

Maternal Mortality, Unplanned Pregnancy
and Unsafe Abortion in Timor-Leste:
A Situational Analysis



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Suzanne Belton, Andrea Whittaker and Lesley Barclay

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Preface

Statement Kirsty Sword, Chairwoman, Fundasaun Alola

Fundasaun Alola is proud to have initiated this research project on an issue of fundamental importance and relevance to the lives of women and their families in Timor-Leste. My special thanks go to Suzanne Belton and the other authors for agreeing to take on the challenge of heading up this project and for bringing to their work a wealth of experience of researching maternal and reproductive health in other countries in the region. UNFPA's support of this project is also greatly appreciated.

In 2005, East Timorese law-makers began drafting a Penal Code for the new nation which included an article on the sensitive issue of abortion. It was a matter of great concern to the Alola Foundation and to the women's movement in this country that only scant data and anecdotal evidence existed to inform the process and that the opinions and ideas of women on a matter so intimately linked to their lives and rights had not been sought in a systematic way. Between June and September 2005 the Alola Foundation facilitated a series of public fora in which NGO representatives, members of the Catholic Clergy, officials of the Ministry of Health and the UN Specialised Agencies participated. The results of these debates which focussed on the issues of abortion and prostitution were compiled and presented to the Ministry of Justice for consideration in the process of drafting of the Penal Code. They highlighted the participants' concerns that a range of exceptions to full criminalisation of abortion be included in the Code and that young people and families across the country be granted access to quality information and services relating to planned and responsible parenthood.

In subsequent meetings with the then Minister of Justice, Domingos Sarmiento, reference was made to the dearth of research on the incidence of unsafe abortion and the issue of unplanned pregnancy in Timor-Leste. Consequently, Alola was asked to consider leading a research project that would shed light as to the reasons why Timorese women seek abortion and the consequences of unsafe abortion for their reproductive and general health.

Four years on, and at a time when the nation's Penal Code is once again being debated and revised, the Alola Foundation is proud to present the findings of its research. May the story it tells of women's realities and aspirations inform the decisions of our leaders and law-makers, and may its recommendations be embraced by all those committed to addressing the tragedy of the preventable deaths of women and girls in our young nation, Timor-Leste.

Statement Hernando Agudelo, UNFPA Country Representative to Timor-Leste

Timor-Leste has a Total Fertility Rate (TFR) of 7 children per woman, the third highest in the world. This high TFR is amongst the factors that has lead to an estimated maternal mortality ratio in the country of 660 per 100,000 live/births, the highest in Asia after Afghanistan. Globally, maternal deaths are clustered around labour, delivery and the immediate postpartum period due to haemorrhage, infection, obstructed labour, complications from unsafe abortion and hypertensive disorders.

In countries such as Timor-Leste, where low use of contraceptive methods leads to many unwanted pregnancies, the practice of unsafe abortion is an increasing health risk. Inadequate knowledge about contraception within Timor-Leste is an aggravating factor - according to the 2003 Demographic and Health Survey, only one in three women was aware of at least one method of family planning and only 30% of men surveyed were aware that family planning methods exist. The low knowledge about contraception by both sexes is likely to lead to many unwanted pregnancies, a catalyst for unsafe abortion. This calls for concerted efforts to promote family planning methods not only to reduce unsafe abortion but more importantly to improve the lives of women and to reduce the very high maternal mortality ratio.

In order to achieve the Millennium Development Goals, specifically Goal 5 on improving maternal health the Ministry of Health is scaling up its efforts to advance the health care system and thus reduce the number of diseases, deaths and disabilities. Well targeted plans and strategies for achieving goal 5 require comprehensive, accurate and current data on issues related to maternal health and maternal health care services. Due to social, cultural and religious issues in Timor-Leste however, there is limited information about abortion practice - the need for up-to-date and reliable data is particularly salient given abortion's direct association with maternal death. The Safe Motherhood pillar of the MoH's National Reproductive Health Strategy – Timor-Leste emphasizes the need for skilled health personnel to prevent, detect and manage obstetric complications. Although the strategy does not explicitly emphasize abortion and post abortion care, women that do have abortion complications will receive Emergency Obstetric Care (EMOC) services.

With the view to developing an understanding of the magnitude as well as social, cultural and religious issues surrounding unsafe abortion in Timor-Leste, research was undertaken by the Alola Foundation. This study provides evidence based information on the prevalence of complicated abortion care cases presenting to hospital as well as the quality of post-abortion services in Timor-Leste. It also provides recommendations concerning the need to improve post-abortion services and establish clear treatment protocols, including follow-up, offering modern methods of contraception if appropriate, and proper counselling for affected families and individuals.

The United Nation Population Fund (UNFPA) is very proud to have funded this study and of being partner for its implementation along with Alola Foundation and Charles Darwin University, Darwin, Australia.

Lastly, the UNFPA would like to thank the Alola Foundation for taking the initiative in undertaking this study and importantly for its commitment to investigating the realities and issues associated with abortion in Timor-Leste. We now look to representatives from the health sector to utilize the findings from this research to improve on the quality women's lives in Timor-Leste.

'We have to grasp that maternal mortality is not just a personal tragedy. It is not just a development, humanitarian and health issue. Maternal mortality is a human rights issue'
(Hunt 2007) p12.

Corresponding author:
Suzanne Belton
Graduate School for Health Practice
Charles Darwin University
Darwin, Northern Territory
Australia 0909

Email: suzanne.belton@cdu.edu.au
Telephone: +61-8-89466896

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Stories from Timor-Leste

Case Study - Fernanda's socio-economic problems

Mana Fernanda has been married for several years and has two children. She is still breastfeeding her baby. She is pregnant and does not want to be. She heard something about family planning but nobody really explained it to her. Her husband has no work and she works and earns the money. She worries about who will feed the family when she has to look after the children. She decided to talk with the neighbourhood 'Aunty' who understands these things. 'Aunty' gave her some cool tasting herbs to drink in a tea. She drank the tea but nothing happened. 'Aunty' showed her how to press her stomach. Everyday Fernanda pressed and pushed to get rid of the baby. Nothing happened. Now she is frightened to go for antenatal care because she thinks that the doctors can tell what she has been doing. She thinks the baby will be born deformed. She feels very bad.

Case Study – Jacinta's experience of rape

Mana Jacinta remembers the attack all the time when she closes her eyes. She trusted him not to hurt her. She remembers his anger, his violence, his breath on her body. Jacinta ached for days afterwards and couldn't speak for shock. Her periods stopped and her breasts swelled. Her mother asked her one day why she was so quiet and finally after she told the whole story they both cried. She does not want this man's baby. Jacinta does not want a baby conceived in hatred and fear.

Case Study – Imelda's serious health problem

Imelda is 19 and in love with her husband – her heart races with delight. She visits the doctor because she feels a little weak. The doctor listens to her heart beating and tells her she has a serious health problem. He says she must not get pregnant as it will be too much of a strain on her heart. He does not test her for pregnancy or give her any family planning advice. Five months later she returns to the clinic in labour. During her labour she becomes very weak and breathless. Imelda finds it hard to push. The doctor gives her oxygen and medicine and Imelda delivers a baby girl. Within thirty minutes of the birth she cannot breathe and her heart is failing. Her family watch as the doctor tries to save her life but she dies.

Case Study – Augustina tries to find out about family planning

Mana Augustina works on a coffee plantation high in the cool mountains. She has been pregnant nine times and has five living children. She is frequently tired and her blood is as thin as the mountain air. When she got pregnant this time her husband gave her palm wine to drink. She started to bleed and have severe pains and the midwife helped her to come to the hospital. The midwives are busy and do not talk with her about family planning until the foreign doctor suggests it. They quickly talk about lots of medicine that Augustina has never heard of and she feels confused. Augustina's husband is worried that it will harm her health and make her weak and he says they don't want it.

Timorese Testimonies of Unwanted Pregnancy and Unsafe Abortion: case studies based upon stories collected during this study from people speaking of their own experience or that of their family, friends or clients'.

Acknowledgements

Many people contributed to producing this report. Firstly let us thank the men and women of Timor who spoke candidly about their opinions and experiences. This is not an easy topic to discuss due to cultural issues and illegality, yet they engaged enthusiastically and contributed to public debate. We had been told that abortion was taboo and people were unlikely to speak, in fact, in most instances this was not the case. Even women who had experienced a pregnancy loss took time to explain their situation to the research team.

As the data collection period occurred over a long period of time, the research was approved by two Ministers of Health, Drs Rui de Araujo and Nelson Martins. The Minister of Justice Lucia Lobato also supported this work.

Many Timorese and expatriate doctors and midwives gave their time to talk about the complexity of their work, their professional achievements and challenges. We were not only interested in their clinical practice but their personal viewpoints and they kindly shared their most intimate thoughts. Timorese and expatriate judges, lawyers, prosecutors, police and prison wardens also participated. Nuns and priests of the various orders of the Catholic faith spoke of their pastoral care.

The authors would specifically like to thank Tanya Wells Brown, Veronica Correia, Mira Fonseca Amaral, Alita Verdial, Maria Guterres, Anne Finch, Anne Bunning, Jenni Graves, Andrew Marriott, Karen Otsea, Rebecca Cook, Charlotte Hord Smith, Charles Ngwena, Fred Nunes, Esther Richards, Sue England, Tracey Morgan, Bernardo Domingas, Lena Borges, Patricia Pais, Avelina Costa, Meg Quartermaine, Denis Shoesmith, Rob Wesley Smith, Jill Joliffe, Jennifer Hulme, Anya Dettman, also representatives from the Timorese Lawyers Association and the Associação Dos Médicos Timor-Leste. We are not able to thank those people by name who gave interviews as we wish to maintain their confidentiality.

In this report we privilege the voices of Timorese people while acknowledging the international body of thought on the subject of unwanted pregnancy and abortion. We hope that this report inspires further public debate on the quality and degree of reproductive health care women are entitled to in this new country.

Suzanne Belton, Andrea Whittaker, Lesley Barclay

Terms

Abortu – Abortion or Miscarriage?

Language is loaded and the language surrounding abortion can mean different things to different people. This is especially so when different languages are used by researcher and the researched! Kleinman (Fadiman 1997) suggests asking people what they call the problem. In our research we noticed that many people did not distinguish between spontaneous miscarriages and induced abortions as they were being interviewed. They slid between terms and meanings. Richards (Richards 2008) also noted in her findings that terminology was ambiguous. She says,

‘aborto’, or ‘abortus’ is used for both spontaneous abortions (miscarriages) and those that are induced. One of the men I spoke to told me that the confusion surrounding the term ‘abortion’ sometimes led to women bearing blame for miscarriages, as these may be understood as induced by people who don’t understand the difference between the two. I encountered some of that confusion with two women who it turned out were referring to spontaneous abortion, or miscarriage, when being asked whether they knew of abortions occurring in the community.

In plain English people speak of ‘miscarriage’ or ‘abortion’ and people with medical knowledge use the terms ‘spontaneous abortion’ or ‘termination of pregnancy’, ‘induced abortion’ and ‘elective abortion’. In other languages other words are used and we have included some of these in the glossary of terms. The World Health Organisation definition means the loss of a baby before 20 weeks of pregnancy or one weighing about 500g, in other words a baby that could not possibly live outside of its mother’s body as it is too physically immature. When a paediatrician was asked at what stage a foetus (a baby that is still developing) would be able to survive if it were born early in Timor, the doctor said about 30 to 32 weeks as the equipment required to save very premature infants is not available. Thus we found that there are not only multiple languages but also interpretations of abortion. The international definition of around 20 weeks gestation is not a reality in Timor-Leste, as maturing babies must be quite developed if they are to survive. Legal definitions can also be important and in countries where there is regulation of termination of pregnancy, abortions can be called ‘criminal’ or ‘illegal’ abortions. Timor is multi-lingual and we have provided this table to assist with understanding this report.

English	Medical English	Indonesian	Tetun
Miscarriage	Spontaneous abortion		Abortu espontanius/ natural
	Stages of abortion Threatened abortion Inevitable abortion Incomplete abortion Complete abortion	Abortus insipiens Abortus imminens Abortus incomplit Abortus complit	
Abortion	Induced or elective abortion		Aborto provokativu
Unwanted pregnancy			Isin rua lakoi ho hakarak
Unplanned pregnancy			Isin rua laho planu
Unsafe abortion	A termination of pregnancy this is performed by the woman or an unqualified person without legal sanction		Abortu la ho seguru
Safe abortion	A termination of pregnancy that is performed by a qualified health worker according to regulations and laws		Abortu ho seguru

Box 1 Glossary of Terms

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Executive Summary

Unsafe abortion is the third largest cause of death during pregnancy globally and contributes to deaths and serious illness in Timor-Leste. This study is a situational analysis of the quality of treatment and preventative care available to women with unwanted pregnancies and unsafe abortions in Timor-Leste. It examines the testimonies of women, doctors, nurses, priests, nuns, judges, prosecutors and lawyers and a variety of other key people with direct experience of unwanted pregnancy or unsafe abortion and reviews the current literature, policies and legal context. It includes a maternal death audit and monitoring of service provision relating to safe abortion services in four health facilities.

The objectives of the study were:

- To undertake a literature review of unplanned pregnancy and fertility regulation in post-conflict situations in Asia;
- To identify and analyse national policies and laws on reproductive health, unwanted pregnancy and unsafe abortion;
- To describe the service delivery in terms of the experience and outcomes of unwanted pregnancy for women, their families and community;
- To produce a paper presenting the results of this study to the Ministry of Justice, Ministry of Health, Fundasaun Alola and the United Nations Population Fund (UNFPA).

The report finds that induced abortion occurs in Timor-Leste:

- and is performed in clandestine ways which increases the health risks and compromises safety;
- Traditional and modern methods are used to terminate unwanted pregnancies;
- Women asked doctors and midwives to terminate their pregnancies;
- Doctors and midwives found it difficult to speak with women about induced abortion;
- 40% of all emergency obstetric care involved managing and treating complications from early pregnancy losses;
- Access to family planning information, education and supplies was limited (particularly for young people) and opportunities to promote family planning were missed;
- In three of the four health facilities investigated, evidence-based protocols in the provision of post-abortion care were not used; and

- Policies and protocols reviewed did not give enough emphasis to the termination of pregnancy and unsafe abortion as a public health issue.

Due to the lack of accurate recording of health or maternal mortality data, and secrecy surrounding abortion due to its illegality, this report does not estimate the numbers of induced abortions in Timor-Leste. However, the report systematically documents the knowledge, experience and opinions of respondents on unwanted pregnancy and unsafe abortion. It demonstrates the need for better prevention of unplanned and unwanted pregnancies, systematic reporting of maternal mortality, information for women experiencing unwanted pregnancies, and quality care for women experiencing post-abortion complications.

Women were not well informed about modern methods of contraception but were often curious to learn more and consider their options. They felt ashamed and morally conflicted about terminating their pregnancies except in the very early stages when they considered it 'just blood'. With poor knowledge and use of contraception women and men do not have the opportunity to plan parenthood effectively. Catholic health clinics do not offer modern methods of contraception. However, the Catholic Church supports spacing between pregnancies and recommends self-control, abstinence and natural family planning methods. These are beneficial, although evidence-based natural family planning methods such as the sympto-ovulatory method could be better promoted.

The policies and protocols reviewed in this report (National Reproductive Health Strategy, National Family Planning Policy, Standard Treatment Guideline for Primary Health Facilities in Timor-Leste) do not give enough emphasis to the termination of pregnancy and unsafe abortion as a public health issue. In order to meet Millennium Development Goal number 5 to reduce maternal mortality by forty percent by 2015, some attention needs to be paid to the issue of unwanted and unplanned pregnancies and unsafe abortion and larger studies are required to estimate the number of cases accurately. Furthermore, international conventions like CEDAW to which Timor-Leste is a signatory, stipulate that women deserve special care without discrimination and access to life-saving and health preserving care.

The Indonesian Penal Code criminalises all terminations of pregnancy for any reason. Some Timorese entered the judicial system for the crime of abortion and some have been imprisoned for infanticide. During 2007 and 2008 a new Penal Code for Timor-Leste was developed and several versions of it in multiple languages continued to criminalise termination of pregnancy and used restrictive clauses. Many Timorese clinicians and legal professionals suggested the law needed to be reformed and some thought that at an absolute minimum provision to save a woman's life should be included. Village people were adamant that women deserved to survive

pregnancy, even if it meant the termination of a pregnancy. There were a diversity of opinions as to the provision of elective legal termination of pregnancy for other reasons such as rape, incest, foetal deformity and social and economic reasons.

Summary of Recommendations

- **Prevention of unwanted pregnancy and abortion:** Respondents spoke of wanting to prevent unwanted pregnancies and unsafe abortions. Implementation of the National Reproductive Health Policy and the National Family Planning Policy in effective and visible ways in service delivery would effectively reduce unwanted pregnancies and unsafe abortions. Family planning and modern methods of contraception should be promoted in multiple ways in the community, as well as during in-patient or out-patient contacts with the health system.
- Public health promotion programs approved by the Ministry of Health should promote child-spacing, modern methods of contraception and the risks of unsafe abortion. The inclusion of methods for men and youth friendly messages and services would be beneficial.
- **Reporting and Monitoring:** As the deaths of women who die from reasons relating to pregnancy and birth are not recorded well, a systematic and mandatory reporting system facilitated by the Ministry of Health should be developed. While the vast majority of women die at home or on the way to hospital, this report recommends the inclusion of questions on maternal deaths in the next national census. In any future research, care should be taken about what methodology is used in sampling, questions asked and analysis of the data to allow confidence in data collected, and ability to review trends over time.
- Facility-based maternal death audits that feed into improving the quality of care need to be implemented by senior obstetricians and midwives with the support of the Ministry of Health, recognising that this only captures the minority of women who die in hospital or a health post. Surgeons and physicians also need to report cases that come under their care in non-obstetric/gynaecological departments.
- The quantity and type of emergency obstetric care should be monitored annually to assess the impact of public health initiatives. International indicators can be readily adopted to assist in this measurement.

- **Quality of Post-abortion Care:** In facilities where post-abortion care is provided, advanced training and supervision for doctors and midwives on the provision of comprehensive evidence-based post-abortion care could be given. It should cover ethics, reproductive health rights, non-directive counselling and education strategies to teach family planning.
- A standard protocol for the management of post-abortion care should be written by senior obstetricians and midwives and used in all health facilities.
- Women need to be offered a choice of modern methods of contraception on discharge from a health facility after any type of pregnancy and not be expected to return at a later date.
- Men should be included in supporting their wife's health if this is appropriate and with consent of the woman.
- **Advocacy on Women's Rights and Law:** Experience from the international arena suggests that criminalising induced abortion makes it unsafe it is advisable from a public health approach, not to criminalise the termination of pregnancy but regulate it. Law-making should be guided by principles of public health, CEDAW, and the actions suggested by the International Conference on Population and Development taking into account cultural sensitiveness.
- The formation of an inter-sectoral group to advocate for reproductive health including Ministry of Health, Ministry of Justice, health professionals, legal professionals, police and civil society groups. Parliamentarians may wish to seek out Population and Development programmes in other countries.
- **Access to Information:** Women (and men) have a right to clear and correct reproductive health information and women reported they needed more information. A confidential pregnancy advisory service to provide evidence-based public health information on all pregnancy options such as adoption, foster care, antenatal care and safe/unsafe abortion could be established by non-government or government organisations.

Chapter One

Introduction: Maternal Death and Illness

The deaths of healthy women during pregnancy or childbirth are an avoidable tragedy. Global estimates state that 529,000 women die every year, 25,000 of whom are in South East Asia. Many millions of women suffer illness or disability due to the consequences of pregnancy or childbirth. The majority of women who die or are disabled, are found in the poorest and unstable regions of the world (Faundes and Barzelatto 2006). Very few women die in wealthy countries with developed health systems and infrastructure (Guttmacher Institute 2008) (See figure 1.).

Mortality rates vary between countries. The following countries were chosen as comparisons with Timor-Leste because they either have experienced extreme violence and disruption (Cambodia), or are countries with a predominantly Roman Catholic population (Colombia, Philippines, Portugal) or similar topography to Timor-Leste (Indonesia, Philippines) or were previous colonising/occupying countries of Timor-Leste (Portugal, Indonesia).

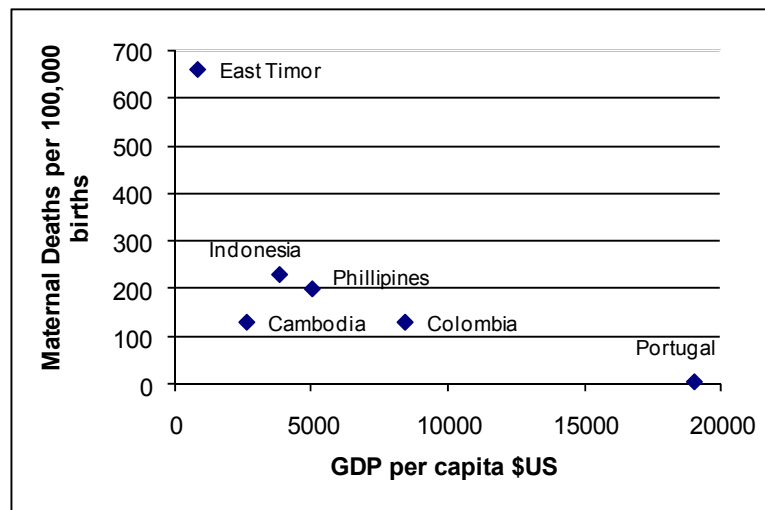


Figure 1
Comparative Maternal Deaths by Country and Wealth

Sources: Websites - Population Reference Bureau 2006, UNFPA Country Profiles 2006, World Bank 2006, (Central Intelligence Agency 2007).

Figure 1. shows that Timorese women die in large numbers and that there is an association between the wealth of people and their country and maternal death; however, wealth is not the only factor.

The causes of death and disability during pregnancy are well known and are treatable. They include excessive bleeding (24%), infection (15%), **unsafe abortion (13%)**, high blood

pressure or eclampsia (12%), and obstructed labour (8%) . The focus of this research is unsafe abortion. Unsafe abortion is the third most common reason for pregnant women to die. Figure 2 shows the global estimates and available means of prevention and treatments.

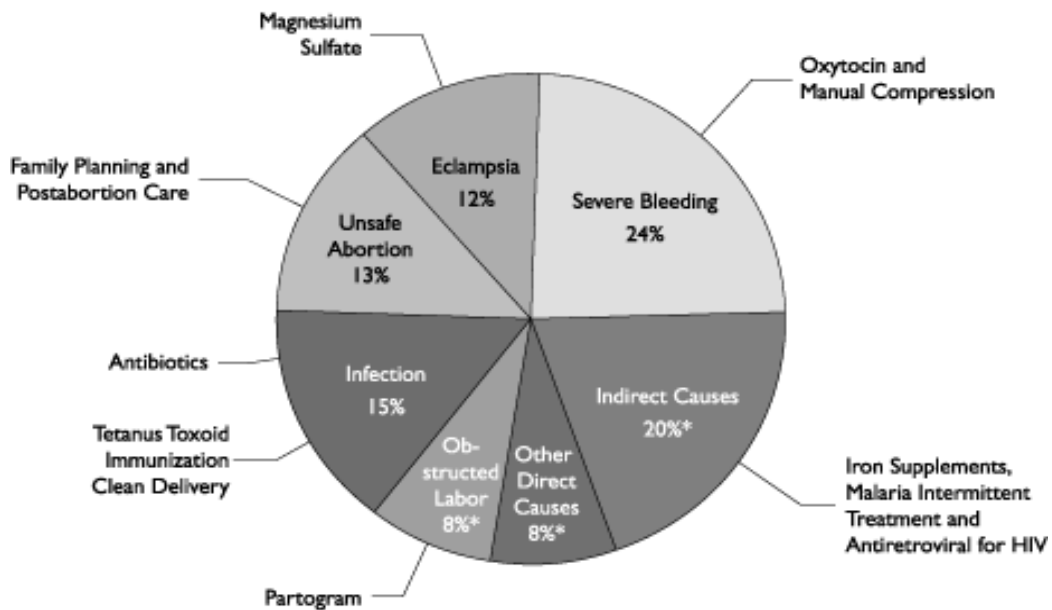


Figure 2 Causes of Maternal Death and Treatments to Prevent Death

Source: http://www.usaid.gov/our_work/global_health/mch/mh/techareas/maternal_mortality.html

This diagram is not complete as access to caesarean sections and safe abortions also save women’s lives and are a component of comprehensive obstetric care.

Other causes of death and illness that are not directly related to pregnancy but can kill a pregnant woman due to her biological vulnerability include malaria, HIV/AIDS, anaemia, congenital heart or kidney problems, and trauma from violence. In many cases the prevention and treatment are very simple. UNFPA have proposed three ways to reduce maternal mortality:

- All women have access to contraception to avoid unintended pregnancies
- All pregnant women have access to skilled care at the time of birth
- All those with complications have timely access to quality emergency obstetric care

These measures save women’s lives.

What is Unsafe Abortion?

Abortion is a very common event – globally 46 million abortions are performed annually and about 19 million are outside the legal and formal health systems. The Guttmacher Institute

notes that globally almost a quarter of all pregnancies are terminated. In developing countries, more than one-third of pregnancies are unintended and 19% end in abortion, with 11% of those unsafe abortions (2008).

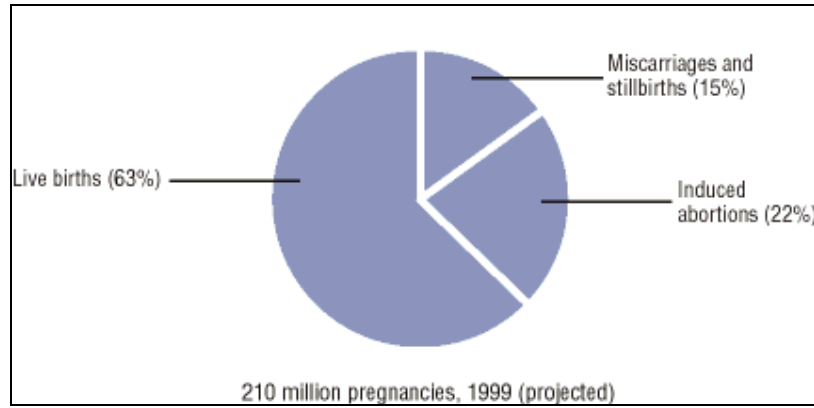


Figure 3 Global Numbers of Pregnancies, Induced Abortion and Miscarriages

Source: http://www.guttmacher.org/pubs/fb_0599.html

Abortions performed by unskilled people, in unhygienic conditions, in inadequate places that in general are outside of the legal framework, are called 'unsafe'. As noted above, unsafe abortion causes 13% of all maternal deaths – it is the third most common reason pregnant women die. In countries where there is limited access to modern contraceptive technology and where elective termination of pregnancy is not legal or easily accessible, deaths of pregnant women due to unsafe abortion can be very high. In Uruguay it is the cause of 29% of maternal deaths (Briozzo, Vidiella et al. 2006) and up to 50% of maternal deaths in parts of Africa (Mesce and Sine 2006). Unsafe abortion causes considerable amounts of death and disability in Burma (Thein Thein Htay, Sauvarin et al. 2003); India (Jain, Saha et al. 2004); Nigeria (Sedgh, Bankole et al. 2006); Nepal (Rana, Pradhan et al. 2004); Philippines (Singh, Juarez et al. 2006) and Uganda (Singh, Moore et al. 2006). As maternal morbidity and mortality information is not collected systematically at present in Timor-Leste, it is not possible to know the percentage of pregnancies that end and the causes. But using a similar formula and assumptions as the Guttmacher Institute model above, a rough estimate may be that if there are 44,000 births expected annually in Timor-Leste (Democratic Republic of East Timor 2004), there would be associated 10,000 (15%) miscarriages and an unknown number of induced abortions. As most women do not avail themselves of professional health care, only a few cases will be found in health posts and hospitals.

Desired fertility

In Timor-Leste, the Demographic and Health Survey reveals that Timorese families are large. Timorese women have on average 8 children and the authors comment, 'this is higher than the current fertility of any country listed in the most recent United Nations' assessment of demographic trends...it is now clear that Timor Leste not only has the highest fertility in Asia, it has probably the highest in the world'(Ministry of Health, National Statistics Office et al. 2004) p69-70. Undoubtedly this has many causes and one of the more obvious is that the Timorese people have experienced enormous loss of family and friends due to the conflict and are now enjoying a post-war baby boom. However, high fertility rates have individual and social consequences and the current government is supportive of more moderate sized families and promoting family planning services (Democratic Republic of East Timor 2004).

The survey reports that fertility rates are much the same across locations and social strata and that women are commencing their mothering at earlier ages than previous generations. In the area of fertility preference, one quarter of the women who responded 'were undecided about whether they would like a/another child' and 17% stated they wanted no more (p.115). Some older women felt their family was complete. The ideal family size is 5 to 6 children. Clearly the demand for family planning services is low but even that low demand is not being fully met.

A report from Ermera District (Bradley 2006) which surveyed 300 rural respondents noted that women were stunted, and reported food shortages. They reported that their children died frequently and they knew of other women dying in childbirth. Men and women's reproductive health knowledge was low and there were very limited primary health care services. Men reported being worried that they could not feed or school their children and desired smaller families. However, experience in other countries suggests that Timorese parents will be reluctant to limit their fertility if many infants do not survive childhood.

Abortion and religious belief

Poverty and Mercer (2002: 618-619) in their article about health in Timor state,

Abortion is even more anathematized by rumours of forced abortion during the occupation and by Catholic teaching. The haemorrhages and infections that complicate unsafe abortions are appearing in health services. Deaths undoubtedly result, rarely reported as such because of the stigma.

Abortion is a personal and moral decision. This report recognises the profound moral conflict abortion poses to many East Timorese. The stigma associated with abortion in Timor-Leste makes open discussion of the issue difficult and discourages women from seeking care. The stigma associated with abortion is associated with its illegal status and also derives from the religious values held by many East Timorese. The Catholic Church is strongly opposed to

elective abortion on any grounds (Pope Paul VI 1968) and, as will be seen throughout the report, this position affects people's attitudes towards abortion and affects access to comprehensive post-abortion care. It should be noted that despite the Catholic Church's teachings many predominantly Catholic countries, such as Colombia, Spain, Portugal and Peru have abortion rates similar to non-Catholic populated countries and Italy has one of the lowest fertility rates in Europe with a liberal abortion law (reference Box 1.)(Bernardo 2005). The Catholic Church's position on family planning also affects people's attitudes and access to modern methods of contraception that may help prevent unwanted and unplanned pregnancies, and allow families to space their children more effectively. The government of Timor-Leste has articulated a vision of reproductive health in the National Reproductive Health Strategy which supports modern methods of contraception and access to post-abortion care, though not safe termination of pregnancy (Democratic Republic of East Timor 2004).

Research Methods

This study used several research strategies to generate data. These included a literature review, selective interviews and focus groups, as well as observations, health facility audits, legal and policy analysis.

Data were collected from a variety of sources: the health sector, the legal sector, men and women in villages, women who had received post-abortion care, representatives of the Timor-Leste government and non-government sectors as well as religious pastoral caregivers. Rural and urban areas were sampled.

A complete description of research methods can be found in Appendix A in this document.

Methods and Sampling

Intimate, illegal and hidden activities do not lend themselves to research methods such as random surveys of the general population. Information about miscarriage and induced abortions, unwanted and unplanned pregnancies need to be sought using other methods (Whittaker 2002). This study used a mixture of qualitative and quantitative methods to generate data. People were not randomly approached but were approached with purpose and intention. People were selected for specific reasons such as their connection to the topic; so for example, we did not pick any doctor rather those who worked on maternity wards or who had clinics or qualifications that would attract patients with reproductive health issues. Midwives were chosen as they work only with pregnant women. The same with lawyers, we only spoke extensively with those who had experience or who would have been exposed to the types of cases we were

interested in. We spoke with nuns who worked with women and children and priests who were willing to be interviewed. We spoke with women who had recently experienced a pregnancy loss. More Timorese were recruited to be interviewed than expatriates from other countries. We also tried to cover a range of urban and rural areas. Logistics did not allow us to go to all six hospitals; however we audited the two large hospitals and two other health facilities. All obstetric emergencies were counted for several years in these two institutions.

Summary of Data Sources

Who or what?	How? Sample?	Data type?	Where?	How many and how long
Literature review	Unpublished and published material	Secondary	Australia and Timor-Leste	Relevance and availability
Observation -local environment and living conditions Hospitals and clinics		Observation-participation De-identified	Urban and rural	55 days of field work
Informants such as village leaders, police, CEDAW, NGO workers, and government officials	Purposive and snow-ball sampling	Interviews – semi structured De-identified	Urban and rural centres	15
Maternal death audit and Safe Abortion assessment	Demographic and bio-medical variables Guidelines WHO and IPAS	De-identified	Dili and one district 100km from Dili	2 hospitals + 2 Dili based clinics that offer reproductive care
Health professionals privately practicing and state employed midwives and doctors	Purposive and snow-ball sampling Criteria	Interviews – semi structured De-identified	Urban and rural centres	Doctors 11 Midwives 10
Traditional birth attendants	Purposive and snow-ball sampling		Rural areas - varied	3
Village men and women	Purposive	Vignettes	2 rural areas one 80km the other 30km from Dili One group in Dili	25 women 11 men
Women with complications from spontaneous or induced abortion	Purposive with criteria	Interviews – semi structured De-identified	In health facilities but had come from various districts	21

Representatives of the church	Purposive and snow-ball sampling	Interviews – semi structured	Catholic Churches and clinics Rural and Dili	Priest and nuns 5 + Richards work with 8
Legal professionals	Purposive and snow-ball sampling	Interviews – semi structured Vignettes	Dili	Judges, Prosecutors, Lawyers 13

Limitations of the Research

The political crisis during 2006 disrupted and delayed the study. The lack of reliable baseline data in Timor-Leste is a difficulty faced by all researchers and not one that uniquely faced us. We are unaware of any previous research in Timor-Lest on the topic of unwanted pregnancy and unsafe abortion. One group that was not sampled well due to logistic constraints was the traditional midwives who provide the majority of reproductive health care to women in the community. We were only able to interview a few of these women. This is undeniably a limitation although they were mentioned by many people during the course of interviews.

The topic of unwanted pregnancy and unsafe abortion is personal and sensitive in many cultures, and it is unlikely to spontaneously appear in natural conversations between relative strangers without some trigger. Moreover, where termination of pregnancy is not legal, it is further shrouded. The authors are skilled in eliciting sensitive information and working cross-culturally (Barclay 1989; Barclay, McDonald et al. 1994; Whittaker 2002; Belton 2007). Huntington and associates (Huntington, Mensch et al. 1993) in research in Africa suggest that direct questioning about abortion is unlikely to work and value-free statements are preferred. This was the approach taken in the study.

Ethics

This study was given ethical permission by the Human Research Ethics Committees of Charles Darwin University and the University of Melbourne (Registration Numbers 06092 and 0712577). The study was approved by the former and current Ministers of Health Dr Rui de Araujo and Dr Nelson Martins and additionally was endorsed by Minister of Justice Lobato.

Privacy, confidentiality and anonymity

All participants were assured of anonymity and confidentiality. This is a difficult task in Timor-Leste where many people are related or places easily identified. We have used pseudonyms and have tried to de-identify people, specific events and locations. Because of this and because many people are illiterate, in some cases oral consent was collected. However, literate people read and signed consent forms.

Chapter Findings – Local and International Literature

- Maternal deaths occur in the poorest, most disadvantaged women.
- Unsafe abortion is the third killer of pregnant women.
- Unsafe abortion occurs in countries that block legal and practical access to elective termination of pregnancy.
- Desired fertility changes according to education, location and stage of development of a country.
- A number of countries which profess Catholic faith have low population growth, access to legal termination of pregnancy, and use of modern methods of contraception.
- Timor-Leste has suffered occupation by countries that colonised and at times destroyed the health system and have influenced attitudes toward family planning methods.

Chapter Two

Measuring Maternal Mortality

This section discusses the difficulties in measuring maternal mortality and techniques used to measure it, notes how deaths are not counted, gives a case study of a death that could have been avoided if the woman had been given good quality information or an elective termination of pregnancy, outlines men and women's views on saving women's lives, and presents the numbers of women presenting to hospital with complications from all types of abortion.

Maternal mortality is very difficult to measure accurately. Generally a maternal mortality ratio (MMR) of 50-250/100,000 means that the quality of care is not sufficient while a MMR greater than 250 means that access to skilled maternal health care is a problem (World Health Organization 2006).

A woman's death is recorded as a direct or indirect cause of pregnancy¹ and up to 42 days after she has given birth. Maternal deaths are normally rare events. Even in countries with well developed resources it is remarkably difficult to collect death related data and there is no one method that is agreed to be the perfect way (World Health Organization 2006). This is due to multiple reasons.

- Women die at home or on the way to hospital and their deaths are unrecorded
- Autopsy or coroner processes are not in place
- Staff mis-diagnose cause of death or do not report it
- Data collection systems are not in place or are dysfunctional
- Families and staff can feel guilty and omit to mention women's deaths
- Unsafe termination of pregnancy is often illegal and therefore underreported

Box 4 The Reasons Why Women's Deaths are Under Reported

In Timor-Leste, probably most of these reasons hold true, however the one under investigation here is the last reason, which is the termination of pregnancy in unsafe conditions.

There are three main ways this data is collected; vital registration of all births and deaths in a population, health facility collection and community surveys or population surveillance. To

¹ Direct obstetric deaths are those resulting from obstetric complications of pregnancy, labour or the postpartum period from interventions, omissions and /or incorrect treatment. Indirect obstetric deaths are those resulting from previous existing disease or a disease acquired during pregnancy which was worsened due to the pregnant state.

date only large-scale surveys of all deaths of fertile age women in a census approach, or excellent vital registration reporting can give accurate numbers. All other methods are estimates only.

While numbers are important they do not provide the reasons why or possibly even how the women died. To be able to develop appropriate policy, qualitative information, not just quantitative information is important (World Health Organization 2004). Processes like confidential, 'no blame' enquiries conducted to determine specific cause of death and good clinical information systems are very useful. The drawback can be that these are often based in hospitals and rarely focus on the community. In places where large numbers of women die outside of institutional care this is not always beneficial.

Maternal Mortality in Timor-Leste?

Very little is known about maternal mortality in Timor-Leste and there have been no rigorous and definitive studies. In a letter in *The Lancet* several years ago, (Walley 2001) complained that a report into the general health situation in Timor failed to mention the appalling state of maternal health (Morris 2001). A 2001 source quoted a MMR of 890/100,000 or double that of Indonesia (Povey and Mercer 2002). Later in 2006 the UNDP quoted a similar figure of an MMR 800/100,000 (United Nations Development Programme 2006). Neither source explains how these figures were made.

Timor-Leste faces considerable challenges in being able to measure maternal mortality accurately using a facility-based approach due to a lack of maternal death reporting processes, the low numbers of women using health facilities and the illegality of termination of pregnancy. The authors note that the next country-wide census includes several questions to elicit maternal deaths and steps are underway in the Ministry of Health to improve maternal death reporting. There is wide acceptance by the Timorese for participation in democratic processes and large scale surveys, and this may be a more accurate way of collecting the deaths of young women in the population than facility based monitoring (Galpin 2001; Head 2007). However, hospital audits and maternal death committees could also provide information more frequently about the quality of obstetric and midwifery care in institutions.

Conflict in Timor-Leste has had a detrimental effect on the ability to provide health care services (Galvin 2000; McAuliffe and Grootjans 2002). Intermittent post-independence instability continues to disrupt services. Two reports into maternal health services indicate that staff have struggled with a lack of essential supplies and equipment, as well as basic skills when trying to do their work (Revilla, Bucens et al. 2006; Sullivan 2006). Continuous up-

grading and monitoring of staff's ability to save lives will need to be a priority for the health system if women are to be encouraged to trust hospitals for their pregnancy care.

Maternal Mortality – who counts?

Four health facilities were asked about cases of maternal deaths and the research team assessed records where possible. None of these health facilities conducted maternal death reviews and researchers were not able to accurately count the number of women who died from obstetric causes due to poorly performing recording systems. Health Clinic D experienced an avoidable maternal death during the study that is discussed here in detail. Health Clinic D offers limited reproductive health services in urban Dili including delivery. The medical officer in charge gave permission to write about this tragic outcome.

Case Study – A series of mistakes

A 19 year old woman presented to Health Clinic D four months prior to her death and was diagnosed with a serious heart condition (mitral stenosis). She was married and her husband came to the clinic with her. She lived within 20 minutes of the health facility in urban Dili. A medical officer advised them not to get pregnant. She had never been pregnant before.

She next presented to the health facility four months later in labour and 4cm dilated with weak contractions at 10am. After some initial care by midwives it became apparent that she was short of breath and not coping with labour. A medical doctor was called to attend her. At 3.20pm her membranes were artificially ruptured, episiotomy performed and a live term baby delivered at 3.50pm. The placenta was expelled at 4.10pm.

She was given oxygen and her episiotomy was sutured. By this stage she had an IV with slow infusion and had been given a drug to diminish fluid in her body as her lungs began to fill with fluid making it difficult for her to breathe (frusemide to relieve the pulmonary congestion). Her vital signs were abnormal with respirations 40-50/ minute and pulse 150 and the last blood pressure measurement was 120/90. She was exhausted and decompensated as she was being transferred to hospital. She never left the clinic but cardio-respiratory resuscitation was commenced. She died at 5pm. Her husband, family and some friends had accompanied her and they took the 3kg baby home.

A Preventable Death

This death did not occur due to difficulties in delays or access to health care nor because the woman was unwilling to present for professional health care, it was poor quality obstetric management and a lack of information. The diagnosis, which was not confirmed with an autopsy, was pulmonary oedema due to mitral stenosis compromised by pregnancy and labour. In other words her heart had a defect that worsened due to the pressure of being pregnant and giving birth. The heart could not cope with the extra fluid load in her body. These types of heart defects are very common in populations who live in deprived circumstances (Carapetis J, Mayosi BM et al. 2006). They cause serious illness and death in pregnancy.

This was an avoidable death. If this couple knew about the heart problem before they were pregnant they may have chosen to use family planning and plan their pregnancy very carefully. If elective termination of pregnancy was available, the couple may have chosen to end the pregnancy in an early stage knowing that the woman could possibly die as a result of giving birth. If the couple were aware, or the doctors had realised the serious implications earlier, they could have transferred her to a larger health facility with obstetricians, physicians and surgical support. She may have survived.

Views from the Village

We asked clinicians and villagers about this scenario of a complicated pregnancy which impacts detrimentally on women's health and the possible ways of dealing with it. We called it the story of Maria and Antonio (not real people's names).

Older and younger men and women were very keen to share their opinions and 36 people responded. They talked openly about the situation described in the story (which replicated the case study above), abortion, family planning and how to deal with these issues. In general terms, they spoke of children strengthening the love between husband and wife but they were also seen as workers for the future of the family. They were aware of the responsibilities of raising children and some stated they wanted their children to attend school. They spoke of modern concepts such as hygiene, health and law but also of traditional beliefs and customs like witchcraft and dowry systems. They also spoke of the dignity of women or something akin to the rights of women.

In response to Maria's situation, many people felt she was too young and they requested that the Ministry of Health write some directive for the people of Timor to protect women from marrying at an early age.

They had a comprehensive message for doctors. Doctors should not use their religion to withhold treatment to women, even abortion. Doctors should try to save two lives but if they can only save one, then the woman's life is paramount. In this complicated scenario they suggested that a witness be called and they all sign an 'agreement' (consent in medical terms) so that the doctor could not be blamed if he/she needed to perform a termination of pregnancy. They also said the best place for a termination of pregnancy is in the hospital as it is safe and clean. She should also probably have a tubal ligation. They said that the scenario doctor was good because he/she explained everything to them so they could understand and help with the decision.

The women said,

‘As family member we are feeling sad but the important thing is to save Maria’s life and maybe she can do some good things for the family.’ They said, ‘Life is important not law.’

The men said,

‘We know that religion forbids the termination of pregnancy but health is also important. If doctors and midwives let women die because of pregnancy complications like this one, it is a mistake that cannot be pardoned by God.’

They spoke of why this situation had occurred and how women do ‘traditional home abortions’. They also used their traditional system of logic. They thought that Maria was clearly unwell and would never be able to produce children if she survived. There were several options; she accepts her fate and allows a second wife to marry Antonio in the traditional system or she may go home to her parents with part of her dowry. They felt the first option was better as marriage is for life.

Counting emergency obstetric care

The research team conducted audits of two hospitals in Timor-Leste. In Hospital A the obstetric/ midwifery log books were available and figures were recorded from this source and confirmed by the head midwife and obstetrician. Unfortunately due to a combination of the political crisis and reconstruction, women’s individual medical records could not be accessed. In Hospital B both log books and de-identified medical records were audited. Health Clinic C handed all clinical services contact data to the research team and Health Clinic D contributed by permitting observations of services. All health facilities consented to their staff being interviewed.

Table 1 All Delivery Outcomes in Hospitals A and B during 2006-7

Delivery Outcome	Number and percentage in 2006		Number and percentage in 2007
	Hospital B	Hospital A	Hospital B
Normal Vaginal Birth	752 (86%)	2215 (85%)	873 (89%)
Caesarean Section	110 (13%)	313 (12%)	101 (10%)
Manual assisted delivery	9 (1%)	75 (3%)	6 (1%)
Total	871	2603	980

Experience with post-abortion complications

In both hospital A and B, an audit of all cases of emergency obstetric care showed that around 40% of cases require post-abortion management for incomplete and complicated abortions (all types of early pregnancy loss). It is a common event.

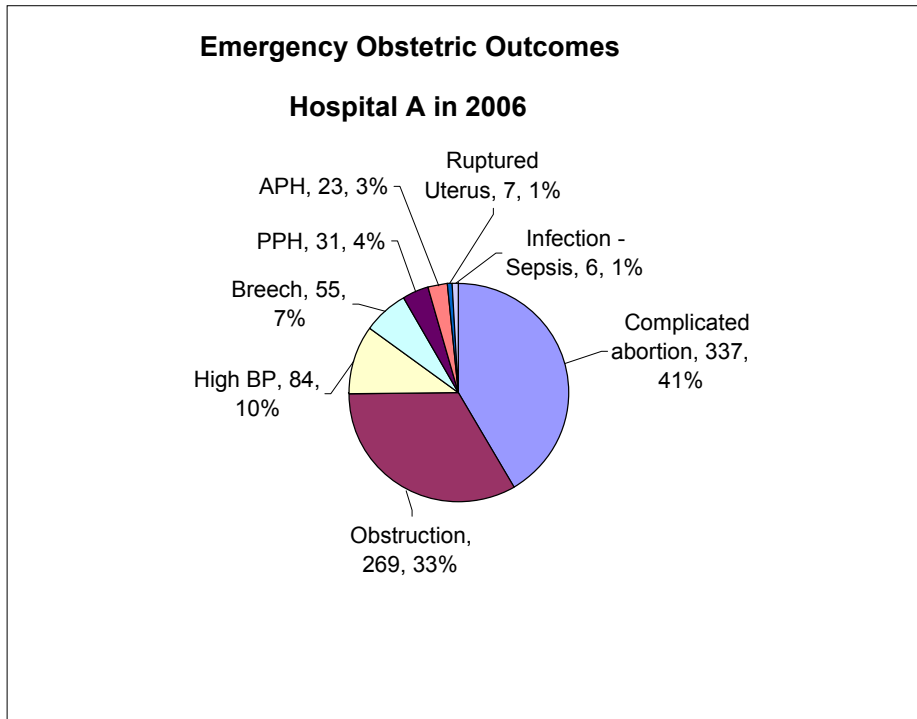


Figure 4 All Emergency Obstetric Care in Hospital A in 2006

This figure disaggregates the reasons for emergency obstetric care of 782 women. All of these conditions can be life threatening. Forty-one percent or 337 women were admitted for management of a complicated abortion with post-abortion care.

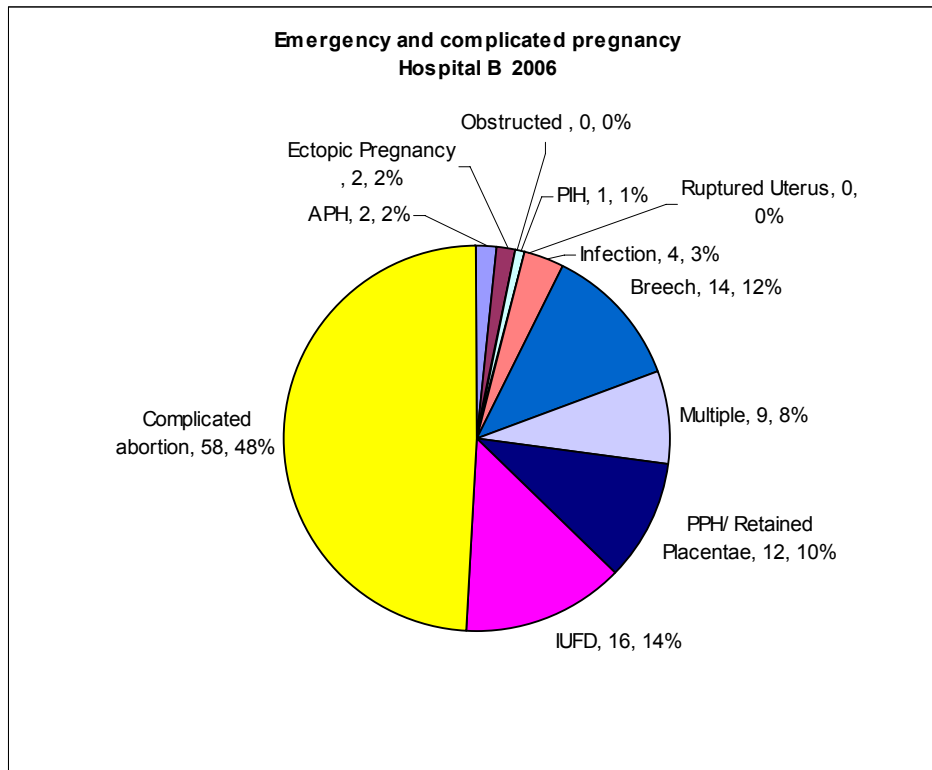


Figure 5 All Emergency Obstetric Care in Hospital B in 2006

This figure disaggregates the reasons for emergency obstetric care of 172 women. Forty-eight percent or 58 women were admitted for management of a complicated abortion with post-abortion care. In the year 2007, Hospital B managed 75 cases of complicated abortion (43%).

The records of 59 women admitted to Hospital B for post-abortion care in 2006 were examined in detail. Their average age was 30 years; it ranged from 18 to 45 years. There were only two 18 year olds, three 19 year old and one 20 year old woman; the remaining 53 women were 21 or older. Three women had sepsis and fever and two had a history of intra-uterine foetal deaths. A quarter (15) of the women had experienced a previous early pregnancy loss, some multiple times. Half the women (29) lost the pregnancy in the first three months of pregnancy, 26 women in the second three months and 4 women did not have a gestation recorded. The following graph shows that half of the women had had five or more pregnancies, some as many as thirteen.

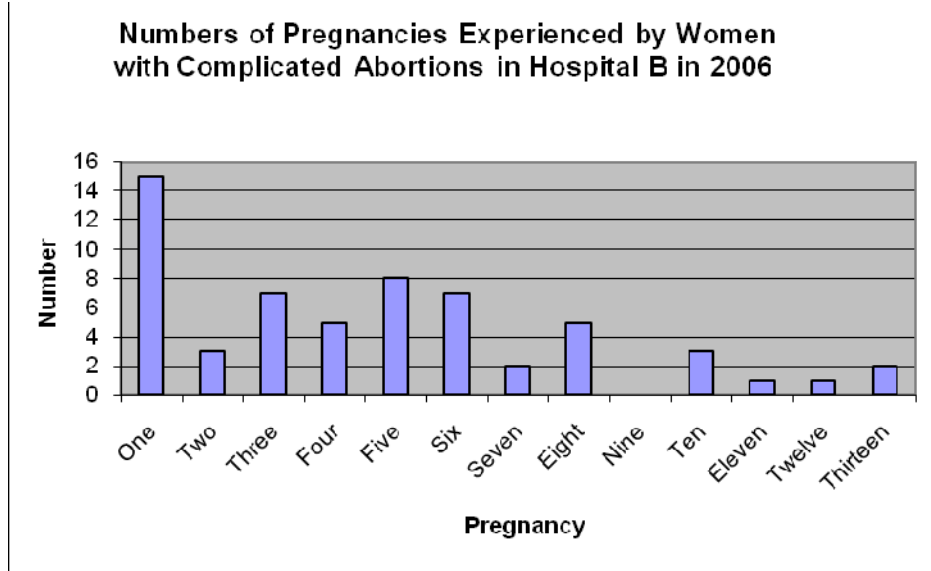


Figure 6 Numbers of Pregnancies Experienced by Women with Complicated Abortions in Hospital B in 2006

A few practitioners reported caring for women who died due to the complications of abortions. One case of a young woman who did survive but with sterility, was repeated by several clinicians. She had visited a ‘quack doctor’, became critically ill and had her uterus removed.

This is rare, maybe I saw one in two years. The women stay at home until it is severe and then they come to us. Many people are illiterate, they think the bleeding is normal – we know it is dangerous but they do not. When they arrive here their condition is acute.’ [M2]

A couple of doctors recalled cases where the mother’s life was in jeopardy due to severe medical conditions and they had participated in a decision to end the pregnancy in order to save the woman’s life; in terms of the law an illegal act at the time.

There was little severe morbidity and a few cases where fever and infection were present. Doctors and midwives did not report seeing uterine or bowel perforations, objects inside genital organs or pelvic or genital trauma. One doctor who had worked in the rural areas said he had seen women with bruising and blistering indicative of traumatic attempts to terminate pregnancies by pummelling (using the feet) and hot water applications. Midwives who had worked in rural areas knew that women used traditional methods like eating sour pineapple, drinking whiskey and visiting traditional midwives. Women conceded when pressed by their health provider, that they had taken herbal and other medications to end their pregnancies.

Three doctors reported that pharmaceutical abortifacients were available and many suspected this was used by women who presented with vaginal bleeding to the hospital or their practices.

Chapter Findings

- The maternal mortality ratio for Timor-Leste currently quoted in the literature is an estimate only and is likely to be inaccurate do to poor data availability.
- Measuring maternal mortality in most circumstances is exceedingly difficult.
- The records in hospitals do not provide accurate information on the numbers or causes of maternal morbidity or mortality.
- Hospital A and B deal with large amounts of early pregnancy loss, in fact it comprised 40% of emergency obstetric care.
- There are very few recorded cases of mortality or morbidity from induced abortion.
- Doctors in Dili report that women use medicines to end their pregnancies which probably accounts for the low numbers of serious complicated abortions and deaths.
- There are varied views about in what circumstances a termination of pregnancy is desirable or possible. Many people at village level and working in hospitals believed that women have the right to survive pregnancy and so if the pregnancy was life threatening or detrimental to a woman's health, they could forgive termination of pregnancy.
- In cases where a woman has a serious complication such as rheumatic cardiac disease, TB, preeclampsia, gross anaemia, or malaria the viability of the neonate is at best 30 to 32 weeks. This means that obstetricians face very complex cases with limited legal ability to save a woman's life (or infant).

Chapter Three

Local Understandings of Conception and Abortion

How do Timorese women understand their bodies? How do they think about their growing babies? What is an abortion from a Timorese perspective? These research questions were answered by women and men, NGO workers, priests and traditional midwives in focus groups or interviews.

Cool Blood and Hot Blood

Five mature, married female informants on the outskirts of Dili who had produced multiple children (7, 8, 8, 10 and 10) told us how they became pregnant and how their babies grew. Only one woman in the group spoke of sperms and eggs, for the rest of the women a Timorese view of conception and embryology prevailed.

Babies are made by men and women who mix their 'blood' together during sexual intercourse. Men have 'cool' blood and women 'hot', when they meet at the correct time a baby begins to form. Women have the capacity to conceive a baby every day and this starts with menstruation at around 14 years of age. When the couple have conceived successfully the woman is said to be '*isin rua*' or 'two bodies' which is glossed as pregnant. The sex of the baby is decided by where the blood travels. If the man is 'weak' (*frako*) he will produce babies with disabilities and if the woman is 'weak' the woman can haemorrhage or be ill during pregnancy.

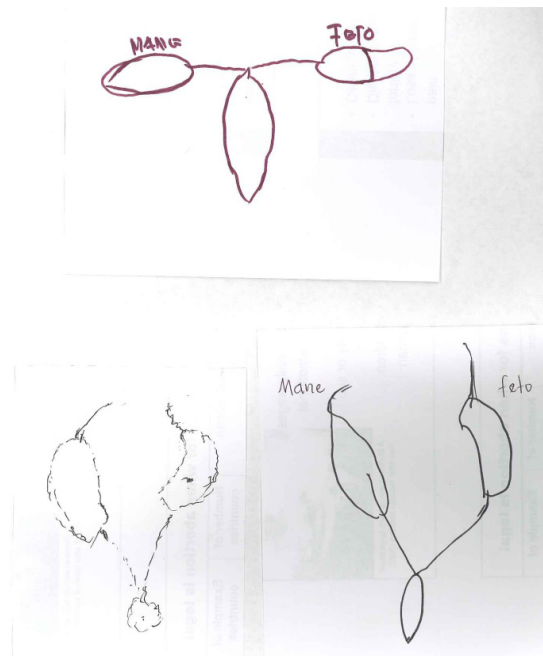


Figure 7 Male and female wombs

Each Timorese woman has two wombs, one for boys and one for girls. Women can tell if they are carrying a boy or a girl depending on which side of the body the baby lies on. Our

informants conflicted about whether the right or left womb produced boys or girls. The women said they knew this because they had seen miscarriages and felt their babies growing inside them. They drew pictures to illustrate their knowledge.

Each woman was able to give a detailed account of normal embryo (tiny baby 1 to 2cm) development. We relate some to illustrate their notions. Mana Lourdes explained:

When the baby is only one month it looks like a clot of blood and it is very small, at two months the baby has a head but it is like a bandage, the blood starts to run around the body to help develop the baby's body. At three months the baby's body is not yet complete; the fingers and toes are not there, and the baby starts tapping the mother's womb. At four months the baby starts to have a placenta and starts really moving in the womb.

Mana Terezinha clarified:

At one month the blood is clotting, at two months it starts to develop into a human being. At three months the baby has hands and feet and eyes. It is as big as a palm of a hand. It starts tapping hard inside the womb. At four months we can see the baby's body but it looks transparent and we can tell at this stage if it is a boy or a girl.

And Mana Luciana confirmed:

When the baby is one month it looks like a small piece of blood and at two months the baby looks like a fish. It doesn't have a bottom and it is in a curled position. At three months the baby can tap the mother's womb and it looks like a human. It's got eyes and hands and feet but it's still not complete. The baby's position is still very curled up.

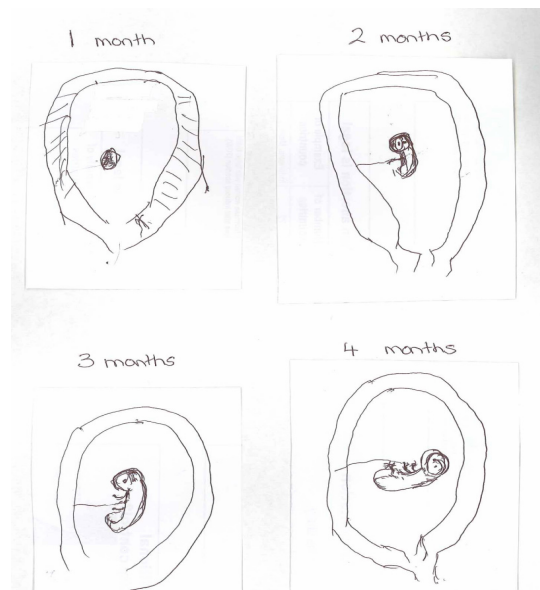


Figure 8 Timorese Embryology

While the women believed the development to be incomplete and only blood, something like a fish or not yet human, they simultaneously acknowledged that there was a spirit present from the beginning. The spirits of dead babies are feared and are ritually managed (Hicks 2004). One

woman who had been pregnant twelve times, had five living children, and had recently lost her baby told us during an interview:

‘I know that children are the gift of the Lord but if he wants to get it back, I just say thank you. I will go to the priest to ask for mass for my five pregnancy losses so that I can feel safe. If I don’t do this I will have bad luck. I will have severe fever and then die. Their spirits will come and ask why they died.’

Women were aware that their babies were not fully formed and perhaps not fully human in the first three months of pregnancy, and they possessed spirits that could be malevolent.

A female Timorese NGO worker spoke similarly of her understanding of early termination of pregnancy.

‘I think if a woman causes an abortion before one month it is not a sin, we can use medication to stop it. Our religion says that if we induce abortion we will not go to heaven.’

A priest informed us that he was well aware of unwanted pregnancies and induced abortions due to women and some men confessing to him. He said:

‘Maybe they don’t understand biology and human development...according to the bible it does mention that life begins in the sexual relationships between men and women.’

Our participants, despite all being Timorese, did not hold one belief, but multiple understandings about early baby development that blended animist, Christian and embodied experience together.

Traditional methods of terminating a pregnancy

Three traditional midwives spoke with the research team. This midwife gave a full account of her practice and considerable skills which she had learned from her grandmother. We asked her about miscarriages and induced abortion.

‘Sometimes I have had to help the babies that die inside. I help take them out. I have been asked to help with doing abortions but I never help with this. [We asked her why not?] There are not enough people in Timor-Leste now. We have to grow the population. And a child is the gift of God. You have to sustain them. [But are there women here that help with abortions?] Not here... and I don’t know of any. Traditional medicine can stop the baby. Yes it can but I have never used it.’

Women also mentioned knowing traditional midwives who could massage them or give herbs which would affect their fertility and possibly end an unwanted pregnancy.

‘Yes I heard about herbs in my village but I don’t do it. If I don’t want a baby I will come to hospital and I ask for my tubes to be tied.’ [Patient 7]

And when we asked is there someone in your village who can stop the pregnancy this woman replied:

‘Yes in (rural area) women do abortions. Women give away their babies too...there are police investigations about this now.’ [Patient 5]

And another patient concurred:

‘Sometimes women go to the *liman badaen* (traditional midwife). They use a leaf or a piece of wood. They roll it in their hands and the baby comes out. Some do it like a doctor and there is no problem. I didn’t do this though.’ [Patient 1]

It would seem that many people believe in and use forms of traditional medicines and some of these are concerned with fertility promotion and inhibition. Most women know that traditional midwives or women with special knowledge can help with unwanted fertility.

Chapter Findings

- While many women think that an early termination of pregnancy is ok because it is only ‘blood’, Catholic priests however, believe that life begins during the sexual act if conception occurs.
- Traditional methods of fertility management are commonly known.

Chapter Four

Post-abortion Care

What is Post-abortion Care?

Post-abortion care (PAC) refers to the suite of actions after the loss of an early pregnancy. The essential elements of post-abortion care for any type of pregnancy loss, either spontaneous or induced, are very similar. Women require treatment, counselling, family planning information, other reproductive health services and links between the community and health providers (Postabortion Care Consortium Community Task Force 2002). Some models promote the involvement of women's husbands and boyfriends so they can support the woman and delay sexual activity and assist in family planning decisions (Rasch and Lyaruu 2005). Brief discussions with Timorese midwives attending the Safe Motherhood workshop in November 2006 revealed that there is a steady flow of women seeking post-abortion care at health posts and hospitals, and some health providers identified cases where they thought the abortion was intentional.

A recent report 'Basic Emergency Obstetrical and Neonatal Care Training for Health Providers at National and Referral Hospitals'(Revilla, Bucens et al. 2006) documents the process of improving the skills of health workers to save lives and provide basic emergency obstetric care to women and their babies. One aspect of life-saving obstetrics is manual vacuum aspiration (MVA), which is a procedure to remove the contents of the womb after any kind of pregnancy loss; it is a key competency. The participants included doctors and midwives and the course clearly demonstrates an increased skill level in all areas.

While MVA is a life-saving technical skill it is not the only component of post-abortion care (Corbett and Turner 2003). The international literature suggests that post-abortion care is done poorly, with women left to wait, castigated for their behaviour, left in pain, not given any counselling and not offered the means to prevent another unwanted pregnancy in countries like Bolivia, Kenya, Thailand, and Ethiopia (Huntington and Piet-Pelon 1999; Belton 2007; Fetters, Tesfaye et al. 2008). The literature also suggests a strong association between unwanted, mistimed pregnancies, pregnancy loss and domestic violence (Kaye 2001; Taft, Watson et al. 2004). As domestic abuse and violence is common in Timor this is worthy of asking women about their experiences (Hynes, Ward et al. 2004; Cristalis and Scott 2005). Offering quality post-abortion care is one method to reduce further use of unsafe abortion as well as saving women's lives.

This section of the report focuses on three intake years in two hospitals named Hospital ‘A’ and ‘B’ and summarises the maternal health outcomes of 4,454 women. It includes information regarding 470 women who presented with complicated early pregnancy losses during the same time period. It also includes data from two small health facilities called Health Clinic ‘C’ and ‘D’, which offer reproductive health services in urban Dili and information from nuns who work in Church clinics.

Demographics

Twenty-two clinicians consented to be interviewed, eleven were medical doctors and eleven were midwives. Sixteen were Timorese nationals and six were expatriates. The majority of respondents were female as all of the midwives were female and five doctors were female. The majority expressed Catholicism as their personal religion but the expatriate doctors held other major world religious beliefs.

Table 2 Numbers of Midwives and Doctors Interviewed

	Foreign	Timorese	Total
Midwives	0	11	11
Doctors	6	5	11
	6	16	22

All of the midwives and some of the Timorese doctors had been trained in Timor-Leste or Indonesia. The expatriate doctors reflected the broad diversity of their countries of origins from Africa, Asia and Americas and individuals from the Cuban Brigade also participated. One Catholic nun who was also a qualified nurse and midwife provided information about her clinic services.

The midwives were all experienced clinicians with not less than five years of work experience. The range was from five to thirty-three years of clinical practice. The doctors were also experienced and the expatriate doctors had all worked a minimum of two years in country.

When women presented with vaginal bleeding doctors and midwives were reluctant to ask questions and they stated they found women evasive to the point of outright lies. One doctor stated that women are fearful:

‘They don’t want to tell us what they have done. Sometimes after we have saved their life they do disclose what happened. I am not sure why they lie. We would never call the police.’ [D2]

Expatriate doctors found the language barrier a problem in gaining quality histories. However many clinicians were also reluctant to speak openly. One midwife said: ‘Usually they just come

with severe bleeding and we don't spend a lot of time questioning them.' [M5] Many clinicians simply merged vaginal bleeding with induced abortion.

A doctor working in a rural area said:

'The ones with induced abortions come in with complications, they present late, and they will not talk about what happened. They seem full of shame and closed to talking about anything. I usually hear from a third person that she doesn't have a boyfriend or the husband is working far away for a long time, so 'she couldn't possibly be pregnant'. These women are not willing to share their feelings. The induced abortions have the severest complications. They normally present as haemorrhaging, or bleeding with infection.' [D6]

Women ask for abortions

Five out of eleven doctors and four out of ten midwives were asked by women to perform terminations of pregnancy for them. The clinicians believed that they were asked this because women had taken lovers, had too many children, were not married, were too young or were still at school, had not used contraception or used it and it had failed. They thought that most people had low knowledge about health generally and especially family planning.

Only one midwife spoke of how she explicitly attempted to gain the woman's trust. She talked about providing privacy during the consultation and assuring the woman of confidentiality. She had only worked in her area of reproductive health for eight months and had had four requests for elective abortion. Some doctors had been offered large sums of money. One doctor acknowledged the difficulty. 'Our women are taking risks and it is painful to think that our women are so desperate that they do this (consider abortion).' [D1]

One Timorese doctor suggested that there would be difficulties when the cohort of medical students who are training in Cuba return. Cuba has low maternal mortality and accessible safe abortion and family planning. The young doctors will have been exposed to a very different type of maternal health care. Furthermore, the doctor said that there were many types of medicine being practiced due to the diversity of nationalities.

'It's difficult here as there are doctors from different places. The Cubans say something, the Australians say something, the Canadians something else. The midwives also get confused with the different styles of medicine here.' [D1]

Several doctors thought that the Timorese Doctors Association needed to direct the debate and form their own practice guidelines.

Clinicians Views

As the termination of pregnancy often evokes a personal response we questioned health staff about their beliefs. One doctor said,

‘My personal belief is there are two reasons for termination of pregnancy and these are where the pregnancy is a risk to the mother’s life as in the case of chronic illness, cardiopathies, renal disease and so on and also in cases of genetic malformation that are incompatible with life in the baby. Oh and yes rape of course and incest too. I really don’t like abortion...’

The midwives were conservative and could not excuse abortion under any circumstance as they felt this was against their religion. Health staff found the idea of providing elective termination of pregnancy a difficult concept, not because of the law banned it, but rather that their conscience forbade it. However, there was a diversity of opinions and some said if the law changed they could offer this health service.

Without professional guidelines or written protocols most relied on a combination of their personal conscience and awareness of the Catholic Church’s position as well as the law. Timorese doctors and midwives conflated Catholic Church doctrine and law – there appeared to be no difference. This midwife said: ‘If the law and the Church agree then we can do it (abortion). It is difficult to go against the Church.’[M5] Some clinicians were not aware of a law about this in Timor-Leste but they knew the Catholic Church prohibited it. And another midwife said: ‘Our religion is against elective abortion. We are careful as we don’t want to be implicated in an induced abortion. Our law says this but one day in the future maybe it will change for our daughters.’ However, this midwife then responded when asked if she would assist with a termination of pregnancy if it ever became legal: ‘God will see us. I wouldn’t help the doctor with that. I would leave the room. I do not want to assist.’ There were very mixed feelings from the Timorese clinicians about performing elective terminations if they became legal after any new law. The expatriate doctors who had performed termination of pregnancy in other countries were aware that they could not perform an elective voluntary abortion in Timor-Leste.

Both hospital A and B had experienced maternal deaths in the previous five years. Hospital A and B had no maternal death review system in place at the time of the study. The midwives recorded deaths in the logbooks and nothing further was done with the information to improve clinical care. Records held in hospitals were incomplete and contradictory. In the Hospital A between 2003 and 2006 there were 13 maternal deaths and the researchers had the impression that this was incomplete data. In 2005, 2 women died from complications associated with septic

abortions. It must be pointed out that only 10% of Timorese women present to a health facility for assistance with maternal health care – if this is the situation then these cases of death are the tip of the iceberg and maternal death is grossly under reported.

Evacuating the uterus, education and counselling, family planning advice

Doctors admitted that they use the procedure they felt most comfortable with and this varied between curettes, electrical and manual vacuum evacuation (MVA) of the uterus. There were no written protocols in three of the four health facilities audited, for doctors or midwives to follow and a diversity of methods in use. One facility was not able to use curettes or MVAs and simply put up oxytocic drips to expel the contents of the uterus.

Advice to women regarding commencement of sexual activity was variable from one week, two weeks, three months to whenever she wished. Expatriate doctors expressed frustration with Timorese midwives who were reluctant to educate or counsel women and men about contraceptive methods, and one doctor referred to several ‘hot’ conversations where she had tried to persuade the midwives to do more.

All clinicians were asked about the ideal family size. The Timorese said that between three and five children make a good family size.

Timorese Respondents	Suitable number of children
n=13	
Two respondents	Not discussed during the interview – or in other terms
Two respondents	Talked about child spacing
Four respondents	3
Three respondents	4
Two respondents	5

Table 3 Clinicians’ Views of Family Size

Several clinicians spoke of spacing:

‘The idea to rest between babies is acceptable to women. They are worried about side-effects and myths about family planning. The methods are free in the clinic or you can buy them at the pharmacist. There are no problems with supplies from the Department of Health.’ [D1]

And further:

‘There should be a space between babies, usually I suggest four years. Timorese marry at 18 or 20 years so they have many babies and the children are sometimes neglected. Now we want to promote the image that family planning is about spacing not to stop having babies. The Church agrees with this idea. The nuns and priests attended workshops about this.’ [D9]

Things are changing and especially if clinicians take initiative. This doctor told of his effort in this area.

‘I do see young women coming and asking for condoms. They don’t ask for other types of methods. There aren’t many, but some are starting to come. What happened was that, I started talking about reproductive health openly, and people were really interested. Usually, the Church is resistant to this, but since I have a good relationship with the priests, they also supported this work.’ [D6]

One midwife said:

‘After I moved here to Dili, maybe because of the crisis, I feel people are more aware. And the Church also gave a public opinion that it was OK to space babies so this was a way for the people to access family planning. Women come by themselves and they ask for IUD or Depo. If they have more than 10 children they often choose sterilisation. Some of them feel that it’s enough! If they have less than five children they ask for IUD, Depo or Implants. Vasectomy is rare because the men expect the women to do everything. Women do pregnancy, birth, breast feeding and so somehow family planning is their job too [smiles].’ [M2]

One example of family planning information from medical staff given to a 29 year old woman with 5 living children, two miscarriages and one deceased child, demonstrates the failure of counselling to respond to a clearly expressed desire to finish child-bearing and a medical indication of poor health.

Woman: ‘I already used a family planning method Depo but after I used it I felt pain, headache. Because I was busy everyday with my child sometimes I felt angry so I decided stop using Depo. After I lost this baby my husband said I must have my tubes tied, but the doctor said that I was too young and it was not appropriate to use this method. I must wait. And then the midwife and doctor said that we must postpone next pregnancy, so not have sex until three months.’

Consistent guidelines for family planning counselling and training to improve skills of staff are required.

One nun who worked as a clinician reported educating and counselling couples on family planning. She was well informed about all methods but promoted only natural family planning methods. She only spoke with her patients about modern methods of contraception if they asked her specifically. The research team asked her why she could not speak about modern methods of family planning. She said:

‘The Pope says ‘no’ so we must follow what he says. If I were free I would do it. Up until now I never saw a woman who should have artificial family planning. When women have 12 or 13 children then they should have a tubal ligation.’

Demand for reproductive health care

This urban based health clinic provides a variety of reproductive health services to men and women in urban Dili. It charges a fee and serviced a total of 1,897 clients in 8 months in 2008 and 1,248 in the previous 12 months. The numbers are increasing. Half of its work is preventative in that clients are provided with information and supplies to prevent unwanted pregnancies and sexually transmitted infections. In 20 months of recorded client contacts 13 women requested the Emergency Contraceptive Pill and many hundreds more received modern methods of contraception. In 20 months of recorded activity 17 women presented with a complicated pregnancy loss which required post-abortion care.

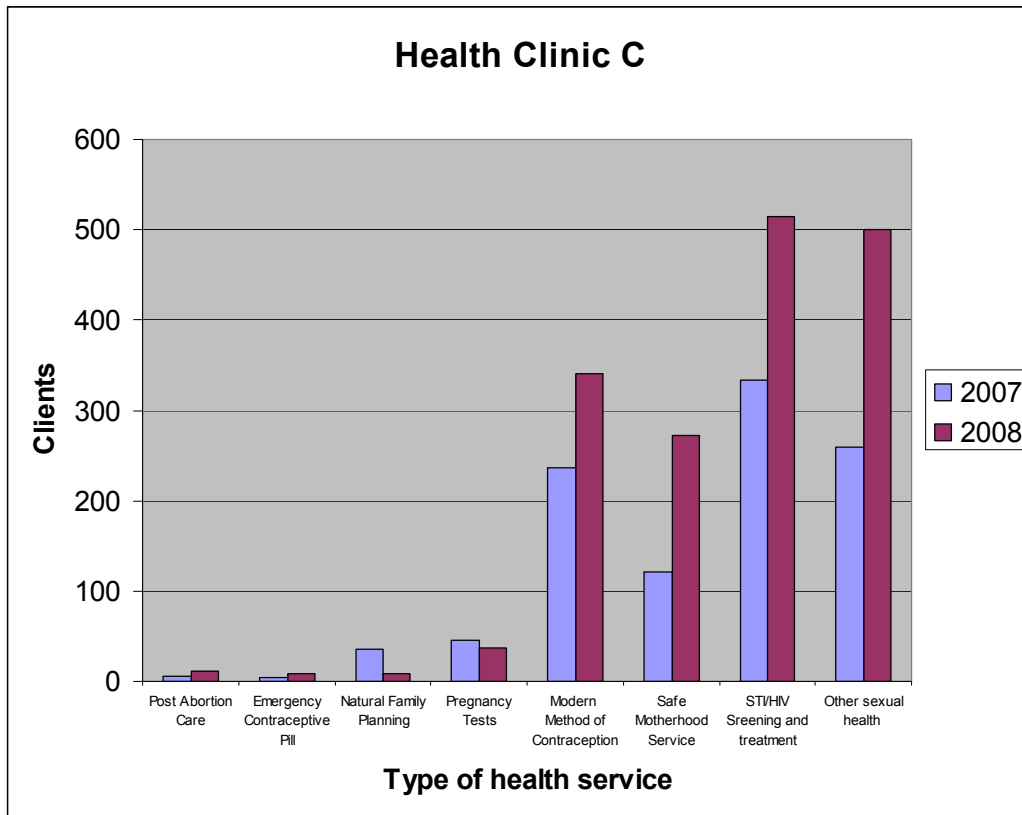


Figure 9 Types of Reproductive Health Care Provided by Clinic C in 2007-8

Source: Health Clinic C –nb 2008 contains only 8 months of data.

Providing women with family planning information and supplies

We interviewed 21 women who had experienced an early pregnancy loss and we specifically asked them about their views on family planning and their experience of getting information and supplies from health workers. We spoke with some women several times during their admission to hospital.

Some women spoke of traditional methods such as herbs:

‘Yes, not only hear about it but I do it for myself, the herbs like leaves. We can cook this herb with rice. I eat it and it can space my children. This herb I know from my grandfather and grandmother. The doctor and midwives don’t talk about any family planning yet.’ [Woman 13]

Some women were not sure about the idea of modern methods:

‘I didn’t hear any information about family planning yet but I want to know about this information. If I don’t know about this method and I use it, I am afraid it will impact with my health Maybe after I had some counselling I can choose the best method for myself.’ [Woman 9]

Most of the women in this study were not given any supplies and were told simply to not have sexual intercourse:

‘The doctor and midwife said that I don’t have any child so they didn’t explain it to me about the family planning. But they did explain to me that I should not get pregnant for the moment - until three months. I should not have sex. So me and my husband must wait for three months.’ (She laughs and doesn’t say anymore) [Woman 10]

This woman was angry with her husband. He had not assisted her to come to hospital despite heavy bleeding and an emergency admission:

‘I asked my husband to stop having children. I don’t want any more but he wants more. I would like some space. We did talk about it...when I started bleeding he left me alone. My friends were shocked. I thought I was going to die. The nurse talked with me but my husband was not there to help me. He didn’t come for two days- but my sister looked after me. I felt stupid, abandoned that my husband did not come. Now I have to consider my own health. I have to solve my own problems...In the past I didn’t use modern methods of contraception but now I have a plan. I will ask the midwife about family planning even if he doesn’t want it. I will get it. I am sick, not him. If he doesn’t visit me, I will not look after him when he is sick. I must look after my health!’ [Woman 5]

This husband was more supportive:

‘I am still young so I will probably have more babies. I am very angry because when the baby is still small and just walking I have another one! I want to have family planning. My husband also agrees. Before I came to the hospital the health worker asked me what I wanted and my husband knows about this. The types of family planning for me depend on the doctor’s decision. My husband wants me to stop having babies but I still want to have one more pregnancy to have a baby girl because I have only one girl. I am very happy to talk with you because we don’t speak with health workers like this. It’s good to sit and talk about these things, especially the family planning.’ [Woman 1]

We found that nearly all women were interested to talk about family planning and while not all women wanted a modern method, they usually were interested to share their ideas and thoughts.

Summary of assessment of quantity and quality of post-abortion care

This box summarises the assessment of quantity and quality of post-abortion care.

Indicator	Comments
1. Are enough facilities providing PAC?	
Amount of PAC available	If all five hospitals provided PAC it would be enough. However, Timor's population is expanding exponentially and the quality of PAC needs to be improved.
2. Are PAC services well distributed?	
Distribution of PAC health facilities	Most midwives are trained to provide MVA but whether this is comprehensive PAC is debatable. There is a problem with obtaining emergency blood supplies even in hospitals. Furthermore, as many women do not present to either health posts or hospitals, one issue could be accessibility across the country. Other research may show where facilities need to be placed so they are more accessible.
3. What proportion of services for women with obstetric complication is directed towards post-abortion care (PAC)?	
Proportion of women treated for obstetric complications that are PAC	Three years of data from two hospitals show that at least 40% of all emergency obstetric care is due to women requiring post-abortion care for complications due to all types of abortion. This needs ongoing monitoring. As child spacing programmes are more effective this percentage should decrease.
4. How common are serious abortion complications?	
Proportion of women treated for PAC that are serious?	This type of information is difficult to retrieve from medical case notes or logbooks. Few women had fever, sepsis, and perforations or required blood transfusions but the recording of this type of information is poor. There were cases of serious morbidity and mortality for pregnancy related reasons but they are not recorded in a systematic way. Health reporting and auditing systems need to be implemented.
5. To what extent are elective abortions being provided (to save women's lives)?	
Proportion of women who receive an elective TOP	No women received an elective termination of pregnancy. A few doctors spoke of acting to save women's lives despite the legal restriction. A reformed law would assist clinicians to protect the health of their patients.

6. Is there use of appropriate technology and evidence based care?	
Proportion of MVA or D&C or other procedure	Despite MVA being the safest method to evacuate the contents of the womb in most cases, there were a variety of methods used. Some doctors preferred D&C but all midwives used MVA. In one clinic neither MVA or D&C were available and cruder methods were used. Standard policy and protocols as well and in-service training should be implemented.
7. Are offered a modern method of contraception prior to discharge from the facility?	
Proportion of women who receive a method	Nearly all women did not receive a modern method of contraception on discharge from hospital. They were asked to return at a later date. In many cases women were asked to refrain from sexual intercourse for 3 months. This should be monitored further. Standard policy and protocols as well and in-service training should be implemented.

Box 3 Assessment of Post-abortion Care in Timor-Leste

Chapter Five

Legal Perspectives and Human Rights

This section of the report discusses the variation in laws regulating women's access to safe abortions around the world and some of the guiding principles used to develop and reform law. The framework of reproductive health rights is useful. The notion of 'traditional' and 'modern' law and criminalised abortion are introduced with specific examples from Timor-Leste are given. Clinical and legal practitioners provide local understandings.

National laws relating to the regulation of abortion

About sixty per cent of the world's population live in countries where access to legal abortion in some form is possible and about twenty-five per cent live in countries where termination of pregnancy is not legally possible (Centre for Reproductive Rights 2008). The following diagram based on 2005 data gives a visual representation of the scope of laws which regulate abortion around the world.

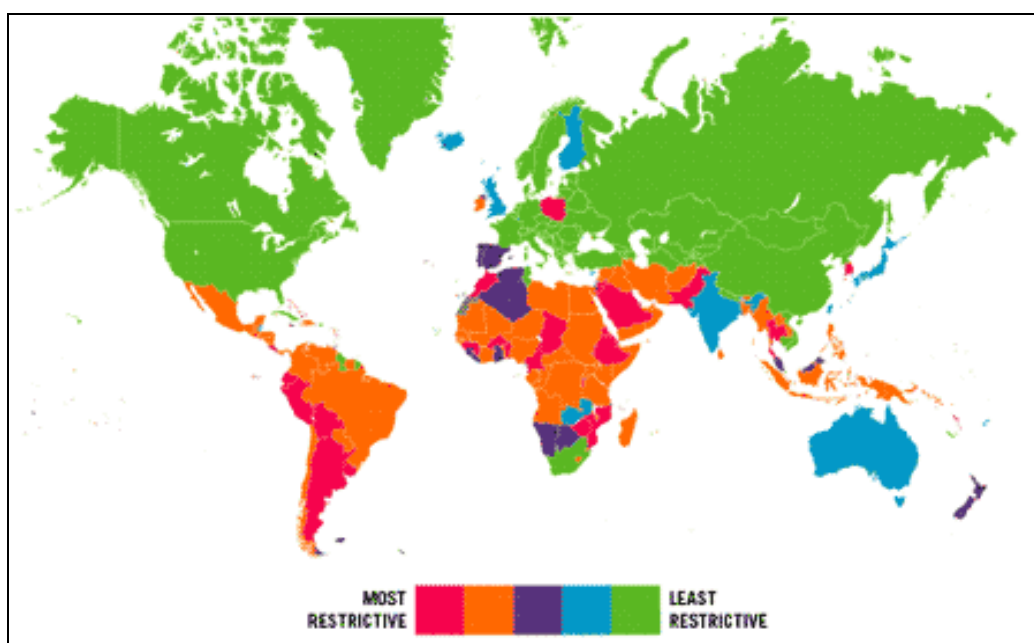


Figure 10 The World's Abortion Laws in 2005

Source: Centre for Reproductive Health Rights

http://www.reproductiverights.org/pub_fac_abortion_laws.html [Access date April 2007]

Categories of Law

Laws can be categorised into the following ways from conservative to liberal. The box shows laws in five categories from totally prohibited to on demand and the particular countries.

<p>Category 1 Prohibited Altogether or Permitted Only to Save the Woman's Life</p> <p>The most restrictive laws are those that either permit abortion only to save a woman's life or ban the procedure entirely. Many countries in this category explicitly permit abortion when a pregnancy threatens a woman's life. In other countries, laws that make no explicit exception are often interpreted to permit abortion under life-threatening circumstances on the grounds of "necessity." Such an exception may also be recognized in national norms of medical ethics.</p> <p>Countries Afghanistan, Brazil, Haiti, Indonesia, Myanmar(Burma), Nigeria, Malawi, PNG, Philippines, Uganda</p>
<p>Category 2 Physical Health Grounds</p> <p>Laws that authorize abortion to protect the pregnant woman's life and physical health form Category II. These laws sometimes require that the threatened injury to health be either serious or permanent. While laws in this category do not explicitly permit abortion to protect mental health, many are phrased broadly enough – referring simply to "health" or "therapeutic" indications – to be interpreted to allow abortion on mental health grounds.</p> <p>Countries Argentina, Costa Rica, Mozambique, Pakistan, Peru, Thailand, Uruguay</p>
<p>Category 3 Mental Health Grounds</p> <p>Laws in Category III expressly permit abortion to protect the woman's mental health, as well as her life and physical health. The interpretation of "mental health" varies around the world. It can encompass, for example, psychological distress suffered by a woman who is raped or severe strain caused by social or economic circumstances.</p> <p>Countries Malaysia, New Zealand, Northern Ireland, Spain</p>
<p>Category 4 Socioeconomic Grounds</p> <p>Laws in Category IV, which allow abortion on socioeconomic grounds, permit consideration of such factors as a woman's economic resources, her age, her marital status, and the number of her children. Such laws are generally interpreted liberally.</p> <p>Countries Australia, Great Britain, India, Taiwan, Zambia</p>
<p>Category 5 Without Restriction as to Reason</p> <p>Finally, the least restrictive abortion laws are those that allow abortion without restriction as to reason. Most countries with such laws, however, impose a limit on the period during which women can readily access the procedure.</p> <p>Countries Cambodia, Canada, China, Cuba, Italy, Nepal, South Africa, Vietnam</p> <p>54 countries are in this category – or 40% of the world's population</p>

Box 4 Diversity of Law and Country Details

Source: http://www.reproductiverights.org/pub_fac_abortion_laws.html [Access April 2007]

Within these categories a number of countries mention three other reasons for abortion; rape, incest and foetal disability. Faundes and Hardy (1997) argue that restrictive laws do not stop abortion they simply make it unsafe and more likely women will die.

Most countries have some provision for qualified clinicians to provide terminations of pregnancy and this is not necessarily correlated to the national religion or state of development

of a country. According to (Cook and Ngwenya 2006), the underlying principles in drafting law for health care should be that:

- Law should be evidence-based rather than reflect personal morality;
- Legal guidance for women and health care providers should be clear;
- and the law should be applied without discrimination against women.

Legal Status of Abortion in Timor-Leste in 2008

Much of Timor-Leste's judicial system is currently being developed with the assistance of Portuguese lawyers and on reading the legal code inherited from Indonesia, it appears that all forms of abortion are illegal in Timor-Leste (1982). The Code states:

Article 346 (p81) Any woman who with deliberate intent causes or lets another cause the drifting off or the death of the fruit of her womb, shall be punished by a maximum imprisonment of 4 years.

Article 348 (p81-2) Any person who with deliberate intent causes the drifting off or the death of the fruit of the womb of a woman with her consent, shall be punished by a maximum imprisonment of 5 years and 6 months. 2) If the fact results in the death of the woman, he shall be punished by a maximum imprisonment of 7 years.

Article 349 (p82) If a physician, midwife or pharmacist is an accomplice to the crime in article 346, or is guilty of or is an accomplice to one of the crimes described in articles 347 and 348, the sentences laid down in said articles may be enhanced with one third, and he may (sic) be deprived of the exercise of the profession in which he commits the crime.

Under these articles, the act of termination of pregnancy is criminalised by its positioning within the penal code. There appears to be no provision for doctors to be able to save the woman's life in cases where the survival or health of the mother is jeopardised by the continuation of the pregnancy. This may leave doctors in Timor-Leste in compromised situations if they wish to save the lives of their adult patients.

The legal system is evolving in Timor-Leste and there is considerable complexity in forming governance structures in volatile contexts (Kingsbury 2005; United Nations Development Programme 2006; Shoesmith 2007). The various sectors of power and authority are the

traditional custodians (*liruai*), the Catholic Church, the political parties and factions, the multiple organisations of the UN and the local and international NGOs.

Draft Penal Code

During 2007 and 2008 a draft Timorese Penal Code was written and several Portuguese and translated versions circulated through Dili NGO networks. No consultation with local NGOs or clinicians or agencies such as WHO or UNFPA occurred during this time regarding abortion regulation. Appendix B includes drafts of proposed legislation and Article 141 which was passed by the Council of Ministers early 2009.

Modern and Traditional Law

The legal sector in Timor-Leste can be conceptually and historically divided between the traditional and the evolving formal systems. Authors point out that both appear to be valid in the present context (Mearns 2002; Hohe and Nixon 2003). Mearns' report is supportive of the traditional system which is functional, highly accessible and meaningful to many Timorese but notes that international human rights' standards do not prevail and this particularly disadvantages women and children. Mearns (p41-42) outlines the problem.

‘A further, particular example of the issues raised appears in the context of what are often glossed as ‘abandoned women’. These are women who have become pregnant to a man who is not their legally sanctioned husband and then find that the man refuses to support them and the baby. In many cases these are young women who have formed a relationship with an unmarried man. In other cases, the man concerned may already be married to another woman. In Indonesian law the act of adultery is still considered a crime. However, UNTAET passed an early regulation decriminalising adultery. Many local people do not know this or do not understand why it is no longer a crime. It is especially galling for a woman impregnated by a married man but also affects the original wife and her family who have been dishonoured. There is no obvious legal recourse for a woman who feels herself to be wronged in such circumstances as, in addition to no crime having been committed, no effective possibility of obtaining paternity decisions and maintenance orders exists.’

This lack of protection for women who effectively find themselves without a father who will take responsibility for their baby is problematic. Furthermore, rape is conceptualised as loss of dignity and families are financially or materially compensated as though the woman is a spoilt commodity. This suggests that for women who have unplanned and unwanted pregnancies, either through consensual or non-consensual relationships, that they and their families use traditional mechanisms to find solutions. Our respondents suggested that village leaders mediated in these circumstances. Infanticide, or killing the baby shortly after birth, is another response to the consequences of difficult personal circumstances.

In our research, a police officer who was stationed in a town (not Dili) spoke about his experience with induced abortions. He knew they occurred but suggested that nobody made direct complaints to him:

Our law, religion and culture do not permit us to induce abortion. In my opinion if people do abortion it is because of their own selfish interests; for example because they are ashamed if they are not married and some because they have no food or money. If I knew that abortion occurred I would do something.

[How do you work with these cases?]

We cannot do anything because no one complains to me. I think abortion is a disaster.

[Do you send the women to prison?]

We never send women to prison.

[Do any women die due to abortion?]

I have heard that women die at home from abortion but we can't do anything. We just hear about it. We don't have any information.

[Who helps the woman do abortion?]

If someone helps the woman to induce abortion we will catch them. We will investigate.

[Is there anything else you want to say?]

The health workers need to come and explain the women the dangers of inducing abortions because doing abortion at home can be bad for women's health.

This account suggests the difficulties and ambiguities faced by police officers in enforcing the law on this issue. Serious crimes against a person do not require 'complaints' to be made. It is the officers' role to investigate if he believes that a crime has been committed. It suggests that many families do not take complaints to official formal authorities and evidence is difficult to get. There is a simultaneous condemnation of the women who abort and concern for their health and welfare.

Men and Women in Prison

Late in 2008 a case of abortion was proceeding through the judicial system and reported by the Judicial System Monitoring Programme (JSMP). This is JSMP's press release (<http://www.jsmp.minihub.org>):

Edition: November 2008

VICTIM AND FETUS DIE FROM ABORTION

On 19/11 the Oe-Cusse District Court conducted a hearing into a case of abortion involving the defendants LL and ES. The victim of this case died. The prosecutor's indictment stated that in March 2007 in Betasi, Taiboko the defendant LL entrusted some traditional medicine to the defendant ES to be given to the victim J and to be taken in accordance with instructions set out by the defendant LL. The aim of the two defendants was to enable the victim to abort her four month old fetus. The defendant instructed the victim to take the medicine regularly for three weeks. After several days the victim gave birth and neither the victim nor her baby could be saved.

During the trial the defendant ES denied all charges presented by the public prosecutor in relation to the death of the victim as the result of aborting her four month old fetus.

In response to questions about the death of the victim, the defendant ES said that he was not aware because he was in police custody. The defendant and witness were reluctant to state that they knew about the victim's pregnancy. They said that they only found out about the victim's pregnancy after her death. Based on monitoring conducted by JSMP, the witness in this case did not provide sufficient testimony, because all the witness said was that he did not know about the abortion. Coordinator of Legal Research, JSMP

According to this man's account, he sourced some traditional medicine to give to his girlfriend who took it. Any type of pregnancy loss at four months can be life-threatening due to the retention of the placenta and copious bleeding. This may be what happened to the young woman. Alternatively the man and the traditional healer may not be telling the complete truth about how they induced the abortion and how the woman died in the process. Notwithstanding truth and tragedy, it shows several things, firstly the desperation of men and women to end unwanted pregnancies, the dangerous nature of unsafe abortion and the legal complexity of prosecution where evidence is scant.

During our study we checked with judicial and prison authorities and they confirmed that women had been investigated for acts of abortion and some imprisoned for the crime of infanticide. The Prosecutors Office reported managing 6 cases of criminal abortion in 2003, 1 in 2007 and 2 in 2008. Prison authorities reported 2 women were jailed for 3 to 4 years for killing infants less than one month old. The numbers were very small and could not be confirmed by court records, as the records were disrupted during the 2006 crisis.

The Indonesian Penal Code defines infanticide² as:

² Thus the Indonesian penal code defines infanticide as requiring premeditation – 342°, lacking premeditation the conduct is qualified as infant-manslaughter – 341°.

Article 341

The mother who, driven by fear of discovery of her confinement, with deliberate intent takes the life of her child at or soon after its birth, shall, being guilty of infant-manslaughter, be punished by a maximum imprisonment of seven years.

Article 342

The mother who, for the execution of a decision driven by fear of the discovery of her forthcoming confinement, with deliberate intent, takes the life of her child at or soon after its birth, shall being guilty of infanticide, be punished by a maximum imprisonment of nine years.

Infanticide and abortion are legally not the same. From comparative study pertaining to infanticide the common denominators of most laws are: the mother kills her child; it occurs at the time of birth or shortly after; there is recognition that mothers may suffer from a mental disturbance related to pregnancy and birth. There is contested difference regarding the period of time. For instance, if it occurs shortly after birth it is considered infanticide and not murder, benefiting the woman. Some laws only say during or after birth, others mark out a period of time, for instance the child must be less than a year old (United Kingdom) or seven days (Brazil).

Unplanned and unwanted pregnancies may also result in the baby being abandoned or relinquished into the care of others. Informal family agreements to care for and raise children may also be arranged. Some Catholic pastoral services cared for children in the short and long-term. In our study people noted they had difficulty accessing formal judicial processes.

Doctors and midwives views of the law

All clinicians were interested to engage in a conversation about the variety of global laws regulating abortion and some conveyed surprise that this diversity existed. They expressed divergent viewpoints about what they believed were appropriate grounds for a termination of pregnancy. Nearly all stated they would want to be able to save a mother's life and many understood that physical and mental health reasons were important to consider, as well as foetal illness and deformity in making decisions about the viability of a pregnancy. There was less agreement for social reasons such as poverty and clinicians preferred offering family planning and support in these cases. Most acknowledged that incest and rape were common occurrences that had profound impact on the desirability of a pregnancy. There was a range of responses from those who felt the woman had no choice but to accept her fate and continue (with counselling and support); to those who felt that the woman should be able to end her pregnancy legally.

Another overwhelming response from many respondents was the lack of awareness of the law regulating termination of pregnancy. Most respondents, clinical, lay people or NGO workers were unaware of the Indonesian Penal Code. They simply ‘knew’ that abortion was forbidden and when asked who forbade it, they replied ‘The Church’.

During interviews with clinicians, only two doctors, one expatriate and one Timorese, referred to reproductive health rights and World Health Organization definitions. The Timorese doctor said:

‘If an emergency case comes we must save the woman’s life. We must think about human rights. In the future if all the Timorese are educated we will decide by ourselves. We will respect all rights and the right to abortion. We need to understand the definition of health according to WHO, so mental health is included. This means that if the woman doesn’t want this pregnancy this is her right. Also in my position, I will use the WHO definition which includes mental health of the woman.’

The right to information was noted in the literature, and there is an example of clinicians working in South America who managed to provide women with evidence-based information about pregnancy options that did not contravene law and reduced the health risks associated with unsafe abortions (Briozzo, Vidiella et al. 2006).

Legal Professionals views of the law

We interviewed 13 legal professionals; some were court clerks, lawyers, prosecutors or judges. Most were Timorese only 3 were foreigners. The majority were male and one Timorese Judge declined to be interviewed.

Table 4 Numbers of Legal Professionals Interviewed

	Foreign	Timorese	Total
Lawyers	0	4	4
Prosecutors	3	2	5
Judges	2	1	3
Court Officer	0	1	1
	5	8	13

Only one had dealt directly with cases of induced abortion, many had worked on infanticide cases, rapes resulting in pregnancy and domestic violence. They spoke of their professional experiences and some gave opinions about a hypothetical abortion case.

A Timorese prosecutor said:

‘Yes, I worked on 10 to 15 cases of infanticide committed mainly in (district name) and (district name). I remember that one woman was convicted to 7 years imprisonment [case of infanticide]. It is very difficult to collect evidence in both crimes – abortion and infanticide. In many cases the family helps to conceal the pregnancy until birth and also helps killing the baby. They feel shame because the woman/girl is not married. There are many cases in the other districts. Women are victims of sexual abuse; they get pregnant and reject the child.’

Timorese lawyers want Timorese legislation and most commented on the inadequacies of the Indonesian Penal Code. One Timorese lawyer said of the penalty for induced abortion:

‘Indonesian penal code gives a maximum penalty of 8 years. A woman can never have an abortion. I think the penal code should be more modern.’

But not all were reformist:

‘The Indonesian penal code is not easy to apply... As to the articles I think the penalties are not enough since it is about taking a life. The penalties should be higher. The penalty is insufficient in face of the criminal act, it is killing a person.’

These types of crimes are elusive and rarely enter the judicial system. An expatriate Judge explained:

‘There are cases of abortion where women are co-author. They are forced by their partners to take medicines to terminate the pregnancy. The cases take place particularly in the district of [name]. I have seen more than three cases. No case reached hearing. The cases got to court during Indonesian times and suffered from procedural deficiency therefore could not be judged.’

One Timorese judge held a reformist perspective and spoke strongly about women’s rights to choose and to have protection in law:

‘First of all I think that the Timorese people need to be educated, they have no knowledge at all regarding everything. It is complicated because of the economic and social situation. Women are economically weak and more uninformed; if they did they would protect themselves against these kinds of situations; abortion, domestic violence, all. A big issue here is the Catholic Church, religion. Timorese are very narrow-minded. Only a few, a very few Timorese have knowledge and they can’t influence the majority that doesn’t have knowledge. The penal code is under review and the law should have exceptions allowing women to perform abortions, namely when they are raped or even when they can’t raise the kids because they don’t have money. Women should be able to choose.’

Reproductive Health and Rights

Despite many development challenges, Timor-Leste is part of the General Assembly of the United Nations, and has accepted the goals and targets of the Millennium Development Goals

in 2005 including a commitment to Goal number 5 to improve maternal health (United Nations 2000) .

The United Nations Decade for Women (1976-1985) crystallised action and advocacy in reproductive health however, the right to terminate an unwanted pregnancy remains contested in many countries (Cook 1994; Petchesky 2003; Cook and Ngwena 2006). Reproductive health encompasses the well-being and function of human reproduction, for men and women. The most commonly used definition of reproductive health came out of the ICPD in Cairo in 1994 and is endorsed by the World Health Organization:

‘Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.’ (Palmer, Lush et al. 1999) p1691.

Timor-Leste has signed and ratified several international conventions that carry implications for national laws, policies and the practical delivery of health services to men and women. The following table names these international instruments.

International Convention	Date
International Bill of Human Rights International Covenant on Economic, Social and Cultural Rights International Covenant on Civil and Political Rights	Accession – 16 April 2003 18 April 2003
Convention on the Elimination of all Forms of Discrimination Against women	Accession – 16 April 2003 Optional Protocol – not signed

Box 5 International Conventions Endorsed by Timor-Leste with Implications for Health

Source: (University of Minnesota 2007)

Regarding the prevention of women dying or being injured from unsafe abortion the relevant rights include:

- Guarantees of life and health
- Right to reproductive self-determination
- Right to freedom from discrimination
- Right to enjoy the benefits of scientific progress

These rights are found in the Universal Declaration of Human Rights (Articles 3,25:1, 12,15:1b); International Covenant on Civil and Political Rights (Articles 6, 2:1); Programme of

Action of the International Conference on Population and Development (Principle 1); CEDAW(Articles 1, 10h, 12:1,16:1e) ;Economic, Social and Cultural Rights Covenant (Article 2:2). National laws or policies which contravene these international agreements stand in opposition to the essence and meaning of the agreement. The versions of the proposed Penal Code which circulated in 2008 criminalised the termination of pregnancy (see Appendix B) despite CEDAW's specific entreaty to prevent discrimination against women.

CEDAW Part 1, Article 2 states:

States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:

- (a)...;
- (b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;
- (c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;
- (d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;
- (e) To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;
- (f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;
- (g) To repeal all national penal provisions which constitute discrimination against women.

As only women can die or be severely disabled by pregnancy and birth, and furthermore as only women carry the burden of an embodied and visible pregnancy (men can walk away or deny unwanted pregnancies), special provisions need to be given to women.

Timor-Leste has, like many colonised countries, inherited its religion and law from other countries and now has an opportunity to consider the future. Timor-Leste is signatory to several conventions which express fundamental human rights, access to a reasonable standard of care and the right to choose the number and timing of children are within the conventions signed. The Indonesian Penal Code criminalises all forms of abortion and does not allow a health worker to safely or legally terminate a pregnancy for any reason. On evidence this suggests that Timorese women die and are seriously disabled due to this law.

There are examples of acts of parliament from South Africa and Guyana with guiding principles that are a useful counterpoint. There are examples of post-colonial legislation from Africa which have embraced human and reproductive health rights which can be useful templates to

those who wish to write progressive law. Nigeria, Guyana and South Africa are prominent examples (Oye-Adeniran, Long et al. 2004; Buchmann, Kunene et al. 2008). The South African 'Choice on Termination of Pregnancy Act 1996' is regarded as leading the way. The Act goes on to clearly define the parties to a termination of pregnancy, the circumstances under which one can be performed, outlines late terminations, where the procedure is to be performed, consent, required record keeping, confidentiality and potential consequences for those who do not follow the law. It is explicit and recognises reproductive health rights. It also mentions medication and surgical abortion procedures.

When the termination of pregnancy is included in a Penal Code, as it is in Timor-Leste, it criminalises and restricts Timorese women's access to safe abortion which will mean that women (sometimes aided by men) will continue to terminate their pregnancies in shame and with high health risks. The legal professionals have mixed views on the appropriate wording but all call for legislation that is debated by everyone. It appears that women organise their own terminations of pregnancy and a few kill their newly born infants. These cases rarely reach the judicial system as they are dealt with in the family and by village elders. If women are sentenced they face jail terms and public humiliation. This Timorese member of the Ministry of Health reflects on the lack of choices women have:

'It is a dilemma to change the people's ideas in a day. Perhaps in the next generation people will approach this differently. It will change. We don't want other countries' laws. Maybe in the next 5 to 10 years we can adapt these laws in our country but it is difficult. We are a young country so step by step. We must always consider that our ideas are for a country and not just one person. We need to decide together in forums. To change the law we would invite the doctors....mostly the doctors know.... For myself I think when girls or women are not ready there should be terminations of pregnancy. I can imagine that a woman does not want the baby; she may neglect it or abandon it. I even asked the priest about that and he said family planning and abortion are the same thing. I said OK tell me what is better to prevent an unwanted pregnancy or infanticide or neglect? These are the real choices for women.'

Lawyers and parliamentarians can save women's lives by reforming law. The evidence is very clear from around the world that the criminalisation of the termination of pregnancy directly causes the deaths of women who have unwanted pregnancies and who have no recourse other than unhygienic unsafe abortions. There are few countries now where all termination of pregnancy is criminalised. In most countries there is some provision for access to safe legal abortion for particular reasons and circumstances. The variation in global laws regarding termination of pregnancy is not related to religion, nationality, development levels or origins. The global trend is a liberalising one (Harvard University 1974 to 2004).

Chapter Findings

- Abortion by traditional methods are rarely reported to official legal officers.
- Timorese lawyers do not want inherited laws from other countries.
- The Prosecutors Office reports managing small numbers of criminal abortion.
- Gleno prison reports 2 women were jailed for 3 to 4 years for killing infants less than one month old.
- Most people wished to see other types of laws from different countries but they said that this needs to be discussed regarding Timorese culture and tradition.
- Most health practitioners are unaware of the Indonesian Penal Code's regulations against any kind of termination of pregnancy.
- Women have a right to information about safe and unsafe abortion.

Chapter Six

Policies and Protocols Relating to Reproductive Health in Timor-Leste

There are several key documents that were reviewed for this section 1) the National Reproductive Health Strategy 2) the National Family Planning Policy and 3) Standard Treatment Guideline for Primary Health Facilities in Timor-Leste. This analysis is intended to highlight the gaps in these key documents with regard to the prevention of unsafe abortions. A representative from the Ministry of Health spoke about the formation of some of these documents and the absence of Timorese perspectives;

‘It (Reproductive Health Policy) was developed in 2002; none of the Ministry of Health staff could speak English then. We had a lot of *malae* (foreigners) here, they wrote it! Now when we read it we notice that there are mistakes. We will review it and change it, like the Family Planning policy too. The age of marriage is missing and it doesn’t mention spacing children, these things need to be included.’

National Reproductive Health Strategy

The National Reproductive Health Strategy (NRHS) of Timor-Leste (Democratic Republic of East Timor 2004) acknowledges the right of Timorese people to understand their reproductive health and access health services. It mentions the ICPD Programme of Action and the Beijing Platform for Action as a framework. The reproductive health package states that it is designed to meet the needs of family planning, sex education, Safe Motherhood, and protection against HIV/AIDS and STIs. Reproductive health is modelled as a life-cycle approach and categorised into Young People’s Reproductive Health, Family Planning, Safe Motherhood and General Reproductive Health (see page 2). The 59 page strategy document identifies problems and constraints, responses, goals, objectives, targets, an institutional approach and implementation.

The stated goals of the strategy are to ensure that people can:

- Experience healthy sexual development and maturation and have the capacity for equitable and responsible relationships and sexual fulfilment;
- Achieve their desired number of children safely and healthily, when and if they decide to have them:
- Avoid illness, disease and disability related to sexuality and reproduction and receive appropriate care when needed;
- Be free from violence and other harmful practices related to sexuality and reproduction. (p8)

These goals will not be achieved without preventing unsafe abortions.

Maternal Mortality

The strategy acknowledges the high rates of maternal morbidity in Timor-Leste and attributes it mainly to a lack of skilled birth attendants present at the time of birth and the inability to detect and predict obstetric problems. While this is probably true, a potentially significant contributor to maternal mortality is early pregnancy loss either spontaneous or induced. The data in this report demonstrates that Timorese women experience unwanted pregnancy and high levels of pregnancy related illness. This report has collected evidence to suggest that unsafe abortions, and certainly complicated early pregnancy losses, are occurring in Timor-Leste.

Fertility and contraception

Fertility is noted as being high and knowledge and use of modern methods of contraception very low. The National Reproductive Health Strategy suggests there is an unmet need for fertility management by some women, particularly those with many children already. These women may be using more traditional and available methods such as abortion to regulate their fertility.

Abortion

In the definitions of statistics of reproductive health in the National Reproductive Health Strategy, the word abortion is not defined and is referred to in basic and emergency obstetric care as 'removal of retained placenta' or 'evacuation of the uterus'. A simple word count shows that the word abortion appears about 12 times in the context of 7 points. It mainly refers to spontaneous abortions and complications of abortions in young people. This is an assumption that only young people have unplanned and unwanted pregnancies. This quote from page 58 refers to defining the percentage of admissions to health services from abortion related causes.

Percentage of all cases admitted to service delivery points, providing in-patient obstetric and gynaecological services which are due to abortion (spontaneous and pre admission induced, but excluding planned termination of pregnancy).

Unsafe abortions are recognised but due to the current legal framework in which it is written there are no planned elective abortions. This reflects the interpretation of law whereby all terminations are considered illegal under all circumstances. This Strategy does not use globally available evidence or local evidence on unwanted pregnancy or the prevention of unsafe abortion to support its stated goal of the reduction of maternal mortality.

Multiple understandings of abortion

Definitions and categories have cultural explanations which make sense locally and the viability of the embryo, foetus or even neonate, is dependant on the perceptions of the woman

and health care provider. Local understandings of foetal anatomy and physiology need to be included when analysing pregnancy loss, not just legal or bio-medical categories. Furthermore, where elective abortion is illegal, as in Timor-Leste, the official classification of a pregnancy loss into ‘spontaneous’ or ‘induced’ is in practice difficult (Baretto, Campbell et al. 1992; Tamang 1996). Not all cases are clear.

Positioning of abortion

The National Reproductive Health Strategy categorises reproductive health into Young People, Family Planning, Safe Motherhood and General Reproductive Health. Abortion is only mentioned in connection with adolescent health and in terms of emergency obstetric care within Safe Motherhood. If the legal status of abortion were to change this would need to be reflected in the strategy and may need to be mentioned more explicitly in a category of its own or included within all of the current categories. So if it were possible to offer a termination of pregnancy to women in order to preserve their physical and mental health this would need to be reflected in the new policy document.

Strategic Approaches

The following table takes specific approaches mentioned in the Strategy and adds some comment regarding pregnancy choices.

<p>Approach 1: Substantially increase the level of knowledge in the general population on issues related to pregnancy and childbirth.</p>
<p>Comment: Men and women need to be informed of the dangers to health of unsafe abortion to women and foetus and where to look for maternal services and counselling</p>
<p>Approach 2: Improve quality and coverage of prenatal, delivery, postnatal and peri natal health care.</p>
<p>Comment: All women require counselling and support if they are ambivalent about their pregnancy, or request adoption.</p>
<p>Approach 3: Improve emergency obstetric care through recognition, early detection and management or referral of complications of pregnancy and delivery.</p>
<p>Comment: Health workers need to be able to counsel, refer and support women who have unwanted pregnancy.</p> <p>Health workers need training in high quality post-abortion care and family planning.</p> <p>Women will still require good quality post-abortion services for spontaneous abortions which are life-threatening.</p>

<p>Approach 4: Integrate effective detection and management of STI cases, including HIV, in maternal and peri natal care</p>
<p>Comment: Some communicable diseases such as syphilis and HIV have a large impact on the foetus and mother. In many countries abortion is offered on compassionate grounds in specific cases.</p>
<p>Approach 2: Increase male commitment to sexual and reproductive health</p>
<p>Comment: Men contribute to unwanted and unplanned pregnancy by having low levels of knowledge about family planning or acting in controlling ways regarding fertility choices. Some cannot afford to feed and school the children they produce. Some men rape women. Men need to be supported to understand sexual and reproductive health better and to act in responsible and respectful ways towards women.</p>
<p>Approach 3 Increase availability of high-quality, culture and gender sensitive and non-stigmatizing services for the prevention, care and management of STIs and HIV/AIDS and to provide care for people with HIV/AIDS.</p>
<p>Comment: This is very similar to the point made above – only women pass on HIV through their bodies to their children, and while antiretroviral do decrease vertical transmission, women may not wish to bear more children knowing that their children may be orphaned in the near future. A gender sensitive approach to unwanted pregnancy and HIV positive women needs to be included.</p>
<p>Approach 4: Provide a confidential, sensitive and culturally appropriate response to victims of gender-related and sexual violence.</p>
<p>Comment: Women need counselling and support to carry a child conceived by rape.</p> <p>They will need information and education about unsafe abortion and good quality post-abortion care.</p>

Box 6 Strategic Approaches to Reproductive Health

In summary, the National Reproductive Health Strategy provides a useful framework but has several gaps. Its overall intention is to reduce the high rates of maternal mortality and improve the sexual and reproductive health of Timorese people. This will not be achieved by ignoring unwanted pregnancy and unsafe abortion. These are always sensitive topics for any culture and should be dealt with in culturally appropriate ways but not by silence.

National Family Planning Policy

The National Family Planning Policy (Democratic Republic of East Timor 2004) outlines the very high fertility rates of Timorese women and the low rates of contraceptive use. It carefully notes the broad community inclusion in the development of the policy and the support of the Catholic Church. Concepts of ‘responsible parenthood’ and ‘planning a family’ are mentioned. It briefly touches on the guiding principles, service delivery, location of services, human

resources, information, education and communication, as well as institutional approach and evaluation. It notes that family planning information, education and communication should be 'cultural-religious sensitive, should respect people's individual choices, and should be devised in the context of 'Responsible Parenthood' (p15). The only concern raised is that young people are often not perceived as planning a family or ready for responsible parenthood and could be discriminated against regarding access to contraceptives. There is no mention of specific contraceptive technologies and their appropriateness for Timorese.

The inclusion of midwives as key professionals who have the capacity to offer family planning services is important. It is not clear from the document whether this means that midwives will be trained or will be given the authority to prescribe hormonal contraceptives, fit IUCDs or diaphragms, insert implants, or perform vasectomy. As medical doctors are often male and not widely distributed in rural areas, midwives and community health nurses are an important resource to skill and authorise to perform special technical functions to increase access to family planning.

On monitoring, several indicators are suggested and another that could be added is the number of admissions for post-abortion care to all health facilities. This is a readily measurable indicator, and while it will include miscarriage as well as induced abortion, numbers should drop over time as larger proportions of Timorese choose to space their babies with modern family planning methods.

The National Family Planning Policy does not mention abortion. It does not suggest anywhere that even with perfect human resources, excellent coverage and a population that accept and use modern methods of contraception, unwanted and mistimed pregnancies will still occur (albeit much less). While there is consensus in the international literature that abortion should not be promoted as a form of family planning, there is considerable evidence that traditional methods of family planning are widely used and abortion is one of them (see previous discussion in Chapter Three). The Policy does not address traditional methods, by this we are not referring to natural family planning (mucous, ovulation timing, temperature method); we mean the use of herbs, proscription of sexual behaviour in certain contexts, pregnancy and post partum separation of husband and wife and breastfeeding. Exclusive breastfeeding for the first six months of a baby's life is not only beneficial to the baby but mother as well, as it delays ovulation considerably. This should be encouraged and supported in the National Family Planning Policy. Mention should also be made for the need to ensure the quality of the promotion of natural family planning methods by those services which do so.

Standard Treatment Guideline for Health Facilities in Timor-Leste

The Standard Treatment Guideline for Primary Health Facilities in Timor-Leste (Democratic Republic of East Timor 2004) is a large document over 248 pages covering a range of common illness and disease. This critique will focus only on the section covering Chapter 2 Reproductive Health.

While Chapter 2 is titled Reproductive Health it only addresses pregnancy and not other reproductive health issues such as family planning, HIV or abortion. In fact early pregnancy loss from any cause is barely mentioned at all. This is surprising as it is very common and can lead to a health crisis and death. Obstetric sepsis is mentioned in relation to the post partum and miscarriage and very briefly on page 36 as abortal sepsis. Evacuation of the contents of the uterus by MVA is not mentioned and as many midwives in Timor-Leste can do this, it is worth including. Other complications of pregnancy are listed such as high blood pressure, urinary tract infection, malaria, diabetes and anaemia. Most can cause early pregnancy loss or premature labour but this is not elaborated. This is a large omission and in next editions the identification, management, treatment and referral of early pregnancy loss from all causes needs to be included.

A clear post-abortion protocol would add value to this document. The WHO provides the *Complications of Abortion: technical and managerial guidelines for prevention and treatment* (World Health Organization 1995). Other good examples in the international literature where basic health information about early pregnancy loss is covered is 'A Book for Midwives A manual for traditional birth attendants and community midwives' (Klein 1995) and 'Where Women Have No Doctor: A health guide for women' (Burns, Lovich et al. 1997). The clear information and explicit discussion of the causes and management of induced abortion would form a useful framework .

Care also needs to be taken when using Western medical reference books on abortion for the Timor-Leste context. This is because the writers of most Western obstetric text books rarely treat unsafe abortion. They work in countries where access to elective abortion is possible and do not understand the resulting sepsis, tetanus or perforations that can occur. They are not written with recognition of the lack of technology to be able to diagnose a viable pregnancy in remote settings or the difficulties with communications and referral.

Chapter Findings

- The three leading documents reflect a great deal of work and thought by many people in Timor-Leste.
- Reproductive health is perceived in rather narrow terms that mainly focus on pregnancy, birth and some family planning.
- The principles of human rights and reproductive rights are acknowledged.
- Reproductive health issues are contentious and contested in most countries and Timor-Leste is no different and these documents reflect these tensions.
- The absence of unwanted pregnancy, early pregnancy loss, and induced abortion in any significant way needs to be addressed in further editions and modifications to these documents.

Recommendations

The following pages contain the recommendations from the study which include the prevention of unwanted pregnancy and abortion, reporting and monitoring, quality post-abortion care, advocacy on women's rights and law and access to information

- **Prevention of unwanted pregnancy and abortion:** Respondents spoke of wanting to prevent unwanted pregnancies and unsafe abortions. Implementation of the National Reproductive Health Policy and the National Family Planning Policy in effective and visible ways in service delivery would effectively reduce unwanted pregnancies and unsafe abortions. Family planning and modern methods of contraception should be promoted in multiple ways in the community as well as during in-patient or out-patient contacts with the health system.
- Public health promotion programs approved by the Ministry of Health should promote child-spacing, modern methods of contraception and the risks of unsafe abortion. The inclusion of methods for men and youth friendly messages and services would be beneficial.
- **Reporting and Monitoring:** As the deaths of women who die from reasons relating to pregnancy and birth are not recorded well, a systematic and mandatory reporting system facilitated by the Ministry of Health should be developed. While the vast majority of women die at home or on the way to hospital, this report recommends the inclusion of questions on maternal deaths in the next national census. In any future research, care should be taken about what methodology is used in sampling, questions asked and analysis of the data to allow confidence in data collected, and ability to review trends over time.
- Facility-based maternal death audits that feed into improving the quality of care need to be implemented by senior obstetricians and midwives with the support of the Ministry of Health, recognising that this only captures the minority of women who die in hospital or a health post. Surgeons and physicians also need to report cases that come under their care in non-obstetric/gynaecological departments.
- The quantity and type of emergency obstetric care should be monitored annually to assess the impact of public health initiatives. International indicators can be readily adopted to assist in this measurement.

- **Quality of Post-abortion Care:** In facilities where post-abortion care is provided, advanced training and supervision for doctors and midwives on the provision of comprehensive evidence-based post-abortion care could be given. It should cover ethics, reproductive health rights, non-directive counselling and education strategies to teach family planning.
- A standard protocol for the management of post-abortion care should be written by senior obstetricians and midwives and used in all health facilities.
- Women need to be offered a choice of modern methods of contraception on discharge from a health facility after any type of pregnancy and not be expected to return at a later date.
- Men should be included in supporting their wife's health if this is appropriate and with consent of the woman.
- **Advocacy on Women's Rights and Law:** Experience from the international arena suggests that criminalising induced abortion makes it unsafe it is advisable from a public health approach, not to criminalise the termination of pregnancy but regulate it. Law- making should be guided by principles of public health, CEDAW, and the actions suggested by the International Conference on Population and Development taking into account cultural sensitiveness.
- The formation of an inter-sectoral group to advocate for reproductive health including Ministry of Health, Ministry of Justice, health professionals, legal professionals, police and civil society groups. Parliamentarians may wish to seek out Population and Development programmes in other countries.
- **Access to Information:** Women (and men) have a right to clear and correct reproductive health information and women reported they needed more information. A confidential pregnancy advisory service to provide evidence-based public health information on all pregnancy options such as adoption, foster care, antenatal care and safe/unsafe abortion could be established by non-government or government organisations.

Appendix A Research Methods

Literature Search Strategy

This literature search was conducted using the following approaches. The search was conducted through several search engines. Technical references were accessed from specialised websites such as the World Health Organization, IPPF, UNFPA, UNICEF, UNDP, World Bank, Population Reference Bureau and Guttmacher Institute.

Websites for reproductive health information

<http://www.prb.org/Home.aspx>

http://www.guttmacher.org/pubs/fb_0599.html

http://www.reproductiverights.org/pub_fac_abortion_laws.html

http://www.ipas.org/About_Us.aspx

<http://www.unfpa.org/mothers/obstetric.htm>

http://www.who.int/reproductive-health/unsafe_abortion/

<http://www.hesperian.org/>

Box 7 Reproductive Health Websites

A further search was carried out to find country reports on population policy and programs using www.google.com. This searched for further grey literature published by non-governmental organisations or international agencies regarding family planning programs. Due to the difficulties of obtaining literature on Timor-Leste from the databases, we collected literature directly from the relevant organisations. The National Library of Australia's bibliography of works on Timor-Leste was also used. The literature review was confined to the areas of medicine, public health, tropical health, law, anthropology and social issues.

Interviews

Activists, government officials, health staff, villagers, nuns, priest and lawyers and judges were interviewed. Fifteen informants from the general community and government and non-government sector gave information, thirteen nuns and priests, as well as three traditional midwives. In addition, the following groups of people were interviewed:

- ***Interviews with lawyers, prosecutors and judges (13)***

Thirteen legal professionals told the research team their age, religion, nationality, country where they were trained and areas of expertise. They were asked if they were aware of cases of manslaughter or murder charges related to unwanted pregnancies, they were asked to explain their knowledge and experiences of working with the Indonesian Penal Code, cases of criminal abortion, infanticide, cases of sexual assault where a pregnancy was the outcome, or any case involving domestic violence where pregnancy loss was the outcome.

- ***Interviews with obstetricians, doctors, midwives and nurses in health facilities (21)***

Twenty-one doctors and midwives from four health facilities in two large urban areas who provide post-abortion care were purposively recruited. Clinicians were assured of confidentiality and the de-identification of their contribution. Some clinicians spoke English and others requested a Tetun translator. The interview schedule covered a range of issues such as clinical experience and practice, as well as knowledge and beliefs in

caring and treating women with post-abortion complications. Clinicians were asked to recall specific cases, talk about diagnostics, treatment procedures, understanding and interpretation of the law, personal values regarding the provision of elective abortion and family planning. Questions were worded slightly differently depending on the role and seniority of the clinician and they lasted for about one hour. Interviews were conducted in the health facilities and handwritten notes were taken. No clinician was tape-recorded. The notes were then typed up and some clinicians asked to read their responses (but most did not). The transcripts were thematically analysed.

- ***Interviews with women with any type of early pregnancy loss (21)***

All female patients between 15 to 45 years of age who were admitted to the health facility for any type of abortion/pregnancy loss (before foetal viability) or who had pelvic trauma indicative of unsafe abortion were eligible for interview. This included spontaneous abortion, threatened abortion, missed abortion, incomplete abortion, septic abortion, complete abortion as well as any bowel injuries, genital trauma, uterine perforations that were assumed to be caused by unsafe abortion practices.

Twenty-one women gave details of their ethnicity, religion, age, marital status, years of schooling, location of home. They were also asked about their economic status and work conditions; reproductive health and health history; experience in hospital and pregnancy loss experience; fertility regulation; methods of fertility management; and relationship issues. Women's names were not recorded and only handwritten notes taken during interviews.

Focus groups and vignettes

Thirty-six men and women responded to vignettes about unwanted pregnancy and abortion. Using stories or vignettes is a way to elicit information about potentially embarrassing or sensitive topics (Whittaker 2002; Mitchell, Halpern et al. 2006). People were not directly asked to speak about unwanted pregnancy and pregnancy loss which are confronting and taboo topics. Instead the research team generated real-life vignettes or stories to which people could choose to respond. These vignettes were used to begin discussions with NGO workers and village people. The questions were varied slightly according to people's educational capacity. Only NGO workers were asked about human rights.

Story 1- Maria and Antonio

Maria is 19 years old and is having her first baby. She is happily married with Antonio. They are in love and they want this baby. As her pregnancy grows she becomes increasingly weak. She is breathless when she has to walk. One day as she is doing the washing her lips go blue and can hardly catch her breath. Antonio quickly takes her to hospital. As she falls unconscious she says she wants to live...

The doctor and midwife tell Antonio that she has a serious heart problem and the pregnancy is too much of a strain on her weak heart. The doctor and midwife tell him that the only thing that will save Maria's life is if they stop the pregnancy.

Questions: What should the doctor do in this situation? What should Antonio do in this situation? What are your thoughts?

Story 2 – Juana

Juana is 30 years old and lives 5 hours from Dili in a remote village. She is married to Domingos who is alcoholic and violent. She has had 12 pregnancies and now has 6 living children. She is very poor and doesn't know how to feed all her children. She worries day and night about this. She does not want any more children as she is very tired. She heard about family planning but Domingos does not agree with this idea. One day she thinks she is pregnant again. She goes to the village midwife and asks for a massage to bring back her menstruation. The village midwife says she can do it and she is very successful at stopping pregnancies. **Questions: Why does Juana go to the midwife? What does the midwife do? What should Juana do in this situation?**

Common understandings of conception

How people understand and conceptualise conception, baby growth and development influence their opinions about termination of pregnancy, so we asked women about their understanding of embryology (or the growth of the baby inside the woman's womb). One focus group was conducted with a group of women in Dili who drew and discussed how they believed and understood conception and embryo development to occur in the first three months of pregnancy.

Health Facility Audits

Four health facilities that offered post-abortion care were audited. Two were large hospitals and two were community health centers. All emergency obstetric care and maternal mortality was assessed in those facilities. Three years of clinical data was analysed. In one hospital medical records were recalled on those women identified as receiving post-abortion care. In one hospital it was not possible to view the records.

Step 1 A retrospective medical record audit

The inclusion criteria were all female patients between 15 to 45 years of age who attended the health facility for an obstetric emergency in the previous 12 months. This data was de-identified and no names were recorded.

Step 2 Maternal Deaths

The criteria were all deaths thought to be due to direct or indirect maternal mortality in the past 5 years that occurred in the health facility. This data was also de-identified.

Step 3 Safe Abortion Indicators

The Safe Abortion Indicators developed by Healy, Otsea and Benson (Healy, Otsea et al. 2006) were used as they are current international standard regarding measuring services for this type of obstetric emergency.

Basic services

- MVA or D&C available during regular out-patient hours < 12 weeks
- MVA or D&C available 24 hours/ 7 days a week out-patient hours < 12 weeks
- Variety of modern contraceptive methods available and provided
- Essential antibiotics 24 hours/ day 7 days a week
- Administer intravenous fluid
- Administer oxytocic

Comprehensive services (all of the above plus...)

- MVA or D&C available 24 hours /7 days a week > 12 weeks
- Administer blood transfusion
- Perform laparotomy

1. Are enough facilities providing post-abortion care?
2. Are post-abortion care services well distributed?
3. What proportion of services for women with obstetric complication is directed towards post-abortion care?
4. How common are serious abortion complications?
5. To what extent are elective abortions being provided (to save women's lives)?
6. Is there use of appropriate technology and evidence based care?
7. Are offered a modern method of contraception prior to discharge from the facility?

Appendix B

New Timorese Penal Code passed by the Council of Ministers in 2009

Article 141 - Interruption of Pregnancy

- 1- Any person who performs abortion through whatever means and without the consent of the pregnant woman shall be sentenced to 2 to 8 years imprisonment.
- 2- Any person who performs abortion through whatever means and with the consent of the pregnant woman shall be sentenced to up to 3 years imprisonment.
- 3- Any pregnant woman who consents to an abortion procedure by any other individual or induces abortion as a result of her own deeds or those of a third party shall be sentenced to up to 3 years imprisonment.
- 4- The provisions on the previous items are not applicable in cases when the interruption of pregnancy is the only means to counter the risk of death or irreversible lesion to the body and physical or psychological health of the mother or the fetus, as long as the procedure is authorized and monitored by a medical team and performed by a doctor or health professional in a public health institution with the consent of the pregnant woman and/or her life partner.
- 5- The provisions of item 4 of this article will be the object of a separate regulation. [Official translation sent on 22 March 2009 by Alola Foundation]

Draft Penal Code – version late October 2008 – Articles 144 and 145

The Portuguese lawyer (Ms. P Pais) on our research team translated articles 144 and 145.

Article 144° Termination of pregnancy

- 1 – A person who by any means and without the consent of the pregnant woman makes her abort is punished by 2 to 8 years imprisonment.
- 2 – A person who by any means and with the consent of the pregnant woman makes her abort is punished by a maximum imprisonment of 3 years.
- 3 – The pregnant woman that consents to the abortion performed by a third, or that, by her own action or alien act/other person's act/ unpredictable event, abort, is punished by a maximum imprisonment of 3 years.

Article 145° Termination of pregnancy non-punishable

- 1 – The termination of pregnancy is not punishable if performed by doctor or medical practitioner and with the consent of the pregnant woman, when according to knowledge and medical practices:
 - a) Constitutes the only means to remove risk to the life of the woman or grave and irreversible injury to the body or physical or mental health of the pregnant woman;
 - b) Is necessary to prevent risk to the life of the woman or to prevent grave permanent injury to the body or the physical or mental health of the pregnant woman and performed during the first 12 weeks of pregnancy;

- c) There is safe evidence to predict that the unborn child will suffer from incurable illness or congenital malformation and is performed during the first 24 weeks of pregnancy, proved with ultrasonography, or any other adequate method according with 'leges artis', with exception of infeasible foetus, in which cases interruption of pregnancy can be performed at all time;

2 – The consent is taken:

- a) In document signed by the pregnant woman or on her request and, if possible, with a minimum precedence of 3 days to the date of the procedure; or
- b) If the pregnant woman is under 16 or mentally incapable, by the legal representative, ascending or descending line or by any relatives on the collateral line.
- c)

3 – If the consent according to the previous paragraph is not possible and the termination of pregnancy is urgent the doctor or medical practitioner decides according to his conscience and in face of the situation, in the presence of a witness.

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