more realistic perspective of the research and experiences, and enable readers to determine whether transferability of findings is appropriate (Creswell, 2009).

Ethics

Approval was granted for this research project by both the Human Research Ethics Committee, Cabinet of Health Research, Ministry of Health, Timor-Leste, reference number MS-INS/DF-DP/XI/2013/688 (see Appendix 4), and the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research, HREC reference number HREC 2013-2084 (see Appendix 3). Written permission was also provided by MSITL (see Appendix 5), and written support was provided by UNFPA (see Appendix 8).

Reflexivity

In 2011, with two midwifery colleagues, I visited Timor-Leste as a self-funded volunteer. We spent time in a number of health care facilities, in the capital city of Dili, and in the rural mountain town of Viqueque. As an Australian educated and practising midwife, this visit was my first experience of engaging with health care provision in a non-western, developing nation. I was confronted, challenged and humbled by what I experienced. The contrast between the health resources, services, facilities and opportunities we have available in Australia, compared with that in Timor-Leste, is astronomical.

To witness women birthing on rusted beds with torn vinyl upholstery, no linen apart from the woman’s sarong, no running water for hand washing within the hospital, and oxygen tanks for neonatal resuscitation unable to be opened due to corrosion, was truly humbling…..and these are the “fortunate”, less-than-thirty-percent of women who birth in a facility. To travel in the shell of a van to retrieve a woman, from a dark, smoky grass hut, in a remote mountain hamlet, who was half way through birthing twins, with only our hands, presence and prayers as supportive contributions, was truly frightening. To learn that women in Timor-Leste were walking around with haemoglobin levels that I did not think were compatible with life, were birthing high numbers of closely spaced children, experiencing even more pregnancies, and more often than not could name a woman, or women, they knew who had died while pregnant, giving birth or in the postnatal period, was my call to action.
This chapter has outlined the research methodology employed during this study. The following chapter presents the results.
Research Question 1: Why do women choose not to use MMC, long or short acting, to delay or cease having children?

The choice to access and use MMC, is not one the women make independently. Rather, their choices are influenced by their worldview where family, community and tradition may take priority over individual desire or need. Three categories of decision makers were identified within the data: i. Husbands; ii. ‘Understanding’ between wife and husband; iii. ‘Other’, including parents-in-law, Church and State.

For the women we spoke with in the rural parts of Viqueque, it was the ‘Husbands’ that most impacted on the choice regarding contraception, while for the urban women of Dili, the theme of ‘understanding between husband and wife’ was most predominant. The women from the peri-urban area, identified the theme of ‘husband’ as most dominant in decision making regarding contraception, but also expressed ‘deviant’ themes of disobedience on the part of women to access and utilise contraception. A field note entry from this focus group (FG) notes:

It was as though they were transitioning from a more traditional cultural perspective, to a perspective that would acknowledge their views, opinions and wishes; making the transition from the choice being completely the husband’s decision, to a position where some mutual understanding or discussion could take place (Wallace, 2013).

i. Husbands. The majority of discussions we had with women in the rural areas, identified that it was ultimately the decision of the husband as to whether the woman would be allowed to access and use contraception:

The decision is in the hands of the husband, so if the husband would like to have more children, the woman just needs to be patient and accept it. (Participant, FG4);

Husbands are the ones to say whether we are allowed to participate in family planning. (Participant, FG 5).

Many of the rural women expressed their gratitude that the research team had come to speak with them regarding family planning, but expressed a degree of incredulity that we were speaking to women only. They explained that for the information to be meaningful,
their husbands needed to be present to hear the information and gain an understanding into family planning matters:

Thank you for offering the family planning program, but we don’t have our husbands here to listen to the explanation and information, so they won’t understand about the family planning that you are talking about. (Participant, FG2);

It is better that by sharing such information in the public like this, the presence of our husbands is really important so we will all hear the same information your team has shared, and then it will be meaningful to us on how to space and participate in family planning. (Participant, FG3).

A number of women explained that once their husband had such information, this insight would enable him to have a greater understanding of family planning, and therefore a greater chance of allowing women to access and use MMC:

If the husband can have an understanding he can allow his wife to participate in the family planning. (Participant, FG2);

If we want to space our births, we will go to the clinic and ask for the midwife and ask for some clear information. We will then tell our husband the information, husband will then decide about family planning. (Participant, FG1).

However, for some women their perception was that their husbands would be reluctant to engage with information regarding family planning, and therefore lack insight into contraception and potential health consequences for women. This lack of understanding influences the husband’s decision, impacting on a woman’s access to MMC.

One participant explained that many husbands are resistant to information regarding family planning as they want the wife to have many children, and the man may sometimes direct their displeasure towards health staff for providing family planning information:

Sometimes the situation is that the husband didn’t give any value to the wife and didn’t consider about their health. We can realise that some neighbours have this situation and when they go to the hospital and talk to the midwife about spacing their births and to participate in the family planning but the husband didn’t want to understand that situation and they want to keep on getting their wife pregnant and to give more babies in the coming years. Sometimes the husbands blame the health
facility staff for providing the information that informs a woman how she cannot have more babies in the future. (Participant, FG3).

**Women’s wishes.** Many women were explicit in stating that no matter how passionately they wished to cease or delay having children, these wishes were ignored if the husband wanted more children. Many of the rural women we spoke with expressed a personal desire for information, access and utilisation of MMC for the ceasing or spacing of births. They recognised however, that permission and understanding from their husbands was paramount to these wishes being fulfilled, and that failure to gain such permission, may lead to disharmony between the couple:

I am ready to go with you to take any kind of medicine – pill or injection or whatever type so I’m not pregnant again until I die. (Participant, FG2);

We the women really want to participate in this [family planning] but as we are only the women here to listen to your information then we can say that our husbands or the man will not understand our situation….their intention is that they can go ahead with whatever number [of children] they want - there is no understanding from the man’s side regarding the family planning issue. (Participant, FG2);

This is a situation that sometimes happens – husband and wife will argue about the spacing of children and the use of family planning. (Participant, FG3).

**Influences on husbands:** The women identified three main influencing factors they believed contributed to the husband’s willingness or otherwise to grant permission to access and use MMC. These were: i. knowledge and understanding of family planning options and methods; ii. Barlake; iii. the husband’s parents (‘parents-in-law’).

Quite often, the traditional practice of barlake was described as being the major influencing factor for the parents-in-law, who in turn would directly influence their son. The following diagram represents these influences, with barlake and the parents-in-law being cultural and familial influences, and the knowledge and understanding being educational influences:
ii. ‘Understanding’ (‘kompriensaun’) between wife and husband. Decisions regarding family planning were greatly influenced by what the women called ‘understanding between wife and husband’. This concept of ‘understanding’ appears to have a number of components:

**Information sharing and knowledge gaining.** For the rural women, this concept embraced information sharing and knowledge gaining with regard to family planning, so that wife and husband could access appropriate information together, and then be more informed to make decisions regarding number and spacing of children. Given that these women also consistently nominated the husband as the dominant decision-maker with regard to family planning, one needs to ask whether this ‘understanding’ is a mutually respectful, balanced decision-making partnership, or whether the wife defers to the husband, and this is regarded as their communal viewpoint.

**Physiological understanding.** Another component of this concept of ‘understanding’ described by most of the focus groups, is that of physiological function and principles of conception. One group of rural women explained that ‘understanding’ between wife and husband included ‘respect’ for each other and engaging in the traditional method of family planning of ‘withdrawal’:

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**Figure 4.1: Diagram of influence on women’s ability to access and use family planning**

- **Barlake**
- **Woman’s Parents-in-law**
- **HUSBAND**
- **Knowledge & understanding of family planning**
- **Allow/disallow woman to access & use family planning**

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We can live together and have sexual relations but the sperm can be ejaculated and spread outside so there will be no pregnancy. (Participant, FG5).

An extension of this physiological component described, was the understanding by women of their menstrual cycles, and their ability to convey information regarding this to their husbands. Some women explained that by knowing when they had entered the fertile phase of their cycle, through respect and dialogue pregnancy could be avoided by restricting sexual relations. This is the Catholic church sanctioned ‘rhythm’ method of family planning.

With regard to the husband wanting sexual relations and we already have many children or we want to delay the birth of the next child, we should consider our menstrual cycle and explain to our husbands that for this certain period we should not get together for sexual relations. (Participant, FG7);

We should have a mutual understanding about the issue of having more children…we should know when it is safe to have sexual relations so that we don’t have more children. (Participant, FG6).

Significantly, women across the geographical, age and educational strata, believed that an understanding such as this between wife and husband, could delay pregnancy for many years, and that women did not need to access or use MMC to prevent or delay pregnancy:

It just depends on the understanding, the planning of sexual relations, between husband and wife – we can not use family planning and not get pregnant. You can depend on this understanding as a method of family planning for 3-4 years. (Participant, FG 8);

Once there is an understanding between the couple, you can have the sexual relations once per week and pregnancy might be preventable while you are not attending family planning. (Participant, FG5);

They can live together and if there is good understanding between the couple they can delay having a baby for as long as they want. (Participant, FG6).

**No understanding.** The women also described the consequences of the wife and husband not having an ‘understanding’:
They are having lots of children because they have no understanding between the couple and therefore they keep on producing the child every year. (Participant, FG5);

They didn’t control the sperm and it went in and they got pregnant. (Participant, FG5).

The Timorese members of our research team felt that this concept of ‘understanding’, on the whole, represented an idealistic view of many women’s realities, and as such is an area of women’s experiences that warrants further investigation.

iii. Other; including parents-in-law, church and state.

*Parents-in-law.* Many women explained that the influence of the parents-in-law with regard to the number and spacing of children, and use of family planning, was due largely to *barlake.* ³ This was most evident in the experiences described by the rural women:

The mother-in-law and father-in-law expect the number of children to represent and compensate for the *barlake* given to the woman’s family, so they want the woman to produce more children. (Participant, FG5).

Associated with the influence of *barlake,* was the familial expectations regarding the desired sex of babies born. In some circumstances the women were ‘required’ by the family to keep having babies until they had produced enough sons to continue the family line, or enough daughters to generate *barlake* income in the future, or a balanced number of each sex:

> We need the number of children to be equal, like if you have had four boys then you will try to have more baby girls so both sexes will be equal in number. If the equal number is not reached, sometimes the mother-in-law or family members can try to influence the woman to have more children to equalise the sexes. (Participant, FG3);

Mother-in-law and father-in-law will say I have given this amount of *barlake* so I need more grandchildren. If they have only boys [grandsons] they will say I need girls [granddaughters] to compensate for the *barlake* that I’ve given. (Participant, FG6);

The baby girls when they grow up will produce more *barlake* for the families, but the men will remain there to maintain the generation and the status of the family for the future. So both should be equal [number of male and female babies]. But if no boy

³ *Barlake* will be explored in greater detail in the ‘Barriers’ section.
babies, women have to keep getting pregnant so they can get more boys. (Participant, FG3).

If the woman disobeys the mother-in-law’s wishes for more grandchildren, the woman may be subjected to physical violence:

I now have two boys and two girls – I think that’s enough even though my mother-in-law might beat me, I will say I just want this amount only. (Participant, FG6).

Similarly, if the woman does not give birth to a baby of the familial-desired sex, the mother-in-law may encourage her son to find a second wife to try to have a child of the desired sex:

Parents-in-law will say ‘you [daughter in law] come and give birth to a baby girl’ and if all the children are baby girls, they will say ‘we want more boys’, otherwise the husband will look for another ‘small’ wife to give birth to some boys. (Participant, FG3).

The mother-in-law’s encouragement of her son to find a second wife may also occur if there is a delay having children. If a period of time passes after the woman and man have married and no pregnancy is apparent, the parents-in-law will begin to question the woman’s fertility, and perhaps encourage the establishment of a second wife:

Family on man’s side might ask ‘Why are they living together for two years and not having a baby yet?’ They may think that the woman is infertile and encourage the husband to get a second wife. (Participant, FG8);

Delaying the child after two years of marriage, it is a bit difficult, because all our parents are aware of our status of being married, and they will be wondering that after two years of living together why we have not given birth to a child. They will be asking ‘What’s the problem’ and they will be thinking about infertility on the woman’s side. (Participant, FG6).

The women from the urban discussion groups spoke about the importance of the parents-in-law considering economic factors and circumstances when insisting on more grandchildren:
When we are giving birth to many children it doesn’t mean that the mother-in-law and father-in-law are going to pay to feed them and look after them. We need to think of our economical background for our daily needs. Once the parents-in-law give the barlake, that’s all that they can decide at their end – their influence should then stop. (Participant, FG 8).

A field note entry following Focus Groups 7 and 8 states: “economical considerations were very prevalent in FG 7 & 8… not much mention of women’s health considerations….I wonder if these women have less health concerns than the rural women??” (Fieldnotes).

**Church and State.** There was a scarcity of overt reference by the women to potential influences on contraceptive choice by either the church or state. Given that Catholic church representatives have strong views regarding family planning, it is likely that it has a significance that is not reflected in the data. Certainly at a grass roots, ‘micro’ level, the women were not overtly talking about the church when discussing choices or barriers regarding contraception.

The women from one of the urban discussion groups, and interestingly the group in which all the women had attended tertiary education, were the only women to explicitly mention the church, and they were adamant as to the non-influence of the church or state regarding decisions concerning family size or child spacing:

The church doesn’t have an impact. The church doesn’t have the right to prohibit the number of children we have. (Participant, FG8);

I still remember the speech of the former president Jose Ramos Horta that we the Timorese are still very few after getting our independence, and so the women shouldn’t attend any family planning – we need more people. But we will not follow this comment or statement, because if we are going to have more children it is not the president who is going to come and feed our children. (Participant, FG8).

For some women pro-natalist propaganda by the state was not relevant to their everyday lives, and many appeared oblivious to the influence of the church.
Research Question 2: What are the perceptions the women of Timor-Leste have regarding family planning using MMC?

i. Which MMC do women identify? Almost all of the women were able to nominate a MMC that they had heard about. The injection was overwhelmingly the most commonly nominated method, and this was consistent across age range, education level and geographic location. The least nominated method, again consistent across age range, education level and geographic location, was the IUD. This is consistent with the results obtained during the ‘Demographic Health Survey Timor-Leste 2010’ (DHS, 2010). The urban women nominated more MMC than the peri-urban or rural women. Similarly, women who had post-junior-high-school education consistently nominated more methods than the women with less education. There was no distinct pattern with regard to the age strata.

Other methods of family planning nominated by the women across the focus groups included: the calendar method (whereby the women counted the days of their menstrual cycle to identify their fertile period); condoms; sterilisation; ‘understanding’ between wife and husband; abstinence; and traditional medicine.

ii. Perceived benefits of contraception.

Control for women over bodies and fertility. Many women described family planning in terms of gaining control over their bodies and fertility:

The woman needs to take a break and rest and give space for the next child, so not to stop permanently, just to give space through family planning. (Participant, FG3);

It is better to have children after two to three years and make a bigger space between children. (Participant, FG1).

The women nominated the ideal space between children as ranging from two to ten years, depending on health and financial circumstances of the women and their family, with the ideal number of children ranging from three to ten.

Health consequence for women. Many of the women identified beneficial health consequences from use of family planning. These included benefit from being able to “rest” and have a break of a number of years between pregnancies:
She should rest for at least three years before she gets pregnant again. After three years, when the mother feels healthy again, they can have more babies. (Participant, FG4).

A number of poor potential health consequences were highlighted if the women did not have access to family planning. These ranged from physical exhaustion, infection, haemorrhage, and most severely, maternal death:

She needs to take a rest of around three years otherwise her uterus will get an infection if she keeps getting pregnant continuously. (Participant, FG4);

One baby per year is too much; if you get pregnant too soon, you will still have ‘dirty blood’ left over from the last pregnancy – this will mean that the woman will lose a lot of blood with the next birth. (Participant, FG5);

If our situation is going to happen like Maria, who has lost a lot of blood, it is very dangerous and we should stop having babies because we could lose a lot of blood and we might die. (Participant, FG3);

If we do not attend family planning it is not good for women as it impacts on our health – if we lose a lot of blood, it is not good for our health. If I was in the position of Maria, I would discuss it with my husband and attend family planning otherwise I am at risk and might die. (Participant, FG8).

**Freedom for women.** Within all but one of the focus groups, the women raised the concept of ‘freedom’ as a perceived potential benefit of access to family planning. The women spoke of family planning being the key to women breaking free from the perpetual cycle of pregnancy after pregnancy, child after child. They explained that with no access to family planning, women would have many children with little space between, decreasing the women’s freedom and resulting in the women being required to remain in the home caring for all the children with little support from their husbands:

We should also think about family planning so we can be free and do some activities apart from keep on giving birth to the children. (Participant, FG1);
Many children are always disturbing us to do things and we cannot do our activities, and husband is always going to work so I am staying at home alone and looking after all the children – that’s boring and a bit difficult to manage. (Participant, FG4);

Using family planning means that we can have space between our children – if we don’t use family planning and keep having babies, we are the ones stuck in the house with all the children. (Participant, FG8);

By giving space [spacing the births] by four to five years it will help women do more activities, especially helping the husband do the farming. (Participant, FG1).

The freedom afforded by family planning for this type of activity would therefore contribute also to financial benefits for the women and their families.

**Financial benefits.** Many women, particularly those from the peri-urban and urban focus groups, identified positive financial consequences from access to family planning, as well as the importance of considering financial circumstances when deciding to have more children:

We should consider the economical background with regard to the number of children – we need to be able to feed them and fulfil their needs. This is an important consideration when deciding to have more children. (Participant, FG7);

Or because I don’t want more children because I already have five, I can sit together with my husband, mother-in-law and father-in-law and then discuss if I can stop at this number. And then I can be free to find a job to help support all these children and pay the school fees – we need consider the economical issues with this number of children. (Participant, FG8).

One group of women perceived the financial considerations as so important, that they suggested disobeying a husband who had not given permission to use family planning methods:

It is better to attend family planning rather than follow what Abelio [husband from vignette] wants, because economically we need to consider the cost of the clothes, the schools, the food for all these children. (Participant, FG6).
Additionally, the suggestion was made that if women do not have access to methods of family planning and are therefore economically disadvantaged, this may result in domestic violence:

Sometimes there is domestic violence because of the economic situation of a big family – sometimes wife and husband do violence, or son against father or daughter against mother, because they feel their needs are not fulfilled. We should limit the number of children we have in order to have a better economic situation in general. (Participant, FG 7).

**Improved future prospects.** The majority of focus groups perceived use of family planning as contributing towards more prosperous futures. Women identified the use of family planning to limit and space births resulting in healthier children, not only through the mother being healthier and more able to provide adequate care, but through perceived financial benefit and positive consequences of this. Women suggested that by using family planning methods, women could increase their freedom, improve their life circumstances, and work towards a more healthy and prosperous future.

**iii. Perceived side effects and timing of contraception.**

**Side effects.** With regard to the pharmacology of MMC, some of the women were able to explain that if one did not take the OCP every day then the woman would become pregnant, or that once the woman had the implant removed, then the woman could become pregnant. A number of women also believed that the OCP “cleaned” the uterus.

Some women, particularly those from the urban focus groups, articulated the potential benefits of choosing and utilising a long-acting contraceptive method (for example, the implant or the IUD):

She can use the one that is placed in the uterus or the arm – this will give her 5-10 years protection from getting pregnant. (Participant, FG 3).

Only a small number of women were able to nominate potential perceived side effects from using MMC. The following Table 4.1 lists these side effects according to whether the knowledge surrounding the side effect is accurate or inaccurate:
Table 4.1: Perceived side effects from MMC:

<table>
<thead>
<tr>
<th>Method</th>
<th>Accurate knowledge of potential side effects</th>
<th>Inaccurate knowledge of potential side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection</td>
<td>Weight gain</td>
<td>Lazy</td>
</tr>
<tr>
<td></td>
<td>Dizziness</td>
<td>Coldness</td>
</tr>
<tr>
<td></td>
<td>Headaches</td>
<td>Narrowing of uterus</td>
</tr>
<tr>
<td></td>
<td>Decreased bleeding</td>
<td>Decreased bleeding leads to a dry uterus</td>
</tr>
<tr>
<td></td>
<td>Difficulty conceiving in future (takes longer)</td>
<td></td>
</tr>
<tr>
<td>Implant</td>
<td>Decreased bleeding</td>
<td>Difficulty conceiving in the future</td>
</tr>
<tr>
<td></td>
<td>Infection</td>
<td>Activities need to be limited due to infection risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypertension</td>
</tr>
<tr>
<td>IUD</td>
<td></td>
<td>Only good for women with a slim body</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Women unable to do heavy work due to risk of IUD moving</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May cause death if moves to the wrong place</td>
</tr>
</tbody>
</table>

Regarding side effects, the women said:

[The injection] can sometimes make our uterus become narrow, our blood will decrease and become dry. (Participant, FG8);

Implant is not good as it will decrease our blood and we may not be able to get pregnant again in the future. (Participant, FG8);

The IUD is good for those who have a slim body, but for those who have a big body it can be a bit dangerous. (Participant, FG7).

My Timorese colleagues elaborated on this and explained that if a woman has a bigger body, she is physically stronger and able to do ‘heavier’ work, and it is believed that this heavy work may cause the IUD to migrate.
A number of the groups agreed that if one particular family planning method was not agreeable, then the woman could try something different:

We should consider our health and physical condition and consider if the method is appropriate for our bodies and consider the effect, for example, comfort or whether we are getting headaches or other side effects. We need to understand that we can have it changed to something more suitable for us. (Participant, FG7).

Similarly, many women agreed that despite potential side effects, it was much more beneficial to the women to attend and utilise family planning:

It is better to attend otherwise we will be suffering. (Participant, FG8).

**Timing.** Many women identified that fulfilling goals and dreams, such as completing school and earning enough money to buy a house, depended on a woman’s ability to exercise control and choice over her fertility:

To be able to reach their dreams, women have to follow family planning. (Participant, FG1).

However, there was also recognition, across both the rural and urban women, that the concept of delaying the pregnancy and birth of a couple’s first child, even when this is a planned decision, may be problematic in a variety of ways. As spoken about previously, the woman may be assumed by the parents-in-law to be infertile, prompting the parents-in-law to encourage their son to seek a second wife. Additionally, some of the women themselves asked:

Why would we wait two years to have a baby? We want to have babies straight away, immediately. (Participant, FG5).

Women perceived that once they were pregnant, it was too late for family planning, although a number of groups identified traditional medicine, herbs and healers as ways to stop a pregnancy continuing or prevent a pregnancy in the first place:

But even if the person is already pregnant, there are some traditional medicine they can take and after boiling it and drinking it they can prevent the pregnancy. (Participant, FG 5);
We should try to find traditional herbs, traditional Timorese medicine, to prevent pregnancy. These herbs change the position of the uterus so that we can’t get pregnant. If we want more babies, we can drink another traditional medicine to improve our uterus so we can have more babies. (Participant, FG7).

A number of groups spoke of not even considering accessing or using family planning until a woman has birthed several children:

For those of us who have already had three to four children, we should get our husbands to support us in using family planning. (Participant, FG 2);

I heard from our neighbours that if you’ve only had one baby, don’t join family planning. (Participant, FG 8).

Thus some women claimed knowledge and access to traditional abortifacients and contraceptives that could be used to regulate desired fertility, while others identified the culturally important practice of “proving one’s fertility” before engaging with family planning.

iv. Perceived avenues for information. Neighbours, peers, family members and traditional healers are perceived as potential sources of knowledge regarding methods of contraception. However, more commonly, the women nominated health posts, health centres, hospitals, midwives and clinics as knowledge sources.

Research question 3: What do the women of Timor-Leste perceive as barriers or disadvantages of family planning using MMC?

Cultural and traditional barriers.

Barlake. Many women stated that the ‘understanding’ between husband and wife was a more influential determinant of spacing and number of children than the influence of barlake. However, this sentiment was contradicted in most of our discussion groups, across age, geographical and educational strata, as the women went on to explain just how the practice of barlake worked, how it impacted on their reproductive lives and influenced use of MMC. Women articulated that they believed it should not be such a significant influence,
but at the same time they recognised the importance of the practice from a cultural and traditional perspective:

It is according to our custom or traditional way, that when a man would like to get married to a woman, he should give *barlake* – it is important. If we implement the *barlake*, the child we are going to have will be ours, meaning to the family of the man, because they have compensated to the woman’s parents. The children to whom we are giving birth will be part of that family, so it is important to value that family and the number of children. (Participant, FG 5);

Yes *barlake* has an impact. For me it is influential. It is not very good for our health. It is a tradition. We shouldn’t have to give a certain number of children depending on the *barlake* given. (Participant, FG 8);

This is one of the reasons why we have to have so many children when we get married, because we have had much *barlake* from the man’s side. (Participant, FG 2);

If we give you ten buffalo and cows, we have to have ten children as well [to compensate]. (Participant, FG 4).

As demonstrated by Figure 4.1 on page 39, the tradition of *barlake* is often important to the parents-in-law, who exert influence over their sons with regard to number and spacing of children. Many women perceive that their husbands honour this cultural practice at the expense of the woman’s health and wellbeing:

When they are given the *barlake* they want more children – about ten. They do not consider the health of the woman – they need more children to equal the amount of *barlake* given. (Participant, FG 3).

Many women described that once the *barlake* obligations had been compensated, they could then approach their husband regarding permission to access and use MMC:

We did discuss a lot about the *barlake* given to us, but we have many children already – eight – and that is part of the fruitful things we have from our marriage of having so many *barlake*. So now my husband is allowing me to go and take any kind of contraception to stop pregnancy. (Participant, FG 2).
If the *barlake* obligations are not met, the women explained that the husband may find another wife with whom to have more children:

The husband wants the number of children to equal the *barlake*. So if the wife stops giving birth, the husband will leave the wife and go and find a second wife who will give him more children. (Participant, FG 6).

The women identified *barlake* not only potentially impacts on women’s health through multiple, often closely spaced pregnancies, but impacts also due to potential domestic violence directed towards the women:

The husband just wants to keep having babies – could be two babies in one and a half years. (Participant, FG 3);

The man says ‘I have given the *barlake* for you, I have paid for you, so I can slap you any time I want’. (Participant, FG 4);

If there is a misunderstanding and the husband slaps the wife, if the wife asks ‘why are you beating me?’, the husband says, ‘I’m not beating you, I’m beating my buffalo – my *barlake* that I gave for you’! (Participant, FG 4).

Despite many women identifying that *barlake* should not impact on their reproductive health choices, it is clear that it remains a significant influence for many women, and potentially affects their health and wellbeing in many ways.

The following diagram illustrates potential pathways with regard to women fulfilling or not fulfilling their *barlake* obligations:
Women find themselves in a precarious position; on one hand, fulfilling *barlake* requirements provides them with social status and security while potentially impacting negatively on their health, while on the other hand, to not fulfil their *barlake* requirements puts them at risk of being culturally ostracised.

**Perceived value/role/status of women – the Ideal Timorese Woman?** Throughout the focus group discussions, various qualities were identified by the women which they perceived important when defining what I have called the “ideal Timorese Woman”. These perceived qualities and attributes include patience and acceptance:

The decision is in the hands of the husband, so if the husband would like to have more children, the woman just needs to be patient and accept it. (Participant, FG 4);

We need to be patient and wait until the time comes to get a baby. (Participant, FG 5).

Resignation, fatalism and deference to one’s husband were also identified:

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**Figure 4.2: Potential pathways with regard to fulfilling *barlake* obligations**
We intended to have two to three children and that would be enough. But because husband and wife live together and have sexual relations, they will probably have more children. (Participant, FG 2);

If we live together just for two months, there will be a baby on the way already. (Participant, FG 5).

The ‘ideal Timorese Woman’ also needs to have an inexhaustible ability to ‘produce’ the requisite number of children of the desired sex to ensure longevity of the family line, and a future “income stream” from any daughters’ barlake. She needs to be self-sacrificing, putting family and tradition ahead of any individual desire or aspiration. The responsibility of children appears to weigh heavily on Timorese women – they recognise that the parents-in-law will not feed and clothe their children, the president will not feed and clothe their children, and their husbands, once the barlake has been paid, often have the view that their familial responsibility has ceased. Children are perceived as gifts from God, with many children signifying a blessed marriage.

Many of this attributes, when considered either singularly or in combination with each other and within the context of reproductive health choices, have the potential to prevent women from accessing or using MMC.

**Access, resource and health literacy barriers.**

**Geographical and logistical.** The women spoke of the importance of having access to health services that were located geographically close to where people live.

Could we therefore suggest that a health post be established in each village and that a midwife should be stationed there so that we can attend and have access to that service close to our home.(Participant, FG 6);

The Ministry of Health at the national level should also consider if there are sufficient facilities in the health centre or health post to attend to people’s needs. (Participant, FG 3).

Many women perceived a link between geographically close health services, the provision of health information, and the control a woman may have over her body and fertility:
If there is no health post in the area, they might have trouble getting information and then they keep on having children. (Participant, FG 7);

It is really important to have this information and we need to be able to get it from the health post or health centre, so we feel free to space our children for about three to five years, and especially for us in this particular sub district—we really need this family planning but we have a lack of information about how to access the family planning. (Participant, FG 3).

The potential health, financial and wider societal impact of geographical and logistical barriers to MMC is significant. Women identified that a lack of information often meant a lack of access to and use of MMC, resulting in unintended pregnancies which may contribute to the woman not fulfilling her dreams (for example, finishing school).

**Health literacy.** The women perceived that a lack of accessible and appropriate information may contribute to a decreased level of health literacy. The data collected from each woman during the body mapping ethnophysiology exercise provided us with insight to the varying perceptions held by women regarding the anatomy and function of the female reproductive system with relation to family planning and conception.

On the most part, as demonstrated below, the drawings were sparse with few details. Some women chose to label their drawings, while others chose to make marks on the page. Two women declined to draw, but verbally ‘mapped’ their perceptions with us. As previously stated, the body maps from Focus Group 4 were excluded from analysis, as this group received coaching and instruction from a local midwife as to what to draw and label.

The content of the drawings did not vary significantly by age, geographic location or educational level attained, as demonstrated by the following Figure 4.3:
Figure 4.3: Body mapping examples demonstrating sparse details regardless of schooling or location.

*Uterus and stomach.* Two thirds of the women identified the uterus as the place where the baby grows. Of these women, over half situated the uterus in either the central pelvic region or central abdominal region. A number of the women who situated the uterus on either the left or right side, explained that this was due to the sex of the baby, as illustrated in the following drawings:
Figure 4.4: Three body maps illustrating the different positions of the single uterus depending on the sex of the baby.

Even though some of the women drew what appeared to be a uterus on either side of the template’s torso, they explained that there was only one uterus, but this uterus went to the right if the baby was male or to the left if the baby was female. Previous research by Belton et al (2009b) utilising body mapping techniques, described two uteri. Results from Van Schoor’s (2003) study, however, concurs with our results, with participants describing the left sided or right sided position of the uterus being dependent on the sex of the baby.

A number of women believed that the baby grew in the stomach, and this was the same stomach as the ‘food stomach’, as illustrated in the following drawings:
Figure 4.5: These body maps illustrate the central organ where the baby grows, identified and named by the women as ‘the stomach’.

Conception requirements. Most women nominated the need for sexual relations to take place between the husband and wife for conception to occur. Just over a third of women identified the need for sperm and ovum for conception, with more identifying the need for sperm and in many instances, naming the ovum as “sperm from the woman”.

A quarter of the women believed that conception happened when ‘blood’ from the man mixed with ‘blood’ from the woman. This concurs with research by Belton et al (2009b) and Butt (2001). Also, for successful conception, the blood needed to ‘match’. When asked, the women were not able to explain how one ‘knew’ prior to marrying one’s husband, if his blood would be the right match or not. The following drawing illustrates ‘blood from the man’:
Figure 4.6: The blue squiggly line on the right hand side of this woman is the ‘blood’ from the man.

The ovarium. The ovarium was a word used by a number of women in their drawings and descriptions. It appears to be a number of different things, and unable to be directly translated to one organ or region in English. For some women, the ovarium appeared to equate with what we would call in western medicine ‘the ovaries’. For other women it was an organ or a region, most commonly situated in the lower pelvic area. And for others, it was identified as the place where the baby grows. Thus although a commonly used term, there appears to be no consensus among the women as to a common function, definition or location of the ovarium. The following drawings illustrate the ovarium firstly as a region, and secondly as an organ:
Figure 4.7: These body maps illustrate the ovarium as a region (A) and an organ (B).

*Pregnancy and labour physiology.* Some of the women believed that the baby grew in one part of the body for the majority of the pregnancy and then moved to another part of the body in preparation for labour and birth, as illustrated in the following drawing:

Figure 4.8: Fetal movement.
The illustrator of Figure 4.8 explained that the baby sleeps and grows in the space drawn in the right upper quadrant of the abdomen, and that when it is time for the baby to be born, “the baby will run to the uterus and then come out” (Participant, FG 5). Butt’s (2001) research also describes perceptions that the fetus ‘roams about’ the woman’s body.

The women had various ideas regarding fetal development and labour physiology, as well as perceptions of ‘entitlement’ following the ‘suffering’ of labour and birth. Many women described labour and childbirth as a suffering to be endured by women, and as such they perceived that they were entitled to access and use MMC for family planning:

To give birth to a baby is a real suffering and critical moment for the woman…by having such a situation and such suffering from delivering a baby and giving birth, we would like to join the family planning. (Participant, FG 2);

Husband may feel sad or feel our suffering during the delivery period, but after a few months when the baby is growing up they will feel that they will want us to produce again….they won’t think about our pain or suffering – the husband always be asking for more babies. (Participant, FG 4).

In many instances, the ethnoanatomy and ethnophysiology identified by the women was sparse in detail, with limited or different physiological interpretations to that which is recognised in western biomedicine. Women perceived that the suffering they endured during their pregnancies and labours should entitle them to use MMC, but they were unable to describe in any detail how these methods worked.

**Research question 4: What are the areas of need with regard to access to information, services and resources concerning MMC in Timor-Leste?**

The women identified the importance of their husbands having access to information and gaining understanding into matters of reproductive health and family planning. Many of the women believed that once their husbands understood about the health effects for the women of closely spaced, multiple pregnancies, that they would be more supportive of accessing and using MMC.

It is unclear from the data as to whether the women believed access to reproductive health information for the parents-in-law would be beneficial in terms of reducing the expectation for the women to birth many children. The cultural practice of barlake appears to be strong, and a significant influence on the number of children a woman is expected to bear.
The data suggests that amongst these respondents, knowledge and understanding with regard to reproductive health physiology, is often quite limited, even for the women with post-secondary school education. The women identified the importance of having appropriate and reliable information that was accessible to them, from a geographical, financial and cultural perspective. They requested such information be provided at each health post.

It is clear from the data the importance of the midwives and local health care providers receiving up to date and accurate education and training regarding reproductive health and MMC, including accurate knowledge of potential side effects, as this is who the women nominate as the key informants in this area. The women identified the importance of access at a local level to reproductive health services. They emphasised the importance of these services being adequately resourced, in terms of staff, facilities, equipment and medicines.

This chapter has presented the findings from this research project. The following chapter, employing a feminist lens, discusses these findings and their potential implications and significance, using the framework devised by Willis based on Mills’ concept of the sociological imagination (Germov, 2009).
CHAPTER 5 - DISCUSSION

The 21st Century Timorese woman is situated at an exciting point in history. Her nation is new and carries the hopes and aspirations of a new beginning, encompassing independence, freedom and opportunity (Molnar, 2010; Sword Gusmao, 2003). Part of the challenge appears to be that while celebrating and embracing the components of culture and tradition that define what it means to be Timorese, simultaneously limiting the potentially negative impact of these constructs on the health and lives of Timorese women. Also challenging is the development and sustainability of robust, appropriate and accessible reproductive health services for all women in Timor-Leste. La Sama de Araujo (in Ruest-Archambault, 2010,p.5) argued, “[a]s we [the Timorese] came together to struggle for our independence, we must come together again to achieve the best possible reproductive health for our people, particularly women and youth”. In many ways, the women’s journey reflects that of the nation, and while many of the women appear to be in transition, so too does the Timorese culture and the country of Timor-Leste.

This research highlights the diversity of perspectives that exist between two districts within Timor-Leste with relation to family planning choices and contraception, and identifies a range of barriers faced by the women when engaging with these issues. At a micro level, some of this difference is evident between women and their families. At a mid-point level, difference is evident between women from different geographical locations or districts, or from different educational backgrounds, while at a macro level, contention potentially exists between the state and church and the position they are advocating, compared with the everyday lives of women. There are also points of difference with relation to tradition and modernisation, and the potential for these to impact on the reproductive health choices and lives of the women of Timor-Leste is very real. The diversity and difference that exists throughout Timor-Leste is well documented (Hicks, 2007; Molnar, 2010; Kingsbury, 2012a).
(Women buying local produce at a roadside stall between Baucau and Dili, source: H.Wallace).

**Historical factors.**

Historically and globally women have sought control over their fertility (McClaren, 1990). This control exemplifies the choice, freedom and autonomy a woman has, or does not have, over her body and her life (Simelela, 2006; Richards, 2010a). Across time, women’s fertility and women’s reproductive health have been used for political purposes – often to the detriment of women’s health and lives (Correa, 1994). The women of Timor-Leste bare the legacy of both recent and ancient historical events (Carey, 2001). Their reproductive health has been influenced by a range of actors, including colonisers, the Catholic church, and other powerful global forces such as the UN and various NGOs (Mercer et al, 2014).

In ancient times, in indigenous traditional Timorese society, the males were responsible for the visible, “public” world, of which decision-making is a component, while the women were responsible for the inner, sacred, private realm (Niner, 2011; Hicks, 2004). Timorese women held defined positions, and roles and status were re-enforced through ritual and ceremony (Hicks, 2004; Bye, 2005). The colonisation of Timor-Leste, and subsequent Catholicisation, interfered with these Indigenous processes, emphasising and supporting the patriarchal, conservative components of the Timorese social structure, while diminishing power or status afforded to women (Niner, 2011).
This conservative patriarchy is evident in many of the perceptions voiced by the women in this study. Many women nominated their husband as the voice of authority, while simultaneously self-depreciating any personal opinions. This underlying philosophy emerged in the focus group discussions, where women were not used to having their opinions sought on a topic, and stated such things as “but as we are only the women . . . .” (Participant, Focus Group 2). Rimmer (2006, p.339) stated that the Timorese “culture does not allow women to speak out”, while Niner (2011) argued that in much analysis and commentary in Timor-Leste, the women are seemingly ‘invisible’, and the men assume to speak for the women. Mercer et al (2011) stated that during their research in Timor-Leste, there was a degree of reluctance from women to discuss family planning without their husband or mother-in-law present. This is in contrast to our research, where although women found it novel to be asked for their perspectives, they were willing, on the whole, to share their thoughts. This may be partly attributable to the method of using vignettes to prompt discussion about a hypothetical other, rather than asking for direct first person accounts. The dominance of men as decision-makers regarding the use of contraception, has been demonstrated in other studies across a number of different districts in Timor-Leste, and is not unique to Timor-Leste (Mercer et al, 2011; Dawson & Waters, 2013; Saikia et al, 2009). While the dominance of Timorese men has historical roots, its persistence into contemporary time may be attributed to the militarisation and conflicts which have been a feature of Timorese life over recent decades (Myrttinen, 2005).

The women of Timor-Leste endured much during the Indonesian occupation (Carey, 2001; Niner, 2011). They witnessed the murder and mutilation of family members, they were the victims of rapes, assaults and deprivation of rights and liberties, and they were dispossessed of their land and culture (Bye, 2005; Rimmer, 2007). Additionally, although not spoken about by the women in this study, their fertility and reproductive health was hijacked by the coercive and pervasive KB ‘population-control’ program administered by the Indonesians (Sissons, 1997; Richards, 2010a).

Paradoxically, the Indonesian times afforded Timorese women a degree of domestic opportunity to assume responsibility that would have traditionally and culturally been dominated by males (Rimmer, 2007). In the absence of the men due to the Indonesian occupation, the women were required to head households, make decisions, provide for family members and attend to traditionally ‘male’ activities, as well as contributing to the guerrilla resistance (Bye, 2005; Rimmer, 2007). The conclusion of Indonesia’s occupation, coupled
with the circumstances of Timor-Leste’s journey towards independence, has forced a shifting of responsibilities and redefining of roles for Timorese women (Niner, 2011; Bye, 2005). Additionally, the expressed desire of many Timorese males to celebrate and affirm Timor-Leste’s independence by shunning predominantly “Western” ways (for example, gender equality), and rather embracing or rediscovering “traditional” Timorese culture, puts Timorese women in a precarious, disempowered and potentially health-detrimental position (Carey, 2001; Rimmer, 2007; Broom & Germov in Germov, 2009). Niner (2011) argued that there are many examples whereby practices are promoted as “traditional” in direct opposition to notions of western feminism, placing women in positions of disadvantage and discrimination. This scenario shares some similarities with the experiences of many western women following the conclusion of the Second World War (McLaren, 1990).

The return of the men as ‘head of the household’ once independence was won, has resulted in women being required to relinquish some domestic and social responsibility (Bye, 2005; Carey, 2001). Pires (in Carey, 2001, p.256) stated that “[a]nd now, as the men come out of hiding and return from the mountains, they [the women] don’t want to go back to their traditional roles”. Niner’s (2011) research found that this relinquishing of responsibility and diminishing of autonomy, has been extremely challenging for some women. Our research suggests that there are varying perceptions held by the women with regard to embracing the so called “traditional” Timorese way. The results of this study suggest that the women living in the rural areas of Viqueque still very much embrace many traditional aspects of life with regard to gender role stereotypes and custom, and Hicks (2004) has argued that Viqueque has been one of the more traditional and unexposed districts of Timor-Leste. The women from urban areas appeared less constrained by tradition, while the peri-urban women demonstrated a degree of defiance with regard to tradition. This difference of perspective between the rural, peri-urban and urban areas has been described in the literature, and Hicks (2007, p.15) stated that “[a]s communities favour their own language, so, too, they identify with their local adat rather than with new values filtering down from the capital. Male authority, primacy of elder over younger, social status arising from birth, and rank validated by ancestral myths are the values that define villagers’ social identity”.

Cultural factors.

Diversity of perceptions is evident in this research when examining the notion of “choice” with regard to using MMC. Many of the rural women appeared resigned that decisions regarding family planning and contraception were made by their husbands. The urban women however, appeared more inclined to focus on the importance of discussion and understanding between the wife and husband, suggesting a degree of partnership. While the peri-urban women recognised the husband as the decision-maker in the marriage, but expressed a desire for women to have a more active role in such decision-making, even suggesting ‘disobedience’ on the part of the woman to choose to utilise contraception. Mason and Smith (2000,p.308) found in their research in south and southeast Asia, that the “more highly gendered-stratified the community, the stronger the impact of the husband’s fertility preferences on whether the couple was using contraception”. The diversity in perception between the different localities of women is perhaps partially influenced by how gendered-stratified their particular community is, and as a result, how much input a woman has over decision-making processes.
While men are the established decision-makers in Timor-Leste, our research suggests that now, as previous feminist historical paths have demonstrated, some Timorese women are beginning to question this male domination, and express deviant ideas or behaviours. This is particularly evident in the women from the peri-urban areas. The population of women, transitioning from a more traditional environment to one associated with western notions of empowerment and equality, is reflective of the transition happening across Timor-Leste as a whole, a transition that for many is causing disharmony and uncertainty (Hicks, 2007). Hicks (2007,p.16) argued that “[w]hen traditions are challenged by categorical innovations it is not difficult to understand why tension arises between the new and the old”. The challenging of such traditions however, is recognised as being crucial to decreasing the health vulnerability of Timor-Leste’s women and children (Soares in Ruest-Archambault, 2010). But as the nation faces obstacles to reaching its full potential, so too do women face barriers to succeeding in autonomously defining their roles, identities and futures (Niner, 2011; Hicks, 2007). Rimmer (2007,p.332) declared that in Timor-Leste, “unfortunately, women’s liberation is not a natural outcome of national liberation”.

(Mother and child, Ermera District, source: H.Wallace [consent obtained from subject]).
Barlake provides a pertinent example of the discord between tradition and modernity. In this research, barlake was especially important for the rural women. This concurs with Zwi et al.’s (2009) study in Lautem and Viqueque, and Dawson and Waters’ (2013) research in Liquica, that found that women from these districts were more likely to discuss the influence of barlake on reproductive health behaviour. In the past, barlake has provided an accepted and prescriptive custom to ensure familial, community and ancestral harmony, and an accepted explanation for life or community events, as well as contributing to the social status and valuing of women (Khan & Hyati, 2012; Niner, 2012; Hicks, 2004).

The Timorese women in this study recognised their barlake expectations to have many children, with these expectations often reinforced by the husband or parents-in-law, and often without consideration of the woman’s health. The women explained that they are expected by their husbands to have as many children as required to compensate for the barlake paid, and to ensure sufficient numbers of children of desired sex to continue family lines or guarantee ‘income streams’ from future barlake. The ‘child producing’ pressures felt by Timorese women from this study, echo the sentiments expressed by women from previous studies from other districts of Timor-Leste (Mercer et al, 2011; Zwi et al, 2009; Dawson & Waters, 2013). Many women in this study, especially those from peri-urban and urban areas, acknowledged that barlake should not be such a significant influence on a woman’s reproductive health, but simultaneously behaved in ways that uphold the traditional barlake customs. One rural focus group discussed the importance of barlake for the future of the children, and my Timorese colleagues explained that traditionally if the barlake custom has been observed, the children will be blessed, valued and have good fortune. This constitutes additional pressure for women to comply with barlake expectations.

Barlake has transitioned from its traditional form, resulting in the loss of some of the more positive attributes of the custom, to one in which the rights of the women are severely impacted, and women (and their fertility) are viewed as commodities that may be “bought”, and therefore controlled, by men (Niner, 2011; Bye, 2005). A number of women in this study disclosed that if they did not fulfil their barlake requirements or did not render control of their reproductive health choices to their husbands’ and mother-in-laws’, consequences may include domestic violence or the husband taking a new wife. These potential consequences have been cited in other research, and it is documented that domestic violence is a major issue in Timor-Leste impacting significantly on sexual and reproductive health (Taft & Watson, 2013; Dawson & Waters, 2013; Ferguson, 2011; Henfry, 2004). Ferguson (2011)
and Kovar and Harrington (2013) argued that domestic violence is perceived as an accepted practice in Timor-Leste allowing males to exert and maintain authority over females. Many believed that barlake contributed to this (Niner, 2012; Richards, 2010a; Bye, 2005; Khan & Hyati, 2012), and recent research focused specifically on the relationship between barlake and domestic violence found that “barlake is linked to higher levels of domestic violence against women” (Khan & Hyati, 2012, p.34).

This relationship between barlake and domestic violence was illustrated in women’s accounts in this study. Women described husbands beating their wives, with the women claiming that the husbands stated that it was not their wives who they were beating, it was their buffalo – “if the wife asks ‘why are you beating me?’, the husband says, ‘I’m not beating you, I’m beating my buffalo – my barlake that I gave for you’” (Participant, Focus Group 4). This ‘buffalo analogy’ has been described also by Richards (2010a), who argues that some families are now not insisting on barlake for their daughters in an attempt to protect them from future domestic violence (Richards, 2010a). Contemporary barlake may be perceived as a demonstration of the women of Timor-Leste being constrained by culture and tradition, however one needs to consider the challenge for women regarding balancing the biophysical and health risks associated with barlake, with the potentially culturally and socially ostracising risk of shunning the custom.

(Buffalo – important components within the barlake custom, source: H.Wallace).
As with *barlake, adat* is a component of traditional Timorese way of life, and remains strong and significant for many Timorese (Hicks, 2007). However, many recognise that contemporary *adat* practices may also impact negatively upon women’s health and well-being (Bye, 2005; Niner, 2011). Within *adat* custom, there is no such concept as gender equality (Hicks, 2007). Similarly, prescribed and established hierarchies exist describing the status of various members of the community (Bye, 2005). This research demonstrates the division that exists between the status of men and women for many Timorese. It also highlights the differences in status between women and other family members, for example, mother-in-laws. These established, accepted customary practices, impact on a woman’s ability to make autonomous decisions regarding her fertility, her health and her life, and this research demonstrates that her wishes are often not considered and that her health is sacrificed. It is somewhat paradoxical that “proving” her fertility and bearing children as soon as possible within a partnership, improves a woman’s status, and secures her future within her husband’s family, even though this early child-bearing may be at the expense of her health, or any personal dreams not involving children that the woman may have. Consideration as to whether myths pertaining to potential infertility resulting from the use of MMC prior to having a first baby, as demonstrated in this study, exist to encourage women to conform to the cultural norm of early childbearing. Such myths have been documented in research from Cambodia, where women believed that they would be infertile if they use contraception prior to proving their fertility (Najafi-Sharjabad et al, 2013).

The women in this study also demonstrated resourcefulness, speaking of pluralism with regard to the acceptance of combining western medicine with traditional medicine in an attempt to exert a degree of control over their fertility. This blending of paradigms has previously been demonstrated by Wild et al (2009,p.5) who stated that “[w]hile the ‘biomedical’ and ‘social’ models of illness are conceptually polarized, the reality is that people move freely between these paradigms when seeking solutions to health problems”. This pluralism was also evident when the women discussed cultural expectations as opposed to personal desires. The women recognise the strong, cultural expectation to have many children but also express the wish to control their fertility. The language they use is couched in references to freedom - freedom to stop having baby after baby, and have the opportunity to leave the home and take part in income generating activities, like helping on the farm. Zwi et al’s (2009,p.45) research described this confinement to the home with multiple, closely spaced pregnancies as having the effect of “the loss of one arm”, meaning that the woman is
constrained and restricted in what she does because one arm is always holding a baby. This impacts on a woman’s freedom, confines her to the home, reduces her ability to take part in financial, educational or social activities, therefore contributing to the male dominated, patriarchal society of Timor-Leste (Henfry, 2004). As they transition into modernity, the women of Timor-Leste find themselves facing new challenges – the paradox remains – on one hand children provide status and financial security for women, on the other hand freedom from childcare responsibilities affords women the opportunity to gain education, employment an independent financial security (Hartmann, 1995).

(Graffiti in Timor-Leste, source: H.Wallace).

**Structural factors.**

This research demonstrated that women who deviate from prescribed social mores, exhibit values and qualities not aligned with those which are accepted and traditional, or women who attempt to exert a degree of autonomy, thereby ignoring or dismissing the wishes of their husbands and mother-in-laws, leave themselves vulnerable to situations of domestic violence or the possibility of their husbands taking a second wife. These possibilities remove even more potential for empowerment and choice for women, as such circumstances makes
them financially and socially vulnerable, where their only option is to conform. As with domestic violence, poverty is a significant concern for Timor-Leste, impacting greatly on the health and well-being of women (Saikia, Hosgelen & Chalmers, 2011). The peri-urban and urban women in this study spoke of financial hardship resulting from too many children, and a potential consequence of this increased financial pressure being domestic violence. When one also considers the likelihood that women have prematurely disengaged with formal education in order to satisfy cultural and familial expectations of early child bearing, one can appreciate the multiple forces at work keeping women in dependent, vulnerable and disempowered positions.

Education is a key element to women accessing and utilising family planning, and Simelela (2006,p.297) argued “[w]omen who are more educated are more likely to be able to access modern methods of fertility regulation and have the knowledge and ability to negotiate use to fulfil their fertility intentions”. These sentiments are explicitly expressed in the Program of Action from the ICPD (in NHRS 2005-2015). Lack of knowledge is one of the most significant barriers to non-engagement with MMC (Najafi-Sharjabad et al, 2013; Williamson et al, 2009). Hartmann (1995) argued that keeping women uninformed regarding their reproductive health is a way of maintaining control and power over women. Our research participants demonstrated a minimal health literacy in terms of a western biophysical understanding of reproductive anatomy and physiology. This decreased biomedical knowledge was also evident in the inability to explain the function of MMC. The women spoke scantily of perceived side effects and myths regarding the use of MMC, however they expressed knowledge regarding the possibility of changing to another method if the first was not agreeable. This is in contrast to previous research in Timor-Leste which demonstrated a reluctance by women to try another method if the first did not agree with them (Dawson & Waters, 2013).

Many women discussed a link between many closely spaced children and the subsequent potential impact on health and family finances, and many nominated the possibility of maternal death. However many of the women also recognised their inability to engage with practices that gave them control over their reproductive health, due to their husbands’ and cultural obligations. Many women spoke of a perception of entitlement regarding the use of MMC. However they did not speak of this entitlement in terms of ‘rights’; rather due to the ‘suffering’ they endured through the intrapartum and postpartum periods.
Health literacy appears to be an issue in Timor-Leste for both the women and men. Women from this study explained that if a woman did not produce a baby of the desired sex, that the man may seek another wife. This suggests a lack of understanding regarding conception. Additionally, infertility was only ever discussed in terms of it being caused by the woman, thus re-enforcing negative or discriminatory perceptions of women. Previous research in Timor-Leste has demonstrated that “if a woman and a man are unable to conceive a child together, the woman is almost always blamed and may suffer abuse, abandonment or the infidelity of her male partner as a result” (Saikia et al, 2009, p.15).

The ‘understanding’ between a husband and wife, which was a prominent feature in the discussions with urban women regarding family planning, was often referenced with physiological function and appeared to require a degree of basic biomedical knowledge. However, there appears to be a discord between the reproductive health knowledge the women are able to explain, compared with the messages contained within the ‘understanding’ rhetoric, which appears to echo the church sanctioned ‘natural’ family planning method. It would seem these messages have been heard and repeated, rather than any comprehensive understanding regarding biomedical processes. Richards’ (2010a) research confirms and describes this ‘understanding’ as the church sanctioned ‘natural’ family planning, while Bernardo’s (2005, p.8) research cites the Catholic church as describing this process as “a loving dialogue between married couples”. In discussions with other health providers in Timor-Leste, this concept of ‘understanding’ is recognised as complex, where there is no simple translation from the context and meaning for which the Timorese are using the term, to a concept that is recognisable for westerners. Exploring this concept further, and what it encapsulated, is recommended.

The rural women in this study identified the importance of geographically close health facilities from which to access reproductive health information and services. The women identified that limited access to such services was a barrier to accessing and utilising MMC. Additionally, the women recognised the link between the quality and availability of such services, the accuracy of information imparted to women from the health care providers at these services, and the subsequent degree of understanding and choice women had with regard to their reproductive health. Little or poor quality information regarding reproductive health issues were recognised as being potential contributors to unintended pregnancies and potentially impacting negatively on women’s health. Timor-Leste has a legacy of many religious-affiliated, international aid and NGOs providing reproductive health services within
the country, who have their own philosophies and agendas, for example, the ‘natural’ family planning promoted by Catholic clinics, or the ‘development target’ approaches employed by some NGOs (NRHS, 2004-2015; Marlowe & Mahmood, 2009; Ekpo et al, 2008). In developing countries, some of these services may be viewed by the local population with a degree of distrust (Konje & Ladipo, 1999). Marlowe and Mahmood (2009) argued that the coercion and oppression associated with the KB program during Indonesian times contributes to this distrust of family planning programs in Timor-Leste, while Hicks (2007) argued that programs and services built upon western values are not sustainable in rural Timor-Leste.

Konje and Ladipo (1999, p.288) argued that “[m]any family planning programs are ineffective because providers have failed to understand and therefore overcome the cultural barriers of the traditional communities”.

(The roads on a good day, source: H.Wallace).

The conservative culture within Timor-Leste has contributed to discussions regarding reproductive health being viewed as private and taboo (Van Schoor, 2003; NRHS, 2005-2014). Henfry (2004, p.106) argued that “[i]n a society in which discussion of sex is taboo, where health and sex education and awareness is low where access to health services is
limited and Catholic teaching reinforces illiberal tendencies, it may be some time before improvements in reproductive health indicators are seen”. Reproductive health education is limited and controversial, and an example of a policy area within Timor-Leste thought to be greatly influenced by the Catholic church (Richards, 2010a; Belton et al, 2009b). Much research exists describing the extensive influence of the Catholic church with regard to many areas of policy within Timor-Leste, and Lyon (2011,p.2) argued that the Catholic church “is now an autonomous political actor with legitimacy and institutional capacity comparable to that of the current government”. Much of the success of this influence is greatly entangled with the significant role the church played in assisting in the ‘birth’ of the new, independent Timor-Leste (Rimmer, 2007).

The influence of the church was the great ‘unspoken’ in this study. At a micro level the women did not identify the church as an influence on their reproductive health choices. However Petchesky (in Obermeyer, 2001,p.279) argued that “[i]n order to go beyond the level of witness or testimony, we have to look at the larger social and structural context – of which our respondents themselves may be unaware”. This influence is evident with many of the concepts cited within the ‘understanding’ component between husbands and wives with regard to family planning, echoing the doctrine of the Catholic church’s ‘natural’ family planning method, as well as the supporting of patriarchal and hierarchal constructs in Timor-Leste (Richards, 2010a). The Catholic church continues to play a key role in the shaping of reproductive health and education policy in Timor-Leste and remains a significant factor to women’s ability to access and utilise information and services regarding MMC (Richards, 2010a). There can be no doubt as to the influential and important role the church played during Timor-Leste’s quest for independence, and the church was a staunch supporter of the nation’s rights and freedoms (Lyon, 2011). However this support for political independence does not extend into women’s reproductive health (Rimmer, 2007).
Critical factors.

Critical factors within Willis’ framework include potential future directions, improvements and recommendations (in Germov, 2009). A pragmatic approach to reducing maternal mortality involves reducing fertility (Diamond-Smith & Potts, 2011). Basu (2002) argued that there is unequivocal consensus in the literature with regard to the two factors which have the greatest impact on women reducing their fertility, with those being the status of women in terms of gender equality, and the education of women. This study demonstrated that although there appear to be murmurings of women seeking greater autonomy in Timor-Leste, gender equality is advancing slowly. Similarly, the health literacy demonstrated by the women in this study suggests that more extensive education is required.

This research has demonstrated that women, particularly those in peri-urban and urban areas, are voicing their desires to be more active in the decision-making processes that affect their fertility, their health and their lives. Many women are also voicing desires for freedom from traditional gender roles, and are expressing aspirations to engage with activities beyond the family and home. While acknowledging that culture and tradition are significant
and important for establishing and maintaining Timor-Leste’s national identity and way-of-life, the women are also recognising that in many instances their health and well-being is sacrificed for these nation building attributes, based on conservative, patriarchal and historical factors and values. Supporting these women through this transition to greater empowerment is crucial, and requires guidance and support from both the ‘top-down’ Government level through to the ‘grass-roots’ adat level (Hicks, 2007). Recognising the significance of adat and the liurais is vital to the success of reproductive health programs, and Hicks (2007,p.16) argued that “government/agency programmes that do not recognize their [liurais] unique authority will find their goals under threat from the outset”.

Concurrently, recognising that many women remain embedded in a traditional, cultural circumstance by which men are the decision makers, is important, as reproductive health service providers need to consider this when developing programs or initiatives (Simelela, 2006). Najafie –Sharjabad et al (2013,p.185) argued that “[i]nvolving males and obtaining their support and commitment to family planning is crucial for family planning service utilization”. Also important is the acknowledgement that barlake is a significant consideration for many women. Niner (2012,p.149) argued that “[a]ny significant improvements to the lives of the majority of women in Timor-Leste must be made through an engagement with indigenous society and systems such as barlake which penetrate people’s lives to a larger degree than official systems of the state”. It is essential to acknowledge the importance and significance of these cultural practices which impact on choice, access and use of MMC. Wild et al (2009,p.1) argued that “[a]s researchers, health providers and policy makers, it is important that we understand there are different ways of knowing about health and illness and to respect these views as different but valid. In doing so, we will have a stronger foundation from which we can work with communities to improve health outcomes in a way that is both scientifically sound and culturally safe”. Of note, is that this difference and diversity exists within Timor-Leste as one crosses geographical, educational and linguistic boundaries (Hicks, 2007; Molnar, 2010; Kingsbury, 2012a).

This research also demonstrated that health literacy, from a biomedical perspective, is minimal amongst many women in Timor-Leste. Health literacy, and general education, is fundamental to improving the lives, prospects, health and future of women (ICPD in NHRS 2005-2015; Simelela, 2006). Education provides women with literacy, skills and knowledge to improve their prospects in terms of employment, and therefore lessens their financial dependence on men (NHRS, 2005-2015; Simelela, 2006). The women from this study
perceived the importance for both themselves and their husbands with regard to improved education contributing to improved reproductive health. Encouraging further incorporation of reproductive health education and reproductive health rights into the Timorese school curriculum would have benefits, as it would result in both males and females becoming more informed regarding health, financial and societal consequences of multiple, closely spaced children (Richards, 2010a; Najafi-Sharjabad et al, 2013). The National Family Planning Policy Timor-Leste (2004) recognised the importance of reproductive health information, and involvement of males in reproductive health programs and family planning initiatives. Despite this enthusiasm at a policy level, the Draft National Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health (DNSRMNCAH, 2014-2018) stated that male engagement with issues of family planning remains limited.

The Draft National Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health (DNSRMNCAH 2014-2018) stated that even though programs addressing sexual and reproductive health have been developed and introduced into the national curriculum, information is often limited due to these issues being considered culturally taboo. In the interim, reproductive health service providers need to be mindful of the apparent low level of health literacy that exists in parts of Timor-Leste. Opportunities to provide appropriate information to the men and women (for example, husbands and mother-in-laws) of Timor-Leste who have completed their formal schooling need to be identified, so that all members of the community may begin to make the links between culture, large numbers of children, women’s health and outcomes for families, communities and the nation. This has been demonstrated to have positive outcomes for women in other south east Asian research (Najefi-Sharjabad et al, 2013). Simelela (2006,p.297) argued that “[p]roviding more or better information not just to men but to others with influence over a woman’s decision – for example, elders and mother-in-law – would have a significant impact on the use of modern fertility methods”.

Limitations.

It was challenging working cross-culturally and in a language other than English, but the Timorese members of the research team ensured that linguistic, cultural and contextual interpretations and translations were accurate reflections of the sentiments expressed by the women.
Some women found the use of the vignettes challenging, and the concept of thinking hypothetically or in the ‘third person’ was foreign to them. In some focus groups the moderator needed to spend time explaining the components of the stories in a variety of ways to ensure understanding and comprehension.

With regard to the body mapping exercise, most of the women were happy to take part. Two women declined to take a pen to write or draw, but were keen to share their knowledge and perceptions with us and body mapped verbally. The body maps from Focus Group 4 were excluded from analysis, as the women in this group were instructed by the moderator (in this case, the local midwife who had not received adequate training in qualitative research methods) on what to draw and label. The result was a collection of body maps that all looked very similar. On reflection, the analysis of the body maps was quite naïve and ethnocentric. Future research developing a method of analysis much less weighted by western biomedical constructs would be beneficial.

Additionally, future research examining the perceptions and beliefs of Timorese men and parents-in-law, as well as the perceptions and beliefs of reproductive health service providers with regard to MMC, would provide a greater insight into the reproductive health arena that exists within Timor-Leste. Also, further exploration within peri-urban environments may provide a deeper understanding of the gender-role transitions occurring within Timor-Leste.

**Conclusion.**

Millions of women die every year from pregnancy related causes. The overwhelming majority of these women live in the developing world. Global research has demonstrated that to reduce the number of women dying from pregnancy related causes, pregnancies need to be prevented or delayed. Decreasing maternal mortality has extensive benefits not only for women, but for her children, her community and her nation. The most pragmatic solution and intervention to delaying or preventing pregnancies, is through access to quality family planning programs and MMC. While governments, NGOs and global organisations have developed strategies and universal goals and targets aimed at providing such methods to prevent or delay pregnancy, millions of women experience unintended pregnancies every
year, and the unmet need for access to contraception remains significant. As with maternal
death, the majority of these women live in the developing world.

Timor-Leste has one of the highest MMRs in the world. Reducing this ratio and
improving maternal health is a priority and challenge for Timor-Leste, and essential as the
nation works towards the targets set within the MDGs. Timor-Leste has established a number
of policies and initiatives to address the great need that exists within the reproductive health
arena, but the provision of reproductive health services remains challenging and contentious
within this nation. A variety of barriers persist within Timor-Leste with regard to women
accessing and utilising MMC for family planning, and a diversity of perceptions,
misconceptions and realities exist regarding these methods amongst the women.

This research amplifies the voices of Timorese women, and illustrates the diversity of
perceptions that exist across two districts in Timor-Leste with regard to contraception, family
planning and reproductive health. Such diversity stems from historical and geographical
circumstances. Prior to the Indonesian invasion and occupation, the people of Timor-Leste
were not a unified population; rather they existed in linguistically unique, and often
geographically isolated, circumstances. Contemporary diversity of perception arises from
educational background, whether the women live in urban, peri-urban or rural locations, and
whether the women identify with a more ‘traditional’ Timor-Leste, as opposed to a lifestyle
and value set that encompasses notions of modernity.

The women speak of notions of freedom, and of their wishes for controlling their bodies,
their fertility and their lives. Difference appears when discussing actions and behaviours in
this arena, for example, the rural women spoke of adhering to traditional ways of life and
gender roles, despite these practices and positions often being detrimental or disadvantageous
to their health and well-being, while the women from peri-urban areas spoke of challenging
traditional custom and traditional gender roles so as to behave in an autonomous, empowered
way, accepting however that this non-conformity put them at risk of domestic violence or
financial and social insecurity.

Women are constrained by culture, tradition, religion and colonisation, in its past and
present forms. The barriers placed in women’s way with regard to choosing to access and use
MMC include status, level of education, geographical location, cultural practices and familial
obligations. There is a need to decrease the fertility rate in Timor-Leste, from a woman’s
health perspective to a national development perspective. The two factors with the greatest
influence over lowering fertility, the status of women and women’s education, are both areas in need of significant consideration in Timor-Leste.

As the nation moves into its second decade of independence, Timor-Leste will need to confront some significant issues. The political influence of the Catholic church, and how this influence impacts on the everyday lives of the Timorese, is one such issue. The extent to which the Timorese wish indigenous culture and tradition to continue dictating behaviours and hierarchies is another. Timor-Leste will also need to address the balance in terms of ‘colonisation’ or influence from western organisations such as the UN and various NGOs with regard to providing reproductive health care and family planning programs, Timorese autonomy and tradition, and the projected population expansion expected in Timor-Leste.

Reproductive health providers need to recognise the potential barriers and obstacles, and focus on reconciling some of these issues, so that all women in Timor-Leste, if they choose, are able access appropriate, timely and quality programs, products and services. A short report of this study was provided to MSITL for them to incorporate some of these findings into their ongoing sexual and reproductive health programs. This report has also been translated into Tetum for local dissemination.

Women in Timor-Leste need to be supported in gaining education, autonomy and developing empowerment, they need to be supported in recognising their reproductive and human rights, and they need to be supported as they negotiate the transitions happening for their gender, their culture and their nation. It is paramount that reproductive health services and programs are not only geographically and financially accessible to the women of Timor-Leste, but are respectful of and informed by the cultural considerations surrounding the provision of such services in these communities.
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VIGNETTES

*Vignette 1: Maria has been married to Jauo for 3 years. Maria’s barlake was very good and there were buffaloes, goats, cloth and money exchanged at the ceremony. Both wife-giver and wife-taker families are happy and tranquil. Maria and Jauo have 3 children and they feel blessed by God. Following the birth of the last baby, Maria lost a lot of blood and was sick and weak for many months. She is feeling stronger now and able to look after the children and help more in the fields. The baby is now 4 months old and Maria is breastfeeding. Maria is not using any form of family planning.

Example questions for focus group discussion:

-Do you know families like Maria & Jauo’s here in this area?

-What do you think about the number of children they have? What do you think about the spacing?

-How would barlake influence the number of children they decide to have? What else would influence this?

-Given the circumstances, when do you think Maria and Jauo should have another baby?

-Who should influence this decision?

-What do you believe are important issues for Maria and Jauo?

-If Maria and Jauo wanted to delay having another child, what could they do? Where could they get advice in this area?

-What or who would influence Maria’s decision to use modern methods of family planning? Should she discuss it with Jauo? With her mother-in-law? With her friends? With the church?

-What would happen if Jauo did not approve?

-What is available for women like Maria in this area with regard to modern methods of family planning? What services/products? Where can Maria get information?

-What would be the advantages for Maria if she chose to use a modern method of contraception?

-What disadvantages would there be for Maria if she chose a modern method of contraception?
-What are some of the reasons someone like Maria may be opposed to modern methods of contraception?

*Vignette 2: Therese and Abelio have 5 children. All the children go to school. Therese has used Sono every 3 months for several years. Her health is good and she is still a young woman. She needs to walk to the health post, which takes a long time, to get her Sono. Sometimes the Sono is not available, so she has to walk back home again without her injection. Therese and Abelio have discussed it and they think they have enough children.

Example questions for focus group discussion:

-Do you know families like Therese and Abelio’s in this area?

-What do you think about the number of children Therese and Abelio have? What and who influences this decision?

-What do you think about Therese and Abelio discussing together the number of children they have?

-What do you think about Therese using the Sono?

-What do you think about Therese leaving her village to go to the health post to get her Sono?

-What else could Therese do to stop any more pregnancies?

-What would be the advantages for Therese using longer acting forms of contraception?

-What would be the disadvantages?

-What would stop Therese from being able to use longer acting forms of contraception? Who would influence her decision?

-Where could Therese and Abelio go to get more information about family planning?

-What advice have you heard health workers offering to people like Therese and Abelio around the issue of family planning?
*Vignette 3: Delphina and Jose are both 17 years old. They met last year at church and have been girlfriend and boyfriend for almost a year. Delphina goes to school, as well as helping care for her younger siblings and working around the home. She would like to finish high school. Jose would like to get a job driving a microlet for his cousin. Delphina and Jose live in different parts of the town, but are able to walk to each other’s homes. They think they would probably like to get married after Delphina completes high school. Their families are happy with their plans.

Example questions for focus group discussion:

- Do you know people like Delphina and Jose?
- What is important for their future?
- What do you think about their goals and dreams?
- What would stop their goals/dreams occurring? (→ probe for Delphina getting pregnant if not mentioned…..”Do you think Delphina getting pregnant would stop this?”)
- What could Delphina and Jose do to give their dreams the best chance of happening in the future?
- If they wanted information about looking after their reproductive health in the future, where could they go? Who could they ask?
- What is available for people like Delphina and Jose with regard to looking after their reproductive health? If they want to delay having a baby, what can they do?
- What would stop Delphina and Jose getting information about looking after their reproductive health?
- What would influence their choices regarding looking after their reproductive health?
- How important are considerations of barlake for people like Delphina and Jose?
### APPENDIX 2: Table 3.3 Body Mapping Characteristics

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<td>Baby runs to uterus in labour</td>
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<td>Baby circled at 7 months; blood must be =</td>
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<td>Ovum called sperm; comes from blood</td>
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<td>SE, very knowledgeable</td>
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<td>Knows you need something from m &amp; f</td>
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<td>RA</td>
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<td>Don’t need anything from female</td>
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<td>Heard about ovarium; not sure where baby grows; SE</td>
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<td>Different stomach to food stomach</td>
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<td>SE, ovarium is uterus</td>
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<td>White blood male + red blood Female; SE</td>
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**KEY:** FG & id = Focus Group & identification; loc = location; R = rural; PU = Peri-urban; UA=urban; <jhs = less than junior high school education; >jhs = more than junior high school education; uni = university education; CP= central pelvis; CA=central abdomen; LA=lower abdomen; RP=right pelvis; LP=left pelvis; RUQ=right upper quadrant; SE=side effects; F=food stomach; UA=upper abdomen

NB. Focus Group 4 excluded from analysis due to interference and coaching from midwife instructing the women how to draw their body maps.
18 November 2013.

Dr Suzanna Belton
Menzies School of Health Research,
PO Box 41098,
Casuarina NT 0811.

Dear Dr Belton,

HREC Reference Number: HREC 2013-2084
Project Title: Understanding family planning and contraceptive choices in Timor-Leste - An exploration of perceptions, misconceptions and realities

Thank you for letter dated 16/11/2013 and taking the time to respond to the issues of concern identified by the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research at its meeting held on the 04/12/2013.

I am pleased to advise you that the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research has granted ethical approval of this research project.

The nominated participating site/s in this project is/are:

- Marie Stopes International Timor-Leste (MSITL)

Please note that if additional sites are engaged prior to the commencement of, or during the research project, the Coordinating Principal Investigator is required to notify the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research. Notification of withdrawn sites should also be provided to the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research in a timely fashion.


Approval of this project from Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research is valid from 18/11/2013 to 31/10/2014.

This approval will be ratified at the next meeting of the Human Research Ethics Committee to be held on the 04/12/2013. Please note that HREC approval applies only to research conducted after the date of this letter.

This approval is for a period of twelve (12) months. An Annual/Final project progress report is required on or before the 31/10/2014.

APPROVAL IS SUBJECT TO the following conditions being met:

1. The Coordinating Principal Investigator will immediately report anything that might warrant review of ethical approval of the project.

2. The Coordinating Principal Investigator will notify the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research of any event that requires a modification to the protocol or other project documents and submit any required
amendments in accordance with the instructions provided by the HREC. These instructions can be found at http://menzies.edu.au/about-us/board-committees/human-research-ethics-committee.

3. The Coordinating Principal Investigator will submit any necessary reports related to the safety of research participants (i.e., protocol deviations, protocol violations) in accordance with Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research's policy and procedures. These instructions can be found at http://menzies.edu.au/about-us/board-committees/human-research-ethics-committee.

4. The Coordinating Principal Investigator will report to the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research annually in the specified format and notify the HREC when the project is completed at all sites.

5. The Coordinating Principal Investigator will notify the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research if the project is discontinued at a participating site before the expected completion date, with reasons provided.

6. The Coordinating Principal Investigator will notify the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research of any plan to extend the duration of the project past the approval period listed above and will submit any associated required documentation. Instructions for obtaining an extension of approval can be found at http://menzies.edu.au/about-us/board-committees/human-research-ethics-committee.

7. The Coordinating Principal Investigator will notify the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research of his or her inability to continue as Coordinating Principal Investigator including the name of and contact information for a replacement.

8. The safe and ethical conduct of this project is entirely the responsibility of the investigators and their institution(s).

9. Researchers should report immediately anything which might affect continuing ethical acceptance of the project, including:
   - Adverse effects of the project on subjects and the steps taken to deal with these;
   - Other unforeseen events;
   - New information that may invalidate the ethical integrity of the study; and
   - Proposed changes in the project.

10. Approval for a further twelve months will be granted if the HREC is satisfied that the conduct of the project has been consistent with the original protocol.

11. Confidentiality of research participants should be maintained at all times as required by law.

12. The Patient Information Sheet and the Consent Form shall be printed on the relevant site letterhead with full contact details.

13. The Patient Information Sheet must provide a brief outline of the research activity including, risks and benefits, withdrawal options, contact details of the researchers and must also state that the Human Research Ethics Secretary can be contacted (telephone and email) for information concerning policies, rights of participants, concerns or complaints regarding the ethical conduct of the study.

This letter constitutes ethical approval only. This project cannot proceed at any site until separate research governance authorization has been obtained from the CEO or Delegate of the institution under whose auspices the research will be conducted at that site.

Should you have any queries about the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research’s consideration of your project please contact 08 8922 7922 or 08 8922 8705. The Human Research Ethics Committee (HREC) of the Northern Territory

Menzies School of Health Research
PO Box 4006, Casuarina NT 0818, Australia | John Mathews Building (Bldg 58), Royal Darwin Hospital Campus, Rocklands Drv, Casuarina NT 0818
Ph: 08 8922 896 | Fax: 08 8922 582 | Web: www.menzies.edu.au | ABN: 70 043 342 847
Department of Health and Menzies School of Health Research’s Terms of Reference, Standard Operating Procedures, membership and standard forms are available from http://menzies.edu.au/about-us/board-committees/human-research-ethics-committee or from the contact phone numbers provided above.

The Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research wishes you every success in your research.

Should you wish to discuss the Human Research Ethics Committee (HREC) of the Northern Territory Department of Health and Menzies School of Health Research’s review of your project, please contact Ethics Administrators, Ms. Maria Scarlett or Ms. Jennifer Wong on (08) 8922 7922 or (08) 8922 8705 or email ethics@menzies.edu.au

Yours sincerely,

Ms. Colleen Atkinson
Chair
Human Research Ethics Committee
of Northern Territory Department of Health
and Menzies School of Health Research
NHMRC Registration No. EC00153

This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007). The processes used by this HREC to review multi-centre research proposals have been certified by the National Health and Medical Research Council.
No Ref.: MS-INS/DF-DP/ XI/2013/ G88

Sra. Marianne Keamey
Marketing and Partnerships Manager
Marie Stopes International

Assunto: Autorizasaun Peskija

Instituto Nacional de Saúde (INS), fo Autorizasaun Peskija ba Marie Stopes International atu halo peskija ho topiku *Perceptions of Family Planning in Viqueque and Dili* (Timor-Leste).

Marie Stopes International, mak sei iha responsabilidade durante prosesu peskija ida nee, hahu huui koleksaun dadus to'o iha relatorio final, tuir horario nebe determina. Peskija ida nee sei lao tui metodologia hotu nebe hakerek iha proposal no respetta etika peskija nian.

Instituto Nacional de Saúde, la konsente Peskijador atu uja dadus hirak ne'e ba fali interesse seluk, sekarik durante peskija dadus nebe foti uza fali ba interesse seluk ka la tuir etika no proposal, mak INS sei foti asaun forte atu prosesu hasorou Peskijador ka hapara peskija.

Marie Stopes International iha obrigasaun atu halo workshop preliminario nomos relatorio final sei hato'o mai Instituto Nacional de Saúde molok halo publikasaun.

Karik iha informasaun ne'ebe iha relasaun ho Peskija ida ne'e bele kontaktu mai iha No. Telf. 77244444 ou email healthresearch.44@ yahoo.com, mileradho@yahoo.com.

Mak ne'e deit, ba ita nia atensaun no kolaborasaun diak, amí hato'o obrigado wain.

O/d: 15 de Novembro de 2013

Ivone de Jesus dos Santos, Lic. SP
Diretora Executiva I Presidente Conselho Administrativo do INS

CC.
1. S.E. Ministro da Saúde, RDTL
2. S.E. Vice Ministra da Saúde, Asunto Etika no Prestasaun da Saúde, RDTL
3. Exmo. Señor Director Jeral, MdS
4. Director Nasional Saúde Public, MdS
5. Director Servisu Saude Distritu Viqueque
6. Directora Servisu Saude Distritu Dili
August 26th, 2012

Dear Ethics Committee members

Research Proposal: Understanding family planning and contraceptive choices in Timor-Leste – An exploration of perceptions, misconceptions and realities

Researchers: Heather Julie Wallace, Dr Suzanne Belton
At: Menzies School of Health Research / Charles Darwin University

This letter is to confirm that Marie Stopes Timor Leste supports the research proposal of Heather Julie Wallace, and will be working with Ms Heather Wallace to ensure the research is carried out in an ethically, and culturally sensitive way. Marie Stopes Timor Leste is an international aid organization which has provided reproductive and sexual health care to over 100,000 people in Timor Leste since 2007.

Marie Stopes discussed this proposal with Heather Julie Wallace, and her supervisor, Dr Suzanne Belton, including issues such as how best to ensure there is an urban – rural balance in the participants, as well as having an ethnically representative balance, so that the final research results will not be ethnically biased, and will broadly represent attitudes to contraception and family planning across Timor Leste. Marie Stopes has also provided feedback on sensitive issues such as having female translators an engaging Timorese to assist with analysing the data.

We believe that this study will contribute to better understanding how to deliver reproductive health services to families in Timor Leste.

Please don’t hesitate to contact myself, or the Country Director, Nicola Morgan (nmorgan@mariestopenl.org) + tel +670 – 7608 5472, if you have any questions.

Regards,

M. Keamey
Marketing & Partnerships Manager
mkeamey@mariestopenl.org
Tel +670 7700 6263
CONSENT FORM

Study Title: Understanding family planning and contraceptive choices in Timor-Leste – An exploration of perceptions, misconceptions and realities.

Chief Investigators: Dr Suzanne Belton, Dr Ana Soares, Ms Heather Wallace, Ms Natalia Pereira

Local Partners: Ms Nicola Morgan, Director, Marie Stopes International Timor-Leste; Ms Marianne Kearney, Marketing Manager, Mariés Stopes International Timor-Leste

Statement of Participation: (please initial each box)

1. I have read, or have had read to me, the accompanying ‘Information Sheet’ for the above study. I have had the opportunity to consider the information and ask questions about participating in this study. □

2. I understand that my participation is voluntary. I understand that I can refuse to participate in the study without any negative consequences and that I may withdraw from this study at any time. □

3. I understand that any information I provide may be used by the research team in reports, journals or presentations. □

4. I understand that my name will not be used in these reports, journals or presentations. □

5. I consent to participating in this study. □

Name of Participant: ____________________________

Signature: ____________________________________

Date: ____________________________

Witness Name: ____________________________

Witness Signature: ____________________________

Date: ____________________________

Marie Stopes International
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Right Choices Save Lives
APPENDIX 7

For Translation: Appendix B: Information Sheet – This Is For You To Keep

"Understanding family planning and contraceptive choices in Timor-Leste – An exploration of perceptions, misconceptions and realities"

‘This Is For You To Keep’

Chief Investigators: Dr Suzanne Belton, Dr Ana Soares, Ms Heather Wallace & Ms Natalia Pereira

Local Partners: Ms Nicola Morgan, Director, Marie Stopes International Timor-Leste; Ms Marianne Kearney, Marketing Manager, Marie Stopes International Timor-Leste

Invitation: We invite you to be part of this study

Purpose of the study: We want to know what the women of Timor-Leste think about family planning using modern methods of contraception.

Benefits of the study: In understanding women’s perceptions and beliefs, and identifying any potential barriers or myths about modern methods of contraception, culturally appropriate resources and services can be developed. Through strengthening access to information and provision of modern methods of contraception for family planning, maternal health will improve and maternal mortality decline.

What would be expected of you: If you decide to take part in this research, you will be invited to a group discussion. This group discussion will consist of approximately 8-8 women of reproductive age, plus two female researchers. The group discussion will involve the researcher reading out a story to you about some invented people living in Timor-Leste. Based on this story, you will be asked what you think about the circumstances described in the story. The group discussion will take place in a private place. The discussion will be audio taped, and one of the researchers may take notes throughout the discussion.

You will also be invited to draw a woman’s body, and the researcher will ask if you would like to share your thoughts on your drawing. The researcher will ask to keep your drawing, or if you would like to keep it, the researcher will ask to take a photograph of your drawing. This discussion will also be audio taped.

The researchers will explain the study to you and ask for your consent to participate before proceeding with any aspect of the study. You can say NO at any stage if you do not wish to take part.

Confidentiality: The researcher will use the information you provide in a respectful manner. We will not identify you by name or where you live. We will ensure you remain anonymous in anything we write or publish concerning this research. We will make sure your name is not on your drawing.

Your participation: We would be grateful if you participate in this study. However you are free to refuse to take part. Also, even if you agree to begin with, you are free to withdraw at any time of the research by contacting any of the people listed below.

Results of the study: Please advise us if you would personally like to receive the results of this study and if you would like to review material prior to publication.

Persons to contact: If you have any questions, or you would like to withdraw from the study, please contact Dr Ana Soares (ph: 77296114); Ms Marianne Kearney (ph: 73324922) Marie Stopes International, Rua Vieta-Verde, Dili.

We understand our research involves a sensitive topic. If you require further information or assistance due to the nature of this study, please contact the persons listed above, or alternatively, some of the following contact details may be useful: Marie Stopes Hotline ph: 800 1091; PRADET (Psychosocial Recovery and Development in East Timor) ph: 73321552; VPU (Vulnerable Persons Unit) at your local Police Station.

Complaints: Secretary of the Human Research Ethics Committee, Menzies School of Health Research; telephone: +61 8 8922 8196 or email ethics@menzies.edu.au in Australia.

Menzies School of Health Research

For Translation: Appendix B: Information Sheet – This Is For You To Keep

‘Understanding family planning and contraceptive choices in Timor-Leste – An exploration of perceptions, misconceptions and realities’.

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Ref: FPA/Rep/2013/IX-64  

5 September 2013

Dear Members of the Human Ethics Committee,

I am aware of the study ‘Understanding family planning and contraceptive choices in Timor-Leste – an exploration of perceptions, misconceptions and realities’ and I send this letter to demonstrate UNFPA’s support.

Maternal and infant mortality and morbidity remain too high in Timor Leste. Family planning and modern methods of contraception are one way to reduce this health burden.

We understand that a Masters of Public Health student (Heather Wallace) from the Menzies School of Health Research will be coordinating the field work, and she will be guided by her supervisors.

Dr Suzanne Belton and Dr Ana B Soares are experienced researchers in Timor Leste. The researchers intend to talk with a small number of Timorese women about their knowledge and beliefs on this subject. They will work with Marie Stopes TL in Dili and Viqueque. We believe that using a story to generate information from women in focus groups is a good way to provide some privacy and less intrusive questioning.

UNFPA staffs have been invited to be expert advisors on this project and we have accepted this offer.

Thank you for your time in considering this study.

Yours sincerely,

John M. Pile
Representative
UNFPA Timor-Leste

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