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Childbearing in Timor-Leste:

Beliefs, practices and issues

**A thesis presented in fulfilment of the requirements for the degree of Master
of Philosophy in Development Studies**

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ABSTRACT

Timor-Leste is a country with a past, a past that reveals considerable strength and a will to achieve the right to be self-determining. It is also a country that will need development assistance for many years to come. Lack of development by Portugal, the former colonial power, compounded by an illegal and destructive occupation by Indonesia, it was a country largely devoid of infrastructure at the time of independence in 2002. The population of this small half island is diverse, ethnically and linguistically.

The population is considered to be amongst the poorest in the world and women's health, particularly the high maternal mortality rates and the issue of domestic violence have been identified as key areas for development. Women's marginal status in Timorese society is due to traditional and patriarchal practices which enable males to exert control and power over women in many facets of daily life. One of the numerous results of this is that women have reduced access to valued resources including health, education and food. Children are greatly valued, but the high fertility and maternal mortality rates have led the government to identify reproductive health as a high priority. Childbirth is only one aspect of reproductive health but it has traditionally received greater attention.

Utilising qualitative research a small group of rural women shared their experiences and practices of childbearing. One aspect the women identified was a lack of information as childbirth is a taboo subject until a woman becomes a mother. In view of this and the numerous priorities identified by Timorese government for future work, including the mainstreaming of gender health concerns I consider the research findings.

Due to the need for cost effective and sustainable programmes I recommend Adolescent Sexual Reproductive Health (ASRH) as an area for future exploration and consideration. This is an area found to be commonly overlooked in development activities, but can have many positive outcomes. A broad ASRH programme could address not only the issues of poor information but also work toward challenging gender norms and values which are key influences on women's reproductive health and childbearing experiences. ASRH may be controversial, but some consider programmes can be implemented as early as ten years of age. As adolescents are the next generation of parents and the most receptive to change they are the ideal target group for the future health of this country.

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ABBREVIATIONS

APODET	Timorese Popular Democratic Association
ASDT	Association of Timorese Social Democrats
ASRH	Adolescent Sexual and Reproductive Health
EBUNDP	Executive Board of United Nations Development Programme
GAD	Gender and Development
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
INTERFET	United Nations Transitions Authority
MCH	Maternal and Child Health
MOH	Ministry of Health
NCD	Non-communicable disease
NGO	Non-governmental Organisation
PHC	Primary Health Care
PRA	Participatory Rural Appraisal
RRA	Rapid Rural Appraisal
SAP	Structural Adjustment Programme
SEARO	South East Asia Regional Office
SMI	Safe Motherhood Initiative
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
TNI	Indonesian National Military
UDT	Timorese Democratic Union
UN	United Nations
UNAMET	United Nations Mission in East Timor
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
UNPF	United Nations Population Fund
USA	United States of America
WAD	Women and Development
WHO	World Health Organisation
WID	Women in Development

CHAPTER ONE

Introduction

Reason for Study

Over the years considerable attention has been given to countries that have been classified as underdeveloped resulting in a plethora of ideas and strategies to enable citizens of these countries to have 'better' lives. How to achieve an improved standard of living and the consequences of attempts to develop or modernise countries has led to considerable debate (Brohman, 1995; Rist, 1997; Gyebi, Brykcynska & Lister, 2002).

Development affects women in different ways to men, creating and further perpetuating inequities. It has been argued that women have often been invisible in development despite actions affecting them (Moser, 1989; Kabeer, 1994; Gender in Development Programme, 2001). One of the criticisms evident in the literature is that when women have been included in development the focus and subsequent actions have been limited. When attention has been given to women it has focused on mothers that is, childbearing and childcare, the greater emphasis on the latter (Moser, 1989; Asthana, 1994; Pettman, 1996; Green, 1999). As a researcher I am conscious of these criticisms, and I am aware that by exploring the topic of 'Childbearing in Timor-Leste' there is a potential to reinforce the past dominance of women's reproduction when there exists an infinite range of potential topics. So why choose childbearing in view of the criticisms?

Literature clearly shows the atrocious maternal mortality statistics (United Nations Development Programme [UNDP], 2002) that exist for women in Timor-Leste thus childbearing is already on the agenda, nationally and internationally. Any attempts to improve these statistics will need a broad understanding of issues, it is therefore vital that local women have an opportunity to contribute. Readers are reminded that aspects explored in this research are small pieces of a much bigger jigsaw, but to really see the picture one needs as many pieces as possible.

The purpose of this study therefore is to explore the topic of childbearing in Timor-Leste by utilising qualitative research methods in conjunction with secondary sources of information considered to have relevance. It is hoped this research will add to what currently appears to be a small body of literature related to childbearing beliefs and practices in Timor-Leste (van Schoor, 2003). It is believed that if any benefits are to be realised it is essential that women's views and experiences are heard and valued.

Background

Childbearing is only one part of women's reproductive health and cannot be considered in isolation to a multitude of other factors. One could take a purely physical approach to considering childbearing, focusing on the physiology of reproduction and the mechanics of labour, which 'fits' comfortably within western biomedicine, but many would argue this is reductionist (Capra, 1983). These aspects should not be ignored as biomedicine has been and continues to save the lives of many women and infants (Priya, 1992). In the western world due to the strength and male dominance of biomedicine and the subsequent successful 'take-over' of childbirth, many feminists have waged a counter attack on this limited approach (Jordan, 1993; Henley-Einion, 2003).

To take a wider view of childbearing many factors need to be considered. One needs to look beyond physiology and explore history, culture and how society (locally, nationally and I would argue internationally) is structured (Wright Mills, 1959; Germov, 2002; Willis, 2004). Whilst this may assist with insight, 'western experts' need to take care not to define the problem and impose solutions, as experience has shown this type of approach does not necessarily enhance sustainability. In recent years some development planners and subsequent projects have shifted thinking and action away from the 'top-down' approach (Edwards, 1989).

One of the shifts that have occurred is that there is a need for local input and valuing of local knowledge and solutions in development projects. This has resulted in what is often called a grassroots approach. The intended outcomes are evident in the following terms: capacity building, empowerment and community development (Eade & Williams, 1995; Elder, 2001; Middleberg, 2003). A key element is the need for community involvement at all stages, from needs identification to evaluation.

Whilst health projects have been slow to incorporate locals at all stages these ideas should not be overlooked. The Alma Ata conference in 1978 identified principles for Primary Health Care (PHC) in an attempt to improve service delivery and equity of health services (Asthana, 1994). Subsequent international health conferences have shown continued support for these ideals. The Jakarta Declaration (1997) reaffirmed the principles and the need for community involvement. The ideal of shifting the initial point of health service access out of hospitals into communities, whilst having many benefits, has not been easy. One reason is the potential challenge to power structures

including stakeholders' with a vested interest in the retention of a secondary care focus (Green, 1999; Gesler & Kearns, 2002).

The Jakarta Declaration (1997) also emphasised the importance of involving marginal groups, explicitly women, as well as the need to focus on quality of life (Elder, 2001). During the 1990s the International Conference on Population (ICPD) in Cairo (1994), and the Fourth World Conference on Women in Beijing (1995), emphasised the importance of women's rights. These and other forum have marked women's health as issues of equity and social justice requiring wider thinking and action (Bandarage, 1997; Petchesky, 1998).

This does not negate the importance of considering the health and wellbeing of women during childbirth but it does mean that for improvements in women's health to be achieved social, political and economic factors across the lifespan need to be considered. Just as importantly acknowledgement needs to be given to cultural beliefs and practices. As health issues are frequently development issues there are implications for health planners and workers if they are to take on board and work with current ideas.

It is not advocated that current thinking should be unquestioningly accepted, but it does mean that before ideas are negated or discarded critical thinking needs to occur. The current directions do appear to have support from a diverse range of people stating that understanding and valuing of local beliefs and practices are both ethical and moral issues that should not be overlooked by development practitioners (Goulet, 1995; Lefèber & Voorhoeve, 1998; Yorder, 1997).

Improving maternal and infant health outcomes requires one to ask; why are the maternal and infant mortality statistics for Timor-Leste worse than those in other countries? It would be unrealistic to think that there is only one reason or one solution, which is why an integrated approach is advocated to achieve long-term improvements (Ministry of Health [MOH], 2002). Women experiences in Timor-Leste are unlikely to be homogenous as housing, accessibility to health services, financial resources, education level, employment status, marital status and more, all influence health (Germov, 2002) and thus birth experiences and outcomes.

Women, families and all citizens of Timor-Leste are constantly reminded of past events that have occurred. In 1974 the Indonesian government illegally took control and worked toward developing the infrastructure by the building and provision of roads, health services and schools. All of these activities can have positive implications for improving people's health and ultimately quality of life but these were not the only

Indonesian activities. Many people were attacked and killed by Indonesian forces, or local people, directed by Indonesian authorities. Women were raped, children were conceived as a result, families were dislocated and had to spend weeks, months and years hiding in the hills in an attempt to survive (Jardine, 1999; de Sousa, 2001; Cristalis, 2002).

Over these years international awareness and support was limited, until the 1990s. Eventually the opportunity came in 1999 for the Timorese people to vote on the future of their country, the vast majority voted for independence. Whilst the vote was recognised internationally and given considerable media attention devastation in the form of rampage and killing by Indonesian militia quickly ensued. Development that had occurred in the prior 25 years was virtually destroyed and the already poor country and people were left shattered but needing to rebuild their country (Martin 2001; Cristalis, 2002; Greenless & Garra 2002).

Development agencies quickly responded, as considerable rebuilding and development needed to occur. The population was largely devoid of local expertise as Indonesian's who had held many of these positions had left, further increasing the need for assistance. Health was identified as an essential area for aid; malnutrition, infectious diseases such as malaria, mental health problems coupled with domestic violence all existed and when combined with the loss of services and the prevalence of poverty the need could not be refuted (MOH, 2002). Many of these issues are not uncommon to developing countries, but historical, cultural and structural differences make each country and region unique in how the needs are defined and the best outcomes achieved.

Research and Objectives

This research project provides a background to Timor-Leste with attention given to historical and cultural information. Much of the historical information provided may not immediately appear relevant to childbearing experiences and outcomes for women. It is intended that the reader will look beyond this to consider what the implications maybe as it is likely that there are many indirect consequences that will have long lasting effects on women and families, some of which may not yet be apparent.

This study intends to provide insight into childbearing in Timor-Leste, through the inclusion of local information provided primarily by women who reside in the rural sub-district of Soibada, 120 kilometres from the capital of Dili. Additional information has been included, obtained from key participants, data from MOH Timor-Leste and international agencies, providing further insight into health and context. Due to the

limited time available for fieldwork I was unable to obtain information to explain local childbearing beliefs and practices. I have therefore incorporated a number of ethnographic studies from other countries to demonstrate the richness of women's childbearing beliefs and practices.

Past attention to women and childbearing has been limited. Primary Health Care (PHC) principles, technology and secondary care elements of biomedicine have played a prominent role in childbirth in western countries (Kitzinger, 1993). Opposition from some groups have expressed concern regarding increased medical intervention in childbirth (Jordan, 1993). A key objective of this study is to view childbirth through 'different' eyes, placing emphasis on aspects that extend beyond morbidity and mortality or woman's roles and responsibilities associated with reproduction.

It is hoped that health and development workers will explore and value the diversity of local practices encountered, and recognise that they are local solutions to local issues, as openness to diverse views and practices, especially if working in the area of childbirth and development is essential. It is not intended that readers apply this information (ethnographic and local) to all women in Timor-Leste as childbearing experiences are individual. When discussing cultural aspects of any group of people it is wrong to think that a finite list of cultural practices can be developed, from which practitioners' work as this fails to recognise that culture is living and thereby constantly changing (Ramsden, 1993).

Research Location

As a country Timor -Leste comprises the eastern half of an island (see Figure 3.1), a small enclave and two smaller islands, located to the north of Australia. It is divided into 13 districts and 64 sub-districts and comprises three main towns and many villages (MOH, 2002, p.1). A recent national census reveals a total population of 924,642 with 10,872 less females than males (United Nations Population Fund [UNFPA], 2004).

All participants lived or had lived in the sub-district of Soibada (population 2,926 second smallest sub-district population nationally) located in the District of Manatuto (population 38,580, second smallest district population). Soibada's (see Figure 5.1) population in 2004 had reduced by 2.2 percent since 2001 having slightly more females than males (UNFPA, 2004) which are contrary to the national trend.

The sub-district of Soibada comprises several villages located in surrounding hills. The majority of the population appeared to be reliant on subsistence agriculture

but soil is poor, requiring them to walk considerable distances to their gardens. There is no public transport and private vehicles are virtually non-existent. A health clinic operates five days a week, with health professionals taking mobile clinics, travelling by motorbike (one) around the sub-district; they also work 'on call'. The nearest hospital is 60 kilometres away in the town of Manatuto with the country's main hospital in Dili a further 60 kilometres. If emergency treatment requires transfer to hospital an ambulance is sent from Manatuto with a return trip taking four to five hours from the ambulance's initial departure, longer if the person needs to be sent to Dili hospital. The past few years have seen a downturn in infrastructure services.

Thesis Structure

This thesis is presented in seven chapters, comprising firstly an outline of the study. Chapter two provides an overview of relevant literature including development, health, gender, childbearing beliefs and practices. This is followed by chapter three, which some may feel is a longer than warranted historical overview of Timor-Leste. I believe it is important to have contextual knowledge, which includes a country's past. Many current development and health issues have their roots in past situations, which will continue to have long lasting implications for the lives of individuals and families. These will have direct and indirect consequences, currently and in the future for childbearing women.

Chapter five introduces the research, research methods, research issues and a brief introduction to the Sociological Imagination (Wright Mills, 1959). Willis' (2004) building blocks have influenced data collection and analysis. Following is the sixth chapter in which I present primary data provided by women and other participants. This forms the basis of the chapter to which overseas ethnographic studies have been linked in the hope of providing a richer view of childbearing beliefs and practices. The penultimate chapter takes a step back from the primary focus on local women's stories, beliefs and practices, to consider other aspects of relevance to childbearing for women in Timor-Leste. This discussion incorporates and links additional information from primary and secondary data sources. I also discuss aspects of adolescent sexual reproductive health (ASRH).

The final chapter revisits earlier points providing summary and recommendations, primarily Adolescent Sexual and Reproductive Health (ASRH), as a development issue for Timor-Leste. I am mindful of discussions regarding outsider experts imposing their views of needs and solutions and I do recognise that my data collection did not explore

this issue. I do feel that this topic does not 'fit' easily with the idea of conclusion, as childbearing is one of the constants of life and culture. As mentioned previously, every experience is individual and as contexts change so to do experiences and issues.

CHAPTER TWO

Development, Health, Gender and Childbearing

Introduction

The marking of countries as developed or underdeveloped received considerable attention at the end of World War II. Ideas and strategies have changed, often influenced by outsider views on how best for developing countries to progress and become 'modern'. For some the terms modernisation and development have been used interchangeably.

Some believed that development occurs in phases, over several decades, requiring the input of capital and expertise, as well as diffusion of ideas (Rostow, 1956). Others believe that underdeveloped countries are the result of exploitation (Blomström & Hettne, 1984,). It is evident that males have dominated development practice and that influences from some countries, such as United States of America (USA), regarding a global capitalist system of production and exchange have played a key role in many countries' development.

Development and underdevelopment indicate the existence of considerable differences between, and within, countries. When considering health and wellbeing differentials it is evident that people who have greater access to resources, such as wealth, education and power have a greater potential for good health (Evans, Whitehead, Diderichsen, Bhuiya & Wirth, 2001). In addition to this the average life expectancy in developing countries is 10 to 20 years less than in developed countries (Eade & Williams, 1995, p.626). The numbers of infant deaths are considered the major cause, a cause that is preventable (Potts, Janowitz & Fortney, 1983). One factor that has received less recognition is that development affects males and females differently. Despite the frequent invisibility of gender, development strategies affect women even if they are not directly targeted. One area that has received attention is that of women's health but this has largely focused on women's reproduction and associated roles (Kabeer, 1994).

The 1994 ICPD in Cairo placed reproductive health clearly on the development agenda. Reproductive health and thus childbearing has tended, in some localities, to be used synonymously, effectively denying the former (Middleberg, 2003). Women's, though more frequently mother's, health have been targeted in development

programmes, but despite programmes carrying the name of maternal and child health (MCH) it has been shown that more attention is given to children effectively disregarding women (Middleberg, 2003,). One of the explanations for this is that women have tended to be excluded or underrepresented at policy and planning levels, nationally and internationally (Jacobson, 1991), development agencies have also been criticised for their limited inclusion of women.

Maternal mortality and morbidity is a dominant focus of health statistics that are frequently put forward to demonstrate health disparities, for women in developing countries. Diderichsen, Evans and Whitehead (2001) indicate that when considering health outcomes the social context and characteristics of the environment in which a person lives, needs to be considered, which is not always evident in mortality data.

As culture influences individual as well as social practices it is important to explore the context in which women live when discussing childbearing. Childbearing beliefs and practices vary considerably throughout the world; some believe childbirth to be natural, whilst others view medical monitoring as the norm placing it distinctly in the domain of formal health services. For those working in the area of health it is important to be open to diverse cultural practices. There is also a need to understand what development strategies have been used in the past, globally and locally, to enable one to ask whether or not they have been successful, not only in the improvement of health statistics, but also meeting the needs of local people.

The meeting of local needs requires an acknowledgement of local knowledge as well as a valuing of local solutions. For many years experts have played a key role in developing and implementing plans that are top down in approach, but today there is recognition that sustainable change is best achieved utilising bottom up or grassroots partnership and participation (Edwards, 1989).

What is Development and How is it Best Achieved?

The concept of development may initially appear simple and straightforward, it can be hard to clarify, but it is generally associated with improving quality of life. Measurements of development that focus primarily on economics can be considered simplistic (Philips & Verhasselt, 1994) despite this they have tended to dominate, many assuming that "...economic development leads to social development" (Gyebi, Brykczynska & Lister, 2002). Attempts at achieving development have revealed that it is slow, uneven and at times fragile (Edwards, 1989) and Rist (1997) identifies that it is not necessarily helpful to exclude approaches that fail to maximise potential or enable

choices. One of the problems with many explanations of development is that they “...are based upon the way in which one person (or set of persons) pictures the ideal conditions of social existence” (Rist, 1997, p.10). To understand fully the concept of development it needs to be explored widely giving consideration to historical and global factors (Brohman, 1995).

The Universal Declaration of Human Rights (1948) emerged in the post war era in response to atrocities that occurred in World War II Nazi camps considerably influencing development thinking (Rist, 1997). World War II and its aftermath are seen as a turning point in development in that it heralded the new world powers of the Soviet Union and the USA. The most immediate issue for a number of countries at that time was the need to rebuild Europe utilising capitalism as the underlying strategy. The evolving political situations in the West in 1949 saw President Truman (USA) announce an extension of aid to poorer countries. This extension provided some acknowledgement that previous imperialist relations had resulted in exploitation and profit extraction of non-western countries. What was envisaged was that development should be democratic and fair (Risk, 1997).

The 1950s and 60s revealed a range of notions about development, influenced by long standing beliefs often informed by Eurocentric attitudes. Brohman (1995) indicates that value differences between countries were seen as obstacles to modernisation. Modernisation was often used synonymously with development ultimately favouring European values, whilst those of less developed societies were considered inferior and the cause of a country's decline.

Dividing the world into developed or developing countries served the interests of some countries but further marginalised others. It was thought that increased production, which required advanced techniques and knowledge, was central to prosperity (Rist, 1995). Development was viewed as a process, most important being the “take-off” phase which required an investment of capital and changes in production techniques and practices, it also needed people with impetus and authority to respond to opportunities. Underdeveloped countries required developed countries (primarily the USA) to share information, technology and aid (Worsley, 1984). After decades of growth it was thought the maturation of production would benefit the population through increased wealth and consumer goods (Rostow, 1956).

The idea that developing countries should, and could, follow the direction of developed countries reveals a tendency of modernisation theorists to be ahistorical and

acontextual (Rist, 1997). Limited consideration was given to social and cultural contexts of development and when acknowledgement was given, for example, to ethnicity, it was typically considered an obstacle. Ultimately Brohman (1995) believed that modernisation theory was too reductionist, vague and ignored important issues such as class, ethnicity, gender and other social relations that result in inequities. It had limited "...relevance to the developing world because it was really a celebration of the achievement of the advanced industrial countries" (Brohman, 1995, p.125).

These ideas of development were dominant during the post-war era but by the 1960s some were embarrassed and disillusioned particularly with USA's dominance (Brohman, 1995). During the 1980s aspects of modernisation theory re-emerged under names such as neo-liberalism, some believing this was in response to 1970s explanations of inequality. Neoliberalists espoused that underdevelopment was due to a country's poor policies and actions, such as social welfare provisions and trade barriers believing development required countries to be open enabling greater global trade (Brohman, 1995).

In the late 1960s and 70s attention shifted as attempts were made to explain poverty and underdevelopment of and within countries, many of which had been colonised. Frank (1970) believed that capitalism created economic development for some, but underdevelopment for others, thus underdeveloped (satellite) nations were the product of past and current interactions with colonial powers and advanced capitalist nations (metropolis). This relationship was essential to the emergence of a global capitalist system that predominantly served the interests of the metropolis. Exploitation was thus a characteristic, the movement of surplus value and metropolis domination hampered a satellite country's potential and created dependency (Blomström & Hettne, 1984).

It was argued that contrary to some views development did not require diffusion of capital, values and ideology from already developed countries as they were "no one's satellite" (Frank, 1970, p.9). Indeed development was most successful when this power relationship was not present (Blomström & Hettne, 1984, p.68). Wallerstein (a World Systems Theorist) believed that global market integration created an international division of labour, further dependency and diminished local small businesses (cited in Harrison, 1988).

The nature of dependency varied and shifted, for many countries it resulted from colonisation but more recently from multinational companies as they extended control

and domination (Dos Santos, cited in Harrison, 1988). Central to World Systems Theory is the idea of unequal exchange, that is, the labour of workers from less developed regions are not accorded the same monetary value as those from developed countries, this reduces costs enabling multinational companies to be more competitive. Debate does exist as to whether inequality is due to production, markets or a combination (Harrison, 1988).

More recent explanations have emerged, broadly labelled as Alternative Development, emphasising that greater consideration needs to be given to how development affects locals with many arguing that dominant past practices had been deficient as goals should to be based on local needs. Edwards (1989) asks “[w]hy is it that our increasing knowledge of the Third World does not enable solutions to be found”, believing the fundamental reason is a deficit in making links between “understanding and action” (pp.116-117). The use of western ‘experts’ and the transplantation of skills can inhibit local experimentation and problem solving. The belief that transference of ‘western knowledge’, is the prerequisite to development ignores the need to understand local realities, knowledge, attitudes and the multitude of variables that effect people’s lives (Edwards, 1989). It also fails to acknowledge the importance of time, process of knowledge acquisition and personal or community trust all are central to achieving sustainable changes in areas such as equity, political freedom and economic growth (Edwards, 1989). Failing to acknowledge local factors creates barriers and can perpetuate dependency through the implementation of ‘top-down’ strategies.

A power differential between developed and developing countries has dominated development and prevents the emergence of grassroots strategies. Until there is an understanding of local, change strategies are unlikely to be successful (Edwards, 1989). Edwards (1989) advocates participatory research, requiring researchers to listen and learn from local people as they identify not only issues but also solutions.

Health and Development

The World Health Organisation (WHO) defined health in the late 1940s as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (cited in Spector, 2004, p.48). This looks beyond the mechanical and physical functions of the body enabling the incorporation of how a person feels as well as social dimensions that effect health. Discussions about health can include quantifiable aspects of disease as well as less tangible and more subjective domains

such as wholeness and quality of life, which some see as vague and immeasurable (Gesler & Kearns, 2002). Gesler and Kearns (2002) argue that definitions of health and subsequent responses can be closely linked to existing societal economics and power structures. It is therefore important to acknowledge how those with a vested interest perceive health, as this influences not only individuals and communities but also development planners and funders (Green, 1999).

Western healthcare services have generally placed emphasis on an individual's physical or biological state, broadly labelled as the Biomedical Model of health¹. Many have criticised this approach, as it tends to look for one cause, with a specific treatment, effectively ignoring external factors that affect the health of a person (Capra, 1983).

The WHO (Elder, 2001) identifies that good health is a basic right, and is essential for social and economic development. To achieve good health requires "...peace, shelter, education, social security, the empowerment of women, a stable ecosystem, sustainable resource use, social justice, respect for human rights, and equity" (Elder, 2001, p.11). A frequent link to development is that health, or lack of good health, can significantly affect one's ability to be productive and contribute positively to society. The desire to increase health funding has at times required advocates to promote links between health and productivity, primarily indicating an investment in health via healthcare has positive outcomes on an individual's ability to participate in the production of saleable goods (Green, 1999).

Within developing countries patterns of health, illness, quality of life and mortality differ from those of developed countries (Elder, 2001). Poverty is considered to be the major determinant of health as it affects people's ability to access satisfactory housing, sanitation, water, education and employment. A significant consequence of inadequate living conditions is an increased incidence of infectious diseases as well as other diseases that are considered preventable. Poverty also reduces one's ability to access and utilise 'appropriate' healthcare (Kloos, 1994, p.200; Whitehead, Dahlgren &

¹ Biomedicine sometimes referred to as western medicine or cosmopolitan medicine is the dominant health care system in the western world, and its development has occurred hand in hand with science. It can be described as reductionist, in that its focus is on the body and how it works. The body is viewed conceptually as a machine, with wheels and cogs, disease is the result of a malfunctioning or breakdown, with the doctor as the mechanic and expert. Overtime, with the assistance of technology, the body has been viewed in smaller and smaller parts, from a beginning awareness of blood circulation, then microscopic to bacteria and viruses, followed in more recent times to aspects such as hormones and DNA. Frequently a specific cause of a disease was/is sought which then forms the basis of treatment, for example with antibiotics for an infection. Critics of biomedicine indicate that its narrow focus on the body means that other factors such as social relations, psychological and spiritual are ignored in the pursuit of a specific scientific explanation (Capra, 1983).

Gilson, 2001). Throughout the world young women and children are extremely vulnerable to experiencing situations of poverty (Elder, 2001).

Difficulty exists in obtaining social and health data in many countries creating problems for health planners and policy makers (Whitehead, Dahlgren & Gilson, 2001), but this has not prevented infant mortality data being used as a measure of a country's health status (and poverty status). The United Nations International Children's Fund (UNICEF) sees a greater indicator being the mortality rates of children under five (Kloos, 1994). Children experience a range of life threatening diseases, simultaneously or repeated attacks and scrutiny of likely causes of death reveals the complexity of situations. Many conditions persist into adulthood revealing that some short term approaches for children have a limited impact. To achieve improvements in health requires co-ordinated socio-economic and health strategies (Kloos 1994, p.20; Whitehead, Dahlgren & Gilson, 2001). In addition to the ongoing impact of childhood disease, adults in once isolated and more traditional societies now have the added burden of diseases associated with industrialisation and altered lifestyles. Smoking, alcohol consumption and altered diet, in particular processed diets, and reduced physical activity has led to what has been classified as chronic non-communicable diseases (NCD) for example certain cancers, non-infectious respiratory conditions and diabetes (McMurray, 2001).

Recently acknowledged, at international and national levels as a development phenomenon, is the issue of conflict and violence². Violence is considered a health issue (Momsen, 2004) which has consequences for all citizens, both short and long term, including physical and psychological harm, requiring different strategies aimed at all citizens (Chen & Berlinguer, 2001). It is believed that increased centralised control, commodity production and the undermining of social support structures, which are needed when people are anxious and fearful, are all significant factors in the increase in violence (Bandarage, 1997). Evidence has revealed the global extent of gender-based

² The existence of violence in developing countries is not new. Bandarage (1997) indicates that much of the Cold War conflict took place in developing countries. The accumulation of nuclear weapons was used (or threats given), in a number of incidents between 1947 and 1973 against people of colour. It is considered that without outside support (USA is cited as a key player) Third World dictatorships would not have had the ability to survive local opposition. A few countries provided resistance in the form of communist or socialist movements. Not surprisingly many industrialising countries are openly critical of democratic and human rights due their western origins. If some are correct violence will not disappear due to issues such as terrorism, national and environmental security (Hartmann, 1999, p.2). Hartmann indicates that population groups, have ceased on the "images of an overpopulated, environmentally degraded and violent Third World" with subsequent fears of increasing numbers of refugees which help to substantiate concerns regarding third world population growth being greater than first world..

violence but as Chen and Berlinguer (2001) indicate a cure to violence is not available in vaccines or drugs but requires, as a starting point, a change in attitudes.

Healthcare

The 1978 Alma Ata (Kazakhstan) conference led to the formulation of principles of PHC. The Declaration of Alma-Ata affirmed that health extended far beyond bodily functions and improvements in health required wide ranging strategies across diverse sectors of society, including environmental, economic and social factors (Asthana, 1994). By the end of the 1970s there was increased acknowledgement of the links between social justice, equity and health, recognising that people's health was influenced by political and economic decisions and actions.

Improvement in population health required actions beyond health service delivery (Eade & Williams, 1995) and required development ideologies and approaches to be broader than that of modernisation. Five key aspects needed to form the basis of health action: equity, prevention, appropriate technology, intersectoral action and community participation (Walt & Rifkin, 1990, p.14). Kabeer (1994) indicates that the achievement of these does not require significant changes in infrastructure; instead attention needs to focus health strategies on prevention and the inclusion of communities in developing strategies.

Whilst there is considerable credence given to prevention and disease management, curative services (secondary care) have tended to receive greater funding, giving the message that prevention is less important (Stein, 1997). The shift from larger urban hospitals to small rural centres has been difficult to achieve, despite recognition that considerable benefits can to be achieved from PHC, over secondary and tertiary health services (Walt & Rifkin, 1990). Since 1978, subsequent international health forums have seen the formulation of the Ottawa Charter (1987) and Jakarta Declaration (1997)³, which have re-emphasised the principle of health as a human right and essential for development. Elder (2001, p.11) is critical of aspects of these principles but not of the underlying importance.

³ The Ottawa Charter highlights the need to strengthen community action, develop personal skills, create supportive environments, reorient health services, building health public policy (1986). The Jakarta Declaration priorities are: the promotion of social responsibility for health (public and private); increased investment in health from a social perspective, for example through emphasis on education and quality of life that is relevant to needs of marginalised groups; partnerships between all groups including communities and policy makers to enable positive health promotion; attention to empowerment and capacity building and a secure health infrastructure (cited in Elder, 2001).

Despite the Alma Ata principles receiving virtual universal support, application has not been easy or rapidly forthcoming (Asthana, 1994) even though evidence indicated the western biomedical approach was not having the desired effect of meeting population health needs. Structural adjustment programmes (SAP), linked to aid money and country debt, were frequently imposed through organisations such as the World Bank and International Monetary Fund (IMF). The results were considerable reductions in state spending with healthcare being targeted for funding cuts; governments also encouraged private enterprise involvement (Green, 1999). One outcome of these changes has been the cessation in the reduction of mortality rates (Bandarage, 1997).

Green (1999) critiques the ideology of market involvement in healthcare, using Marxist economic ideology. He believes a system that requires people to pay and compete for healthcare ultimately results in some citizens being excluded due to an inability to afford access, resulting in a system of exclusion and discrimination. When this is considered in relation to the WHO view that health is a human right, one's ability to achieve a reasonable level of health should not be solely dependent on one's ability to pay.

Acquiring healthcare funding frequently means competition for limited resources and uneven distribution. Elder (1999) states that this commonly results in an imbalance of resources between hospitals and PHC, between preventive/promotive care and curative care, between different social groups, between different regions or geographical areas, between staff salaries and medical supplies, or between different types of staff such as auxiliaries and specialist. The consequences of this is that those with the greatest power can influence spending which is not always consistent with strategies for sustainable improvements in population health.

Many international aid agencies believed "...that given financial and practical constraints, governments of developing countries would be better advised to select and target diseases on the basis of prevalence, morbidity, mortality and feasibility of control" (Asthana, 1994, p.183). An outcome has been selective primary health care with particular emphasis on child health, due to the perception that this is cost effective. Selective targeting, for example, immunisation campaigns is generally based on decisions made at the top and imposed rather than based on local needs (Kabeer, 1994). Not surprisingly many campaigns have received criticism due to their limited approach and failure to address underlying disease cause as well as a failure to involve locals (Rifkin & Walt, cited in Asthana, 1994). When targeting specific health needs,

attention needs to be given to wider issues (Elder, 2001), for example immunisation programmes should be implemented alongside programmes that work to reduce poverty and inequalities.

Gender

Biological differences of genitalia, anatomy and hormones are key markers of difference between female and male, but also of importance are the social relations that surround and influence everyday lives and inform behaviours classified as feminine and masculine. Over the centuries the differences between women and men have been widely debated with credit given to different explanations at different times. Frequently argued is that one's biology determines behaviours, roles and status, therefore they are fixed (Broom, 2002). Many criticise these explanations, believing they perpetuate inequalities and maintain the status quo (Broom, 2002). An outcome of biological determinism is that common or learned behaviours result in prescribed opportunities, roles and responsibilities (WHO, 1998) which fail to acknowledge the role of society in socially constructing differences. "...[G]ender is much more than the socialized relations between individuals [i]t is a key form of social stratification" (Östlin, George & Sen, 2002, p.175). Gendered differences influence one's abilities to access valued resources such as income and services, resulting in differentials in health and education (Kickbusch, 2001)⁴.

The existence of divisions of labour, both within the household (private) and outside (public) clearly demonstrate gendered activities and responsibilities (Östlin, George & Sen, 2002). Despite considerable rhetoric women's work cannot be reduced to discussions of domestic work and reproduction through the utilisation of biological determinist explanations (Pettman, 1996).

Incorporating Women into Development

Development approaches utilised over the years have been influenced by the dominant thinking of the day. At times all women have been viewed through a universal lens and programmes targeting women were based on biological or social roles which assumed mothering was central. This has been broadly described as a

⁴ Education and literacy are key determinants of health. Kickbusch, (2001) claims there is an abundance of reports from developing countries which highlight the benefits of both of these, for women's and children's health. More recently ideas of literacy have broadened from that of reading, writing and arithmetic to one that "...accounts for complexity, culture, individual empowerment and community development" (Kickbusch, 2001, p.292), all of which link with health promotion directives as identified by the Ottawa Charter (1968).

welfare approach (Moser, 1989). Ideologies of mothering and gender roles tended to reflect western beliefs, which then became the basis of development strategies. In post-war western societies the 'ideal' roles promoted for women were childbearing and homemaking which resulted in women being financially (and often socially) dependent on men.

Boserup's (cited Rathgeber, 1990) work in the 1970s gained attention because she analysed differences between women and men's work (primarily in agrarian societies) arguing that women *were* involved in production. She also explored issues such as how development effected gendered divisions of labour. She concluded that while women's work continued to be viewed in terms of reproductive roles, women's status would remain marginal. Thus it was essential that women's economic activities be acknowledged and included in development (Kabeer, 1994).

American feminists in their drive to reduce women's disadvantages coined the concept of Women in Development (WID). By the 1970s it was apparent the promoted 'trickle down effect' was not evenly distributed and that development activities effected men and women differently. Egalitarianism, it was thought, could be best achieved by the integration of women into the economy therefore the key to overcoming inequities was to pursue how best to get women into paid employment. Policy makers needed to facilitate women's employment as it was thought economic growth and subsequent improved services such as education and health would enable, overtime, the whole population to benefit. Strategies to address women's workload focused on women's productive work placing an emphasis on teaching women the necessary skills for employment, such as how to access credit and technology, rather than challenging structural or social relations that subordinated women (Rathgeber, 1990). The prevalent assumption was that if women had the ability to access income societal imbalances would be alleviated (Rathgeber, 1990).

WID reviewed the diversity of women's activities across cultures in an attempt to challenge assumptions that linked biology and ascribed divisions of labour, thereby arguing against universality, they also emphasised the need to disaggregate research data. The need to efficiently utilise resources and make women agents, rather than recipients, of development placed women squarely on the development agenda (Kabeer, 1994).

A criticism of WID arguments for equal opportunities was that they downplayed aspects of women's realities that were a consequence of biology resulting in an

indifference "...to the social implications of biology" (Kabeer, 1994, p.28). Whilst WID focused on changing policies so that women were included, they overlooked the implications of women's reproduction that resulted in family and community responsibilities. The failure to challenge the uneven distribution of power and resources and the uneven spread of the global economic system were also criticisms (Kabeer, 1994). Some Third World women were also critical of First World women's ethnocentric solutions.

The mid-1970s saw the emergence of Women and Development (WAD) of which women's subordination was a central focus. The emphasised need to include women in the paid economy was viewed more as a need to maintain the relationship of Third World dependency on First World countries, which perpetuated global inequalities. Consequently the focus centred on the relationship between development and women, acknowledgement was also given to the status of Third World men (relative to First World), but it appears that local gender relations were not explored (Rathgeber, 1990).

WAD considered the concept of class important but did not view a linkage between race, ethnicity, gender and class as significant (Stein, 1997) which had a tendency to homogenise the diversity of women. There was no real exploration of issues such as patriarchy, organisation of capitalism or women's inferior social status and oppression. The assumption was that an improvement in women's status would result from equitable structures in society. The limited voice of women in social institutions, such as economic and political, was not linked to the gendered relations that existed in society. WAD and WID concentrated on economic and political factors relating to women's employment participation, but largely ignored women's private lives. Implementation of WAD ideology was difficult, as outcomes were hard to measure. Expectations required power shifts which some argued was "...unacceptable interference in [a] country's traditions" (Moser, 1989, p.1811).

The late 1980s saw new approaches emerging attempting to link women's reproductive roles with all aspects of their lives. Importance was given to understanding how society shaped people's lives (women's and men), assigning specific roles, recognising that realities were socially constructed and not fixed. Notions of development advocated by Gender and Development (GAD) saw women as change agents rather than passive recipients of aid. Attention was given not only to the private sphere as it was believed the state had a role to play in promoting women's participation and freedom. For women to be effective agents of change they needed a political voice,

this required mobilisation and solidarity. Women's legal rights became an important focus, one that challenged traditional custom and political systems alike. A GAD approach questions fundamental structures of society including how power is acquired and maintained by elite groups, and the effect this has on those (women and men) with less power. Development actions thus require strategies that enable the sharing of power as well as structural change (Rathgeber, 1990).

It is possible to see similar shifts between women's development and the direction of health and development. An initial focus on women's health was one which emphasised women's biology and their role as mothers, in health programmes such as nutrition education and population control. More recently women have been more actively involved in identifying their own needs and solutions leading to a diversity of health related projects, for example the linking of domestic violence, societal inequities and power structures. There is a need to identify how these effect women's health and what multiple level actions are needed to achieve the desired outcome. The latter is more consistent with PHC principles.

Identifying Realities

Lewis and Kieffer (1994) believe societal and biomedicine's views of women's health are narrow. Historical evidence reveals that women have often been excluded from participating in medical research (Broom, 2002) except in the area specifically related to reproduction and childbearing. This has hindered the ability of practitioners (health and development) to respond effectively to women's health needs (WHO, 1998).

An understanding of women's health requires an understanding of the gendered nature of society. Inequality based on gendered prescriptions can either constrain or enhance one's ability to access economic and social resources. This is frequently evident in the area of income and wealth distribution as approximately seventy percent of the worlds poorest are women (Marphatia, 2001, p.2). Even when women are able to achieve an independent income the amount is commonly 75 percent of males' income (WHO, 1998, p.2). Feminisation of poverty exists in both developed and developing countries, but it is more evident in developing countries (WHO, 1998). Societal and structural inequalities increase women's vulnerability to illness, ability to access health services and the quality of care received (de Koning, Derbyshire, Dickson, Dockery, Doyle, Gilks, Kemp, Martineau, Price, Squire, Standing, Thomas & Tolhurst, 1998). Working to overcome this requires change in areas as diverse as political and economic

structures and cultural beliefs and practices, all of which effect behaviours (Price, 1994, p.139).

Women 'rights' have often been limited, due to unequal legislation in areas such as marriage, divorce and ability to access resources. Since the mid-1970s and the UN Decade for Women, there has been increased attention given to women's realities. Documentation of women's subordination and oppression reveal links to legislation and politics, in and between states. What has tended to happen is that women's needs and issues have been articulated as special needs influencing programme development, but this fails to address the gendered nature of societies, funding agencies and societal structures (Pettman, 1996).

Women's relationships with the state have varied. Pettman (1996) states women are frequently invisible in state decision-making and actions. Despite opportunities in some societies to exert considerable power and influence within families and sometimes communities, women are far less able to influence government decisions. This is partially linked to the private public debate regarding gendered spaces in society (Nussbaum, 1995, p.99). Pettman (1996) asks "...[if] women are overwhelmingly absent from state power, and state political constructs are masculinist, where are women in relation to citizenship" (p.15)? There are a number of facets to citizenship, including membership, rights and participation. Many western feminists have argued that women have been excluded from full citizenship by explanations of 'unsuitability' based on biology, assumed inability to reason, emotional predisposition and disruptive tendencies (Pettman, 1996).

Women's work of reproduction, production and community are what Moser (1989) aptly labels, women's triple roles and burden, and demonstrates women's work extends over many roles and long hours. Women are often involved in a wide range of community activities, including taking responsibility for the allocation of scarce community resources and organisation of groups working proactively for change. For many, workloads have increased for example caring for sick or elderly relatives, as a result of SAPs imposed by international and national elite (Bandarage, 1997).

The marking of women's work as natural enables decision makers, predominantly men, to ignore them resulting in a lack of planning to correct inequalities (Kabeer, 1994) thereby maintaining the status quo. Stein (1997) indicates that women are often treated in development as minor or less important members of male-headed household which fails to acknowledge their significant contributions to family. Development

strategies affect women, indirectly, such as in rural areas men's agricultural workloads and productivity have received assistance through the provision of machinery but subsistence work of women is ignored. This has resulted in women becoming more dependent on men for their survival (Stein, 1997).

Women's lack of power and status is evident in religion, for example in Catholicism there has been a long history of women's relegation to a 'lesser status' than men. Based on particular beliefs women have not been eligible to become priests due to their lack of 'seriousness'. Gardner (2001) describes the apostles, Peter and Paul's, apparent aversion to women resulting in regulations that strategically limited women's status whilst allowing males to dominate. The Catholic Church's actions are at times contradictory, for example in Brazil it has facilitated the development of women's movements, feminist campaigns and assisted with activism on issues of social justice and equality (Bandarage, 1997). Yet it has opposed calls for family planning, contraception and abortion (Bandarage, 1997). Another factor that is linked to women's status is violence; of particular relevance is domestic violence. Violence, often considered in physical terms, can extend to neglect and psychological abuse and involves a relationship of power or force, regardless of whether threatened or implemented (Momsen, 2004). The WHO (1998) describes all acts of violence as gendered, regardless of the victim's identity but accurate information regarding the extent is hard to obtain. Males disproportionately perform violent actions, the underlying reason for this is unknown but it is thought that men, as perpetrators of violence, can be motivated by a desire to express power and control (WHO, 1998). There does seem to be consistency in the view that violence is greatest in societies with significant inequities, rapid social change and situations of poverty (Price, 2003; Momsen, 2004). Kabeer (1995, p.149) identifies "...that vulnerability to sexual harassment and domestic violence is an aspect of the gendered nature of poverty" and is widespread. Momsen (2004, p.93) describes study findings, involving 23 transition and developing countries, where only nine percent of respondents from poor households reported that domestic violence was rare, which leads one to assume that 91 percent thought it common.

Women's health has traditionally been linked to women's reproductive roles resulting in attention focusing on MCH (Green, 1999) due to the view was that "what is good for the child is good for the mother" (Rosenfield & Maine, cited in Kabeer, 1994). In the 1980s, UNICEF indicated that these strategies had saved the lives of some four

million children (Price, 1994, p.142) but later broadened approaches to include 'mothers', for example birth spacing and education (Price, 1994). The WHO Safe Motherhood Initiative (SMI) in 1987 clearly indicated the need to include aspects of women's health in the MCH equation, but even in the 1990s language around targeted actions continued to emphasise the child (Price, 1994).

A shift to including women's health has predominantly meant reproductive health but attention is predominantly women's reproducing years, ignoring the fact that females are vulnerable at all ages (Price, 1994). The prepubescent period is vital for ongoing health and can influence birth outcomes. Failure to achieve maximum health can impair a girl's growth and anatomical development, which has negative consequences during pregnancy and birth for both the mother and child. It can affect the progress of labour and birth and ultimately lead to the death of both (WHO, 1998). Poor health includes malnutrition, both acute and chronic infections, as well as NCD such as hypertension and diabetes, which are all exacerbated by pregnancy. When combined with often heavy and arduous physical work during pregnancy the incidence of morbidity and mortality associated with childbearing increases significantly (Middleburg, 2003).

Concerns about maternal and infant morbidity and mortality have meant that women have been targeted for family planning. Links have been demonstrated between women's increased education and literacy levels and increased family planning, resulting in decreased infant mortality and morbidity rates (Middleberg, 2003). The shifting of resources to ensure girls and women are educated (Petchesky, 2003) does not automatically ameliorate the myriad of social and cultural factors that result in inequities.

Childbearing at a young age and increased pregnancies are two significant maternal risk factors (Lewis, 2002) thought to account for as many as one third of the world's total infant mortality (Price, 1994, p.142). In 1990 the World Bank estimated that an annual investment of US\$2 per person would be sufficient to halve this rate (Price, 1994, p.151), as repeated pregnancies significantly affect a woman's health and the overall ability to sustain a viable full term pregnancy. It is estimated birth spacing should optimally be greater than 24 months (Price, 1994, p.149).

Debates about population and family planning have frequently been contentious as they encompass issues of rights, national sovereignty and inevitably incorporate both social and cultural norms and values (Johnson, 1995). The ICPD (1994) included a wide range of attendants including non-government organisation and religious groups.

The formation of an alliance between religious groups and tensions between USA representatives and the Vatican lead many to believe that consensus was unlikely (de Jong, 2000). Conference principles reveal a shift from Neo-Malthusian⁵ concerns to a greater focus on individual women's reproductive and sexuality rights. They identify the need to address: the consequences of sexuality and reproduction in women's health; gender relations as a key factor in reproductive decision making and sexual behaviours; and population health within the settings of social context and justice (de Jong 2000). These provide a mandate and a challenge for the future of reproductive health strategies (Johnson, 1995). Some commentators believe that a translation of the ICPD agenda maybe difficult cross-culturally, including meanings of gender, sexual health and empowerment (DeJong, 2000) as it cannot be assumed that a universal notion of rights exists (Petchesky, 1998).

Since 1994 many countries have made positive changes to health policy, gender equality and equity. Progress related to abortions, sexual and reproductive rights and male responsibility have been less positive. Corrêa (1999) notes a number of obstacles exist including "...cultural and religious resistance, lack of clarity, institution inertia, policy design and resource allocation: the challenge of health reform [and] the 'enabling environment': political, economic and social aspects" (p.22). Attempts were made to place issues such as abortion under the umbrella of health rather than moral, cultural or political but despite this they have remained controversial (Haslegrave, 2004).

Sexuality and sexual health can be significant societal issues. In societies where male desire and control over 'passive women' take precedence, it is difficult for women to express their sexual needs, ability to be safe, have control of sexually transmitted diseases (STDs) or pregnancy (WHO, 1998). If a perceived threat of violence exists, the risk of unsafe practice may be a lesser priority than the (potential) more immediate consequences (WHO, 1998). Cultural beliefs about the women's roles and place in

⁵ As early as 1789, Reverend Malthus believed that virtually all problems of society could be linked to population increases and thus advocated the need to control (Bandarage, 1997). His ideas regained prominence in the post World War II era when Neo-Malthusian ideology played a dominant role in policy making (Corrêa 1994) as it was considered that population growth, poverty, environmental destruction and political unrest were all interrelated (Hartmann, 2001, p.3). India received much attention; some believing that population growth hindered the transition from agricultural to industrialisation and thus modernisation. In the 1950s efforts to control population lead to family planning programs that targeted Indian peasants (Hodgson & Cotts Watkins, 1997). During the late 1950s trials of the oral contraceptive pill were occurring both in South America and USA. By the 1960s enough support had been gained, for the US, to introduce an international policy of population control which overtly stated their concerns about the high fertility rates of women world-wide (especially third world countries) and that the only solution was to limit family size through planned parenthood. Hodgson and Cotts Watkins (1997) indicate no recognition was given to potential infringement of reproductive rights for women, especially those in the third world.

society, as well as shame (as there are tendencies to blame the woman) and self-blame often result in a code of silence about STDs. These all result in a potential for an increase in negative health consequences both physical and emotional.

Women have difficulty escaping, reporting or removing themselves from unsafe conditions; this may be due to economic circumstances, fear of not being believed or victimisation (WHO, 1998, ch.3). Health consequences of 'gender based' violence include:

- physical: STDs, injury, unwanted pregnancy, miscarriage, headaches, gynaecological problems, asthma, irritable bowel syndrome, injurious health behaviours (smoking, unprotected sex) and alcohol and drug abuse
- mental: post-traumatic stress disorder, depression, anxiety, sexual dysfunction, eating disorders, multiple personality disorder, obsessive compulsive disorder
- fatal: HIV/AIDS, suicide and homicide (Heise, Pitanguy and Germain, 1994, cited in WHO, Ch3).

All of these come under the umbrella of reproductive health, the incidence and prevalence of many of these reveals that they are more than a personal problem, rather they are a social issues (Wright Mills, 1995; Willis, 2004) that needs attention.

Women and men experience reproductive health issues differently, for both groups the consequences can be fatal. It is argued that women can not exercise their rights, including reproductive health rights in conditions that are not empowering. This requires local, nation and international changes (Eade & Williams, 1995). At the local level it may be the availability of transport, or family supporting her attendance at school, nationally it may involve the promotion of PHC universally and globally it may be revision of debt servicing (Eade & Williams, 1995).

An area of reproductive health that is often ignored is that of ASRH, which the WHO (2004a) indicates is relatively new. "Reproductive health is a lifelong process the decisions you people make have an impact on their current and future health" which makes this vital issue is any country but more so in developing countries where information can be harder to access (Family Health International, 2004). Emotional and physical changes are the hallmark of adolescents, for females and males it also the time when they start to consider independence, sexual relationships, they seek information and clues about appropriate behaviours. But not all information is correct, and some is misleading. Programmes should include discussions related to gender and sexual roles and relations, address gender differences and issues of gender equity (WHO, 2004a).

When these are combined with needs and solutions identified by adolescents, the potential to improve the overall reproductive health of both females and males exist.

Current Ideology

Gender analysis is important as it enhances positive planning for change. An anticipated outcome of analysis is "...to overcome inefficient resource allocation" (Miller & Razavi, 1998, p.6), this is not easy or without problems. The aim is to gain a comprehensive understanding of realities enhancing the ability to address gender inequalities (Gender in Development Programme, 2001). Gender analysis should not be used to exclude aspects of inequality and exclusion, in particular class, location, occupation and race (Miller & Razavi, 1998).

In view of the principles and aims of PHC as well as the links between violence, centralised power and diminished social supports the more recent shift to community empowerment as a strategy for improving health should not be overlooked. Community empowerment has many definitions but three key factors exist: it is a process, it is collective in nature and the third being an outcome of increased community capacity in the areas of knowledge, skills and resources, thus reducing the overall vulnerability of those involved (Middleberg, 2003). Middleberg (2003) identifies that there is a tension between community empowerment and targeted areas of health.

The aim to improve quality of life and life expectancy for women can be effectively incorporated in PHC principles, in association with community involvement. This places emphasis on:

- increasing women's socio-economic, legal and education status of women;
- providing accessible and appropriate family planning;
- ensuring antenatal to postpartum services that provide regular checks by trained birth attendants (TBAs) incorporating health promotion principles and last but not least;
- access to safe obstetric emergency services (Price, 1994).

Women's ability to access healthcare varies considerably, due to factors such as economic, geographical limitation and socio-cultural restraints such as women learning that suffering is part of being a woman. Limited self-esteem and embarrassment of the woman, and family / community disapproval compound this situation (WHO. 1998). In areas such as domestic violence, rape and STDs female aid workers, in participation

with local people, have worked toward change utilising information sharing as a key strategy (Kabeer, 1995, p.233).

To improve women's health, diverse strategies need to be utilised giving recognition to societal and political factors that can influence health status. This requires collaboration with local people and incorporation of PHC principles. Considerable benefits exist in recognising and including local and cultural practices that are beneficial, and acknowledging those that maybe harmful (Eade & Williams, 1995). This requires care and consideration of power structures including identifying those with vested interests.

Culture and Childbearing Beliefs and Practices

Identifying behaviours and norms requires an understanding of the centrality of culture which is important as it enables greater sensitivity and responsiveness to differences. The need to address human rights and social justice when working with individuals, communities and groups, requires cultural and social factors to be acknowledged and valued (Leininger, 1994). Health, illness and childbirth are all influenced by culture as they are expressions of cultural knowledge, norms and values (Leininger 1994). Leininger (1994) identifies that health and illness behaviours are "...linked to cultural, ecological, political, economic, religious, social and kinship factors" (p.23). Whilst health professionals may hold ideas and knowledge related to definitions and causes of 'problems' this may be different to the understandings of individuals and communities within which one is working (MacCormack, 1982).

To facilitate good health one needs to understand local causes of ill health and culturally defined responses. Protecting oneself from poor health may entail the use of specific objects worn or strategically placed in the home, substances may be consumed, and rituals, prayer and burning of candles are other strategies (Spector, 2004). The western biomedicine system is but one example of a healing system that is culturally determined.

Dundes (2003) indicates that "[o]ne might logically but incorrectly assume that human birth is essentially a 'natural' phenomenon, biologically and physiologically determined to a degree making the details of parturition more or less universal" (p.1). Depicting childbirth solely in biological or natural terms fails to recognise the influences of culture and society on women's experiences (Oakley, 1980; MacCormack, 1982). Childbearing is influenced by the setting in which it occurs, meaning the

experience is not solely determined by the individual or their biology (Bates & Newman Turner, 2003).

The studying of childbearing by anthropologists (Kay, 1982), has at times been hindered by the use of culturally (western) determined categories of pregnancy, labour, delivery, and puerperium⁶. These are far from universal classifications and can be confusing, for example, the beginning of pregnancy may be classified at different times anywhere from the beginning of the last menstrual period, in some cultures, up until 120 days later in others.

Understandings as to how or why conception occurs and how the body functions vary. For the Tamil people of Sri Lanka menstruation is understood as the flowering ...of an open uterus, is seen as a monthly safeguard, draining away women's excess strength and desire so that men remain socially dominant. Semen is made from blood, and men seek to store it as a way of promoting their physical, and ultimately spiritual development, rather than letting it drain off into too much sexual activity...For fertilization to occur, both partners must achieve orgasm so that both male and female fluids can be ejaculated into the uterus...Menstruation ceases during pregnancy because all woman's 'excess blood' is needed to nourish the fetus. (McGilvray in MacCormack, 1982, p.4)

This description incorporates cultural knowledge of how the body works as well as women's and men's position within society and is very different to that of western biomedicine that focuses on aspects such as hormones, ovulation cycles, body temperature, and sperm motility.

Many belief systems exist around the world that are locally interpreted and applied. For many people a range of alternative healing systems may coexist and be used interchangeably or to complement each other. Descriptions can be found of women combining aspects of, what have been classified as, personalistic and naturalistic (humoral) healing systems⁷ (Cosminsky 1982). Culture and religious beliefs

⁶ Puerperium is the time following birth, in western terms from the time of the birth of the placenta until the end of the sixth week.

⁷ Sullivan (2001) indicates there a range of explanations regarding causes and subsequent treatments of disease and ill health. A personalistic health system is based on animistic beliefs. Disease is unnatural and can be caused by outside forces such as spirits, ancestors, at times living people as well as someone doing something that is considered wrong or bad such as an infringement of a taboo upsetting a spirit. A range of healer may exist including shaman or diviners. Alternatively in a naturalistic healing system disease is considered to result from a more natural process. It is believed that the body is comprised of a number of elements, thus if these are in balance one is healthy. Ill health occurs as a result of disequilibrium, internal or external. Healers may be herbalists or physicians.

maybe closely intertwined and it is not uncommon that aspects of childbirth are linked to religious beliefs (Bates & Newman Turner, 2003) with the healer and priest being one and the same person. For Cuna Indians of Panama, a midwife may call a shaman if the labour and birth was difficult (Bates & Newman Turner, 2003). An epileptic fit maybe thought to be due to spirit possession or caused by spirits (Kitzinger, 1993).

Attitudes surrounding pregnancy vary greatly; in some cultures children play games imitating aspects of conception and birth, whilst other cultures go to great efforts to maintain secrecy and privacy about all facets of reproduction. To maintain secrecy birthing may be a taboo subject, births maybe hidden and even witnessing an animal giving birth may be prohibited (Newton & Newton, 2003). Women in Nigerian generally keep their pregnancy secret as long as they can, being fearful of a barren women's envy, or the evil eye, which may cause harm or miscarriage (Adetunji, 1996).

Traditional midwives may use strategies to help keep the woman safe such as the woman wearing an amulet for protection. Alternatively a special mixture of "...coconut sprouts, herbs and eal-heads" may be mixed to an oil consistency and applied to parts of the woman's body, another deterrent may be a combination of rice, salt, turmeric, tamarind and soot scattered around the house (Lefèber & Voorhoeve, 1998, p.25).

Equally important might be the need to maintain the woman's body in a state of balance requiring actions by the woman as well as those around her (Cosminsky 1982). Pregnancy maybe considered a hot state due to the increased amount of blood (hot) within the woman's body requiring certain foods to be avoided or consumed, as an overheated state is considered harmful. Goldsmith (1990) indicates that for Gros Ventre women heat is to be avoided, thus precautions when cooking are required, such as the wearing of heavy apron.

Rules about sexual intercourse may exist. Some cultures believe semen nourishes the infant, in other cultures sexual intercourse is forbidden during times of menstruation and for a period following birth as women are thought to be 'ritually unclear' or their blood to be dangerous to men (Kitzinger, 1993). Following birth, Enga couples (New Guinea) are required to adhere to a 'prolonged' period of sexual abstinence lasting for two or more years. Semen is thought to hold potent war magic and if mixed with breast milk can lead to death of this infant and maybe the next (Gray, 1982). Similarly rules prohibiting sexual relations during breastfeeding have been described in traditional Kanak society (Tabet cited in Salomon, 2002).

In many cultures the placenta and umbilical cord have specific meanings and require prescribed actions. Many believe it is important not to cut the cord until after pulsation has ceased (Lefèber & Voorhoeve, 1998). Pondo women of South Africa use a range of practices one of which is putting colostrum on the umbilical stump, but as Goldsmith (1990) indicates whilst sounding strange it has antibacterial benefits. Many cultures cauterise the cord, but these and other practices have been criticised on the basis of 'other knowledge' (Cosminsky, 1982) as practitioners often carry ethnocentric ideas of worthiness and perceived benefits of their own practices over traditional practices. There is evidence suggesting they are not always have better outcomes (Dundes, 2003).

It appears that a shift in practices often occurs following contact with outsiders, an example is that of labouring and birthing positions. Traditional practices often include vertical positions favoured by women of Papua New Guinea, such as squatting, sitting and kneeling (Fiti-Sinclair, 2002) other positions may include lying supported in a hammock (Jordan, 1993). Priya (1992) indicates that in Sumatra contact with western obstetrics has lead to some notable changes for example women lying on their backs, perhaps due to the perception of being modern, but not all cultures are convinced of biomedicine's superiority. Priya (1992) expresses concerned that it is "...yet another example of how totally inappropriate methods are being exported to third world countries" (Priya, 1992, p.80). She indicates that as the west begins to realise the physiological benefits of being upright to give birth, the less efficient western ideas are taking hold in developing countries.

Western societies should not be viewed through a lens that precludes critique of childbearing beliefs and practices. Many practitioners have been greatly influenced by biomedical ideology with explanations of actions and recommendations authoritatively given, supported by empirical evidence. The use of science to support strategies which are often couched in terms of 'safety' to mothers and infants are also criticised as reducing birth to a biological act, which is fixed and universal. It could be argued that empirical or scientific knowledge is also a form of cultural knowledge, which does not exclude it from debate (Capra, 1983).

In the United Kingdom childbearing is largely situated within the medical arena (Henley-Einion, 2003). This means that the medical fraternity sets the norms, for example, of giving birth in hospital with a doctor in control. Physiological processes largely define reproduction and childbearing. This reductionist approach justifies

regular medical surveillance to detect deviations from medically defined norms. The ability to monitor the body legitimises intervention during this time of 'potential crisis'; thus childbirth is only viewed as normal in retrospect (Henley-Einion, 2003).

Many western biomedical childbearing rituals and prescribed behaviours exist (Mallet, 2002). Examples include ultrasound of the foetus, attending antenatal classes, vaginal examinations to check progress of labour, the shaking of the obstetrician's hand and the giving of thanks for 'his' job well done. Rarely if ever did a woman enjoy the prospect, let alone the reality of being placed in the situation of being required to lie on her back with legs apart and genitalia displayed all of which go against the norms of appropriate societal behaviour (personal communication).

Mallet (2002) describes the practices of one western trained health profession whom she says 'presided over' the women not seeking their opinions, examining, measuring and utilising his expertise, exerting his power and authority. Jordan (1993) cited women as indicating that once they entered a western medical facility their ability to make personal decisions was limited, they experienced a loss of control and were aware of health professionals' use of authority. A consequence of labouring in a supine position is a loss of control (Jolly, 2002).

Biomedicine does offer a wide range of technologies to monitor and test the health of mother and foetus, as well as intervene if 'things go wrong' which have positive benefits (Priya, 1992). Western societies have become increasingly technological and the arena of childbirth is not exception. Jordan (1993) reminds us that 'appropriate technology' is important in PHC but technological up scaling tends to create particular biases in health service delivery, which development planners need to be aware of. For example there is a tendency for one-way referral systems, from primary to secondary, which may lead to unnecessary and inappropriate use of healthcare finances, especially if the perceived benefits are not forthcoming (Jordan 1993).

The availability of technology has other downsides. In societies where sons are valued, sex discrimination has led to selective abortions of female foetuses, following pregnancy ultrasound (Eade & Williams, 1995). Technology, both maintenance and utilisation require considerable expertise and come at great costs, some costs extend beyond financial to that of social, through inappropriate use, loss of valuable skills and expertise including indigenous knowledge.

Timor-Leste - Health and Childbearing

“Health outcomes in Timor-Leste are among the lowest in East Asia” (World Bank, 2003, p.vi), it is not surprising that health, including maternal health, is clearly identified as an important development issue. The WHO (1998) identifies the need to be sensitive to Timorese culture. The western world has not always done this, and within its own environs some have seen the need to develop the concept of Cultural Safety⁸ (Ramsden, 1993) as a strategy to work toward identifying and working with issues of difference.

During the transition to independence, a number of international agencies assisted in the financing, management and review of health services. Formal health service delivery was virtually destroyed during the conflict, which occurred in the lead up to, and following, independence from Indonesia. The redevelopment of the health sector needed to include immediate delivery of basic services and a need to look to the future, to ensure that sustainable strategies are developed and implemented (UNDP, 2002).

The limited involvement of qualified professionals during childbirth is seen to have a strong correlation with the high maternal mortality rates of 420 to 850 per 100,000 births which is double that of any other South East Asian or Western Pacific country (UNDP, 2002 p.1). It was estimated that the number of midwives available was 196 following independence, down from 600 during Indonesian rule (UNDP, 2002, p.1). Also of significance is the fact that on average the number of births for a woman is eight (Hull, 2004). It is thought that having three or more births with spacing less than two years places women and infants at higher risk of harm (Dixon-Mueller & Germain, 2000).

The health and wellbeing of Timorese women reveals that many suffer from a number of conditions including a high incidence of malaria and anaemia. The frequent pregnancies and associated risk of postpartum haemorrhage, coupled with the lack of services in rural areas indicates that childbearing women are vulnerable. The health of children, many of whom are malnourished, increases the likelihood of impaired development, which subsequently affects childbearing outcomes for the next generation (UNICEF, 2002, p.1). Health strategies for 2003-2005 include improved availability of

⁸ Cultural Safety emerged initially in New Zealand in the late 1980s. Cultural Safety objectives were directed at educating potential nurses and midwives to shift from a victim blaming approach, requiring health professionals to self reflect on their own beliefs, values and realities. There is a need to be open and flexible in attitudes and service delivery. Ultimately Culturally Safe practice is determined by the recipient of health care (Ramsden, 2005).

skilled midwives, improvement of emergency services and the promotion of family planning (UNFPA, 2002, p.28) with an overall aim to improve reproductive health.

The status of women is reflected in the high, and rapidly increasing rates of gender based domestic violence, which is thought to affect all families (UNFPA, 2002). Wife beating is said to be partially the result of the culture of violence and trauma that has been experienced in recent years. The severity is so great that over 50 percent of married women indicated that they felt unsafe in their marital relationship (Boudre, 2004, p.1).

Conclusion

Development as an ideology has never been straightforward, like health, gender and childbearing it involves a range of beliefs and practices, which have changed over time and place. A dominant factor in development has been economic growth and an assumption that an improvement in the wealth of a country, through its ability to produce and export goods, will have a trickle down effect to all citizens. This approach has been argued as too simplistic, benefiting some and not others.

If an improvement in birth outcomes is to be achieved, for any country or region, many factors need to be considered. The complexity of healthcare incorporates a wide range of factors including availability of health services, affordability and appropriateness. PHC is considered to be a cost-effective approach to meeting population and local needs, over that of secondary services. The latter have tended to gain not only greater funding but also greater support from governments and international agencies. Centralisation of health services often means the most vulnerable people in society miss out. There are many social, cultural and environmental determinants of health which need to be considered and it is thought that an integrated and co-ordinated approach is more likely to be successful.

Over the decades women have had limited input into development projects and it is said that all projects effect women in some way. As women are often represented in those identified as vulnerable, it is essential to include women and women's knowledge at all project stages, from planning to evaluation.

Not to be overlooked is the importance of cultural beliefs and practices of individuals, communities and societies. These encompass every aspect of daily life, including reproduction. If attention is to be given to reproductive health, childbearing is likely to be a key focus if past and present experiences are anything to go by. This will mean that many development strategies will be planned and implemented under this

umbrella. It has been shown that selective targeting of health programmes has not always had the benefits that were anticipated. Also of limited benefit is the direct transferral of projects, unchanged, from one population to another, as insight into local beliefs and practices as well as locally identified needs are all vital aspects to be addressed.

If the aim is to increase the numbers of women utilising healthcare services and thus improve maternal and infant mortality and morbidity it is essential that every attempt is made to ensure health services are viewed as appropriate by women. Until this occurs they will continue to be under utilised. Failure to address and respond to cultural issues in the development and provision of health services ultimately means the failure to meet the WHO belief that health is a basic right (Elder 2001).

Current development ideology indicates that involvement of individuals and communities at all stages of a project increases the likelihood of positive outcomes. This being the case it is important that care is taken to ensure that women are included, particularly those that are intended to be the recipients of project benefits. This requires that attention is given to ensuring that barriers to participation are considered and overcome.

CHAPTER THREE

Timor Leste

Introduction

The history of Timor-Leste tells the story of its people today, people who have shown a strength and determination to survive. They have demonstrated a resilience that persisted over centuries, culminating in independence in 2002. The people of this small country have experienced outsiders exerting power and control over them for centuries, but international recognition of their right to be self governing has finally be achieved (Marker, 2003).

Traditional Timorese society was hierarchical headed by chiefs. Status and rights were inherited and gendered norms clearly marked rights and expectations (Taylor, 1995; de Sousa, 2001). The practice of dowry as payment for females in marriage unions continues to exist today. Large proportions of the population have always been reliant on agriculture for their survival, which is subject to the dictates of nature, both geographically and climatically. The weather and terrain have a major impact on production techniques and produce (Taylor, 1995).

The arrival of the Portuguese and Catholic missionaries in the 1500s has had a lasting effect. Prior to the arrival of missionaries animist beliefs and practices dominated, but by the end of the 20th century Catholicism had become the dominant religion (de Sousa, 2001). During the time of Portuguese colonisation and Indonesian occupation influential and administrative positions were largely in the hands of the ruling group, leaving the local people with little authority resulting in diminished opportunities. Today this has left the country with reduced expertise as opportunities for acquiring knowledge and valued skills were not evenly distributed. Education and other formal structures have, at times, been used as tools of control and indoctrination (Inbaraj, 1997; Jardine, 1999). A country that has been largely devoid of development over the centuries, and the recently destroyed infrastructure means the need for support will continue for many years.

The rebuilding of the nation including an infrastructure that meets functional and cultural needs of the people is essential. Individuals and agencies assisting at this crucial time need to be aware development is neither uniform nor universal. Workers in a country other than one's own need to take time and responsibility to acquire

awareness and understanding of what has gone on before, as the past significantly effects the present and the future.

Geography and Climate

Timor-Leste is located to the north of Australia and west of New Guinea, being part of the Lesser Sunda Islands. To the north of the island is the Wetar Strait and south is the Timor Sea. Alternatively it is described as lying at the south-eastern end of the Indonesian dominated archipelago. The 14,610 square kilometre area, formerly known as East Timor, comprises the eastern half of the island (the west belonging to the Republic of Indonesia) as well as the small enclave of Oecusse, and the islands of Atauro and Jaco (de Sousa, 2001, p.183).

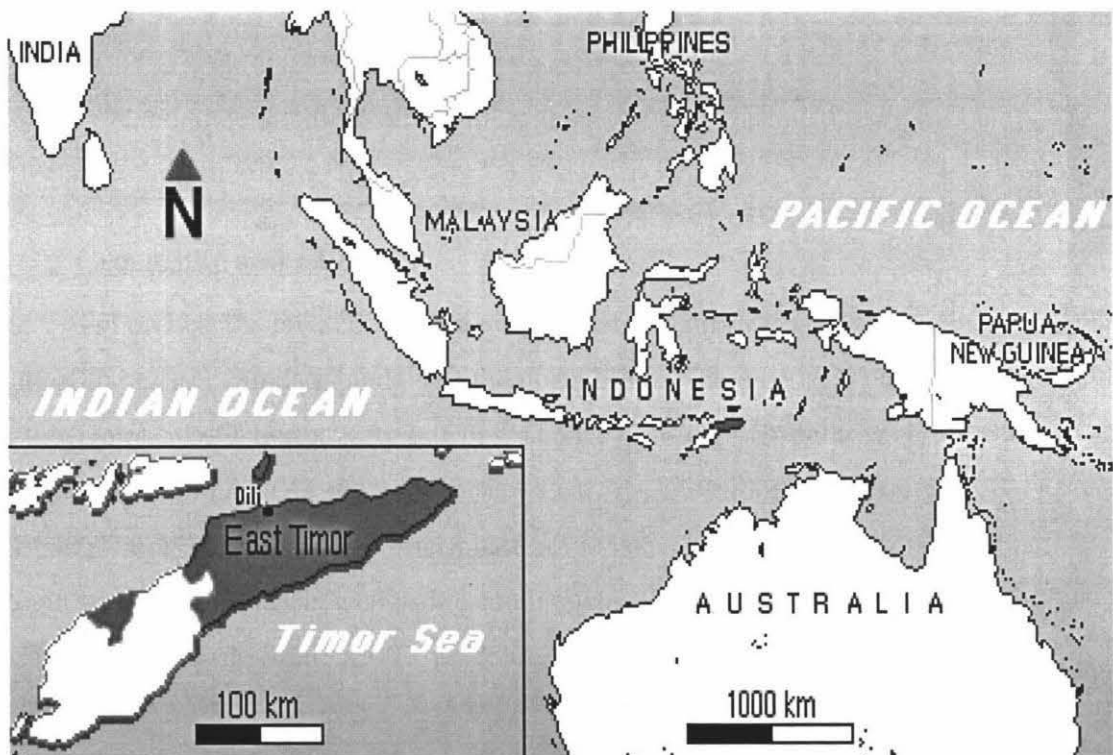


Figure 3.1. Map showing East Timor, Indonesia and Australia (East Timor Action Network/US, 2005)

There are marked differences in climate with two relatively distinct seasons, dry from May until October, particularly in the central and northern regions and November to April brings monsoon conditions over the majority of the country. Many of the rivers shift course during the rainy season (Dunn, 1983). The average temperature is 21

degrees, with a range from as low as four to 31 degrees centigrade during October to December, these being the hottest months with high humidity levels (MOH, 2002, p.1).

The island's geography varies presenting a terrain of great diversity. The mountainous range runs from west to east and along parts of the northern side of the island the mountains drop almost directly into the water. There are areas of fertile valleys with natural spring and along the north and west are sectors of lowland, with coastal plains on the southern side of the island (Taylor, 1995). The vegetation varies from grasslands to tropical rain forests, making cultivation in some regions difficult (Dunn, 1983).

Background to Timorese Society and Traditional Understandings

Taylor (1999, p.2) described the original inhabitants as Melanesian. Over the centuries the island has seen the arrival of many diverse peoples. Pre and post European contacts show immigrants from the Middle East, Portugal, African colonies, Melanesia, Polynesia and a number of Asian countries including Indonesia, Malaysia and China (Inbaraj, 1997). The succession of migrants at differing times in history has led to a linguistically diverse population. Since independence in 2002 there are two official languages, Portuguese and *Tetum* (Greenlees & Carran, 2002).

There is evidence of trade links with China and India as early as the 1400s (Taylor 1995). Sandalwood trading was a lucrative business initially attracting the Portuguese in 1512 and missionaries in the latter 1500s who settled on a nearby island. Early missionaries, mainly Dominicans, also undertook evangelical work with local inhabitants (de Sousa, 2001).

Life in traditional society was influenced by behavioural norms of lineage and status, which were maintained through a system of nobles and commoners. A patrilineal structure ensured that inheritance was passed to the next generation through the eldest male, with rights being conferred to men only. Power was distributed at territorial and village levels with each region having a *liurai*⁹ who represented the dominant lineage (de Sousa, 2001). The political system comprised three main layers: the village, principdom and kingdom, which "...highlighted the importance of exchange and justified the hierarchy" (Taylor, 1995, p.331) and provided markers of difference for the population. Exchange was central to production and reproduction and incorporated important cultural rituals associated with birth, marriage and death.

⁹ *Liurai* - a traditional ruler with aristocratic status (Taylor, 1999, p7)

Clear rules existed regarding marriage which facilitated the building of links with other villages (de Sousa, 2001). Tribal elders generally arranged marriages, a role that assisted in maintaining their status (Taylor, 1995). Wives were chosen from outside the village and required the payment of a dowry, an inability to meet this payment could affect the couple's status and locality of residence. Reasons, other than diminished resources could lead to non-payment, for example, not wanting to share family wealth or wanting to maintain family lineage. Polygamy was not uncommon among the elite (de Sousa, 2001).

Hicks (1976) describes local understandings of creation, people (tribes in eastern part of island) and land, including sacred and secular aspects of life that provided the foundation to religious beliefs. Everyday understandings of the world, both visible and tangible were considered secular, whereas the sacred world consisted of ancestral spirits, mainly female ancestral ghosts. Whilst both males and females inhabited the sacred world, females dominated, whereas the secular world was dominated by males. In everyday life both men and women were considered human but at times of ritual, women's situation could fluctuate between secular and sacred states.

Variation existed in explanations of creation and the subsequent establishment of social structure and order. But Hicks (1976) found consistency existed (within the group he studied) in the view that the first people "...emerged from a womb-like receptacle...this receptacle was the earth" (p.21). Three people were thought to have been the first to arrive by climbing out of the earth and thereby established the order of today's society. These beliefs and understandings of ancestors' arrival continued to influence life in the 1970s (Hicks, 1976).

According to Dunn (1983) "...the spirits of the dead [were] an essential element in the living environment, and their presence as evil or good spirits must always be taken into account" (p.5). Cultural understandings are commonly visible in many aspects of a daily life, for example artefacts, language, rituals and objects. It is not surprising that Timorese people place importance or sacredness on aspects of life such as birth as it symbolises and celebrates the arrival of their ancestors (Hicks, 1976).

The arrival and subsequent penetration of Catholicism may have diminished the impact of these beliefs though Hick's (1976) indicates that they remained in varying degrees. It also appears that some of the supernatural powers that had been attributed to spirits may have been transferred to priests (Dunn 1983).

Arrival of Portuguese and Catholicism

In the mid-seventeenth century the Portuguese invaded the island of Timor with an intention to increase their influence beyond the trading coastline. A swift victory occurred, followed by 'Topasses'¹⁰ immigration, they later provided resistance against Dutch invasion attempts. The Portuguese made several attempts to install a governor on the island, but faced opposition from Timorese, Topasse and later the Dominicans. For a time the Topasses were virtually defacto rulers of the island as they were not afraid to challenge Portuguese authorities. It was not until 1701 that Portugal formally appointed a governor (Inbaraj, 1997, p.2). The Dutch persisted in attempts to establish a claim and by the mid-eighteenth century they had strengthened their presence in the west of the island, resulting in a territorial division, Portuguese in the east and Dutch in the west (Taylor, 1995).

The Portuguese initially based in Lifau¹¹ later moved to Dili, formal colonisation did not occur until 1860 (de Sousa, 2001). During the process of colonisation the Portuguese attempted to undermine the well developed traditional structures of society, Topasse assisted by taking over high level positions, the aim was to weaken the kingdoms, lessening local power and increase the coloniser's power. This did not mean the demise of the indigenous social structures as many traditional aspects of society were maintained resulting in a dual system of authority (Taylor, 1995). The Portuguese administration worked to develop local infrastructure in an attempt to further challenged traditional systems, as they were barriers to expansion (Dunn, 1983).

It was in the late 1800s that Portugal, due to growth in Europe, tried to maximise and exploit their colonies. This saw pressure being placed on the Timorese to increase production of existing crops and to introduce new crops such as coffee, cocoa, rubber and copra, with the prime intention of increasing trade (Dunn, 1983). A head tax was levied in 1898 on all working age males effectively forcing them to increase production to meet payments, for example, working on recently established coffee plantations, or increasing family production ensuring a surplus to sell. Forced labour was utilised to build roads and although the work was imposed some considered the conditions less severe than work expectations of the *liurais* (Dunn, 1983). Part of the impetus, for what Jardine (1999) calls 'heavy handed tactics', was to increase production in Portuguese

¹⁰ Topasse were descendants of Portuguese, Malaccan and Macao traders from the north

¹¹ Lifau is in the enclave of Oecusse, which is located on the northern coastline of the western part of the island, but it remains under the administration of Timor Leste. For East Timorese today access can be either overland through west Timor or ferry from Dili.

colonies with a view to gaining increased political power in Europe. An indirect outcome was increased animosity between the Portuguese and Timorese, resulting in rebellion and the loss of several thousand lives (Taylor, 1995). This provoked the Portuguese to further dismantle local systems of control by increasing the power of a selected few at village level in the hope of overriding kinship associations, but this did not destroy the indigenous political system.

Negotiations between Portuguese and Dutch resulted in formal separation of the island in 1913, (Taylor, 1995, pp.334-335) giving Portugal a greater hold over the country (Inbaraj, 1997). de Sousa (2001) indicated that Portuguese control of the territory served largely as a place to "...exile political opponents and rebels from Portuguese African colonies [rather] than as a territory of economic colonization" (p.3).

The Dominican priests had a greater impact on the people of Timor than the Portuguese in the first two hundred years. Initially settling on the island of Solor, they gradually migrated to the island of Timor (Dunn, 1983). Catholicism was not forced on the indigenous populations, though the ruling elite was pressed into a degree of acceptance and their children were strongly encouraged to attend Catholic schools. Despite the prominent role the Dominican friars played there was, initially, a low level of overall conversion. This resulted in Catholicism being the religion of the elite and educated (Dunn, 1983). Pinto and Jardine (1997) suggest the low numbers identifying as Catholic was largely due to two factors: the unassertive approach taken by the clergy and the existence of disharmony between the Church and the colonial power. This may have been the impetus for the Portuguese authorities to reduce missionary power during the nineteenth century (Dunn, 1983, p51) and at one point the expulsion of missionaries (Pinto & Jardine 1997).

By the twentieth century Dunn (1983) indicates Christianity aided unification and promoted patriotism as "...the state perceived the central role of the church as giving a moral legitimacy to Portugal's revamped colonial order" (p.51). There was considerable local respect accorded to priests and their activities extended to supporting the Timorese cause in administrative matters in an attempt to rectify inequities between colonisers and locals. They predominantly worked in accessible towns and villages, visiting remote villages infrequently, leading some to criticise the lack of attention they gave to a large number of needy (Dunn 1983).

One of the consequences of the Church's position was that by 1974 many of the emerging nationalists had been educated in a Catholic dominated education system

(Pinto & Jardine 1997). It is estimated that less than 33 percent of the population were considered to be Catholic during the 1970s, by the end of the twentieth century this had increased to 90 percent (de Sousa, 2001, p.192). This dramatic increase has been partly attributed to the role church officials played at social and political levels, during the resistance to Indonesian occupation. The Portuguese army and government had left the colony, meaning the Catholic Church was the only remaining institution that supported the Timorese cause (de Sousa, 2001). Also during the 1970s Indonesian fundamentalists utilised the education system to promote the idea that religion and citizenship were intrinsically linked and those that did not follow a religion were not only disloyal but intellectually and morally backward (Aitkinson cited in Nourse, 1999). In line with this Indonesian policy required compulsory affiliation with a 'great' religion (Anderson, 2003).

Early Twentieth Century and World War II

Many felt the Portuguese had only a minimal influence on grassroots Timorese society. A large number of the population considered traditional rule still existed indirectly, and continued to play an influential part in their lives until 1974 (Dunn, 1983). For a 30 year period, following negotiated and formal division of the island between the two colonial powers, Timor-Leste remained relatively peaceful (Dunn, 1983). This uneventful period could have been due to Portugal's economic and political circumstances following World War I, resulting in Timor-Leste being virtually ignored as it was a drain financially and an embarrassment due to the need for ongoing support (Dunn, 1983). Lack of electricity, roads, water, other services and overall development including the continuance of a barter system of exchange meant the depression years had a limited effect on society and living standards (Dunn, 1983). Certainly by comparison to other colonised countries, progress had been 'painfully slow' (Dunn, 1983).

Timor-Leste appears to have been caught in the literal crossfire of two nations during World War II. Within days of Pearl Harbour being attacked in 1941 troops from Australia and Netherland Indies arrived on the island (Jardine, 1999). This had a dramatic effect, violating Timor-Leste's initial neutral status and was in opposition to the views of the Portuguese Governor, who believed protection was unwarranted. A key rationale for Australian to send troops appears to have been to prevent Timor-Leste "...from becoming a stepping stone for Japanese expansion southwards to Australia" (Inbaraj, 1997, p.22).

The Japanese believing the allied forces planned to take control of Timor-Leste invaded two months later (Dunn, 1983). The following warfare led to casualties on all sides, especially Japanese and Timorese. Australian forces, estimated to have been approximately four hundred, lost only forty personnel compared to Timorese losses of 40-60,000, mainly civilians. The limited number of Australian deaths is attributed to the support and assistance of the Timorese who "...fought like lions" (Inbaraj, 1997, p.22). Japanese occupation occurred in 1943 (Jardine, 1999) following the hurried withdrawal of Australian forces, leaving the Timorese to fight and protect themselves whatever way they could. For Australians in January 1943, the Timor campaign was a closed book; but for the people of Timor the war had only just begun. The territory was placed under a tough military occupation, and its people were regarded by the occupying Japanese as hostile. (Dunn, 1983)

In some areas, especially where the Australians had been, families and villages were wiped out by Japanese air raids and burning, as the Japanese pursued 'the enemy'. If Timorese suspected a local of assisting the Japanese they could be tortured or killed. The situation, clearly described by one Japanese commander, was one of grave conditions consisting of forced work, starvation and the raping of women (Shouachi in Jardine, 1999). The devastation affected Timorese livelihoods, for example, farming had to be abandoned leaving many hungry and vulnerable.

Toward the end of the war Portuguese sovereignty was minimal, distrust of Japanese was high and when they finally left, it was from a country that had paid a high price. The final local death toll Dunn (1983) believes was one of the greatest in relative terms during World War II. He also indicates the occupation and fighting in Timor-Leste, by two outside peoples, was largely unacknowledged and even though requests were made for the Allies to return, these were rejected (Dunn, 1983).

The Japanese departure saw a quick return of Portuguese rule to a country destroyed in economic and human terms. Dunn (1983) states "[t]he war seemed to have taken the country back to the stone age" (p.27). The ability of the Portuguese administration to make large or rapid responses was limited, as their position in Europe had further weakened. Their exclusion from the potential benefits of the Marshall Plan¹² and virtual rejection from Western Europe due to their fascist directions compounded their situation (Dunn 1983).

¹² In 1947, following World War II, the USA formulated a strategy (Economic Cooperation Act of 1948) to aid European (Western) recovery from famine and economic crisis with the aim to improve political

Post World War II

The beginning of redevelopment was slow and Jardine (1999, p.22) argues that methods similar to the brutal tactics used by Japanese were at times deployed. Timor-Leste's colonial status changed to that of Portuguese overseas province in 1953, and despite the formulation of a five-year plan for development progress was minimal (Dunn, 1983). After the war, until 1964, the Catholic Church and missions played a key role in primary education, enrolling approximately 60 percent of children (Dunn, 1983, p.31). The Catholic Church had largely supported the Portuguese administration, but some Jesuit teachers questioned aspects of colonial rule including the social conditions in which local people lived (Jardine, 1999).

Indonesian authorities showed no apparent economic or strategic interests during Sukarno's rule¹³ to challenge Portugal's claim on Timor-Leste and officials indicated they would support the Timorese if they wanted independence from Portugal. On occasions, cross boarder disputes arose resulting in a degree of anxiety in Dili about potential challenges, and when Suharto came to power in 1966 relations between Indonesia and the Portuguese appeared to improve (Dunn, 1983). The 1950s had seen the beginnings of a Timorese independence movement, though quietly, from a relatively unknown group in Jakarta.

Gradually Portugal increased attention to the social and economic situation of Timor-Leste and early signs of change were appearing. Towns were being rebuilt; the main wharf in Dili was finally in service in 1965 and commercial activities, including a wider range of goods were becoming available, but rural and remote areas had changed little from early colonial times retaining traditional agricultural practices. Construction of roads were opening up some remote areas and if one had access to a four-wheel drive vehicle it was possible, in the dry season, to travel to places previously inaccessible by vehicles, in the rainy season this remained impossible. There was also some recognition that there was a need to increase production, not just for economic reasons but to improve people's nutritional status (Dunn, 1983).

Prospects for Timor-Leste citizens in the 1960s seemed more favourable and Portuguese strategies were likened to 'benign paternalism' (Dunn, 1983). There was increased involvement of local people in local administration, army and church but their

stability and a return to the healthy world economy. On 5th June, the USA Secretary of State, George C. Marshall called for American assistance, with the aim to restored post war Europe.

¹³ Sukarno was the first Indonesian (1949–66). Whilst some accused him being a communist, which facilitated a successful attempt to depose him, other say he to balance the Communists against the army leaders

overall power and authority remained relatively limited. Portugal attempts to be viewed positively by the Timorese came at time when there was increasing scrutiny from outside regarding the limited development and the overall situation of the people (Dunn, 1983, p.35).

One of the early changes to increase education opportunities saw student numbers rise from 8000 in 1953 to 60000 in 1974, correspondingly there was an increase in elementary schools from 39 to 456 (Dunn, 1983, p.7). The same growth did not occur in secondary education, but there was evidence of increased population literacy. Tertiary education was even more limited as no university existed in the country and those that wanted further education needed to relocate to Portugal (Dunn, 1983).

Achievements in health and social welfare were far from impressive. Tuberculosis, malaria and malnutrition were rife and the infant mortality was estimated as high as 50 percent in the early 1970s (Dunn, 1983, p.45). International commentators reported a severe lack of doctors, equipment and hospitals. Facilities were largely located in urban areas and some villages servicing only 30 percent of the total population, despite this there were signs, by 1974, the population's health was improving (Dunn, 1983, p.46).

Commerce was largely in the hands of the Chinese (and a few Portuguese) and whilst they had never assimilated into Portuguese culture they had played a dominant role importing and exporting goods. Despite some families having spent several generations in the country they still held Taiwanese passports and were considered by some locals as aliens (Dunn, 1983). Their profit making did not always fit easily with either the Portuguese or Timorese as they were seen by some, due to their business practices, as opportunistic and perpetrators of oppression.

Greater urbanisation was becoming evident resulting in the development of small urban centres (Dunn, 1983). Employment opportunities had broadened and Timorese could be found in a wide range of occupations by 1974 including journalism, airport and weather staff, and military and religion positions (Dunn, 1983). The early 1970s saw coffee as a major export industry, with non-coffee export accounting for just over ten percent of export revenue. An appearance of affluence and westernisation was beginning to appear in the early seventies, though this was not universal as the majority of the population remained dependent on traditional agricultural practices (Dunn, 1983).

Portugal's weakened economy (it was the poorest country in Europe) in 1965 resulted in it giving greater attention to its African colonies in the hope that colonial

states' resources would help Portugal's financial recovery. Timor-Leste was considered a relatively low priority and a liability and some would have been happy to hand over power to the United Nations (UN) (Dunn, 1983). The Portuguese army felt they needed to concentrate their resources on responding to emerging challenges from their African colonies. During this period of increasing unrest in the African colonies, a large number of Portuguese military were re-deployed, leaving places for Timorese personnel. A long history of warrior traditions (Dunn, 1983) meant the Timorese quickly dominated the ranks. By 1974 there were 3000 fully trained Timorese soldiers and 7000 with limited training but it was not until 1975 that they held any commissioned positions (Dunn, 1983, p.38).

Despite a gradual shift to include more Timorese in government positions the administrative power still resided in Portuguese dictatorship, denying any form of opposition. State control of media further assisted Portuguese control through its censorship of news (Jardine, 1999) which restricted local awareness of the increasing unrest in Portugal's African territories and struggles of neighbours in West Irian. Portuguese control had been enhanced by the limited political awareness from inside and a lack of interest from the international community (Dunn 1983).

The Portuguese control of information lead to an independent Catholic Church publication, called 'Seara'. This publication provided an alternative source of information (Jardine, 1999) and continued doing so until 1973 when the Portuguese forced it to stop. It was not censored and was written in the lingua franca, *Tetum*, which increased use of the language. The publication provided a forum for debate and included a wide range of topics such as traditional marriage law, criticisms of economic development and moral thoughts related to violence (Pinto & Jardine 1997). Some writers wrote of African liberation activities which helped to lay the groundwork to independence ideas (Jardine, 1999)

There was a degree of awareness of differences between the, by now, Indonesian West¹⁴ and Timor-Leste. West Timor had better education, literacy and more freedom, conversely the economy was viewed as poor and many felt the Indonesian government neglected them. Some anxiety existed regarding Indonesian interest in Timor-Leste and Portuguese officials indicated to locals that they would be worse off if they were no longer a Portuguese territory. Dunn (1983) reports one Timorese who commented that "...[t]here would be no point in our joining with Indonesia after decolonization. Their

¹⁴ 1945 saw the western half of the island shift from Dutch control to Indonesian control at the time the formation of the Republic of Indonesia.

side is poorer than ours, and instead of the Portuguese over us we would have the Javanese” (p .41). There was also a mounting anti-Indonesian sentiment and opposition to Muslim rule emerging from within Timor-Leste.

Changing Political Situation

Portugal’s increased attention to its African colonies meant limited consideration was given to the idea of Timorese independence. It was thought that only two options existed for the country, continued alignment with Portugal or to become a part of Indonesia. The representative of the Military Armed Forces in Timor-Leste indicated the views of Timorese needed to be considered and it is thought he favoured Timor-Leste being handed over to Indonesia (Dunn 1983). In 1974 a third option was suggested by Portugal, that of independence.

Initially the Lisbon uprising had little effect on life in Timor-Leste. News that Portuguese provinces may have a say in their own future development lead to an air of anticipation, by some elite, as well as apprehension. There was underlying discontent from some Lisbon members of the Portuguese military, feeling that they would eventually have to deal with an outdated civil administration and the current social situation.

Despite regulations prohibiting the formation of political parties within one month of the Lisbon coup (May 1974) three political groups had been formed. These were:

- the Timorese Democratic Union (UDT), was relatively conservative and supported the Portuguese
- the Association of Timorese Social Democrats (ASDT - soon after changing it’s name to Fretilin) supported socialism, democracy and independence though recognised that time would be needed for this to occur and
- the Timorese Popular Democratic Association (APODETI) were supportive of “autonomous integration with Indonesia” and whose membership, whilst limited in numbers, included some with strong links to the Indonesian military and soon came under their influence (Jardine, 1999).

All parties included Timor in their name and claimed to represent the population rather than particular groups within (Anderson, 2003).

This rapid development was extraordinary, as there had been no clear evidence of any political nationalism or opposition to Portuguese presence (Dunn 1983). Inbaraj

(1997) indicates that it was not until 1974 that groups felt free to reveal political interests that had started to emerge from the educated elite, in the 1960s. They were very aware of the controlling realities imposed by the colonial administration during their childhood, through the use of an education system that had consisted largely of propaganda (Inbaraj, 1997).

Fretilin volunteers worked in rural areas: helping many to read and write *Tetum*, promoted local culture; giving assistance in forming support groups, agricultural co-operatives; as well as stimulating nationalism. These activities increased their support from locals and by early 1975 they were the favoured party (Jardine, 1999).

Plans by APODETI gained support from President Suharto (Indonesia) and Australian Prime Minister Whitlam. Australian news sources indicated the Whitlam government favoured Timor-Leste's integration into Indonesia (Dunn, 1983). APODETI also worked to weaken the recent coalition (Fretilin and UDT) and in February increased Operation Komodo¹⁵ activities. False reports regarding a planned coup by Fretilin had the desired effect of separating UDT from Fretilin in May 1975. More false information about Fretilin activities in Vietnam, describing communist activities, was released to the UDT. This resulted in an attempted coup by the UDT in August 1975 (Taylor 1999).

During the attempted coup the UDT gained support from Police. Colonel Lemos Pires, the governor of Timor-Leste, attempted negotiations (Taylor, 1999) between the two parties without success and Fretilin quickly gained control (Jardine, 1997). Whilst the coup had been short lived, it led to the departure of Portuguese officials (Dunn 1983, p.53). Many were critical of Portugal's role and the state of the country they left as no strategies were put in place to enable the Timorese to be self-ruling.

Throughout this time Australia and USA intelligence had kept a daily watch on the situation despite claims of limited knowledge. Key reasons for this were the economic and political importance of Indonesia. Also to the north of the island lay the Ombai-Wetar Strait, this deep-water channel could enable submarines to travel undetected, providing a strategic link between the Pacific and Indian Oceans for the USA which was significant if any conflict occurred with the Soviet Union (Taylor, 1999).

During 1974 the Portuguese had turned to Australia hoping to gain support for Timor-Leste independence, however the Australian government clearly stated it did not

¹⁵ Operation Komodo, was named after the Komodo dragon (a giant man-eating lizard) which was to strengthen APODETI and weaken the opposition (Pinto & Jardine, 1997, 28)

want to destroy political relations with Indonesia. Both countries shared a view that independence was not economically viable (Dunn, 1983). Despite a degree of eagerness by some to be rid of Timor-Leste, the Timor-Leste governor needed support from Portuguese authorities but they were focused on internal and African situations leaving them relatively unaware of the emerging situation in August 1975 (Dunn, 1983).

Fretilin quickly set up an unofficial government in September 1975, but repeated stalling by Portugal thwarted attempts at talks between Portugal, Indonesia, Timor-Leste and Australia. Looming invasion from the Indonesian Army in November 1975 lead Fretilin to declare independence hoping to gain international support which history reveals was not forthcoming (Jardine, 1999). At one point the Prime Minister of Australia was questioned regarding Australia's actions if Indonesia invaded Timor-Leste to which he replied "absolutely nothing" (Inbaraj, 1997, p.6). It seems some in the international arena feared an independent Timor-Leste ruled by Fretilin but from within Timor-Leste the Fretilin were the most supported group (Inbaraj, 1997).

The vulnerability of the situation was quickly realised when on 7th December 1975 Indonesia invaded (Jardine, 1999) resulting in rampage and mass killing. People associated with Fretilin were at greatest risk of being attacked, many fleeing to the mountains for safety. It is estimated that in the first two days some 2000 people were brutally killed in Dili. The Indonesian soldiers extended their attacks to towns and gradually into remote areas (Jardine, 1999, p.52). Despite heavy casualties these would have been higher but Fretilin members had, prior to the attacks, established bases with weapons supplies in the hills. As a result of this they were able to maintain a hold until 1977 when the Indonesian forces pushed further inland. Indonesia's increased strength was due to additional support from the USA and other countries, which provided supplies (Chomsky, 1994, p.11). With additional troops, USA aircraft, other western armaments and chemical defoliation spray Indonesia mounted an effective attack, over two years, resulting in some areas being annihilated (Jardine, 1999). Following on from the renewed attacks was 'the fence of legs', where approximately 80,000 Timorese males were forced to walk as a front line to Indonesian troops. Whilst many Timorese surrendered, many were killed or starved. An attempted cease-fire occurred in 1982 but lasted only five months (Jardine, 1999, pp.56-58).

The UN had called for Indonesia's departure in 1975, but many countries including a number of powerful western nations did not support these calls. A number of countries abstained or voted against UN resolutions that condemned Indonesian

occupation. On 31st May 1976 Indonesian authorities declared Timor-Leste part of the Republic of Indonesia and formal integration was complete two months later (Jardine, 1999).

It appears Australian and USA politicians knew of the intended Indonesian invasion and Jardine (1999) states that “[s]upport for Indonesia’s actions in East Timor is a small price to pay for the investment opportunities and political support Indonesia offers. The USA not only refused, to condemn the invasion, but sharply increased aid to Indonesia in its aftermath” (p.41). The Australian government was informed of an impending Indonesian invasion but it was considered in Australia’s interest to maintain favourable relations citing the need to negotiate with Indonesia over the Timor Gap resources¹⁶ (Chomsky, 1994). Business and Indonesian support rating higher than human lives (Jardine, 1999). The USA, Britain, France, Germany, Canada and Australia all provided ongoing assistance, aiding Indonesia’s take-over of Timor-Leste, through a range of strategies including military training and personnel. Other countries continued or increased aid to Indonesia, Japan was no exception even though human rights, freedom and democracy were criterion for aid allocation (Jardine, 1999). Australia was the only western power to officially recognise Indonesia’s claim to Timor-Leste (Jardine, 1999).

Indonesia’s claim to sovereignty required Timorese to become Indonesian. To achieve this required force and in the early days of occupation many Timorese were placed in camps and later resettled into villages, both resulted in close surveillance by Indonesian soldiers. Resettlement also affected people’s ability to maintain agricultural activities resulting in famine and malnutrition. There were attempts to dismantle the existing social organisation, in particular the resistance movement (Jardine, 1999).

Control of the education system further increased Indonesian power through its coercive approach to schooling, for example deeming only Bahasa Indonesia to be spoken (Jardine, 1999). A birth control programme implemented in 1986 proposed to limit families to three children, co-opting the military to enforce women’s participation. One person indicated that “[i]t was one way the enemy has to make our ethnic identity

¹⁶ The Timor Sea, including the Timor Gap resources, is located between the island of Timor and the Northern Territory of Australia. Oil and gas fields are currently worked and considerable financial prospects for the future exist. Negotiations are currently underway between the governments of Australia and Timor-Leste over sovereignty. Since the 1950s negotiations have occurred including debate over the boundary and rights to national ownership, and at different times has included Portugal and Indonesia. Generally these have been unsuccessful in reaching a decision. Currently negotiations reveal that Australia is claiming the majority (the entire continental shelf that is greater than 200metres in depth. The outcomes have considerable implications for Timor Leste future revenue prospects (Brennan, 2004).

disappear” (unnamed author cited in Jardine, 1999, p.64). In 1991 all property ownership were converted to Indonesian title and Indonesians’ seized businesses. The situation in 1995 is described as one of torture and violence; women were raped, drowning attempts, electric shocks resulted in severe burns to either nostrils or penis (Inbaraj, 1997).

During occupation Indonesia invited Portuguese officials to visit so they could see how Timor-Leste was fairing under Indonesian rule. Locals were hoping Portugal would come to their rescue (Cristalis, 2002) and much underground preparation was occurring. The visit never happened but the activities went ahead as a marker of unity, commencing with a requiem mass, a memorial service for Sebastiao Gomes killed on 28th October 1991, two weeks previously. Following the service many moved to the Santa Cruz cemetery where Indonesian soldiers attacked and opened fire. Many were killed - shot, bayoneted and stabbed - those who tried to escape were pursued (Taudevin, 1999). Indonesian reports indicated 19 killed, amended reports increased this to 54 and 91 wounded, but resistance members accounted for 271 killed and a further 200 missing (Cristalis, 2002, p.47).

In many cases the ‘inaction’ of the international media, through their relative silence over the many years, could be classified as covert support for Indonesia’s actions. But a small number of international journalists, unbeknown to the Indonesian authorities, had entered Timor-Leste under the guise of being tourists and managed to capture the events at Santa Cruz on videotape. Suddenly Timor-Leste received international attention. Public protests and activism from within Timor-Leste, Indonesia and world-wide grew calling for Timor-Leste’s right to self-determination. Aid and support came from a number of international agencies (Taudevin, 1999).

Increasing international attention culminated in the Nobel Peace Prize being awarded in 1996 to José Ramos-Horta (chief diplomat of resistance) and Bishop Carlos Belo (leader of Timor-Leste’s Catholic Church), for their role in supporting the Timorese goal of self determinism (Jardine, 1999). It was felt that these awards would aid the pace of emerging international censure (Inbaraj, 1997).

New Hope

Timorese resistance to outside pressure has been a reoccurring theme. 1998 saw the beginning of new era, Indonesia’s increasing political and economic instability and Suharto’s loss of presidency. The newly elected government and President Habibie, under increasing international scrutiny, made an offer to the people of Timor-Leste of

‘special autonomy’ status (Jardine, 1999). Habibie had previously stated that there would be no shift in Indonesian policy, as Timor-Leste was part of Indonesia (Taudevin, 1999). This shift meant internal control was being offered but the Timorese would still be subject to Indonesian rule. At a meeting held by Timor-Leste Students Solidarity Council (ETSSC) it was clear that many rejected the notion of ‘special status’ preferring instead independence (Taudevin, 1999).

From late 1998 onward the increasing move to independence resulted in “...gross human rights violations...committed, with independence activists and presumed supporters, seized, tortured and ill treated; in some cases activists were killed, many homes were destroyed, and inhabitants were displaced” (Martin, 2001, p.25). The perpetrators of these attacks, many believed were the Indonesian military, either directly or indirectly, as there was a long history of paramilitary groups being supported by the military. It appears that a number of influential members of the military were opposed to Habibie’s offer (Jardine 1999).

In 1999 Habibie announced that Indonesia had signed an agreement with Portugal allowing the people of Timor-Leste, with UN support, to vote for independence (Jardine, 1999). This announcement surprisingly received little opposition for the Indonesian parliament. A suggested reason is that many believed the Timorese would vote, either voluntarily or through inducement, to remain part of Indonesia (Martin, 2001).

The Liquica massacre in April 1999 was the worst atrocity since Santa Cruz (1991). Many residents of Liquica wanted independence and resisted Indonesian attempts to increase their influence. On 4th April 1999, the increasing Indonesian hostilities, led some local residents to flee to the mountains, others remained, sheltering in the church. The militia surrounded the church demanding resistance members to surrender. These requests were largely ignored and the militia responded by attacking, brutally killing men, women and children. The nearby rectory was also attacked, the militia declaring that it held weapons. Red Cross officials estimated 2000 people were killed though military numbers ranged from 5 to 25 claiming these were ‘resistance fighters only’. The situation was so gruesome that news film, shot shortly after, was considered too horrific for television (Cristalis, 2002, pp.129-30). Despite the lack of television footage paramilitary actions could no longer be explained as innocent people being in the wrong place. People were forced to fly the Indonesian flag (Taudevin, 1999). Refusing to do so would entail punishment; any red and white material would be

used to make a flag, and when considered safe it would be lowered and put away (personal communication).

Working Toward the Referendum and Independence

On 5th May 1999, an agreement for the referendum was signed by Indonesia and Portugal and witnessed by the UN. Reservations were held as Indonesia had negotiated that it would take responsibility for security (Greenless & Garran, 2002), which lead Ramos-Horta¹⁷ to warn the UN that “[o]ur people, terrorised and traumatised for 23 years, are expected to vote on their future with ‘protection’ provided by the very same army and gang of criminals that have turned the country into hell” (Greenless & Garran, 2002, p.147). The agreement required the UN to conduct a “direct, secret and universal” ballot on 8th August 1999 (Greenless & Garran, 2002, p.148). Increasing turmoil and postponement meant the election was held on 30th August (Taudevin, 1999, p270). Indonesian authorities held opposing views for Timor-Leste, which set the stage for increased violence during the leading up to and following the election (Kingsbury, 2000).

The United Nations Mission in Timor-Leste (UNAMET) were responsible for all aspects of the election, including registration, informing voters to announcing results (Smith & Dee, 2003). Approximately 4000 personnel were required including local and international volunteers. Instruction was given to “...ensure that there was fair play between two sides, one of which had no interest in the rulebook” (Cristalis, 2002, p.160). The registration of some 451,792 voters in two months was a phenomenal achievement. The turbulent environment and increasing outside questioning of security created a volatile situation placing UN workers in a vulnerable situation due to their need to support Timorese rights to vote. As the majority wanted independence UN workers were perceived by some as biased (Taudevin, 1999, p.272). The 5th May agreement stated, and Indonesia was unwilling to re-negotiate, that no foreign troops would be allowed entry into Timor-Leste (Smith & Dee 2003). Some people believed that reconciliation would never occur and while talks between parties could be amicable the rift was too great, despite promises to disarm, many were broken (Cristalis 2002).

¹⁷ Increasing international attention culminated in the Nobel Peace Prize being awarded in 1996 to José Ramos-Horta (chief diplomat of resistance) and Bishop Carlos Belo (leader of Timor-Leste's Catholic Church), for their role in supporting the Timorese goal of self determinism (Jardine, 1999, p.68). It was felt that these awards would aid the pace of emerging international censure (Inbaraj, 1997, p.167).

Voting day saw a massive turnout of 98.5 percent of registered voters, with an overwhelming vote for independence. People walked for miles, old, disabled, sick and pregnant, leaving in the middle of the night, joining queues even before sunrise. Many were feeling anxious, the day dawned quiet and many relaxed. Voting day was relatively free of incident, the worst required one polling booth to close for several hours following a militia attack (Cristalis, 2002, pp.213-4).

Consideration was given to the timing of announcing ballot results. "This problem was exacerbated by the upsurge of violence on September 1, when hundreds of militia converged on Dili and unleashed a campaign of terror, burning, and looting, attacking the pro-independence supporters as well as foreign news correspondents" (Marker, 2003). Many people had left during the lead up to the election, including the majority of Indonesians, who had returned to Indonesia. Cristalis (2002) indicates intentions were clear; the army wanted all foreign journalist and observers to leave, limiting the scrutiny from the outside world. Many pulled out quickly, though not all. UNAMET was forced to evacuate many of the towns; they were clearly unprepared for the emerging situation (Cristalis, 2002).

Several weeks prior to voting day, the UN representative, Jamsheed Marker had believed that a peacekeeping force would not be warranted during the period before and after voting. Not all agreed, one human rights activist accused UNAMET of failing to ensure the Timorese felt safe to vote and that the high turnout on voting day was due to Timorese determination at whatever cost (Cristalis, 2002).

Results were released on 4th September, an overwhelming 78.5% favoured independence (Marker, 2003, p.194). What followed was an eerie silence many had already left Dili realising whatever the outcome their lives would not be easy. The feeling was that "[a]fter twenty-five years of genocide supported or at least condoned by the international community, there was no way that a simple vote would suddenly change things" (Taudevin, 1999, p.278). Their worst nightmares came true, the militia rampaged, and nothing seemed to escape (Taudevin, 1999). Many refugees found themselves in the UNAMET compound which was likened to a war zone. Prior to voting the UN guaranteed that they would remain, but within days they had planned their evacuation, this was later revised. The Timorese had no qualms about the consequences if the UN left. Even with international criticisms the UN would not deploy intervention without Indonesian approval, this finally came, as did a renewed UN evacuation plan (Cristalis, 2002).

For the first time in history UN evacuation plans included refugees, a total of 1500 people left Dili (Cristalis, 2002, p.246) for Darwin on 14th September, ten days after the results were announced (Marker, 2003). In total between 6th and 14th September 2500 evacuees left on Australian and New Zealand Air Force planes (Greenlees & Garran, 2002). The UN international peacekeeping contingency (International Force for Timor-Leste: INTERFET) lead by Australia, eventually included 7500 troops from twenty-two nations, arrived on 20th September, 11 days after authority for the mission (Walker, 2001, p.128). On the 25th October the United Nations Transition Authority took over from INTERFET, and final evacuation of Indonesian soldiers occurred on 31st October, 1999 (Marker, 2003), effectively ending three centuries of colonisation and another 25 years of occupation (Marker, 2003). Buildings and the country's meagre infrastructure had been destroyed, huge numbers of people shifted (Smith & Dee, 2003) either forcibly or through the desire to survive.

People sought safety in the hills. One example was a Catholic sister, with approximately thirty children, hid in the hills for approximately a month surviving on rice hidden prior to the election (personal communication). Shells of buildings stand as stark reminders of the violent attacks that followed the election. Locals, talk of finding mutilated parts of family members other people disappeared all together. One mother had to choose between killing her infant or leaving him with strangers. The later it was hoped would increase the chances of survival for both. A crying infant was a death sentence, for anyone trying to hide, if heard by militia. Others describe people 'not being right', after being tortured by the Indonesians (personal communication).

The situation that remained was daunting, displacement occurred on a large scale. Some had crossed the border into Indonesia with nothing. A member of one family spoke of being forced to leave their burning house with nothing but the clothes they wore. Four years later they remain refugees, rather than returning, they had chosen to remain in West Timor as they have started to rebuild their lives, enough to survive (personal communication).

Reconstruction

Reconstruction requires working on the infrastructure of Timor-Leste, one estimate indicated that seventy percent of the country's utilities and buildings had been destroyed (Executive Board of United Nations Development Programme and of the United Nations Population Fund [EBUNDP & UNFPA], 2002). The loss of considerable expertise, through expatriation and loss of life further compounded the

position of this new country. The entire economy had been virtually destroyed, and the nation lacked virtually all basic facilities, "...not just doctors, dentists, accountants, lawyers and police, but also tables, chairs, pots and pans. Even in Dili, the capital, stop signs, traffic signals, and streetlights are nowhere to be found" (Traub cited in Greenlees & Garran, 2002, p.306).

The emotional scars would take a long time to heal and there is the issue of human rights violations (Marker, 2003, p.2003). Walker, head of the UNAMET mission said "[i]t is beyond doubt that the destruction of Timor-Leste was not merely the result of an emotional response of militia and mutiny of East Timorese within the TNI [Indonesian National Military], but a planned and co-ordinated operation under TNI direction" (2001, p.124). Chomsky (1994) compares the crimes perpetrated in Timor-Leste and the Holocaust, the former worse as it could have been prevented. It is estimated 250,000 Timorese were killed from 1975 to 1997 (without considering the deaths that followed), a quarter of the population (Marker, 2003, p.203).

A long awaited moment arrived "...at the stroke of midnight as 20 May [2002] commenced, in a solemn and moving ceremony, UN personnel under the approving gaze of Secretary-General Kofi Annan lowered the United Nations flag; Xanana Gusmao supervised ... the hoisting of the flag of East Timor" (Marker, 2003 p.211). It was decided that the national language, in fact would be two, *Tetum* and Portuguese. Despite fewer than ten percent of the population being fluent in Portuguese, Gusmao (the new President) argued that Timor-Leste owed much to Portugal including aspects of national identity (Greenlees & Carran, 2002).

International agencies provide some revealing data regarding the population of Timor-Leste based on 2001 information. It is hard to determine the accuracy of this information but it does provide some significant markers that cannot be ignored.

- 2001 estimated population was 794,298 of which 77.7 percent were rural dweller with a household size of 5.2, compared to 23.5 per cent urban residents and household size of 4.9 (UNDP, 2002).
- The rate between males and females is 43.1 and 42.8 respectively (UNDP, 2002). Provisional 2004 census population figures reveal a total population of 924,642 with approximately 11,000 less females than males (UNFPA, 2004).
- Males headed the majority of households in all areas (UNDP, 2002). Almost 44 percent of the population are under the age of 15 years and life the expectancy at

the time of birth in 2001 was approximately 55.6 years for males and 57.4 years for females (UNDP, 2002).

- Maternal and infant mortality rates are high on international scales (UNDP, 2002).
- Contraceptive use (modern methods) is low at about 5.6 percent of the total population (UNDP, 2002).
- The average number of school years of those aged between 20-54 years in urban areas was 7.5 compared to 3.1 percent in rural locations, males having 4.3 years and females 3 years (UNDP, 2002).
- It is estimated that 46 percent of the population have never attended school and in 2002 the student to teacher ratio was 1:62.
- The literacy rate for over 15 years olds is 37.2 percent in rural areas and 81.5 percent in urban areas (UNDP, 2002).
- Homes and living conditions reveal rural urban differences in the use of materials as well as service availability. Access to electricity for lighting, drinking water and sanitation facilities is consistently less accessible in rural areas (UNDP, 2002).
- The degree of poverty is high affecting approximately 41 percent of the population (UNICEF, 2002). Throughout the world the higher the degree of poverty one experiences the poorer is ones health status (Green, 1999).

During 2003 a comprehensive Health Survey was undertaken, but at the time of writing these findings were not available. Some provisional findings indicate that women's fertility rates are rising with a 2003 estimated rate of eight (Hull, 2004). These findings need to be considered alongside the 2004 population census. Both of these should provide some valuable information for people working in the health sector and associated areas.

Past and Future

The colonial eras (Portuguese and Indonesian) produced, and then maintained, structures that excluded women due to their patriarchal ideologies. This not only marginalised women but it also excluded them from decision making processes (Micató, 2001). Men on the other hand were valued and held positions of power. Many women were raped or were forced into marriages and were victims of abuse during the time of Indonesian occupation (Retbøll, 2002). Throughout the duration of the

Indonesian invasion and the subsequent struggles for survival and independence, women have demonstrated their abilities to survive the violence directed at them as Timorese and as women (Women and the Reconstruction of East Timor, 2001, p.2). But they still suffer violence today as part of their everyday lives, violence that largely remains hidden and which Manuela Leong Pereira (leader of the a national women's organisations) believes is persuasiveness and dangerous (cited in Retbøll, 2002)

Whilst national independence has been achieved it is does not automatically mean that women's liberation has been achieved. Prior to the first parliament a 'Charter of Women's Right in East Timor' was written and even if adopted it is believed it would be difficult to fulfil. Women gained more than 25 per cent of the seats in the election, which given the dominance of patriarchy was an incredible accomplishment. Another marker was in 2000 the first acknowledged women's congress was held (a previous one was held 1998 prior to independence) (Retbøll, 2002).

Women in Timor-Leste are vulnerable in many areas of their lives, both public and private. They "...face higher rates of illiteracy, malnutrition, and overall poverty...[they] lack access to resources and power to impact public policies and development strategies" (Women and the Reconstruction of East Timor, 2001, p.2). Poverty, whilst a global reality, has a greater impact on women and perpetuates the lack of access to resources resulting in high rates of maternal and infant deaths (Retbøll, 2002). There are many health problems that exist but for women, one of the most urgent is childbirth (Childbirth: A Major Health Concern for Women, 2001). On top of this Retbøll, (2002) indicates is the dominance of the Catholic Church, whilst supportive of the Timorese desire for independence, it is not so enthusiastic about Timorese women's freedom.

Today even though Portuguese colonisation and Indonesian occupation has come to an end, women are still facing hardship. A number of organisations exist to assist women by working to improve their lives in a range of ways. These include helping to address women's needs as carers, facilitating and enhancing information sharing, accessing resources, promotion of equal rights, developing opportunities for participation in society, and providing counselling to victims of violence. Clearly women want change, a change that gives them equity and decision making abilities, but is will take time and changes in people's thinking (Retbøll, 2002).

Much is still to be done; in October 2003 the presence of UN still remained very visible to an outsider. Whilst considerable progress has been made, data reveals that

Timor-Leste is relegated amongst the twenty poorest countries in the world and the poorest in the Asia Pacific region. It is therefore not surprising that economic growth and poverty reduction are the overarching goals of the newest nation in the world (EBUNDP & UNPF, 2002). Timor-Leste will be dependent on outsiders, individuals, agencies and nations, for assistance, aid and expertise. Independence for some has meant a continuation of some of the issues that existed under Indonesian rule, particularly those of control (personal communication).

Conclusion

Knowledge and understanding of what has gone on before can increase sensitivity to current and potential issues. This is important for all areas of development whether it be economic, education or health. Traditional society and ideas of family, colonisation, Indonesian occupation, education, health and wellbeing are a few ways in which the past will influence today as well as the future.

Health, health beliefs and actions are all influenced by what has gone on before and childbearing is no exception. The limited, and in some localities the lack of, formal health facilities has meant that people have had to take self-responsibility for the health and well-being of themselves, families and communities. Giving up this autonomy may well be difficult and, realistically if it is to occur, will take considerable time and consultation. Data that is yet to be released from the health survey and national census is likely to be extremely useful, but needs to be supplemented with other sources of information, in recognition that generalised and aggregated data needs to be considered carefully.

People who have experienced death and destruction, forced contraception and had power exerted over them by those in authority, will surely experience some effects. How this occurs and how they will react is unknown, also unknown how they will respond to advice from so called experts even if they come with the best of intentions. Their caution and reticence should not be unexpected, nor should people who express these views and act accordingly be criticised. If development is to be sustained, there must be consideration given to the past.

CHAPTER FOUR

Methodology and Researching in Timor-Leste

Introduction

Information on qualitative design and approaches to research vary with some placing emphasis on the need to be flexible. Flexibility enables negotiation and adaptation to the needs of those being researched as well as the environment (Ezzy, 2002a, p.80). There is no one method that can be unquestionably applicable to any particular research. It is therefore important that a range of ideas and strategies are understood before entering the field. Due to the overall aim of this project, that is to gain insight into childbirth in Timor-Leste, qualitative research was the preferred approach as it enables aspects of people's lives to be examined (Ezzy, 2002a).

Participants from Soibada, a sub-district in rural Timor-Leste, were to be the focus of primary data collection. Focus groups with local women became a key method for gathering local information. The women who participated initially appeared shy at the prospect of participating, but this was only temporary as considerable discussion and sharing of information occurred. My overall sense was that the women were keen to have the opportunity to be heard. Strategic to this willingness may have been the utilisation of an interpreter that was not only known but, I perceived, respected by many of the women.

Not surprisingly there were limitations to the project, particularly the very nature of an outsider attempting to gather data about women's experiences from a location that was vastly different. As a beginning researcher venturing into the reality of 'others' I was mindful of past research criticisms regarding the unequal relationships between researcher and researched. To gain comprehensive understanding would require greater information than could be obtained in the time I had available in the field. It is hoped that my portrayal of the data does reflect, as much as possible, the information that was provided. My intention is that this research will in be a small, but positive, contribution to this new nation.

Background to Research

Over recent years, in varying degrees, Timor-Leste has received considerable media attention, especially between 1999 and 2002. Despite having lived all my life in

either Australia or New Zealand I had successfully managed to take exceedingly little notice of the media reports and was consequently relatively ill informed (until 2002) of the political situation as well as the health status of the population. With a long-standing interest in aspects of women's health it seemed only natural to identify a research topic that incorporated childbearing and culture as both have featured largely in my life over the years.

Indicators place Timor-Leste in amongst the poorest countries in the world with an estimated forty-percent of its people living on less than US\$0.55 per day (MOH, 2002, p.2). It is therefore not surprising that one of the key tasks of the government of this newly independent country is to improve the health status of its citizens as there are clear links between poverty and health status. The identified concerns regarding the health status of the Timorese and the subsequent influx of aid organisations and workers from many countries creates a potential for divergent views between health recipients and those responsible for development and provision of healthcare and services. Middleberg (2003) indicates that when working to improve reproductive health one cannot ignore the context in which people live and the influences on actions, choices and behaviours. A number of the objectives identified by the MOH (2002) relate to women with particular attention given to childbearing women. These include the need to: "[r]educe levels of maternal and infant mortality; improve reproductive health in Timor-Leste [and] increase women's access, both to health information and to quality health services" (MOH, 2002, pp.9-10).

I believed I came to this topic with insider knowledge about childbirth, but I recognised that it was a western model of childbirth that largely dominated my views and knowledge both personally and professionally. I had limited knowledge or experience of childbirth in any other cultural form or geographical location and was keen to shift from this narrow worldview. I feel I am not alone as I believe there is a likelihood others are in a similar situation. The identification and subsequent exploration of this topic would widen my horizons and place an element of value on the experiences of women in Timor-Leste. My rationale was multifaceted in that I also hoped to contribute to the body of knowledge about childbirth for people interested or involved in development work, particularly in Timor-Leste.

The purpose of this study was to gain 'thick descriptive' data. Geertz (1973), borrowing the term from Ryle, uses it to explain ethnographic work as being more than straightforward observation. A 'thick description' enables a greater understanding to be

reached of daily realities or particular events. To achieve this, the researcher aims to obtain as much information about peoples lives, primarily from their perspective (Snape & Spencer, 2003). Whilst it is not possible to provide a total view, it does provide the opportunity for deeper understanding.

Research

Qualitative research assists in providing an understanding of the world and the people that live in it. The contexts in which an individual or groups live greatly influence the choices and actions that are available or taken by those people. As Brockington and Sullivan (2003) say, “[q]ualitative methods are used to explore the meanings of people’s world - the myriad personal impacts of impersonal social structures, and the nature and causes of individual behaviour” (p.57).

This research places emphasis on qualitative methods of inquiry. Qualitative inquiry requires researchers to make explicit certain information about the research and the researcher/s in recognition that these influence meanings and interpretations. Reflexivity requires the researcher to consider, what has influenced interpretations, exploration of other possible interpretations, being open about ones viewpoint and associated bias (Laws, 2003). Being reflexive about one’s work is a key aspect of qualitative inquiry as it facilitates the recognition that what we see, hear and conclude is our interpretation. A reflexive process:

...is an attempt to identify, do something about, and acknowledge the limitations of the research: its location, its subjects, its process, its theoretical context, its data, its analysis and how accounts recognize that the construction of knowledge takes place in the work and not apart from it. (Smyth & Shacklock, 1998, p.7)

A person’s views are the culmination of that person’s life including one’s “...nationality, gender, ethnicity, age,...beliefs and values” (Laws, 2003, p.80). Smyth and Schacklock (1998) believe that without self-reflexivity there is a strong likelihood that dominant ideas and positions will go unquestioned, it also facilitates the ability to make visible issues that are either hidden or taken for granted (Laws, 2003). If researchers are aware of their own assumptions (Rubin and Rubin, 1995) this diminishes the possibility of them imposing their own beliefs and values. This lessens the potential of distortion or altered meanings in the translation process. It is essential that those associated with research are acutely aware of the cultural baggage that they bring.

Approaches underpinning this study are constructionism and feminism, both of which influenced the overall justification of the research, the data sought and the ensuing analysis. Also influential are the ideas of Wright Mills (1959) and Willis (2004) and their emphasis on the benefits of exploring wider aspects of society past and present.

Constructionism

It is important to acknowledge that there is divergence in explanations regarding constructionism which is reflected in the wide range of explanations (Velody & Williams, 1998, p.3). Burr (2003) uses the analogy of family to describe the differences, siblings may share characteristics but no two look the same, this can be the same for explanations of constructionism.

Constructionism works on the premise that people's understandings and interpretations of life are influenced by the context in which they live and that rather than one reality there are multiple realities that are formed through a process of consensus. Universal understandings and explanations are explored to give insight and meaning as to why they exist and the power relations that may be involved. The idea of objective truth has no merit, as how people perceive their experiences and lives, defines their reality and worldview (Patton, 2002). Constructionists hold the view that knowledge is not discovered but is constructed which requires researchers to be sensitive to a range of standpoints as our realities are created and influenced by our interactions with others (Marvasti, 2004).

In view of these ideas the experiences of childbirth will be different for women in different situations and environments. Within this view one would not judge the situation of one against another, rather giving recognition to multiple realities. In an attempt to understand realities it is important to consider the context or setting in which people live. In doing so it becomes evident that attempts to generalise across groups would be difficult if not impossible due to the divergent contexts (Patton 2002). Constructionist take a relativist approach giving credence to the idea that knowledge and ideas are not fixed over time or place, and are culturally and socially embedded (Patton, 2002). There are critics of this relativist stance particularly if an extreme position is taken, Green and Thorogood (2004) believe that within health sector inquiry this stance maybe unhelpful.

Kuhn (cited in Patton, 2002) whose work remains controversial, pays particular attention to power in the construction and shifting of ideas and norms. When ideas can

not be explained or 'fitted' into existing norms or knowledge, the old are amended or discarded. For this to occur power is necessary to support those who put forward new ideas, therefore one needs to have a certain amount of power to influence others in the construction of new realities. It is considered that dominant views, at any particular time, serve the interest of those with power (Patton, 2002). Constructionism encourages the questioning or exploration of the often taken for granted; including how power is acquired and how dominant ideas are created and maintained (Green & Thorogood, 2004).

Feminism

Within aspects of feminist thought and research there can be considerable overlap with constructionism, for example both give consideration to the construction of realities and power (Green & Thorogood, 2004). Qualitative research is often viewed as a hallmark of feminist research in its attempt to foreground experiences and social realities of women. Whilst divergence exists among feminists, it is largely about the construction of knowledge rather than variance in the information that is collected. Central to debates regarding feminist research is the importance of who is the 'knower', attention is also given to power relations between researched and researcher and the idea of whether all women are oppressed (Alice, 2003).

Whilst feminist research carries an underlying concern regarding the existence of power relations within society and between groups, the goal of empowerment is not always explicit. The concept of empowerment is utilised in a number of disciplines at times creating some confusion, possibly influenced by divergent understandings of power. How power is understood influences what the term empowerment means. Rowlands (1997) identifies a feminist understanding of power as broad, incorporating tangible and intangible expressions that ultimately create barriers for women at institutional and personal levels and maintain inequities. Thus empowerment is a process, which is "...more than participation in decision-making: it must also; include the processes that lead people to perceive themselves as able and entitled to make decisions" (Rowlands, 1997, p.14).

Attention to equity as a common theme influences methods and inquiry. Emphasis is placed on participation, collaboration and empowerment (Patton, 2002) as opposed to more traditional styles, which tended to ignore women and direct power into the hands of the researcher. Feminist researchers have tended to focus more on

individuals and groups who previously had not been listened to, or have been marginalised (Rubin & Rubin, 1995).

Feminist inquiry incorporates a number of key underlying themes that influence the ideas of the researcher. Consideration is given to acknowledging women's experiences as gendered experiences and acceptance is given to the view that women 'know the world' in particular ways (Patton, 2002). The overarching aims of feminist research are the investigation of social inequities through examination of women's societal positions. Other research may also do this, but feminist research does have a particular focus on "...the social implications of sexual differences" (Alice, 2003, p.62). The fundamental differences to other qualitative research are the underlying values rather than techniques, and as such, regardless of the research topic feminist research is inherently critical (Alice, 2003). Feminist research challenges assumptions, such as the idea that development is unquestionably desirable. The ultimate aiming is for positive change (Schram, 2003).

The Sociological Imagination

The underlying view articulated within the Sociological Imagination is that analysis needs to recognise that many factors effect peoples' daily lives and subsequently play a significant role in decisions and actions. To facilitate analysis the Sociological Imagination provides a framework not only for analysis but also for data collection (Wright Mills, 1959).

Wright Mills (1959) emphasises key aspects that should be pursued in the process of inquiry placing particular attention on historical and socio-structural factors that influence people's ways of life. He identified the need to explore cultural values such as freedom and reason. He believed a "...social study that does not come back to the problems of biography, of history and of their intersections within a society has not completed its intellectual journey" (Wright Mills, 1959, p.6). Emphasis on historical information is linked to the view that neither individuals nor society exist in an historical vacuum. Knowledge and understanding of diversity over time and place facilitates the recognition "[t]hat a given question...most often will be given a different answer when it is asked of different societies and periods" (Wright Mills, 1959, p.146). Wright Mills, (1959) was concerned with what he considered to be a growing apathy to aspects of everyday life resulting from a lack of awareness of values or threat to them. This leads to a sense of uneasiness even though the underlying cause or reasons for concern may not be known (Wright Mills, 1959).

Acquiring an understanding of people's realities requires a consideration of the links between personal problems and social issues, leading one to ask what values are being threatened. Personal troubles are those that are linked to "...the character of the individual and with the range of his (sic) immediate relations with others" or as Willis (2004, p.19) explains it is something that happens to individuals. Social issues are "...to do with matters that transcend [the] local environments of the individual and the range of his (sic) inner life" (Wright Mills, 1995, p.8). The organisation and structure of society significantly influence the existence of social issues (Wright Mills, 1959).

How social institutions are organised into a social structure is a crucial point of analysis. A remedy or assistance to a social problem is not within the range of opportunities available to the individual (Wright Mills, 1959). An example of this could incorporate aspects related to childbearing, such as the increased likelihood of problems for the woman and infant if the woman has a diet lacking in nutritional quality. While this is a personal problem involving consideration of foods consumed, it is also a social issue when a considerable number of the population are in similar circumstances. The solution requires not only acknowledgement of the social issue but also change strategies involving economic and political institutions as well as the other interrelated facets of social life.

It could be argued that Wright Mills' (1959) ideas might well be outdated as the world has changed considerably since the 1950s, but this is not the view of Willis, (2004), who indicates that understanding is just as important as always (Willis, 2004, p.24). In the pursuit of a sociological understanding Willis (2004) believes the use of tools is helpful as they assist manoeuvrability through a maze of obstacles that are present when trying to make sense of the social world. Utilisation of the Sociological Imagination enables one to explore and gain understanding of the connections between individuals and society.

I believed the Sociological Imagination to be useful for data collection and analysis, to facilitate a deeper understanding of childbearing in Timor-Leste. As I worked through the maze of information I asked the following questions using the format suggested by Willis (2004):

- Historical: what has been the effect of Timor-Leste's past on childbearing practices and experiences?
- Cultural: how do local norms and values effect childbearing women?

- Structural: how do social institutions and structures shape childbearing women's lives?
- Critical: what can be done to improve on what exists (Germov, 2002)?

This research does not directly answer these questions, but it does identify and place particular emphasis on some aspects that may provide points to consider, when asking the question: how can things be better. The Sociological Imagination 'fits' well with feminist and constructionist ideology as this tool facilitates exploration of such aspects as power relations and how people's realities are constructed.

Ethical Considerations

Debate has occurred in recent years about researching 'other groups' which includes those in developing countries, the legitimacy of which has been questioned (Scheyvens & Storey, 2003). Some consider it further evidence of the exploitation of less powerful groups, especially if previous relationships of colonisation have existed between the country of the researched and the researcher or if only the researcher gains from the process. Another criticism is that research may be equated with 'academic tourism' (Cowforth & Munt in Scheyvens & Storey 2003).

This has led to the question of who can research whom. Scheyvens, Scheyvens and Murray (2003) query whether gender similarity or difference should be considered when undertaking research in developing countries. They indicate several prominent writers who describe numerous reasons for females to interview females, especially if the topic is sensitive. It is noted though that it should not be taken for granted that women will be able to build a better or workable relationship with other women. Nor does it necessarily mean that males cannot research females, but recognition needs to be given to gendered differences between researcher, researched and the community in which research is being undertaken.

Merriam (2002, p.61) found that the process of undertaking research in other cultures identified issues of "power, positionality and knowledge". This is thought evident in the curiosity of the participants regarding her "whiteness", thus clearly marking her visibly as an outsider which she believed enhanced her ability to enlist some participants. Her outsider status also enabled her to ask certain questions which resulted in an ability to be 'more effective' in exploring sensitive topics (Merriam, 2002). This may not always be the case (Rubin and Rubin, 1995) when interviewing people of other cultures as some may view certain queries as being invasive and personal.

For people to share information with an outsider requires some degree of acceptance. The seemingly naturalness of one's daily actions can be hard to explain as rules can be adhered to without any consideration of their existence. Some information can be learned through participant observation but this can require considerable time and expense, especially if it requires crossing boundaries into people's personal lives and spaces, making it not only unrealistic but unethical. Generally people are willing and happy to talk about their lives and having someone interested can give people the opportunity to share and teach others or it may provide recognition and/or confirmation of role or status (Rubin & Rubin, 1995).

Prior to leaving New Zealand I applied for and received ethical approval based on criteria and processes deemed necessary by the academic institution, Massey University, at which I was enrolled to undertake my Masters of Philosophy. I was unaware of any Timorese structures that existed in relation to ethics requirements so in an attempt to clarify this I wrote to the MOH. Their response requested that I submit copies of my ethics proposal and confirmation of approval from my supervisor. I was able to do this prior to leaving New Zealand, I was then asked to make contact with the Director General of Health or his assistant on arrival.

Research Methods

In the last two to three decades there has been a shift, by some, from undertaking lengthy ethnographic fieldwork to the development and recognition of the value of 'rapid' methods for collecting data, such as Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA). Whilst sometimes controversial they have proved helpful "...in informing many public health interventions, and ...can generate useful data to aid specific projects" (Green & Thorogood, 2004, p.147). Their usefulness is particularly apparent in that they allow data to be collected quickly and cheaply without detriment to overall quality. The more recent inclusion of participatory methods is considered of particular use in assessing health needs (Green & Thorogood, 2004).

Ideologically I had thought that participatory rural appraisal provided a range of methods that would enable participants to share their experiences (Laws, 2003). Core aspects of participatory research are that it values local knowledge and facilitates participation, thus enabling voices to be heard which might otherwise be excluded. A potential outcome is that those being researched are more involved in determining not only research direction but also outcomes, than methods used in the past (Schevyens &

Storey, 2003). It is therefore considered that this type of research will have greater use for participants (Green & Thorogood, 2004).

Participatory rural appraisal (PRA) provides a strategy to undertake small scale research within a short period of time coupled with the ability to gain insight into concepts and practices of diverse groups. There is an "...emphasis on learning with and from groups in the community in a relaxed and flexible way" (de Koning & Martin, 1996, p.1). There is a greater likelihood of acquiring local information within a shorter timeframe than many conventional methods.

Many of the methods that are incorporated under the umbrella of participatory research are not new, but it is the process and how these tools are used that facilitates participation (Mikkelsen 1995). Chambers (1997) indicates that PRA has three central tenets: facilitation, not domination; shifting methods to open, visual and comparative; and partnership between parties, thus for many the underlying theme is empowerment. Some emphasise principles of equality, humility and respect whilst others describe PRA as a commodity, a routinised ritual or instrument that legitimises decisions made elsewhere. New methods continue to evolve due to increased popularity and the ability to adapt to environments. Visualisation methods such as maps and matrices are commonly used; application for some goes beyond tangible descriptions (Pratt & Cornwall, 2000).

By utilising a more mutual and less authoritarian stance in data collection the participants are deemed to be empowered through a process of shared learning and identification of commonalities and differences between those involved. Participants maintain control throughout the process in many ways, such as choosing what information to share and how, and by utilisation of methods that suit them, these can include verbal or visual. Participation can extend to participants having the opportunity to read and correct the researcher's data (Scheyvens & Storey, 2003).

It had been clear from the beginning that to obtain information from women in Timor-Leste that an interpreter would be required. Leslie and Storey (2003) identify advantages and disadvantages associated with this. Whilst on one hand note taking can be easier, it also means that one is dependant on information that has to be relayed making it second-hand or filtered (Mikkelsen, 1995). Researchers often make choices about interpreters based on the qualities and knowledge that they bring.

Timor-Leste - The Experience

Flick (2002, p.46) believes that an often ignored aspect of qualitative research is the formulation of the research question. It is therefore recommended that considerable thought is given to the question before entering the field, though this should not preclude openness to emerging ideas, otherwise interpretation of data may be extremely difficult. The other reason is that prior thinking enables checking of appropriateness of intended methods both before and during the research process (Flick, 2002).

The intent of this research was to make contact with and acquire information primarily from women who had previously given birth, whilst living in Soibada, Timor-Leste. It was believed that they would be able to provide insider stories regarding local childbearing beliefs, practices and experiences. Importance is given to the valuing of women's experiences and a need to facilitate opportunities for women's voices to be heard. This can be a step in shifting the emphasis of childbirth away from the potentially powerful structures of biomedicine (Sookhoo, 2003).

Within two days of arriving in Timor-Leste I meet the Assistant Director General of Health and provided an overview of the anticipated direction and purpose of my study. It was recommended that I try and make contact with the head nurse of the Manatuto hospital who had already been informed of my research application. At this point verbal permission was given to undertake my research. Delayed departure from Dili and a punctured tyre on the outskirts, meant I arrived in Manatuto after working hours and too late to make contact. I was thankful this contact was primarily an act of politeness rather than a requirement, as due to the limited availability of transport I had no second chance.

Literature indicated the existence of a hierarchy in Timorese society; I therefore considered it would be advantageous to obtain approval from the sub-district administrator of the area where I intended to access participants. I presented myself at his office providing him with written information regarding my intended research. This meeting occurred without an interpreter (as no one was available at that stage), but with the use of my translated information and a limited ability to communicate verbally I believe my intentions were understood and no opposition was apparent. We parted with greetings, smiles and a handshake I subsequently took this to mean his consent.

The location I had chosen for this research was not random, in that I placed considerable importance on the necessity to be able to arrange accommodation with people who could speak English, as I am monolingual. I had attempted to learn some

key *Tetum* words prior to leaving New Zealand but had made limited progress. I was fortunate to be given (by a New Zealand contact) the choice of two locations to stay, one rural and one urban. As my intention was to gain insight into childbearing in Timor-Leste, I believed that the destruction, which occurred in the aftermath of the elections resulting in diminished health services, combined with issues of remoteness (Araujo, 2001) would bring particular issues for rural women and families.

One of my most noticeable adjustments once I arrived in Timor-Leste was my sense of dependency on my hosts. I quickly learnt the reality of being an outsider. Due to my hosts local knowledge and status in the community they were able to assist me through hurdles, as they presented, ensuing that my research was able to proceed.

On arriving in the field I discovered that acquiring the services of an interpreter was more difficult than I had been led to believe. Left with limited choices, at one point I needed to consider the implications of having a male who was known in the community or foregoing the research if I could not get another interpreter. I felt uneasy about a male undertaking this role and the potential issues that may emerge, based on my understating of local norms. An Australian midwife, who had spent some time working in Timor-Leste in recent years, had indicated that due to the nature and topic of my intended research women would most likely speak to another woman who had children. An alternative person became available, after a period of time, a woman known to the community as she had lived and worked there. There was evidence that she had a degree of status in the community, and thereby was accepted (in that role), but she did not have children which left me uncertain as to whether this would be a barrier to information sharing by participants. Gender, status and availability were decided as the most crucial factors in choosing an interpreter.

Leslie and Storey (2003) indicate that “[e]thnicity, age, status and sex” (p.133) are key points to consider when choosing an assistant in the field. Fluency in the language of the participants can have many benefits including an ability to interact personally as well as facilitating richer data collection (Leslie & Storey, 2003). On the reverse side of this the researcher can feel frustrated, dependent and have lowered confidence in the ability to succeed if one does not understand the language. Involving local community members in interviewing in their own communities can lead to issues of status and representation (Laws, 2003). It was therefore considered essential that participants were clearly informed prior to commencing data collection that the role of

the interpreter in this context was solely that, and that the researcher would hold all information.

The difficulty in obtaining a suitable interpreter led to time constraints as my time in the field was rapidly diminishing. The interpreter was also only available for limited times. These two factors effected data collection options that I had initially thought might be relevant. The primary methods utilised were that of observation, focus group discussions and key informant interviews. I had, prior to departing New Zealand, explored a wide range of secondary data sources as background information and to stimulate ideas for potential points of inquiry and analysis.

Focus group discussions have the facility to enable a considerable amount of information to be collected increasing the potential for insight into complex situations. "Like in-depth interviewing and participant observation, focus groups have as their basis a promotion of the value of investigating social situations through subject knowledges and life experiences of the respondents" (Alice, 2003, p.64). Therefore in view of the situation, focus groups seemed an effective and efficient method and one which the women appeared willing to participate in.

The use of focus groups and broad open-ended questions provide participants with an opportunity to make decisions regarding their active involvement and what information is shared. Additionally it was felt that some specific information would also be necessary, to achieve this more structured questioning was included. As the researcher I was mindful that there was a huge potential for questions to be considered inappropriate or invasive. Lewis (2003) recommends that sensitive topics are best addressed in a clear direct manner to reduce ambiguity and confusion. In conjunction with this it is important to be observant of the participant's response, especially noting a sense of being ill at ease. The topic of sexual relations was approached, but it was felt the women were uncomfortable responding, so questioning was altered for subsequent focus group discussions. Gray (2003) gives credence to the need for a pilot interview as a start from which the questions and approaches can be reviewed and adapted. I did wonder at times if my sensitivity to what maybe sensitive topics coupled with a keenness not to be overly assertive restricted data collection.

Laws (2003) talks of the need to be flexible when doing research and maximising opportunities as, and when, they arise even if the methods do not fit with the original plan. She does emphasis that the need for permission is always important. Despite some prior thoughts on: how to collect data, from whom and whether individually or in

groups, the outcome was that three groups of women and four key informants participated. The process and criterion for selection and subsequent participation varied due to the particular knowledge sought, ability to access and a need to ensure as much as possible a process of informed and willing participation.

Rubin and Rubin (1998) indicate that a period of participant observation prior to interviewing may facilitate the breaking down of barriers between the researcher and intended participants. Based on this I made a point, from the time I arrived in the field of making myself visible. Every day at different times I would walk around the nearby villages with the intention of geographic familiarisation, but most importantly in anticipation of meeting local people and having the opportunity to commence relationship building. I endeavoured to stop and speak with the local people I meet. I shared information about myself, showing family photos, this generally stimulated additional discussion.

Building a relationship with participants can be important in that it facilitates the sharing of information. People's decision to participate can be influenced by how the researcher is categorised and the roles they are understood to have. Choosing and identifying certain roles over others, Rubin and Rubin (1995) believe does not distort who you are but allows "...you to select those aspects of who you are that make sense in the world of the interviewee and that facilitate conversation" (p.116). I therefore considered that giving some background information about my partner and children would assist in the process of identifying commonalities through women's shared experiences. Flinn (cited in Leslie & Storey, 2003) indicated that in her experiences the openness of women's sharing was greater if they are aware of aspects of one's background.

The notion of shared experience is also linked to the insider/outsider debate. It is argued by some "...that cultural understanding is facilitated by a close relationship of identity between the researcher and the host culture" (Aitkinson, Coffey & Delamont, 2003, p.41). Whilst this may present aspects of advantage it can also have the danger of not being able to see that which is already known, as well as a tendency to oversimplify and make assumptions regarding importance of some information (Aitkinson, Coffey & Delamont, 2003). On the other hand it is thought that an outsider, sometimes, is better able to understand a situation (Brockington & Sullivan, 2003), as they may be seen as less threatening or may be taken more seriously in view of an ascribed status of 'foreign expert' (Scheyvens, Scheyvens & Murray, 2003).

It was suggested to the women invited to participate that they could also invite others, if they knew women who had previously given birth; they would also be welcome to come along to our arranged meeting. Overton and van Diermen (2003) indicate that there are a number of strategies for accessing research participants, including convenience and snowball sampling.

Convenience sampling as it implies has no clear strategy, the researcher chooses participants based on ease of access (Ritchie, Lewis & Elam, 2003). In snowball or chain sampling a participant is chosen based on certain criterion. This person knows of, or assists in finding other likely participants, resulting in an increased number of participants. This technique for acquiring participants is not uncommon and is relied upon to generate access to a greater number who share an interest in the topic the researcher is intending to pursue (Davidson & Tolich, 2003). Obtaining participants using this strategy is also beneficial when there is limited knowledge regarding the population one is attempting to access (Davidson & Tolich, 2003).

Accessing potential participants occurred in a number of ways and included a number of steps. Once I had assured availability of an interpreter I approached women, with whom I had already interacted, thus familiarity (and convenience) with some community members was the key strategy. I provided these women with the translated information sheet, the benefits of which could be debated due to high rates of illiteracy throughout the Timorese population. For the women approached the majority appeared to read and comprehend the information and I attempted to supplement this using my limited *Tetum*. One woman called an adolescent neighbour to read the information to her. Once I sensed the women understood and were in agreement to participating, I organised meeting times two to three days later. We negotiated the place and time to meet, which resulted in two of the three meetings being held in homes, the third on the veranda of a local facility. One can assume the additional women that participated in the focus group discussions were selected by my initial contacts due proximity of residence, they were known to each other and felt comfort in each others presence.

In many situations it may not be possible to interview or access participants that are a representative sample. This can often be the case in developing countries, as adequate data does not exist which makes it difficult if not impossible to determine representation (Overton & Diermen, 2003). At no point was it expected that this research would obtain representative data. Qualitative research does not aim to make generalisations thus population representativeness is less significant. What is

considered important is the need to obtain information using a range of methods and sources. It is through the utilisation of various approaches that enables validity or confidence in the 'accuracy' of the information to be achieved (Davidson & Tolich, 2003).

Due to the time constraints that had emerged it was thought focus groups would be a useful method as it has been demonstrated they can facilitate the sharing of larger and often more complex ideas in a relatively short period of time (Alice, 2003, p.64). This is not to say that there are not disadvantages, for example the depth of information may be less than that given at an individual interview (Gray, 2003; Marvasti, 2004) or some participants may attempt to dominate and override others (Marvasti, 2004; Rubin & Rubin 1995).

A benefit for participants is that there can be a shift in attention from individual to group. This can encourage women to contribute as they are less identifiable and less intimidated, especially in view of the personal nature of the topic (Madriz in Patton, 2002). The sharing of sensitive information may be easier for groups of women, resulting in increased "...confidence and a sense of safety and camaraderie from being part of the interview group" (Patton, 2002, p.389). Parameswaran (cited in Patton, 2002) found that women may resist consenting to participate in individual interviews especially if the topic is considered sensitive.

Focus group discussions can reveal different information to that of individual interviews, as ideas can flow providing a range of dimensions to the topic under discussion (Rubin & Rubin, 1995). This can bring unexpected issues to the fore (Yates, 2004) that can then be further explored. This occurs as the discussion triggers other responses as participants reflect on what is being said. The process is best described as synergetic due to working together and the interaction that occurs in the generation of data (Finch & Lewis, 2003).

Whilst there is a need to ensure discussion provides insight into the topic it is impossible to be too directive about the topic that is posed. A focus group is more than an informal sharing of information as it requires the researcher to ensure the participants are given overall direction, guiding ensuing discussions (Rubin & Rubin 1995). Discussions reveal shared impressions from a group, though individual differences can also be exposed, the result is broader information ranging from broad to specific (Rubin & Rubin, 1995). The utilisation of focus group discussions means the researcher's

views are less likely to influence the data that emerges freely from the group (Gray, 2003).

It is suggested that the role of the researcher is that of moderator who observes and works toward ensuring that all members have an opportunity to speak (Yates 2004). One group interviewed included a woman who was not fluent in the language predominantly spoken by other members, though many could speak her first language. She required additional translation to enable her to understand and thus contribute; this meant she was dependent on group members to include her, which seemed to limit her overall participation compared to other women.

The format of the focus group discussions included a range of approaches including specific, semi-structured and open-ended questions. The women tended to discuss topics amongst themselves, followed by common or individual responses. Other than the women, the others present were young children, the interpreter and myself, sitting together in a circle. When older children or younger women, unmarried and without childbearing experience, attempted to join the group they were quickly sent away.

Key informants are selected for the perceived knowledge of particular subjects and issues, thus it is important to take care in the selection so as to achieve the intended purpose (Kumar, 1993). In the utilisation of key informants and in-depth interviewing it is necessary to consider the type of data that one is hoping to obtain, once again information is not representative as it is only one person's account (Green & Thorogood, 2004). It is considered to be a quick method of obtaining specific collective or specialised information (Davidson & Tolich, 2003).

All key informants chosen had connections to Soibada living there at some point, two were qualified health professionals who also had family connections in the villages. It was intended that the 'expert' knowledge of participants would not override that of the women, the intention was to use their information primarily to build on existing ideas or to clarify points of uncertainty thus questioning tended to be more specific. The two health professionals were interviewed following the focus group discussions.

The other two key informants had resided in the area for a shorter period of time and had no family connections or childbearing experiences. The focus of these interviews was to obtain local information such as general infrastructure, population, insight into pre and post independence changes and an overview of aspects of local realities.

The three focus groups and two key participant interviews were conducted with the use of an interpreter. Key questions and ideas had been identified to the interpreter as well as discussions regarding her role, expectations and processes prior to meeting with participants. The general format included initial formalities, covering the issues of informed consent, introductions then questions and discussion followed. Time was also allowed for the participants to ask any questions. All interviews were tape-recorded having first obtained permission. One key participant was interviewed twice.

Analysis

Regardless of the source and methods of information collection, at some point the researcher needs to interpret and understand the information (Flick, 2002, p.211). There are two main strategies for interpreting texts that can be used together or separately. One requires coding and categorising with the aim of revealing and potential theory development. The other aims to reduce, followed by reconstruction of, the material collected (Flick, 2002).

The collection of data through the use of interviewing can be seen as an expression of life, and is not considered factual due its construction in the form of narrative. The researcher collects experiences that are constructed and works toward interpreting and finally presenting it in a particular form. Flick (2002) indicates that the process involves a process of multiple constructions - by participants, by the researcher, and finally the reader and I would add in this situation the interpreter.

During the period of data collection (both primary and secondary sources) the ideas of Wright Mills (1959) and Willis (2004) influenced my decisions regarding what information was important and what was less important. I found myself spending considerable time obtaining and reading any literature about the history of Timor-Leste, of which there were a range of sources. Only limited information was available describing Timorese culture and Timorese women, which I felt was of significance but I am not confident in drawing any conclusions.

This left me anxious about directions to be taken during my fieldwork inquiry into childbearing. I found myself resorting to my own understandings (western) of childbearing, which ultimately formed the basis of initial questioning. But during discussions with local people as new information was acquired, I was able to broaden the focus. Having also undertaken anthropological study and having worked in the health sector I was mindful of the need for cultural sensitivity and issues of power and informed consent.

Collection of data from various sources, individuals and groups, can assist the researcher to test for validity. During the discussions and later during the analysis phase I attempted to find patterns and similarity in the ideas that emerged. Coding and looking for themes, is commonly used in quantitative research (Ezzy, 2002a). I clustered data together, primarily under western headings, to reveal similarities and differences (Marvasti, 2004). Whilst this may potentially have led to a loss of some individual voices I did have a sense that this had already occurred in some instances during the process of translation and during focus group discussions. Attempts were made not to lose sight of information that was provided by individuals or small numbers. By using this approach I reduced my data, making it more manageable (Marvasti, 2004).

As I was unable to return to participants to acquire deeper and richer data or for clarification, I utilised other data sources in an attempt to reveal a range of explanations for beliefs and practices. Examples from a number of ethnographic studies were incorporated at this point, in an attempt to demonstrate diversity and richness of practices.

At no point is it intended to imply that explanations from other sources should be applied uncritically to the local data. Trying to find universal meanings defeats the purpose of enabling local women's voices to be heard. Increasingly communities are seeking to differentiate themselves from other groups or communities (Goulet, 1995) as a marker of their own identity. Goulet (1995) indicates that every society formulates actions to enable their survival. Those working in the area of health need to be critical of similarities in practices and beliefs between groups and individuals in an attempt to reduce assumptions about behaviours.

Issues and Considerations

The main issue that occurred was the difficulty in accessing an 'appropriate' interpreter. Time constraints were placed on those involved potentially limiting approaches and styles. Reduced attention was given to enabling different local styles of information sharing to occur. Delays and limited availability of the interpreter meant there was no opportunity to revisit and clarify information which could result in the misrepresentation ideas and information.

As the researcher I played a key role in the direction of the discussions, such the utilising the categories of pregnancy, birth and postpartum, based on western understandings of childbearing I had brought. Yorder (1997, p.140) indicates that there

is considerable benefit in constructing questions that more closely reflect local notions and categories. In this context, it could have been beneficial to acquire information regarding local categorisation of childbearing.

Of the four women initially approached, three agreed to participate, all of whom involved family/friends. There was some evidence of participant control in that they made decisions as to who were present, the timing, location and the information shared. Participants from all focus groups expressed a desire for recognition to be given to their involvement.

It is hard to know what could have been done in the planning stages to avoid the delays that occurred other than researching in another locality where accessibility to an interpreter would have been easier. As the researcher I could have chosen the option of researching women in an urban location where it would have been easier to find an interpreter. Avoiding 'hard' places to collect data potentially means some groups within society are likely to remain invisible thus exacerbating the potential for indigenous birth knowledge to be replaced or relegated to marginal or invisible status by 'technomedical imports' (Davis-Floyd & Sargent, 1997, p.13).

Anthropologists and project planners are warned that statements regarding beliefs are not predictive of behaviour; one strategy that may be helpful in data collection is that of participant observation (Yorder, 1997). Consideration needs to be given to the potential benefits in the future of undertaking this type of research.

Conclusion

Research can be undertaken in a number of ways and is influenced by a number of factors. The purpose of the study remained central, impacting on all stages from design to analysis (Mikkelsen, 1995). As I wished to obtain knowledge of childbearing in Timor-Leste including beliefs and practices, the search for appropriate methods and tools was important and involved considering a range of options.

Qualitative research facilitates the acquisition of descriptive data enabling insight into aspects of people's lives to be obtained. It was apparent that to enhance data collection adaptability and flexibility were necessary if opportunities were to be maximised. But for a novice the disconcerting aspect was that there is no one right way of undertaking qualitative research. Past criticisms of researchers encouraged me to incorporate methods that allowed for what I believed to be collaborative rather than ones that had the potential to leave participants feeling powerless.

Feminist and constructionist thinking appeared to reflect aspects I believed were central to this research, including the view that people's experiences are influenced and determined by structures, events and those around them, rather than being fixed and universal. Women over the years have often been ignored in research or assumptions made about their place and the knowledge they carry. When considering the topic of childbearing it seemed important to give credence to women's experiences through the valuing of their reality.

Wright Mills, (1959) and Willis (2004) have developed the concept of the Sociological Imagination, which provides a valuable tool for people intending to gain insight into social issues. They believe consideration and questioning needs to incorporate historical, cultural and structural factors within society. Particular questions need to be asked before solutions can be planned. Data collections, both primary and secondary sources, as well as analysis were influenced by these authors' ideas.

The research methods utilised were focus group discussions and individual interviews. These are commonly used qualitative methods that enable the collection of significant sources of information in a relatively short period of time. Participates were selected because of their perceived expertise either in childbearing, having had children themselves or as health professionals who worked with childbearing women.

The dual purpose of this study was not only to gain insight into childbearing in Timor-Leste, but also to provide a resource for people working in the area of reproductive health. Due to the prevalence of maternal and infant mortality and morbidity in this country and health objectives to improve the health of women, this is likely to be a key component of development.

This leads to the final part of the Sociological Imagination that of 'critical' how can things be better. The ideal outcome of this research is that it will play a small part in initiating positive change. This may be the facilitation of critical thinking by those working in this area, at best an improvement in women's lives that is sensitive to their realities.

CHAPTER FIVE

Childbearing in Timor-Leste and Other Cultures

Introduction

Six weeks in Timor-Leste and a review of the literature revealed that childbearing beliefs, practices and experiences are far from universal. My time with women in Soibada and other participants was brief, and the depth of information I obtained only touched the surface but there is a wealth of ethnographic studies available to assist cultural understandings of childbearing. During my time with participants my desire for more information had to be balanced against other demands on the women and interpreter's time. Further investigation is necessary not only to check for accuracy of my interpretations but also to gain a deeper understanding of meanings and experiences of women in Timor-Leste.

As was indicated by women some of their behaviours during childbearing occurred because they were 'tradition' and had been handed down through families and communities members. For the outside inquirer the 'rationale' and meaning of many of the practices were not readily visible, but this does not make these traditions any less important or valid. To further develop understandings of childbearing, including cultural meanings and actions, local information has been linked to a range of ethnographic studies.

Development has often been viewed by experts and others alike as 'progress', but it can also threaten cultures and traditions (Goulet, 1995). Leféber and Voorhoeve (1998) state "[k]nowledge of indigenous customs is essential for each health worker in the South" (p.1), as for many working in the area of public health there is an assumption "...the biomedical model is normative" (Yorder, 1997, p.132). For many people the biomedical model is far from the dominant healing system as health beliefs and practices are invariably linked to culture diversity prevails.

All groups live by sets of rules, consisting of: local knowledge, norms, values, rituals and symbols; which influence women, families and communities actions. One of the intentions of this research is remind anyone working in the field of childbearing, that people's lives and experiences are diverse, and the knowledge that local people hold should not be overlooked. If one is to be culturally sensitive one needs to take off ones 'cultural lens' in an attempt to see the world through different eyes.

The history of Timor-Leste shows there has been significant immigration over the centuries as well as outsiders exerting authority, both of which have influenced local people in a number of ways. Overtime and during times of crisis people develop their own responses to local situations, childbearing is one example.

The Local (rural subdistrict) Context

As an outsider it was more than apparent that the lives of the Timorese citizens were vastly different to my own. Urban rural differences were evident in the visual images that greeted me the day I travelled from Dili to the sub-district of Soibada, a distance of one hundred and twenty kilometres. The further from Dili we travelled more differences became visible, for example homes were increasingly built using local materials, particularly bamboo. Bamboo was used in walls, roofs, fences and channelling water to improve access.

Transport to villages varied, some towns and villages being serviced by *microlet* (minibus services) but many areas had no public or regular transport of any type. Some village women commented horseback was their normal mode of transport but they countered this by saying that they were joking, as it was not something they did.

Many roads were in a serious state of disrepair and the further from Dili the worse the condition. Road washouts had occurred during the rainy session over the last few years (since the departure of Indonesian authority and subsequent gaining of independence) leaving many roads in a state of disrepair due to financial restrictions on maintenance. The condition of roads appeared worse the further from Dili one travelled meaning four-wheel drive vehicles were needed to negotiate roads even in the dry session. The one river crossing that we needed to negotiate floods during the December to March rainy season (no bridge had existed to cross this river), making it impassable and cutting people off from towns and hospital services.

Many villages were interspersed along the road as were roadside stalls stocked with local produce, materials and wares. The nearest main centre and hospital to Soibada was Manatuto (also the name of the District) approximately sixty kilometres away. Prior to 1999 Soibada had its own ambulance stationed in the area but villagers were now dependent, in medical emergencies, on an ambulance coming from Manatuto to collect patients and take them back to the hospital. I was informed it would take two hours (each way) for the ambulance to travel this distance. I travelled the road on a number of occasions with a driver who knew it intimately, and on all occasions it took longer even in good weather conditions.

Villagers were dependant on the occasional vehicle for rides, and it was not uncommon for the Dominican Sisters who owned the only local vehicles to transport a number of people, many of whom were picked up along the way. On one occasion they left Dili with eight people, including the truck driver and arrived with another thirteen, some of whom had been waiting for three days for a ride to return to their villages.



Figure 5.1. Map of Timor-Leste with location of Soibada (MSN Maps & Directions, 2003).

During my time in the area I always felt welcome when walking around and attempting, in my limited and faltering *Tetum*, to speak to local people but I was constantly aware of being an outsider. This was made very clear to me on numerous occasions when children would see me travelling past and would call '*malae*' (foreigner) resulting in friends, family and children looking and waving.

The sub-district of Soibada consisted of several villages; it had a health clinic which was open from eight in the morning until one in the afternoon, Monday to Friday. The clinic staff of five, three nurses (males) one midwife (female) and one assistant (male and part-time) were 'on call' twenty four hours a day. They could keep and monitor a patient at the clinic but this was not frequent, they also had radio contact with staff at Manatuto hospital for emergencies. As well as daily clinics a staff member would travel, by motorbike, throughout the area holding mobile clinics.

Soibada clinic records showed one hundred and thirty three births during 2002. The Ministry of Health would prefer women to give birth in their local health clinic, but this desire was not universal amongst health professionals. One health professional considered the local clinic as unsuitable for women to labour and birth due to the limited availability of resources. Lighting and water supply were inadequate and it was felt that women's homes were better to give birth in as they had more resources though often neither running water nor electricity were available there either. The situation of inadequate facilities at clinics appears to be a common situation in developing countries. Wiley (2002) makes reference to facilities in India constructed by government development programmes with the aim of increasing access to biomedicine for the population, these had no water, unreliable electricity supply and unhygienic sanitation. Despite these conditions a significant number visited these clinics regularly, though the effectiveness of care, in achieving improved birth outcomes, remains unclear (Wiley, 2002)

Soibada has a government run elementary school and a Catholic secondary school, the latter is private requiring a fee to be paid. Children's school hours were dependent on the supply of teachers. To enable all students to have access to tuition, elementary classes were staggered, approximately three hours per day to cope with the teacher shortage. Secondary school hours for the children were longer but staffing was also a difficulty. Anyone wanting to continue onto tertiary education was required to relocate to Dili. Other facilities include the police station staffed by three policemen, a Catholic Church, two shops which carried a small but wide range of goods and on Sundays villagers ran a local market selling their own produce. Each village has its own chief (each sub-district would have several) and a sub-district representative was elected for a two year term as district representative in Manatuto. In the distance on a hill is a national shrine, 'Our Lady of Aitara', where people from all over Timor-Leste make a pilgrimage every two years. Despite the difficulties of access this area had a special symbolic significance.

Since 1992 the Dominican Sisters have run an orphanage in Soibada, currently accommodating approximately seventy children. Whilst some of the children were orphans, many others were there due to their family's extreme poverty. It is likely this arrangement provided some of the children with their only opportunity to access education, particularly secondary. The children were from anywhere in the country.

Each village, estimated to be approximately 100 to 150 people, had one communal water tap and one village only had access to tap water during the morning. During the dry season tap water may run out as the spring dries up, when this occurs the closest water is the river, several kilometres walk through the bush. Currently under construction is one toilet block per village, at present villages do not have a sanitation system.

Only a small number of homes have electricity connected mainly for lighting, appliances were virtually non-existent. Between 2002 and October 2003 no electricity was transmitted to this sub-district, it resumed during my stay (unannounced) though it was unreliable. Transmission was from approximately 6pm to 10pm. The Dominican Sisters at the orphanage had their own generator which they used morning and evening even when power transmission resumed as it was not strong enough to run a refrigerator.

Village lifestyle is largely one of subsistence agriculture. Due to a terrain which is hilly and has poor stony soil, villagers need to walk two hours each way to tend their gardens. Generally men and women tend the gardens, but exceptions did occur for example women needing to care for young infants. The main crops include cassava, sweet potatoes, turnips and squash. Other foods grown may include bananas, mangoes, lemons and sometimes ginger and mung beans. On rare occasions if transport is available produce is sent to Dili markets. This source of income is infrequent and sparse. Chickens tend to be free-range and are the main source of meat. Some people have pigs but these tend to be kept and killed for special celebrations. Other infrequent sources of meat are wild animals including deer, horse, cow, monkey, snake, dog, goat, eel and freshwater fish.

The Catholic Diocese owns the surrounding land including land on which homes are built, also the football, netball and volleyball play areas. Houses are built predominantly of bamboo, but other materials such as palm leaves, corrugated iron and occasionally handmade cement bricks are used. Homes are generally one to three rooms and had a life of approximately five to ten years. Foundations and floors are commonly made from stone with dirt floors or raised on poles. Family households were commonly multigenerational and extended.

Childbirth in Soibada

All the research participants either currently lived in Soibada or had in the past. They included two health professionals, two local key informants, and fourteen local

women who made up the three focus groups. Two focus groups consisted of three women and one of eight women. All focus group participants had previously been pregnant and given birth. Two women identified having children whom died. Of these one had no living children, her first child having died as a toddler, she was pregnant at the time of interview. The total number of children that each woman had given birth to varied, from one to eight (see Figure 5.2, for information from two of the three focus groups).

At the time of interviewing a number of the women were pregnant. I was not able to determine the average number of children born to women living in the area, though I did speak to one woman who had fifteen siblings. Whilst this did not appear to be the norm, many families were large, especially by western standards.

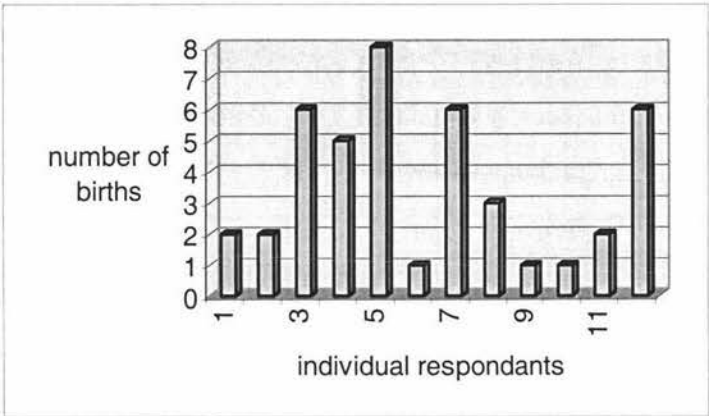


Figure 5.2. Number of births experienced by women interviewed

The women I interviewed initially appeared embarrassed discussing pregnancy and childbirth, but this dissipated as discussions continued and women talked amongst themselves; many responses appeared to represent the views of the group. As a strategy to minimise unnecessary stress and embarrassment, I decided to collect some statistical information first. As can be seen from Figure 5.3, the age of commencing childbearing, for nine of the participants, ranged from 19 to 25 years. Many of the women interviewed were still having children, making it impossible to determine the age childbearing commonly finished.

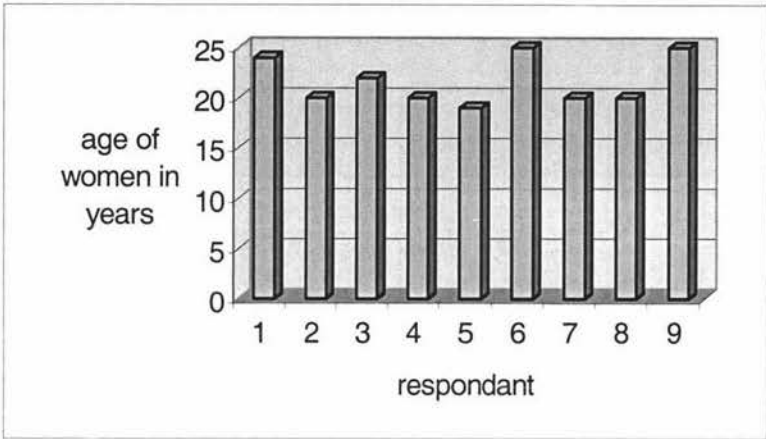


Figure 5.3. Ages of some participants at time of first pregnancy.

Women stated they knew very little, if anything at all, about childbirth prior to becoming pregnant and many indicated they would not ask parents for help or advice. Only one woman indicated her mother had given her ‘some information’. Some women had not realised they were pregnant until they were in labour and about to give birth. Several women indicated they had found, particularly their first experience, to be frightening. It appears reproduction is a relatively taboo subject. Due to this overall lack of information it was difficult for knowledge to be shared from one generation to the next. It was not until pregnancy occurred, or following, that childbearing was discussed, and only then by those who had children. It was hard to determine exactly what was discussed but as the women later indicated they often upheld traditional practices; it might be assumed these factors formed the basis of discussions.

In many cultures it appears that discussion related to childbirth can be restricted. Jordan (1993) indicates that women intrinsically know what to do when it comes to childbirth, without needing to know the details. For Yucatan women (Mexico) birthing information is given at the time of birth, primarily on what appears to be a need to know basis, as information is not considered important prior to this time. It is felt that even though information was not formally shared before the event it is not necessarily unknown as in Yucatan culture birthing occurs within the context of family, indicating that many had been in close proximity to birthing women.

For Soibada women their initial exclusion from birthing would have severely restricted this form of knowledge transmission. It was only after their first experience that childbirth was discussed and it tended to be with those of their own generation (female) who had children. It was only after acquiring the status of mother that a

woman would be included in another woman's birth. Therefore it was generally indicated that the main sources of information, especially for their first pregnancy came from either health professionals or the Catholic Sisters. The everyday cultural norms about who could and would talk about pregnancy and childbirth, regardless of gender or past experiences, this did not seem to apply to either. Both groups were viewed as having professional knowledge or expertise that legitimised their ability to impart information.

Women indicated in future the lack of information may be less of an issue as it was felt, by some, that with increased education, beyond elementary school into secondary and even college that access to information about reproduction would be increased. Also commented on was the role and explanations that were being given by the church before couples married. One participant told me that whilst pre-marital counselling was given by the priests, it was believed they emphasised parenting responsibilities and were unlikely to include fertility or practical aspects related to the bodily processes and experiences of pregnancy and birth.

Many of the women indicated they attended antenatal clinics during their pregnancies. The clinic statistics, for 2002, showed approximately 50 to 60 percent of pregnant women attended regularly. Reasons for visiting the clinic varied including, to have 'checks' done or to obtain information or assistance, especially if friends or family were unable to provide it. It was during the antenatal visits that women would be given a course of tetanus injections (if not already immunised), and if the resume was incomplete at the time of birth it would be completed afterwards. Tetanus immunisation during pregnancy has the potential to protect mother and infant as it crosses the placenta (MacCormack, 1982).

Strategies to maintain health and wellbeing existed beyond the government provided health system. A number of women identified the use of local herbs¹⁸, and also indicated the existence of traditional health systems. What this actually entailed was not clear, with the translator using the term of 'quack' doctor¹⁹ and when later questioned she was unable to give an equivalent *Tetum* word, leaving me in a quandary

¹⁸ Women were not able to provide names for these herbs, I was assured this information was not secret and later discovered that there was a book in Bahasa Indonesia which focused on the topic of herbal medicines from this area.

¹⁹ Colette Livermore (2002) in her research in Aileu, a district west of Soibada, uses the term '*daiyas*' for traditional birth attendants. No person (local women or other participant) specifically identified the presence or use of traditional birth attendants in this locality. I believe that the 'quack' doctor and the traditional birth attendant are not the same roles, though this is not to say that there could be some overlap depending on the skills and abilities of the individual person.

as to what this meant. It was identified that most villages had at least one ‘quack’ doctor who could be either male or female and was considered to have extraordinary powers. These powers could be passed down through a family or resulted from dreams. Another respondent indicated that traditional healers had a greater role in more isolated areas, and their role was helping rather than utilising ‘professional skills’.

van Schoor (2003), based on her work in Baucau, Timor-Leste, mentions a *matan dook*²⁰ as a person who performs ceremonies, for example in the situation of stressful family relations where the union of a couple is not approved of by parents which leads to ‘bad words of parents’. It is thought that negative feelings could cause the death of the mother if forgiveness is not received. The *matan dook* intercedes to prevent the woman from dying.

Focus group discussions identified a number of beliefs that influenced women’s practices and activities during pregnancy including:

- Pinning a pair of folded scissors inside clothing to ‘protect’ mother and infant. A health practitioner indicated that many pregnant women did this in Dili, it was believed to be common practice throughout the country.
- Keeping hair tied up with metal nails placed within the hair, for added ‘protection’ for mother and infant. It is unclear if the purpose and protection obtained from either scissors or nails is comparable to similar actions in other cultures. Priya (1992, p.26) indicates that in a number of cultures a lunar or solar eclipse is considered potentially dangerous to the unborn child. In Mexico an eclipse is thought to cause growth of extra fingers or toes, or lead to malformation of the nose or ears. In Thailand it was thought that a child may be born with a squint or a mouth shaped as a sun or moon if the mother had seen an eclipse. As protection against these potential occurrences a safety pin or piece of metal could neutralise and thereby minimise the risks. Manderson (2003) speaks of Malay women tying their hair up tightly in which a nail is inserted to protect them from evil spirits.
- Another commented that it was important to keep hair loose; if tight it could lead to difficulties during birth.
- Women are not to go out at night as this may attract the spirits and lead to harm.
- Walking (with company) was seen to be beneficial, especially in the later part of pregnancy.

²⁰ Hull’s (2001) translation of *matan dook* is that of sourcer.

- Restrictions were placed on heavy work including weeding or carrying heavy loads. It was considered important to have adequate rest and family and neighbours would care for children to enable this to happen. Women should not run during pregnancy. Kay (1982) indicates that in some cultures it is important women to remain active during pregnancy, otherwise she will give birth to a 'lazy' baby, meaning that the "infant will not come out" resulting in a difficult birth. Keeping active, for Navajo and Mexican women, limits the growth of the baby, making the birth easier. Despite these examples some reduction in 'normal' activity is commonly allowed.
- Women should not stay under the sun for any length of time. Goldsmith (1990) indicates that many traditional cultures have restrictions during pregnancy to avoid women's over exposure to the sun. Animal studies reveal excess heat can lead to an abnormal embryo, but Goldsmith (1990) gives not evidence that this has been shown to apply to women.
- Rules about hot and cold featured in several discussions and included:
 - not standing near a fire as the baby may become 'scorched or withered' (small);
 - only to consume hot water, though if it has been hot or the woman had been outside in the sun she could consume cold water but this was an exception and
 - bathing in cold water was not acceptable²¹.
- Daily consumption of native wine, one glass per day throughout pregnancy, would make the mother strong for the birth.

Generally women were unable to indicate the origins or rationale for these practices. They described them as 'tradition' as they had been handed down through families and communities. At times a link was made to causing miscarriage. Whilst the consequences of not adhering to some of these practises could not be readily articulated they were still considered important.

Diet and altered eating patterns were clearly important during pregnancy, birth and the postpartum period. The reasons for this were not explicit, as to whether they were based on western ideas of nutrition, humoral (naturalistic) or magico (personalistic) (Manderson, 2003) healing systems. Dietary limitations due to regional and seasonal availability frequently impeded women's ability to supplement their normal diets during pregnancy even though they recognised a need, for example, to

²¹ American studies in the late 1970s considering overheating from a western perspective, also expressed concerns about overheating during pregnancy for example sitting in 'hot tubs or saunas' had been shown to lead to miscarriage or birth defects (Goldsmith, 1990).

have more milk. In a number of countries where gender inequities exist females may be served last and when food is scarce women receive less, even when pregnant or lactating and in times of hardship women may give priority to their children (Eade & Williams, 1995). Whether this occurred in Soibada was not explored. Corn and cassava were dietary staples for residents, I perceived this to be due to availability rather than a belief they were energy foods (Lefèber, & Voorhoeve, 1998).

Some women described cravings for sour foods (unripe mangoes, lemons, tamarind), this was at times the first indicator of pregnancy. Food cravings are not uncommon in many cultures, the foods and reasons vary considerably and despite the fact that some cravings may seem bizarre, there seems to be a common belief that they should be satisfied (Kay, 1982).

Generally women stated that if their periods stopped they knew they were pregnant. Nausea, vomiting, dizziness, fever were commonly experienced early in the pregnancy. Feeling sleepy or lazy could be experienced up until the sixth month and nearer to birth women also commented on 'swollen' or 'heavy' legs. Women in Mozambique expressed a range of 'pregnancy illnesses' including "headaches, fevers, stomach problems, lack of blood, pains in bones and teeth, problems with chest, lungs, and heart, and fear of witchcraft or sorcery" (Chapman, 2003).

The desire for most women to give birth at home was unquestionable, it was generally indicated that if they experienced difficulties they would go to hospital, but only if really necessary. Giving birth at home was considered a marker of love for their families. Births had always occurred at home; their mothers had given birth at home and it was believed the next generation should continue this. Only one woman indicated that her preference would be to give birth in hospital, if they had enough money as she felt it was safer.

Jeffery, Jeffery and Lyon (cited Wiley, 2002) found when studying childbirth that where communities had a history of needing to and coping with childbirth they were hesitant to change. Obermeyer (2000) found a correlation between women choosing to maintain the tradition of giving birth at home greater for women who had limited formal education and fewer material resources. For many women giving birth at home meant that they could have relatives and neighbours around, whereas being in hospital many women found themselves alone for long periods (Obermeyer, 2000).

When a health professional was questioned regarding hospital costs, I was assured that there were no direct charges but indirect costs could be incurred including

food and transport. It was unlikely a woman would leave her village without family wanting to accompany her which would lead to additional costs (not just money). Following discharge, return to the village would be the responsibility of the woman and her family, even if she had been transferred by ambulance. This factor alone could lead to difficulties, that of a mother with a young infant needing to wait by the roadside for transport - whatever and whenever.

There were additional explanations given for not wanting to go to hospital. Several women had heard of bad experiences of some women during hospitalised, in particular the treatment by midwives was considered too harsh. van Schoor's (2003) research reveals some consistency with these views and identifies additional concerns. Women in Baucau described poor facilities particularly the state of disrepair, poor hygiene and sanitation conditions lead to concerns about infection. The beds were described as being too narrow, compounding this were negative attitudes of staff that were described as harsh (van Schoor, 2003).

Privacy and shyness appeared to be intertwined for some of the participants, not all spoke about this but there was an underlying sense of modesty. It was not surprising therefore that it was felt being a patient in hospital did not enable the maintenance of one's 'personal integrity'. Fiti-Sinclair (2002) in her comparison of village and hospital births in Papua New Guinea found many features of village births, that of having family and other women present, homelike environment and having as natural a birth as possible, were features that western women were calling for. She also identified that whilst health professionals in hospitals demonstrated expertise, their behaviour often appeared callous and it was believed their role would be enhanced if they worked toward addressing women's emotional needs, not just physical needs.

Chapman (2003) indicates that are many reasons why women do not seek or utilise health services. Barriers include distance, lack of transport, inadequacy of treatment and costs. A difference in understandings of childbearing, between woman and service providers, was also cited as an issue by Chapman (2003). If a woman is ill informed or unprepared as to what to expect at the time of birth, compounded by the depersonalisation of the hospital environment this can increase the chances of negative experiences (Jones & Dougherty, 1982). A number of these issues existed for women in Soibada, but of particular interest are the references to treatment by staff.

During discussions one woman described three of her four births had happened rapidly, without prior signs of labour, the outcome was she was alone when these

infants were born. In view of the high degree of shyness by some women it would not be surprising if some women gave birth alone as a strategy to maintain their dignity and privacy. Livermore (2002) states that she was surprised to hear of women giving birth alone, questioning whether this might mean without help. She felt "...‘aleness’ does not seem to me to be a very common experience in a Timorese village" (p.3), though on querying this with a number of groups she was assured that birthing alone was not uncommon.

There appears to be some variations in the literature regarding the ‘normalcy’ of women giving birth alone. Priya (1992) indicates that in some cultures this does occur citing examples of Chukchee in Siberia and for African, Benin women, birthing alone is viewed as a marker of a woman’s strength. Jordan (1993) on the other hand states that it is rare for women not to be assisted during birth, as labour and birth involve significant social interaction, thus "...the proper course of birth almost always includes the participation of others" (p.60).

Most women indicated that a health professional would be called before the birth, but what was left unclear was at what stage and why. It seemed that when a problem existed the health professional would be called. If labour or birth was difficult a second health professional may also be involved. It appears the women did not have a particular preference for nurse or midwife, or male or female, instead it appears that the health professional that lived the closest was usually the one chosen.

One group of women mentioned that since the Indonesians had left it was harder to get pain relief, due to reduced availability. Health professionals provided support and encouragement prior to medication, though they could give certain drugs and intravenous fluids if necessary. Emotional support, reassurance and massage are commonly used pain relief strategies by midwives and other attendants at births and was often used alongside other methods including local narcotics for example betel nut (Priya, 1992). A number of people in Timor-Leste use betel nut, but it appeared more common in elder people. I questioned a health professional and was informed that it could be used by women during births. I sensed it could be possibility that a desire for drugs was an influencing factor in having a health professional in attendance during labour and birth.

If an emergency arose an ambulance could be organised to transfer the woman to hospital. If this was deemed necessary, discussion with the family was essential, and the family predominantly made the decision. Of major concern was the risk of a family

member dying alone, the prospect of this seemed even more concerning than the death itself. If a woman was to die in these circumstances the nurse could be blamed by the family, who it appeared felt it would be preferable for the women to stay at home than to take this risk.

When the infant is due or the woman is in early labour it is considered important she does not eat dry food or have chilli, instead only liquid or soup should be consumed. Other cultures mention the need to avoid certain foods including chilli during childbearing due the belief they are 'cold' foods and not good (MacCormack, 1982). Women commonly took a tablespoon of oil, 'to help the baby slip out'. Other methods used to assist labour, mentioned by most of the women, included the use of locally grown herbal medicine generally given in liquid form to assist and shorten the labour.

The women of Soibada identified various birthing positions used, including squatting, lying and kneeling. Both Livermore (2002) and van Schoor (2003) also found that a variety of positions were used by women (based on their research in different localities in Timor Leste). The use of a bamboo or wooden bed on which the women laid was described as common. A rope attached to a roof beam could be held by the squatting woman, assisting her ability to push effectively. van Schoor (2003) describes the use of a piece of wood used as a brace, on which the woman places her feet for support when pushing.

Women who have not previously had children and children (due to their natural curiosity) are not permitted to be present during the birth. The exclusion of children, fathers and others not deemed suitable to be present is documented by other cultures (Jordan, 1993). Neighbours and family help with food preparation, getting the health professional if required, and assisting the labouring woman with positions, movement and massaging, which included the use of herbs and oil. It is the potential father's job to ensure that there is enough firewood to cook chicken and produce heat, both of which are important for the woman after the birth.

If the infant has difficulties breathing after the birth it may be splashed or washed with cold water as one group said 'to wake it up'. In the district of Alieu if an infant is not breathing or is slow to cry it is doused in cold water to stimulate inhalation (Livermore, 2002, p.7). Alternative actions may include smacking, blowing on the face or placing a cut onion under the infant's nose. If a health professional is present they

may give 'medicine' or a bag²² over the infant's face to assist the breathing. Some of the causes of difficulty breathing for the newborn included: being overdue, cord around the infant's neck and 'limited' pushing force by the mother.

How soon after the birth breastfeeding started was variable, for a number of women it commenced once the woman and infant have been washed. The initial feed may only amount to the wetting of the infant's lips as the 'milk is not ready'. Other women indicated that an already lactating woman would suckle the newborn for the first twenty-four hours, allowing the mother to rest. Hmong women in Thailand did not commence breastfeeding until one or two days after the birth believing that the first milk (colostrum) was not good for the infant's wellbeing therefore another woman (kin) would feed it (Symonds, 1996).

Breastfeeding appeared a natural activity. My first contact with one woman occurred near her home and it was only after stopping to talk to her I realised the infant she was holding was happily suckling at her breast and continued to do so as we tried to initiate conversation. On a number of other occasions women did not hesitate to breast feed their infants in my presence.

Following birth the umbilical cord is tied with string then cut with either scissors or a specially sharpened piece of bamboo. If household scissors are used, one group said they could not be used again until the cord stump has fallen off, and if used the infant would get an infection. One group of women indicated that only health professionals used scissors. In some areas of Indonesia the use of metal to cut the cord is considered harmful to the infant as it prevents the child being able to contact the spirits and ancestors, in times of need (Nourse, 1999). The introduction of scissors by western professions have had consequences in some locations and cultures as opportunities to adequately sterilise, by heat or chemical, may not be available thereby increasing the risk of infection (Priya, 1992). Local herbs were applied to the umbilical stump to prevent the baby from becoming 'sick'. Some participants indicated cutting the cord was an important event requiring special words to be said.

Infants had a high incidence of infections, most commonly around the cord. This was thought to be associated with the use of non-sterile equipment to cut the cord. The use of bamboo is not uncommon and has been criticised but Priya (1992) indicates that bamboo contains natural antiseptic properties, thus acts as a protection against infection. It is not uncommon for traditional methods such as this to be denigrated once 'western

²² their description appear to be that of an ambu-bag which is an emergency first aid procedure that health professionals perform to assist a person to breath.

ways' are introduced (Priya, 1992). The umbilical cord is an open wound, making it an entry point for infection. India and other countries have experienced high neonatal mortality rates due to this fact alone. Consideration of environmental factors, such as the presence of cow dung (Punjab women) may increase the risk factors for some newborns (Priya, 1992). MacCormack (1982) cautions us that not all traditional practices are harmful.

The placenta is usually buried near to those of siblings' and in close proximity to the family home. Someone deemed of suitable morals (was identified as a key criteria, suitability was independent of age, gender, or other similar characteristics) is the most likely person to bury the placenta. At this point wishes of a 'well and intelligent life' are offered by all present.

Hicks' (1976) fieldwork in the south-eastern region of Timor-Leste, during the 1970s, shows an integration of spiritual and mythological beliefs and actions associated with childbirth. He described the sacredness of the woman's body and the symbolic connection of the infant's birth, which commemorates the arrival of ancestors. Commencing at the time of the birth and continuing for several days after the birth are the rituals involving the umbilical cord and the placenta. On the fourth or fifth day, depending on the sex of the child, and following prescribed roles and activities, family members take the placenta and umbilical cord to a family shrine located just outside the village. These rituals are associated with the joining of spirits and kin and are followed by feasting and a celebration of the new infant. Hicks (1976) states, the arrival of Catholic missionaries and their attack on local beliefs and practices resulted in many practices changing. There was no mention of these symbolic connections or rituals during my discussions with women, but in view of past attacks on cultural practises this lack of information should not be assumed to mean that they do not exist.

Following the birth the husband and other children welcome the new baby by kissing or embracing, the husband gives thanks to the mother. Siblings are not allowed to care for the new infant until it is about four months of age.

There are several aspects that feature strongly during the period following birth. One in particular, though this might have been influenced by my desire to know more, was the importance of 'the fire'. As an outsider I was fascinated by this practise, largely from practical terms as I found the everyday temperature to be uncomfortably hot and the thought of being beside a fire was something that intrigued me. I specifically questioned participants about this aspect. Grace (1996) refers to the term used in some

societies of 'smoking women' which describes the time beside the fire in the postpartum period. Other authors (Priya, 1992; Cabigon, 1996) refer to this time as 'roasting' or 'mother roasting' which generally lasts for one to four weeks.

Following the birth it appears many mothers and infants stay beside the fire²³, day and night for between one and four weeks. Initially the fire is kept hot, but over time the intensity of heat may lessen and the fire is stoked just enough to keep it burning. It is believed that heat reduces the risk of infection as it prevents the woman getting cold from the wind and rain, heat also helps 'dry up the woman's blood'. If the woman does not stay beside the fire she may become insane, due to 'dirty blood going to the vessels'. A build up of 'air or gases' may also lead to insanity, being beside the fire decreased the chances of this happening. Women in Puerto Rico share a similar belief in that cold can congeal blood preventing it from being expelled, which leads to nervousness or insanity (Manderson, 2003).

Women indicated that when they needed to go outside to the toilet a 'thick blanket' would be wrapped around them to ensure they stayed warm at all times. In some regions of the Philippines women commonly wear heavy clothing or blankets to prevent exposure to cold winds as they are thought vulnerable to cold due to the depletion of heat during childbirth (Cabigon, 1996). Obermeyer (2000) describes that Moroccan women need to avoid the cold and as protection they are covered in blankets. Manderson (2003) indicates many cultures (especially those with Asian associations) believe that birth reduces a woman's health, making her susceptible to cold, wind, magic and disease, thus warm clothes needs to be worn despite oppressive hot weather.

Livermore (2002) describes mothers and infants from Alieu staying beside the fire following the birth; she indicates this practice has its origins in early Mambai²⁴ mythology. She witnessed infants often living in smoke filled environments, which she believed caused them to get coughs and watery eyes. I asked one health professional what effect smoke may have on mothers and infants during the time of 'sitting fire' (van Schoor, 2003). This activity was seen as positive as warmth was considered to have significant benefits for the mother. I was left to consider, what appeared to be, opposing views from two health practitioners educated in very different locations.

²³ A bed is made for the mother so that she is able to lie just beside the fire.

²⁴ Traube (1986) describes the Mambai people as living on the eastern half of the island. They are the largest ethnic group and the language they speak also carries the same name. Their language has connections to Tetum. They have a strong affiliation with the land. The Mambai people believe that they are the original inhabitants making them the rightful guardians of the land. Their mythology informs their belief that they are the "eldest branch of humanity" and other peoples are positioned in relation to them.

Livermore (2002) expressed concern about the effects of high environmental temperature on a newborn infant due their reduced ability to regulate body temperature. One health professional did not believe there was an issue related to additional heat from a fire for a newborn. It was reinforced that fires were kept low, especially after the first couple of weeks, and that smoke quickly dissipated through traditional roofs. On one occasion I was aware of a large quantity of smoke billowing out from under a thatched roof, followed by laboured coughing (from what sound like an adult) coming from inside, smoky homes seemed to effect some people.

Variations regarding the importance of fire were apparent as it was indicated a lot of women in the surrounding villages do not like this practice as it is too hot and they preferred to use drugs to assist with combating infections. Conversely I heard a story of a woman in Dili who had been given an electric fan by visitors as they thought the room too hot. The fan, whilst accepted, appeared not to have been used despite the availability of electricity (at that time there was no charge for), and the practice of 'sitting fire' continued.

'The fire-rest' (Goldsmith 1990) in Thailand is described as one of the most elaborate examples of the use of heat following childbirth. The mother, who is dressed in only a 'loincloth', uses a special room with a large fire. She alternates position approximately four times an hour. She would not leave the room even to go to the toilet, as a space was set aside for this. This routine lasted one to two weeks.

For the first few weeks postpartum, neither the mother nor infant is to be washed in anything other than hot water. It is only after one month that cold water can be used. For some women bathing was an important ritual, with a 'special bath' for mother and infant at the end of the first week. At the completion of this the water would be poured over the placental burial site. Similarities with Hmong practices exist in that cold washes are believed to lead to ill health as it causes the blood to clot which stops the women from bleeding following birth. If this occurs the bad blood remains inside the woman's body, causing loss of appetite and finally death (Rice, 2000). The traditional belief was that a woman bleeds for 30 to 40 days which could explain the time frame of one month to use cold water, as the crucial period would be nearly over.

One focus group mentioned the ritual washing of the infant's eyes during the bath at one week. Each eye was washed seven times believing that this aided good eyesight and healthy eyes. Washing the eyes of the infant on the third day for girls and fourth for boys, is identified by Livermore (2002) who states this practice is thought to "...bring

the infant to a higher level of awareness, by removing the blood of birth that clouds its eyes” (p.8).

Following the birth it was important for the woman to rest, this occurred initially beside the fire, this resting period could extend beyond one month, in some situations up to five months. Other cultures, also place emphasis on a period for rest and heat during this period (Manderson, 2003). A woman’s primary responsibility was to eat, sleep and look after the baby so during this time the woman’s family and neighbours provided assistance. The husband ensured that there was plenty of firewood, water and food; he also did the washing, including the infant’s nappies and made sure the woman is provided for ²⁵.

A daily intake (for the new mother) of three tablespoons of wine²⁶ for the first month was thought (by one group) to promote the mother’s recovery and good health, though ‘not too much and the baby would be drunk’. Goldsmith (cites Talbot, 1923) indicates that in Nigeria hot palm wine aided the production of milk in ‘barren’ women. The practice of ‘hot alcoholic medicine’ to reduce the postpartum bleeding is used by women in Southeast Asia (Goldsmith 1990).

During the first month only soft foods, such as chicken or rice, with a little ginger (hot foods) if available, are eaten as they are considered to be good for the mother’s health. Chicken appears to be a readily available food, relatively speaking, but many cultures also identify chicken as being beneficial. For Hmong tribal people in northern Thailand chicken soup as well as ‘doing the month’ (staying beside the fire) are common practices to aid the mother’s recovery and improve the flow of breast milk (Kunstadter, Kunstadter, Podhistia & Leepreecha, 1993). It is also thought that ‘warm rice and chicken with herbs’ helps the body to recover and maintain health. The consumption of other foods at this time can make a person unhealthy (Rice, 2000). Obermeyer (2000) indicates some cultures place emphasis on special foods during this time those that are considered ‘hot’, for example chicken. In my own experiences of western culture, chicken soup is suggested by lay people as having healing benefits, having been a tradition handed down through generations. Like women of Soibada I believe many who speak of this are unsure of the reasons behind this practice.

Overall it was viewed that childbirth, in this rural area was relatively safe for woman if their pregnancies and births were ‘normal’. I am unsure, in this context, what might be considered normal as I believe this would be culturally influenced. It was

²⁵ Infants I was told wore nappies until about one year of age.

²⁶ I suspect this was palm wine as the participants indicated their involvement in production for sale

indicated that if women were identified as having potential risk factors they needed to be transferred to hospital. Local maternity statistics for 2002 revealed no maternal deaths, but one woman had been transferred to hospital for a Caesarean Section. Some potential risk factors mentioned were prolonged rupture of membranes, elevated blood pressure with associated symptoms and foetal distress. What practice limitations existed for the nurses and midwives in this region were not explored, but it was stated that undertaking a breech birth was within their scope of practice and as such I understood it was not considered a risk.

Obermeyer (2000) identified that whilst many traditional practices are not incompatible with western biomedicine, they are not easily accommodated in clinics or hospital type facilities. If appropriate healthcare is a key aim of health services, regardless of whether primary or secondary care, it is important that development workers are mindful of local knowledge/s and are aware of and sensitive to the need for pluralistic strategies. If this can occur the future is more optimistic, a future which enables cultural differences to be valued, diversity to flourish and people to feel confident about who they are (Goulet, 1995). A more pessimistic outcome Goulet (1995) sees is that in the future "...cultures and authentic cultural values throughout the world will be bastardized or reduced to marginal or ornament roles" (p.142).

Conclusion

This research provides a limited snapshot of women's experiences of childbearing in Timor-Leste. The information provided has been strongly influenced by the questions that were asked, the structure and timing of interviews. Due to time restrictions I was unable recheck my understandings of information shared by participants, thus there is a potential for misinterpretation, but hopefully this does not detract significantly from the richness of data that was provided so willingly.

In an attempt to stimulate further thinking for those considering childbearing as a cultural event, I have incorporated practices and beliefs from a number of ethnographic studies throughout the world. Whilst I may have tended to provide greater linkage and explanations of practices and beliefs related to naturalistic (humoral) healing systems, I do not intend to imply these beliefs are the foundation of Timorese practices. Manderson (2003) indicates practices that incorporate elements of hot and cold are not confined to humoral medicine. She cites a number of examples of similarities in practice such as those of steaming and smoking, for the Yulngu (Australian Aboriginal

community), where no evidence exists to support an underlying belief in humoral medicine.

Many cultural groups have borrowed practices from other cultures, but we need to consider that similar practices may indeed exist independent of outside cultural influences. The geographical location of the island of Timor and the migration patterns may make it easy to assume that much is borrowed; I do not want to perpetuate this thinking without further exploration.

Over the years many views have existed to explain what development means and to how it can best be achieved. Many have believed that to progress less developed societies needed to take on the knowledge and technology of developed countries; health beliefs and practices are certainly not exempt. Whilst there have been many positive outcomes resulting from development, one needs to be mindful of the potential for cultural imposition. As readers will see in the next chapter western 'advances' in childbearing under the guise of biomedicine has received considerable criticism. Goulet (1995) reminds us that local values and actions are closely linked to the identity of the community and that a community does not exist in isolation. Many people view 'progress' as effecting not only their survival but also their culture, thus it is not always seen in positive terms.

The development and implementation of PHC strategies, in response to health needs in many parts of the world, has seen considerable improvements in people's health, but for these to be sustainable local beliefs and practices need to be acknowledged. All cultures develop their own knowledge, including knowledge of the body, how it works, as well as what makes one sick or keeps one healthy. This knowledge does not exist by accident as it has been proven to be useful in that particular context. Failure to value this knowledge surely has moral and ethical implications.

As development workers we need to demonstrate "sensitivity to culture, religion and traditions of the East Timorese people" (WHO, 2001 p2). As reproductive health is a key objective of the current Timor-Leste government it is essential for health workers to acquired local knowledge as a beginning step to achieving this goal. Implementing programmes that do not value indigenous beliefs and values (Goulet, 1995) could be considered ethically questionable.

CHAPTER SIX

Development issues and childbearing in Timor-Leste

Introduction

What the future holds for Timorese women and families is impossible to know but there is a need to reduce maternal and infant morbidity and mortality rates. Recent trends, supported by literature, indicate benefits are achieved when multilayered approaches are used, incorporating broader aspects of society. Before positive change can occur consideration needs to be given to a wide range of factors and the sociological imagination can provide a suitable framework to consider childbearing in Timor-Leste. It would also be beneficial as a tool for reflecting on development ideas, past and current, considering how these can best be adapted to meet local needs, rather than attempting to transfer programmes without wider contextual consideration.

Positive development work can occur through the application of what Willis (2004) identifies as the 'critical building block', that is, actions that result in improvements in people's lives as determined by them. Improvements in reproductive health and childbearing cannot be measured solely in terms of statistics as it is more complex, involving cultural and structural issues and a need to address women's rights. The advantages of including adolescents in ASRH seems to have considerable merit due to their stage of development that is moving into adulthood, their desire for information and their increased receptiveness to change.

Health Planning in Timor-Leste

Timor-Leste, as part of its colonial past, is divided into 13 districts and 65 sub-districts. The new constitution has emphasised decentralisation though this may be difficult due to poor infrastructure and resources. It has therefore been suggested that three regions, east, west and south, with Oecussi considered separately, may be more efficient for the regionalisation and devolution of core services such as health and education (UNDP, 2002). Non-governmental Organisations (NGOs) will continue in the future to fill needs that are not being met by governmental bodies (UNDP, 2002). Some NGOs have done this for a number of years especially in the delivery of health services. Many Timorese tended to trust personnel in Catholic run health clinics as

opposed to Indonesian government clinics, during the period of occupation (World Bank, 2003).

Timor-Leste is faced with many challenges that will continue to effect people's lives for decades. The UNDP Report (2003) has identified key factors for consideration; all have implications for health and well being of women directly and indirectly. These include:

- expanding peoples options and opportunities;
- improving the economic and social status of the poorest citizens;
- improving women's marginal status including working to increase political participation, the identification and meeting of women's needs and responding to issues of domestic violence;
- working toward building the capacity of local people through partnerships with agencies (UNDP, 2003, pp.2-3).

It is anticipated the government's annual budget will rapidly reduce in the next three years. The implications of this will be a reduction in the government's ability to undertake and provide essential services (Oxfam Community Aid Abroad, 2004) let alone what may not be deemed as essential. If a national goal is to improve maternal and infant health outcomes, women's status - socially, economically and politically - all need to be addressed. The above points all have the potential to achieve this but the challenge will be to develop and implement strategies. Any intended actions will have to compete with multiple other funding demands on limited resources.

A decline in the country's economy has already increased urban unemployment (Oxfam Community Aid Abroad, 2004). This downturn could potentially lead to a reversal of migration increasing the 75 percent rural population identified as having insufficient resources and services (Oxfam Community Aid Abroad, 2004, p.5). Guterres (2003) states that "...[r]ural households ...provide their own social security, medical care and welfare. They were responsible for their families' care, including looking after the sick, the elderly and the disabled and the education and training of their children" (p.178).

How to determine what issues to tackle first and what is the best rate of development can be hard decisions but the UN is giving guidance and has set some goals for 2015, which includes a reduction in maternal and infant mortality rates (UNDP, 2002). The government appears to have recognised that health is a social issue rather than solely the problem of the individual (Wright Mill, 1959; Willis, 2004) and

has made it a high priority. A number of specific areas were identified by the interim government in conjunction with the WHO (MOH, 2002) and include:

- A lack of awareness of health problems, including HIV/AIDS and oral health coupled with a diminished understanding of the benefits of good health.
- Limited or no access to health services particularly for those living in rural/remote areas, with acknowledgement of additional access disadvantage for females.
- High prevalence of communicable disease.
- Marriage and pregnancy at a young age and issues of gender inequality.
- Significant levels of malnutrition due to limited resources and favouring of males in food distribution.
- High infant and under five mortality rates due to a number of factors, including those some already, coupled with limited paediatric services,
- Limited allied services including laboratory services and inadequate referral systems.
- Poor infrastructure demonstrated in poor public health facilities of water and sanitation.
- High incidence of mental health issues and limited services to cope with needs.
- Poor communications and transport systems, as well inaccessibility to some locations during the rainy season (MOH, 2002).

All affect childbearing outcomes for example the availability of health services is central to the WHO's SMI initiative and the Millennium Development Goal of reducing maternal mortality rates through the provision of skilled healthcare for pregnancy, birth and postpartum care (WHO, 2002). To achieve this requires adequate backup and referral services to be available to attendants; this includes suitable transport (UNFPA, 2002). It is clear that diverse and multilayered approaches to health are required.

The UNDP (2002) identified several challenges including that of reproductive health and has identified a number of project directions including service accessibility, information and legislation development, the overall goal being one of capacity building. The maternal mortality rate is believed to be as high as 800 per 100,000 births (MOH, 2002, p5), with poor maternal health considered the most significant causative factor. Associated with this is a concerning number of teenage pregnancies and the limited spacing between pregnancies. There is a lack of information related to sexually transmitted diseases and a concern exists that a lack of information regarding sexual

health and risky sexual behaviours could lead to further health issues (MOH, 2002). These factors indicate a need to increase the population's knowledge of health and health promotion has been identified as key directions to improve health (MOH, 2002). Basic health care service provision and the availability of adequately trained health professionals are also essential to the improvement of reproductive health (MOH, 2002).

To achieve these goals the country will need the support of development agencies to provide wide ranging assistance including health, education, capacity building, infrastructure services of roads, water, sanitation, as well as sustainable food production strategies (MOH 2002). The underlying vision to improve the health status of Timorese people requires a commitment to equity, a shift to a more equitable society has significant potential to improve women's health (MOH, 2002).

Childbearing and Reproductive Health

A lack of information was identified as an issue by women participants, as they stated that neither family nor community members discussed childbearing and reproduction. This resulted in a lack of knowledge as well as lack of opportunity to acquire information. Parents appear to have considerable influence, if the example of place of birth and decisions to transfer to secondary care are anything to go by. Attempts to increasing childbearing knowledge by targeting women of reproducing age and only utilising health professionals will be limiting, as only a small proportion of the population will be reached. Women did suggest that increased access to education particularly the senior years would lead to increased knowledge of childbirth. This comment could to be interpreted as implying that they not only expected reproductive health to included in school education but they also agreed with its inclusion.

Any attempted changes to increase knowledge of reproductive health, and thereby an individual's abilities to make informed choices will present challenges in a number of areas, not just health service delivery but also at governmental and educational levels as well as family and cultural norms. It will be essential to work with the population; age, gender and geographical barriers will need to be addressed and overcome to ensure this happens.

Whilst the ideal of including a wide cross-section of the population has merit, care will need to be taken to ensure that some groups do not exert their power in ways that perpetuates inequities. In the west, women have argued that biomedicine has taken control of childbirth and reproduction, making health professionals the expert. This has

resulted in women's voices and experiences being marginalised and less valued (Kitzinger, 1992; Jordan 1993). A consequent of health professional expertise is that women's decisions are predominantly influenced by those with greater control and has resulted in some areas, as described by Fiti-Sinclair (2002), women's physical needs being met but not their emotional needs.

One area of reproduction that has often received attention for a number of reasons is that of fertility rates²⁷. Links between maternal and infant mortality and women's fertility rates have frequently been articulated, particularly in relation to developing countries. Women's fertility rates are complex and are not just a matter of availability of contraception or women's ability to make decisions about birth spacing, many other factors may be involved. In societies where there are high rates of infant mortality women may become pregnant more often in a considered attempt to "...generate a sufficient stock of children to ensure the desired number survive" (Middleberg, 2003, p41). In the case of Timor-Leste the provisional census findings reveal a rising fertility rate (Hull, 2004) could this be to replace the population lost over past decades due to violence and ill health?

Childbearing, particularly successive pregnancies, places considerable physiological stress on the woman's body, which also effects her ability to undertake other forms of work, formal and informal, within and outside the family (Momsen, 2004). For rural women in Timor-Leste, much of this work is harder, due to the added difficulties of accessing resources. In rural areas "[t]he ordinary business of life, keeping clean and cool, cooking food and washing clothes is much harder work [and i]n most cases the eldest daughters in the family have to help their mothers to prepare meals, collect firewood and water and look after the little ones" (Guterres, 2003, p.179).

Middleberg (2003, pp40-42) indicates the use of contraception (the rate is low in Timor-Leste) is only one factor when considering fertility behaviour but development projects, both governmental and NGO driven, have at times focused solely on the dissemination of contraception. During the 1980s and into the 1990s, the Indonesian government utilising strategies that are equated to "ethnocide and cultural genocide" (Storey, 1995) implemented a family planning campaign. This included the use of military personnel who 'encouraged' women to limit their fertility through the use of contraception (Storey, 1995). Clinics were run by the military and in 1985 a five-year birth control programme financed by the World Bank was extended with a plan to reach

²⁷ A woman's fertility is a measurement of the total number of children that she gives birth to (Momsen, 2004, p 49)

95,000 East Timorese women (Beaton 1995, p.1). It appears that all women were forced to participate and not only were extra clinics established but military personnel would visit villages and schools. Some women were injected more than once, some as many as three times. Force and lack of information were common themes, some women believing they were given anti-tetanus vaccines other women were surgically sterilised while under anaesthetics for an unrelated surgical procedure (Beaton, 1995). The results of the campaign to limit women's fertility lead one woman to comment that "[w]e don't have children any more" (Beaton, 1995).

This programme coincided with neo Malthusian concerns of global overpopulation and the perceived effect this could have on the environment as it was argued that the world had a finite amount of resources to sustain the population (Sweetman & de Selincourt, 1994). Women in developing countries were targeted and it was stated that "...fertility is so important to a society that its control should never be left to individuals" (Freedman, cited in Storey, 1995, p8) thus effectively justifying the Indonesian governments actions.

In the 21st century women still talk of control by authority figures. A number of women participants had heard negative comments by other women of their treatment by health professionals when they attended hospitals to give birth. They indicated that this was one reason why they would prefer to give birth at home. Hospital staff's use of authority effected women's experiences and influenced others' decisions not to attend hospital. Beaton (1995) describes women's experiences during the Indonesian campaign as being one of power and control. This could have repercussions today influencing women's and family's perceptions and experiences when they are subject to the dictates of authority figures. This could include health professionals especially if family, as Guterres (2003) indicates, have been and are still, generally responsible for their own health.

These experiences of authority, over what are normally family responsibilities and activities, are surely of significance. Past experiences will have left a mark on families today which health planners need to be mindful of so as to allow consideration and sensitivity whilst working toward strategies that will have positive reproductive health outcomes. One would expect that clear, accurate information and consent will be paramount, but how best to disseminate information will be a key question.

Some of the women indicated that they would have liked to limit the number of or increase the spacing of their pregnancies, but their 'husband would not be so receptive

to this idea'. It seems that where cultural norms limit women's decision-making abilities, the question of women's consensual participation in sexual intercourse simply is not an issue. Cultural expectations would most likely mean women would not consider saying no as an option (Armstrong, 1994).

An example of a woman's lack or diminished ability to be involved in decision making was clear in one story. A woman's only child had become ill and it was the husband that determined the necessary treatment for the child despite the fact that the mother thought he needed medical help. The father decided the child should stay at home, rather than go to hospital. The woman had no choice but to do what the husband wished the child subsequently died.

The concept of human rights and reproductive rights, including the ability to make decisions about one's own body, have been seen by some as 'highly westernized' (Weatherby, Evans, Gooden, Long & Reed, 2003) evoking wide ranging debates including that of western individualism. In developing countries women can be caught between western ideas, from contact with foreigners or media images, or traditional practices which are thought to preserve family and cultural patterns that have existed overtime (Weatherby et al., 2003). What does emerge is that the concept of rights is culturally determined and has not been universally accepted (Petchesky, 1998). There has been some agreement that facilitating women's ability to be self-determining requires fundamental changes within a society, including "...quality and availability of services...structural conditions and state policies that support an unjust economic and social order" (Petchesky, 1998, p.7). Changes need to facilitate women's abilities to be involved in decision making not only at the level of political participation but also in what has been traditionally viewed as the private sphere of the home.

Attention has been increasingly drawn to the prevalence of domestic violence within families in Timor-Leste. Violent acts are not only directed at women, though the incidence for women is a real issue, I also became aware of, through conversations, that children were physically abused, it seemed that adult male family members were the main perpetrators. It is believed there is a culture of violence within the country and "...wife beating has become one of the most common forms" (Bourdre, 2004, p1). Years of guerrilla activity as a survival strategy appears to have influenced how people cope and respond to everyday situations, resulting in a continuing culture of violence (Bourdre, 2004). When domestic violence is linked to the traditional roles, of men being viewed as the breadwinner and women, controlled by their husband and families,

it is found that women have commonly been the recipients of violence. As Mica states, “[m]y business is everybody’s business, then when I get married, it’s my husband’s business and then his whole family’s...[b]eing a girl, you never get out of the chain of control” (cited in Bourdre, 2004, p2).

Linked is the traditional practice of bride price or *baraque* which is still practiced. The influx of overseas workers and use of US dollar has seen the monetary value of the bride price increase. Some families pay as much as \$US2500 and 70 buffaloes if their son wishes to marry a chief’s daughter (Bourdre, 2004, p2). Whilst not all dowries are of this size, there is a relatively consistent expectation that dowry payment gives the male the right to exert control over the women, including ensuring she fulfils the obligations expected of a wife, to produce children (Bourdre, 2004). As stated by one male “I paid for her, so I own her. She has to do what I tell her to do. She cannot leave me unless I give her permission. If she tries to leave me, I will go and get her back” (cited in Retbøll, 2002, p3). A number of aid agencies have worked to provide structures for victims of violence, but as Dan Baker, Chief of Operations of UNFPA in Dili indicates, it is deeply ingrained within cultural beliefs, also that family problems should be dealt within the family. The consequences, Baker believes, is that it will be hard to change people’s behaviours (Bourdre, 2004).

During my stay in Timor-Leste I did not see any evidence of physical abuse, nor do I feel I would have been able to recognise emotional or economic abuse, but this does not mean it did not occur. I did hear of a discussion between an international worker (known to the couple) and an East Timorese couple soon to be married. The future husband was sternly warned not to abuse the woman once they were married, as this type of behaviour was considered totally unacceptable and that she was ‘not his property’.

It appears that some couples today delay a formal church marriage until they have been together for a number of years and have had children. It was unclear whether this practice was due to insufficient resources and needing time to save for the dowry or if the period of living together was a strategy to ensure the fertility of the woman before a formal marriage commitment was made. Implicit in participant’s discussions was the sense that children were greatly valued thus an ability to bear children was an expectation and pressure on a woman.

Eade and Williams (1995) state that “[t]here is a close link between women’s reproductive role, their sexuality and their subordinate position in society” (p.661). The

traditional Timorese practices of male inheritance and female inferiority have continued as is evident in the patriarchal family structures and parental decisions that favour boys in areas such as giving sons priority to education. There is a need to challenge traditional beliefs of women's inferiority and that women are men's property. Doing so would assist women to realise that they have the right to make decisions about - who they marry, the number of children they have and to have sex when they want (Retbøll, 2002). Education, both formal and informal, can be key to this occurring through a process of consciousness raising (Leong cited in Retbøll, 2002).

Internationally fertility rates tend to be higher for indigenous, rural and illiterate women. It is far from coincidental that these women have diminished access to education and family planning services (Momsen, 2004, p.50). Higher education increases women's economic capabilities, as well as political participation, leading to positive benefits not only for the women but the community and country. The overall educational level of women is frequently indicated as playing an important role in reproductive health and birth outcomes (Kinneer, 1997). Evidence reveals that females who have attended secondary school give birth at a later age, has less pregnancies, as well as healthier children (Weatherby et al., 2003,). There appears to be a relationship between a woman's educational level and chances of her child dying, that is, the less education the greater the chance of her child dying by the age of two years (Kickbusch, 2001). Education is thought to give women a potential for increased choice which links education and empowerment, but education does not automatically protect females from experiences or consequences such as coerced sex (Armstrong, 1994).

The Constitution of East Timor (The Constituent Assembly, 2002) states under Section 17 that "[w]omen and men shall have the same right and duties in all areas of family life and political, economic, social and cultural" (p16). Major limitations exist in accessibility to education in Timor-Leste, especially for those living in rural areas. The UNDP (2002) reported that many parents did not enrol their children in education due to reasons of poverty and there are high rates of withdrawal. Adults also hold reservations regarding the overall benefits of education based on the repressive system that existed during the time of Indonesian rule. In 1995 less than 50 percent of the population had completed primary education resulting in 49% males and 64% of females being illiterate (UNDP, 2002, 14) which is one of the highest illiteracy rates in the world (MOH, 2002). Education as a strategy to improve health and health related behaviours, to be effective needs to be able to demonstrate advantages to those being

targeted (Eade & Williams, 1995). One is reminded of Gueterres' (2003) comment of older daughters caring for sibling and undertaking household duties, which one might guess restricts schooling opportunities, and whilst parents may value education who will undertake these roles when adults need to tend their gardens, which might be two hours walk, there and another two hours back each day, this being the only way they can provide food for the family.

It is of prime importance that gendered inequities are identified. Many have already been identified such as the "...unequal distribution of food and healthcare in the family favouring boys. This is similarly the case in the areas of education opportunity and health care" (Worldbank, 2003, p148).

Health Services

Unless fruitful negotiation can occur with the Australian government over the rights to oil and gases resources in the Timor Gap (Oxfam Community Aid Abroad, 2004) health services are likely to remain limited and inaccessible for many, as the Timorese government's lack of resources will restrict service development and delivery²⁸. This revenue could significantly help the Timorese government in their commitment to implement their 'pro-poor' budget strategies to develop rural health and education services. Timor-Leste is already experiencing reduced donor interest and shortfalls in budgets (Oxfam, 2004) thus making the already inadequate health services even more vulnerable thus any strategies need to be cost effective and have long term benefits.

Catholic run health clinics were favoured during Indonesian occupation as they were seen to be independent of Indonesia. Many women either attended Catholic clinics or avoided health services altogether (Retbøll, 2002). As it can be seen in Figure 6.1 the Church provides eight percent of health services. Retbøll (2002) indicates the Church's view regarding the role of women comes directly from the Vatican and is does not promote women's liberation. "The church says no divorce, no use of contraception and absolutely not access to abortion. Maybe sometime in the future the women of Timor-Leste will find the church is not helping them to improve their situation"

²⁸ Australia's claims of being a major aid provider, approximately \$234.5 million since 1999, needs to be balanced against the receipt of \$2.4 billion (ten times that of Timor-Leste) in oil revenue from the Timor Gap (Oxfam Community Aid Abroad, 2004, p6) over the same period. Due to the geographic proximity of the fields to Timor-Leste, international maritime law favours Timor-Leste's rights to these valuable reserves, but Australian authorities have hampered negotiations and continue to reap the benefits.

(Retbøll, 2002, p.5) and it is queried whether its popularity with women will continue into the future because of these and other views.

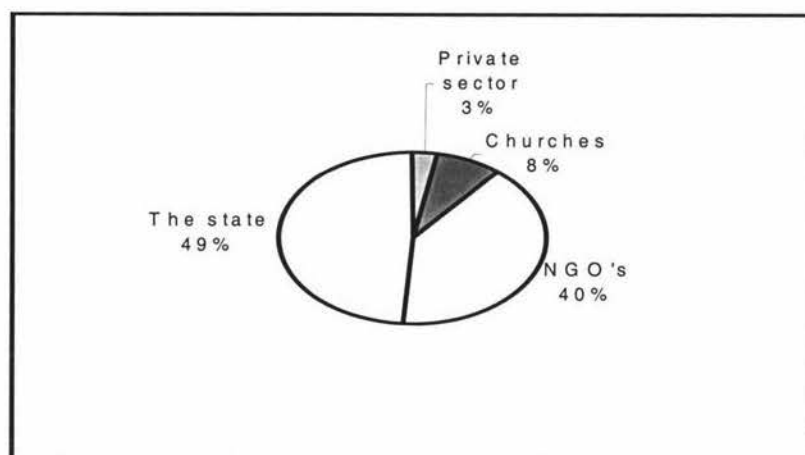


Figure 6.1. Health Service Providers (UNDP, 2002, p14).

As indicated earlier premarital advice from representatives of the Catholic Church focused on parenting responsibilities, so one is left to wonder if the support voiced by the Bishop to space births and limit fertility (van Schoor, 2003) is occurring at the local level. If premarital counselling were to include family planning options there could be some issues with the timing of these sessions as van Schoor (2003) indicates that for couples today traditional marriage occurs and it is not until months or years later that a formal church ceremony occurs. If this is the norm, then 'counselling' by church representative may not occur until after the couple have been together for some time.

Eade and Williams (1995, p 633) indicate that gaps in health service provision in many countries have often been filled by religious missions. In recent years the Philippines and Brazil, (both countries are largely Catholic) two recent democratic countries, have seen a transformation in aspects of women's health (Petchesky 2003). Women's health movements have emerged and are described as strong and well co-ordinated. Filipino NGOs involved in women's health are said to have positive gains in implementing principles from ICPD. Health policy on the other hand has maintained its pro-natalist and pro-motherhood culture which has meant that many women do not have access to quality reproductive health services. Petchesky (2003) goes on to state that "...the DOH [Department of Health] has become captive to 'fundamentalist elements inside and outside the Church' and are impervious to the efforts of women's groups to initiate change" (p242). The reality of this means that women in the Philippines have

restrictive abortion policies, adolescent sexual and reproductive needs are ignored, as is male responsibility and minimal services exist to address violence. Petchesky (2003) goes on to explain that sexuality education, in the form of 'family life', and contraceptive services are subject to approval by the Catholic Church. Women's health policies have been quickly and quietly changed with no involvement of women, organisations or even government departments working in the area.

During the 1990s there were some challenges to the notion that family planning could reduce maternal mortality rates, but support continued in many developing countries (Smyth, 1994) so much so that family planning strategies frequently overtook other approaches to improving women's poor health. Family planning was encouraged in many developing countries due to the perceived cost effectiveness. In Indonesia, over a thirty-year period from the 1960s onward, there was a significant drop in fertility rates. The evidence is confusing as in Bali, which has a high usage of contraception the birth rate has been halved, but maternal mortality remains a higher than average level (Smyth, 1994).

A conclusion made by Smyth (1994) was that family planning can aid in the reduction of maternal mortality, but it is recommended that it is one component of a more comprehensive approach. Rather than selectively targeting health needs, which are responses that have been used by many development agencies in the past and continue today, a more integrated approach appears to be of greater benefit. A comprehensive programme that aims to enhance the health of women, not only mothers, should include attention to economic, education and health for all women (Smyth, 1994).

Many countries have adopted WHO Safe Motherhood initiatives which have at times placed emphasis on top-down health services ignoring local health practices, the role of family and communities as health providers, as well as popular medicine (Smyth, 1994). In South Africa a shift has occurred in the provision of reproductive and sexual health services to one from a less narrow top down family planning approach to one that is integrated and covers the life cycle under the umbrella of PHC services. Included is the need for male responsibility and involvement, consideration is also given to gender violence in recognition that this also threatens women's health (Petchesky, 2003).

In the area of reproduction, one cannot help but query the ability of Catholic Church representatives to provide objective advice in areas such as family planning and

sexuality if past examples are anything to go by. The abilities of religious organisations should not be totally negated as much positive work has been done, but there is a need for project planning, monitoring and evaluation to ensure that needs, and in this case I mean women's needs, and objectives are being met, whatever the organisation (Eade and Williams, 1995). Reproductive health and gender are intertwined and cannot be separated. "The complexity of the household decision-making in reproductive health is largely derived from the differences in roles ascribed to men and women...[and] gender discrimination compounds the vulnerability induced by poverty" (Middleberg 2003, p17).

Examination of health funding distribution in Timor-Leste, at the turn of the century, reveals that PHC receives much less than other levels of service (World Bank, 2003). Beneficiaries of current health spending are generally urban residents in main a centre which widens and maintains the access and utilisation gap. The World Bank (2003) clearly indicates the overall utilisation of health services in Timor-Leste is low, and for rural people it is lower, thus a major concern. An important factor that restricts service utilisation is distance between residence and facility. Clearly attempts are being made to bring health services to rural areas but it will not be an easily resolved issue. On the last week of my research I became aware of a national immunisation programme that was to be implemented. In one region I saw women and children walking to the local rural facility where health staff was temporarily stationed. The percentage of village turnout was impossible to estimate but clearly information had been disseminated and people were attending. Whether this campaign was to extend to more remote areas I do not know, but certainly the four wheel drive vehicles that were sighted would not have been a suitable mode of transport due to the lack of roads in some areas.

In the relation to maternal health services, the difficulties of rural access, cost and distance, (the average one way travel time to a health facility is 62 minutes, and is frequently by foot) are real issues (World Bank, 2003) especially for pregnant women with young children. The limited number of nurses and midwives deemed to have suitable qualifications; as well as transport to deliver a safe service means restricted availability of antenatal and birthing services. The UNPF (2002) initiative to extend midwifery services and provide motorbikes to midwives will provide valuable alternatives for some women, but for those living in more remote areas, accessibility by motorbike is hard to imagine due to the mountainous terrain which would be worsened during hours of darkness and the rainy season.

In Timor-Leste it is estimated that approximately 17 to 25 percent of births have a trained midwife in attendance (MOH, 2002, p.14). Birth attendants and traditional healers have played a significant role in the past and Araujo (2001) does not rule out involvement in the future, but indicates the need for training and monitoring to be part of an integrated health system (2001). MacCormack (1982) indicates the role of the traditional midwife or those that support women during their childbearing experiences may be hard to replicate within a system that is largely dominated by biomedical ideology. She speaks of the extensive services that traditional midwives provide in different parts of the world, which are well beyond the western-trained health professional role. The WHO (2004b) definition used to describe the role of TBAs is limited to one who assists during childbirth, but many TBAs provide care from as early as preconception to early parenting and can include a broad spectrum of activities. Lefèber & Voorhoeve, (1998) believe that even if the WHO broadened its definition to include a wider scope of practice it would be impossible to reflect the breadth of activities such as the "...performance of certain protective ceremonies or rituals before, during or after delivery and providing ... a sense of psychological security for the mother" (p.6). Hicks (1976) describes the midwife's ceremonial actions, related to the placenta and umbilical cord, he witnessed during his time in Timor-Leste. Over the years traditional TBAs have often acquired privileged positions in their communities with their roles extending way beyond that of childbirth (Thompson 1998). Attempts to exclude TBAs from reproduction and birthing could result in the loss of a valued community resource.

The WHO indicates that for the world population approximately 80 percent of people utilise traditional, alternative or informal health care to meet their health needs (Eade & Williams, 1995, p640), this may be due to lack of formal service availability or through personal choice. The concept of PHC is based on the view that health care not needs to be practical and based on scientific understandings, also it needs to be socially acceptable (Eade & Williams, 1995).

The Alma Ata Declaration identified minimum PHC health requirements, which include: health education; adequate food supply and promotion of good nutrition; safe water and basic sanitation; maternal and child health care, including birth planning; immunisation against the major infectious disease; prevention and control of locally endemic disease; appropriate treatment of common disease and injuries; provision of essential drugs (Eade & Williams, 1995). The PHC approach has been criticised by

some as being ineffective, but others believe further work is needed to ensure that improvements are achieved. Eade and Williams (1995) indicated that Oxfam views PHC as “the best way to make health care available to the poorest women, men and children” (p.635).

There are well-documented links between maternal mortality and inequities, not unexpectedly the incidence of maternal deaths varies between and within countries. The idea of avoidable maternal deaths can be understood if one acknowledges that inequities can be ameliorated (Graham, 2002). The structure of the health system, as well as interaction between the health professionals and service user can perpetuate inequities and thus affect mortality rates. If health professionals do not have an understanding and sensitivity to women’s realities, the ability to establish relationships and work together can be seriously hampered. Graham (2002) states that in developing countries healthcare that is considered not appropriate or of poor quality, is a “serious deterrent to women seeking care, as well as direct cause of maternal deaths” (p15).

Jordan (1993, p.128) reminds us that birthing systems are conservative, are designed to maintain the status quo and exist as a component of a larger cultural system. This is not to say that cultural views and practices do not change overtime, especially with exposure to outside ideas which often come with development. “Childbirth practices, by virtue of their articulation within the larger system, are bound to be affected in due time. It is under these conditions that strategic considerations for planned change, in maternal and child health care, become relevant” (Jordan, 1993, p.128).

A PHC approach does not need to preclude the incorporation of a wide range of approaches and responses, including traditional and those handed down through families and villages²⁹. The integration of pluralist health systems has occurred in some areas, for example, Chinese and western medicine increasingly works side by side and in China and Vietnam they now provide a multi-layered level of healthcare. In Zimbabwe TBAs assist women’s access to government clinics. TBAs in some locations are being trained in birthing practices, their role includes identification of women ‘at risk’, whom they refer to formal health care facilities (Jordan, 1993) and Thompson believes that without health system support it is unrealistic to expect TBA to contribute to an improvement in maternal mortality rates (Thompson, 1998).

²⁹ Treatments and health beliefs that are handed down through groups of people, including families and villages can be called popular medicine.

Jordan (1993) believes there is value in accommodating more than one health system into birthing practices. Building on the work of earlier writers such as Williams and Jelliffe (1972), Chen, (1973) and Cosminsky (1977) she promotes the potential for an integration of systems through a considered and informed approach. Policy formulation needs to specify changes in the indigenous system as well as that of biomedicine resulting in modification and adaptation of both. Importantly this results in "...legitimization of the point of view of the indigenous system [which] should open up alternatives to the uncritical, one-sided imposition of the medical obstetric practices" (Jordan, 1993, p.136). Care needs to be taken if multiple health systems are encouraged or practised as consideration needs to be given to issues of equity of access and that training and monitoring is undertaken to ensure that the health and well-being of mother and infant is not compromised. This will indeed be a challenge as many development workers will bring their own ideas as to what this constitutes equity and appropriate service delivery (WHO, 1979).

Important points need to be considered when teaching traditional midwives 'western knowledge' including the need to utilise appropriate teaching methods to facilitate learning. The western world has a tendency to use lectures and other formal methods, and frequently places emphasis on specific learning, including the use of definitions, whereas in many cultures midwives learn through apprenticeship (Jordan, 1993). Those given the responsibility 'to educate' need to consider the best ways to respond to diverse learning styles.

The Worldbank (2003) articulates a number of constraints and problems in relation to development of health and education services in Timor-Leste. Of particular significance is the lack of confidence by the public in both of these services. Cultural inhibitions prevent many people from seeking healthcare until it is too late, though this appears to be formal services rather than those of traditional practitioners. This being the case it would be valuable for planners, education and health professionals to work with local people as Jordan (1993) mentions to achieve the best of the healing systems that are available. This will require considerable work at grassroots level if increased confidence in services is to be achieved and sustainable.

The overall benefits of biomedicine can not be ignored as improvements in health status have been achieved, for example infectious diseases and eradication of parasites, which has been brought about by drugs and scientific knowledge. Surgery and technology have played a considerable part, but machinery and drugs can be expensive

and require skilled personnel and specialist knowledge in its utilisation and maintenance (Capra, 1983). A shift to biomedicine can be expensive for developing countries especially when reductions in aid occur. The benefits and improvements in health can make biomedicine attractive to developing countries, but there are also consequences as costs are associated with its adoption, one being the devaluing of indigenous practices.

The introduction of biomedicine to tended to result in the absorption of childbearing into the medical domain. Bringing childbearing totally under the umbrella of biomedicine should be done with caution, Jordan (1993) advises. The scientific evidence that has supported biomedicine's survival may not always be applicable to women in developing countries. Much of the research has been carried out in well-equipped hospitals (by developing country standards) on women that are relatively healthy. These women are not comparable with most women in developing countries in health status, physically and psychologically for example pain tolerance are unexplored issues (Jordan, 1993).

Western health professionals are increasingly required to utilise evidence-based practice as the foundation for decision making and implementation of cares. Whilst the ability to articulate the use of evidence as the basis of one's practice is valued in the west we are reminded by Ezzy (2002b) that scientific research has particular political and theoretical biases and that findings can not be universally applied. Uncritical or inflexible application fails to value wider aspects that are not included or explicit, such as local, historical, cultural and structural dimensions of health and illness. It is unknown how medication usage varies with birth location and how this is effected women's ability, or lack of, to take control of their birth (Jordan, 1993). Just as development projects are unlikely to be effectively transplanted from one location to another, it appears Jordan is saying the same applies to biomedical beliefs and practices, as outcomes may vary due to a range of factors.

It is important for development planner to think broadly about the appropriateness and cost effectiveness of their strategies. Whilst the rates of maternal and infant morbidity and mortality are high in Timor-Leste, actions to reduce these rates are not the sole province of medical care. This is especially the case if it is practised, as has been in the past, viewing the person and the disease solely in physiological terms (Capra, 1983). The determinants of maternal mortality are multifaceted and are influenced by a range of variables including women's status, poverty, literacy, level of economic development, strength of health systems and barriers caused by regulations

and laws. de Bernis (2002, p.22) goes on to say that “maternal mortality is symptomatic of gender inequality [and that] preventing maternal death and illness is an issue of social justice and women’s human rights”. Östlin, George and Sen (2001) provide support for this by saying that all maternal deaths are avoidable but continue due to societal discrimination which has a very restricted view of women’s health, primarily childbearing, rather than attending to women’s rights as citizens.

The emphasis some people place on education as a health promotion strategy can be a superficial approach if it is the sole strategy to improve people’s health. Emphasis on imparting health information can lead to a situation of victim blaming if the recipient does not change behaviours in response to the messages given (Eade Williams, 1995). It should not be assumed that awareness and knowledge about a health issue will lead to a behaviour change (Villanueva, 2001, p.1). Many barriers to behaviour change exist including a woman’s lack of choice and power to make decisions for herself (Maas, n.d.).

The history of forced contraception by the Indonesians is likely to have left many people suspicious of actions of outsiders, regardless of their rationale. One also needs to be mindful that during the last 30 years many lives have been lost. This has left many with the view that it is important to rebuild the population, with a new and younger generation. With children comes the feeling of security and hope (personal communication). Limiting family size is therefore likely to bring a considerable number of issues to the fore, which outsiders may have little understanding of, or even sympathy for.

Petchesky and Corrêa (Petchesky, 2003) argued for ‘enabling conditions’ for women in relation to reproductive and sexual rights, prior to the Cairo conference, there is continued to advocate for women’s rights including:

- bodily integrity-dignity, respect and freedom from abuses and assaults, which included unwanted sex and the consequences of;
- personhood-right to self-determination;
- equality-access to resources including health and social services and;
- diversity - to be respected, being regardful of group affiliations and cultural differences that are chosen and are empowering to the woman.

To achieve this requires a broad approach and Petchesky (2003) asks why should women be required to choose between services availability, for example, safe water, sanitation or suitably trained health professionals. It has been shown that many women

(as have local and government organisations) have put their own health needs behind that of, for example road building (Petchesky, 2003). International agencies have often focused on working to provide women's education and reproductive health services primarily as "an efficient means towards their own aims rather than a fundamental human right" (Petchesky, 2003, p9).

Focusing on women's reproductive health, can open doors to addressing other issues that exist within a society, such as issues of low self-esteem and low status. Discussing with women how their bodies work can follow onto other discussions, such as sexuality and rights to have control of their bodies and it can assist in exploring myths, challenging women's subordinate status and has the potential to enable women to take control of their fertility (Eade and Williams, 1995).

Development-Where To?

One key direction already identified and being implemented, is the need to increase women's access to skilled birth attendants. This has become a major focus of the South East Asia Regional Office (SEARO) of WHO which is involved in supporting countries to achieve safer pregnancy for women. In Timor-Leste they are providing assistance to increase access and the utilisation of skilled birth attendants. This is part of the Making Pregnancy Safer Strategy which aims to reduce maternal mortality rates as identified by the WHO Millenium Development Goals (de Bernis, Fogstad, Kabra, Lincetto, Portela, Martin Hilber, Sherratt, Zupan, Matthews, 2003) and is a key facet of the national reproductive health plan. This project will take time to achieve, as it is clearly evident that geography and the reduced availability of suitably trained birth attendants place imitations on women's utilisation. The cultural norms of homebirth and family responsibility for health will require local input and education to be ongoing to ensure that the benefits in handing over 'care' to those that maybe perceived as outsiders can be understood by women, families and communities. Until this occurs regardless of the amount of resources that are made available, change is likely to be slow particularly in more traditional areas.

The Timor-Leste MOH has identified that pregnancy at a young age is a current issue as is a lack of awareness of HIV/AIDS (MOH, 2002). Shah, Bott, Warriner, Bathija, Schmidt (2003) identify that adolescent³⁰ sexual health is overlooked in many countries, and Timor-Leste is likely to be no exception. An integrated approach working toward achieving positive population reproductive health outcomes benefits

³⁰ The term youth is often used and includes all between the ages of 10-24 years

from the implementation of ASRH programmes. Many of the issues identified and discussed reveals that adolescent sexual and reproductive health needs to be placed on the agenda of the Timor-Leste government, development agencies, communities and families alike. In view of the culture of silence, the existence of cultural and gendered norms and expectations, domestic violence, identifying and addressing behaviours and issues cannot be delayed.

Recent research by the WHO (Shah, Bott, Warriner, Bathija, Schmidt, 2003) indicates that lack of information and communication with parents is common. Social norms are contradictory in some societies, resulting in females being pressured by males and females feeling unaware of or unable to implement strategies to keep themselves safe. This has led the WHO to identify policies and programmes, which may have some relevancy for adaptation to Timor-Leste:

Gendered norms filter through everyday society and effect adolescent behaviours and decision-making, it thus imperative that programmes identify and address these, developing interventions that enable critical analysis with the aim to facilitate positive change strategies. Poor, or lack of, knowledge about all aspects of reproduction effects decision making, thus adolescents (and adults) need to be encouraged to talk opening (Shah, et al., 2003). Shah, et al. (2003) indicates that ASRH initiatives are an aim of WHO who will provide assistance with knowledge and policy development. It supports research and information dissemination to countries through a variety of forums such as journal article publications, conferences and Internet resources. Assessment of youth reproductive health services by Senderowitz, Hainsworth and Solter (2003) reveals common concerns exist for adolescents regarding health services provision including provider attitudes, privacy and confidentiality, accessibility, supportiveness of policies and procedures, all of which impede usage by adolescents for reproductive health issues.

Rosen, Murraray & Moreland (2004) undertook an international review of school sexuality education programmes and found costs in African countries to be as low as US\$.30, with a median cost of US\$9, per year per person. In Honduras they found that for every \$1 invested in HIV and sexuality education \$4.59 accrued in reduced health spending. This does not include other benefits such as increased education, decreased early pregnancies and abortions (Rosen, Murraray & Moreland (2004, p.7).

A project that targets youth has the potential for wide-ranging outcomes³¹ which can have positive flow on benefits for many of the issues that have been identified in this thesis. Rosen et al. (2004) also found that despite common concerns from adults, parents and community members, that youth would become or increase sexual activity this was not the case. Concerns from traditional and religious leaders were not uncommon and often mobilise opposition from within society, believing such programmes would interfere with traditions and beliefs, but a number of programmes successfully enlisted their support. Strategies to defuse opposition include provision of understandable and accurate information which can aid in increasing support and reducing unsubstantiated fears. Involving traditional leaders, parents, wider community participation and open communication have been shown to be positive strategies for the development of youth reproduction education (Rosen et al., 2004).

Programmes can be specific, targeting issues such as early marriage, or broad and holistic (Williamson, 2004) exploring gender norms and values, power and social control, issues of equity and inequity, body physiology, reproduction, self-esteem, sexuality and human rights. Three rigorous evaluations of programmes revealed that 'abstinence-only-until-marriage' programmes demonstrated no significant impact on "...the initiation of sexual activity, frequency of sexual activity, and number of sexual partners, use of condoms or use of contraception" (Kirby in Rosen et al., 2004, p.7).

Implementation of youth reproductive health programmes can incorporate media, peer education, counselling services, youth centres, theatre groups, religious based programmes and sports programmes, supporting or complementing each other (Williamson, 2004). Michael Holgate (2000) works for Ashe³², a performing arts company in Jamaica. The group is involved in peer education and personal development as it believes that youth need more than teachers, parents and others to assist through the turbulent times of adolescent sexuality, which is not helped by cultural taboos and repressive beliefs. As an adolescent Ashe empowered him (now 27) in many ways, building self-esteem is a key part of the Ashe experience, and is interwoven with attitudes and activities, using the performing arts as a tool. Within this approach sex education incorporates self analysis and discussions most often with peers after performances (Holgate, 2000).

³¹ Rosen et al., (2004) cited findings from sexual health using peer education, initiated in schools then continued into postsecondary areas, of increased knowledge and awareness of interventions, increased sense of capacity to act and make decisions regarding sex and contraception and a reduction in risky behaviours.

³² The name Ashe comes from an African word which broadly means inner strength and self-respect

The WHO has approved a community-based project in China, incorporating sex/reproductive health education interventions, targeting 15-24 year olds, with the aim to increase knowledge regarding sexual and reproductive health and safe sex. As yet there are few studies that indicate sustainability of such strategies and consideration will need to be given to the divergent contexts between China and Timor-Leste.

Programmes need to provide accurate information, build skills, counselling and access to health services including reproductive health and a safe and supportive environment (WHO, 1997). Behaviours of adolescents' change faster than other members of society and societal institutions. Working to address potential issues proactively with this age group will have positive implications for the future (Shah, Bott, Warriner, Bathija, Schmidt, 2003).

The "...increasing evidence of risky consensual sex among you people in developing countries" (Shah, Bott, Warriner, Bathija, Schmidt, 2003, p152) means that tools developed by the WHO Department of Child and Adolescent Health and Development will be a starting point for action. Addressing these issues is a positive move in acknowledging what the ICPD (1994) highlighted as a largely ignored but important aspect, that of ASRH (Shah, Bott, Warriner, Bathija, Schmidt, 2003).

Conclusion

Childbearing is but one aspect of reproductive health thus women's experiences, practices and subsequent issues that arise during this time are influenced by many factors. It is important that the government and development agencies working in Timor-Leste look broadly when considering programmes. In the past international reproductive health has focused on women of childbearing age, with particular attention to mothering and in so doing adolescents and others who have been excluded.

To reduce maternal and infant mortality, a key WHO goal, requires a multi-layered approach. It will be difficult to rank reproductive health programmes, as many will be considered vitally important and evidence will surely be available to substantiate the potential benefits of ideas. Some projects to improve reproductive health are unlikely to reveal immediate outcomes making it potentially harder to justify their priority over other programmes that selectively target particular health issues and have immediate and measurable benefits. This should not preclude programmes that focus on changing behaviours and cultural norms due to the increased timeframe required to reveal outcomes.

The strong arguments provided in the literature for the development and implementation of ASRH programmes is hard to ignore. The potential outcomes are wide and will benefit not only reproductive health, for females, but also males (this is also important, but not part of this thesis). Many of these benefits, if an holistic approach is taken, will carry over into all areas, not only for the individual, but communities and the nation as a whole. The potential outcomes will link with a wide range of international and national health goals for Timor-Leste, as implementation can readily come under the umbrella of PHC.

Women's childbearing experiences are influenced by a diverse range of factors:

- Past events, such as coercive family planning programmes or mass destruction of a population, both of which effect decisions about family size today.
- Cultural norms, which influence who have rights to make decisions about women's bodies and the unequal distribution of power which results in marginalisation of women's rights.
- Women's ability to access resources and participate in the paid economy.
- Government services provision including decisions about whether or not to fund services including health and education for example supporting adolescent sexual health education and health services.

All of these factors have consequences for women as well as the health of current and future citizens. If change is desired it is often adolescent who are the most receptive, thus any strategies for change should consider and involving adolescents (WHO, 1997). Increased education, especially but not only for females, has been shown to improve health outcomes. Reproduction and thus childbearing involves all societal members, targeting adolescents must surely have considerable merit. Due to the potential for multiple outcomes, beyond that of improved health, a programme that enables people to make informed decisions, supports equity and citizens rights, improves self-esteem and one's ability to participate more widely in society can not be overlooked.

CHAPTER SEVEN

Conclusion

Summary

Childbirth is a part of every society, past, current and future and as Middleberg (2003) states “[e]very culture, for as long as history is regarded, prominently features reproduction in its stories and norms” (p.3). Childbirth, despite being only one component of reproductive health, dominates literature. The neglect or limited attention to reproductive health of non-childbearing women such, as adolescents and those who have completed childbearing, has been criticised. A wider view needs to be taken of reproductive health. The issues that confront people vary as women and men experience many different problems biologically, as well as socially, economically and politically (Eade & Williams, 1995).

Working with such multiple variables means no one strategy is the answer. It appears the implementation of strategies to improve reproductive health, whilst some may question, should be commenced from as early as 10 years of age. Holgate (2000) describes adolescence as turbulent times, which suggests that age appropriate strategies would have considerable merit in view of the belief that appropriate knowledge can be empowering, influences behaviours and actions and can result in capacity building.

Western ideas of childbirth and women’s roles have influenced development strategies in developing countries. High maternal and infant mortality and morbidity rates as well as health risks and outcomes have at times determined how reproductive health and in particular women and childbirth are incorporated into development plans and actions. This has meant that projects have not always responded to local women’s needs and there has also been a tendency to treat all childbearing women similarly despite the diversity of realities that exist for example geographical location, class and ethnicity.

In the past a lack of comprehensive consideration of women has impeded the success and sustainability of strategies to improve lives. Considerable ethnographic studies on childbirth have been undertaken in areas such as childbirth but Yoder (1997) indicates the challenge has been negotiating with health professionals regarding the use of relevant information.

A notion within public health is that behavioural change follows changes in beliefs and knowledge; if this is the case it is important that public health workers have a base knowledge of beliefs, practices and realities of the people with whom they are working. This would also extend to others working in associated areas such as teachers involved in health education. Youth education could be a strategic tool with the aim of imparting knowledge, exploring gender norms and inequities and beliefs and practices with the long-term goal of positive behaviour change. Adolescents are the next generation and with recent evidence of increasing fertilities rates and the number of adolescent pregnancies work in this area will be beneficial, due to current issues and risks currently associated with reproductive health.

Chapter two reviews literature, exploring ideas and trends in development, health, gender and culture in relation to childbirth. It is believed that these ideas and trends have the potential to influence projects undertaken in developing countries in relation to reproductive health. The overview intends to reveal trends and divergence in thinking regarding the directions, causes and solutions for countries that are considered to be underdeveloped. The western world, particularly the USA, has been influential in 'developing' underdeveloped countries.

Economic development has tended to dominant, but increasingly social factors have been given greater credence. Some believe that economic development leads to social development, but overtime this has been criticised on the basis that development does not benefit all evenly. Development sometimes results in a widening of the gap between rich and poor, within and between countries (Harrison, 1988).

Despite the considerable knowledge and expertise in the area of development, poverty and other issues have not been resolved for many countries, leading some to question the various approaches utilised. Some areas such as agricultural development have for decades worked with local people, whilst others areas including health have tended to identifying issues and implement programmes targeting a population and utilising particular strategies, such as immunisation or contraception campaigns.

A current view espoused by some is that for development to be sustainable local input at all stages is necessary. Within the area of public health this view was first mooted in the Alma Ata Declaration (1978) and has been supported in principle at international forums since, but implementation has not been easily achieved (Asthana, 1994; Elder, 2001). The view that good health is an individual's right incorporates notions of equity which have been challenging to implement. Explanations of health

and subsequent treatment are culturally determined, as are notions of equity which some believe have resulted in a number of obstacles.

Western health experts have been strongly influenced by the dominant western healing system, that of biomedicine and its associated ideas (Kitzinger, 1992). Increasingly childbirth has been incorporated into the biomedical domain, under the expertise of the doctor's knowledge, which is given greater authority over that of the women's knowledge (Capra, 1983). This has resulted in criticisms of biomedicine, as well as the power exerted by doctors (Jordan, 1983). Males have dominated western medicine, but criticisms of gender relationships have extended beyond medicine to many other areas of society. Increasingly attention is given to questioning how gendered differences affect individuals and groups (de Koning et al, 1998).

Gender analysis has been utilised within some development agencies to assist in development and implementation of programmes. Critics have claimed that females have at times been excluded from development. When women have been included there has been a tendency to pay greater heed to reproduction, both biologically and the socially ascribed roles, ignoring a myriad of other factors such as sexuality (Rathgeber, 1990; Kabeer, 1994; Stein, 1997).

The health and well being of individuals can be associated with one's ability to access valued resources. Women make up a greater number of the poor, have higher mortality and morbidity rates compared to non-poor women, which subsequently affects childbearing experiences and outcomes. Ability to access health services, information, education and income are all seen to be determinants of health and are strongly influenced by social inequities (Östlin, George & Sen, 2001).

Chapter three focuses on Timor-Leste's, past and as well as present. Colonised by the Portuguese 400 hundred years ago, then illegally taken over by the Indonesian authorities in the 1970s has meant considerable power has been exerted over the Timorese. Catholic missionaries arrived not long after the Portuguese and today some 90 percent of the population identify as Catholic. Over the centuries immigration has resulted in a population that is ethnically, culturally and linguistically diverse (Dunn, 1983; Taylor, 1995).

Many of today's population are dependent on subsistence farming for their livelihoods, retaining century old agricultural practices (de Sousa, 2001). Development by both the Portuguese and Indonesian's was spasmodic and little autonomy was given to local people. At times Portuguese development strategies were aimed to accrue

benefits for the home country, resulting in minimal local investment or sustained strategies to enhance the livelihoods of the Timorese. Infrastructure investment was limited, leaving many rural areas relatively isolated. Catholic clinics and schools filled gaps left by the limited Portuguese services. Indonesian authorities did improve access to a range of services including schools which were used as a coercive tool for controlling the population (de Sousa, 2001).

Periods of fighting and warfare have not been uncommon, occurring intermittently between the Portuguese and Timorese. World War II prompted Australian forces to be posted on the island for a short period prior to Japanese occupation. The Indonesian occupation from 1970s until the turn of the century resulted in considerable fighting, many brutal killings, massacres and considerable loss of life (Dunn, 1983; Taylor, 1995). Some believe a consequence of this past violence is evident in the continued culture of violence portrayed in the high incidence of domestic violence (Bourdre, 2004).

Due to past coercive treatments many Timorese put greater trust in the services and facilities provided by the Catholic Church, as they were seen as independent (Storey, 1995; Taylor, 1995;). They also supported many of the local people's needs, though some felt those in rural areas were neglected. The Timorese finally gained the opportunity to vote for independence, in 1999, the vote was an overwhelming yes. Despite UN presence, before and after the voting, Indonesian perpetrated violence continued. Destructive rampaging followed the announcement of the vote, leaving the country devastated, many people fled or were killed, and the infrastructure was virtually destroyed (de Sousa, 2001; Greenless & Garran, 2002).

The dawn of a new era was a country devoid of many of the necessities of life, and a need to rebuild virtually everything. Health statistics were appalling, illiteracy rates high, as was unemployment and expertise in all areas is needed to help this country emerge from the ashes. Many traditional practices continue today which have a marked impact on women's lives. Women's positions are marginal, women have been victims of rape by Indonesian officials; they are also victims of abuse today, have less access to health, education and food (World Bank, 2003). Statistically the maternal mortality rates rank within the highest in the world (World Bank, 2003).

It is intended that chapters two and three provide the reader with a contextual backdrop for subsequent discussions. Not all aspects are revisited but as Wright Mills (1959) indicates historical, cultural and structural factors all influences ideas and actions

today. Neither development workers nor the people that are targeted for project actions live in a social vacuum thus considerable benefit can result from contextual explorations.

Chapter four discusses the research, in which a qualitative approach is used to gain insight into childbearing practices and issues in Timor-Leste. Rural women were the main participants approached for data, due to perceived issues of marginality and through the utilisation of predominantly focus group discussions aspects of women's experiences were explored.

As the researcher I have been influenced by feminism and constructionism, both of which incorporated ideas of socially constructed realities. Another aspect of both of these relates to power, how it is achieved and maintained by some whilst others frequently, but always women, find themselves in vulnerable or inequitable situations. If development is to address maternal mortality rates there is a need for comprehensive understandings, both feminism and constructionism aided the exploration of aspects of women's lives in Timor-Leste.

Whilst this study was small and contains a number of factors that limited data collection it also, through the use of qualitative research methods, enabled me to explore experiences of a small group of women in a remote area of Timor-Leste. The use of focus groups discussions allowed women to share information regarding a potentially sensitive topic, that of childbearing. Their willingness to talk to a stranger left me in no doubt they felt they had something of value to say, and they wanted to be heard. Data obtained reveals that children are greatly valued, local meanings of this need to be explored, as my sense is that they have significant and underlying connections with aspects of this country's past will affect health statistics in the future.

Chapter five links information and stories shared by participants' with ethnographic data from other cultural groups. There were some key reasons for this, one was a lack of time in the field to gain in-depth understanding of local practices, also on occasions women indicated their actions resulted from traditions but they could not provide underlying explanations. Rather than providing specific constructions that might inadvertently be applied to all Timorese women I wanted to leave open the potential meanings of practices, thus women's diversity and individual experiences would not be seen as fixed or homogenous.

Chapter six draws on particular aspects identified by the women and secondary sources that I believed have future relevance for childbearing women in Timor-Leste.

These include the vulnerability of the health system funding, as future spending is likely to be limited (Oxfam Community Aid Abroad, 2004), which emphasises the need for careful planning to ensure that sustainable, cost effective strategies are planned and are able to be implemented. Women's marginal position (World Bank, 2003) within Timorese society reaffirms the need to work actively toward improving health outcomes for all women, but the high maternal mortality rates bring a number of factors to the fore (MOH, 2002). Improvement will require strategies beyond the domain of health services, as holistic and comprehensive approaches to health and wellbeing would require consideration of the effects of societal attitudes and norms on health outcomes. If PHC is to be actively implemented issues of equity, prevention and participation need to be included.

In recent decades ideologies and practices in health and development indicate the importance of participation and human rights. Historically, as well as today, there is considerable evidence of Timorese women's limited involvement in decision-making, personally, within families and politically (Retbøll, 2002). Husbands strongly influence the number and frequency of women's pregnancies, husbands and family can determine access to healthcare for a woman and her children, the extent of domestic violence of which women are recipients is high emphasising issues of power and control, and women are underrepresented at a political level. The continuation of dowry practices further places limitations on women due to underlying messages of ownership, control and associated expectations that are associated (Bourdre, 2004).. The question is, how do they effect reproductive health whether it be directly or indirectly, do these issues exist in isolation and are they able to be addressed?

After identification and discussion of issues, I identify the area of ASRH as being an area of development that has tended to be overlooked in many countries but when implemented has been shown as cost effective in working toward positive change. Holistic ASRH introduced in schools, as in other areas, have long-term benefits which extend beyond health into many other aspects of life for individuals, males and females, and communities (Rosean et al., 2004).

Recommendations and future direction

Determining health needs for any population can be difficult, as it implies that something is lacking, the process is judgmental rather than scientific (Green, 1999). If change is to occur, particularly in the area of attitudes and behaviours, it would seem that youth are the ideal target group as they are the next generation.

The plan to explore women's childbearing experiences took me in a direction I had not initially considered, that of ASRH. I am unclear as to extent to which schools in Timor-Leste incorporate sexuality and reproductive health, but the repeated reference in literature to either neglect or inadequacy of work in this area, internationally, led me to conclude that ASRH as a development issue warranted identification for this new nation. Any projects that attempt to access the youth of Timor-Leste, through schools or any other location will experience limitations due to issues of access, attendance, community acceptance and cost. How to resolve these will not be easy.

A holistic approach to working in the area of ASRH shows the importance of being adaptive, for example, in relation to the age, diversity of needs and circumstances, but a range of positive outcomes can be achieved (Rosen, et al., 2004). One factor that does appear in the literature is programmes that focus on 'abstinence only', do not alter some key sexual health behaviours when results in them being of limited benefit.

Adolescents overall are the most receptive to change. What is apparent is that adolescents and communities need to be involved and that political commitment is essential. As indicated, the WHO have undertaken work in the area of ASRH identifying aspects for policy and programme consideration (Shah et al., 2003) they also provide support through for example information sharing. I therefore put forward this area for further exploration and development. I recognise that I have not explored the idea of programme implement at the local level this would certainly need to occur and would need to involvement communities.

In the past reproduction and reproductive issues have challenged the ideas of many, but the issue of reproductive health cannot be overlooked (Bandarage, 1997; Stein, 1997; Petchesky, 2003). There is considerable literature that identifies numerous directions and approaches to youth reproductive health used in the past or currently being used. The idea of ASRH programmes may be challenging for some, the future can be positive if the right steps are taken, especially if consciousness raising, rights, empowerment and capacity building occur as these will facilitate improvements in emotional and physical health.

Bandarage (1997) identifies that when women's status and self esteem are linked with her reproductive role it is difficult to see that women would consider reduced family size as a positive alternative especially if they could see no benefits in the foreseeable future (Bandarage, 1997). In many third world countries children are considered important in many ways as they offer not only a means of survival but also

pleasure and hope (Bandarage, 1997). This was evident in Timor-Leste, therefore any attempts to change or critique any area of reproduction will require sensitivity, local knowledge and local and political participation and commitment.

In conjunction with this, abusive cultural practices must be stopped, such as acts that disempower women; strategies need to be developed to ensure women are equal citizens meaning equal rights (which includes equal access to education, health services and food) and health status, thus reducing women's vulnerability (Bandarage, 1997). To achieve this will require gender analysis to occur and changes in behaviours and attitudes at all levels.

ASRH have the potential to work on many of these issues involving both males and females at a key time in their development. The outcomes will have positive implications for childbearing experiences and reproductive health. This is the challenge for development workers and the all citizens of Timor-Leste working toward the future of this new country.

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