# Factors influencing rural Timor-Leste women's utilisation of family planning services

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## Abstract

In Timor-Leste, maternal fertility and mortality rates have been reducing over the past two decades; however, unmet family planning needs remain. Family planning is especially relevant for women with low socio-economic status as they often have unmet family planning needs, which is pertinent for Timor-Leste as its population experiences high rates of poverty and primarily lives rurally. Our qualitative descriptive study explores rural Timorese women's knowledge, attitudes, and family planning practices to determine factors influencing their family planning decision-making. Purposive sampling resulted in twenty-five women from the rural Suai-Covalima district participating in three focus groups.

While rural women preferred family planning, many lacked knowledge about specific methods, including misunderstandings about side effects and impact on fertility. Health literacy is central to improving understanding of family planning. Therefore, enhancing service providers' capacity to provide accurate and up-to-date information and training is necessary to build rural women's

understanding of family planning. The patriarchal nature of the Timorese society strongly influenced women's family planning decisions. Hence, including men in future family planning education is essential. Despite the historical influence of the Catholic Church in Timor-Leste, women in this study did not feel its teachings influenced their family planning decisions. Further research exploring the role of the Church in reproductive decision-making and encompassing broader rural Timorese populations, including men, would increase understanding of family-planning decision-making and its influences.

Key words: Family planning, Timor-Leste, rural women, qualitative descriptive methodology

## Introduction

Since Timor-Leste gained independence in 2002, significant socio-economic progress has occurred. Positively, fertility rates in Timor-Leste have declined from 7.8 children per woman in 2003 to 4.2 children per woman in 2016 (National Statistics Directorate [NSD], 2016). However, a large proportion of the population comprises children and adults of reproductive age (World Health Organization [WHO], 2015). Reproductive health remains a public health issue with unmet family planning needs. Our research aims to contribute to understanding these unmet needs, focusing on rural Timorese women's family planning knowledge, attitudes and practices.

Timor-Leste women, particularly those living rurally, face challenges meeting their reproductive health needs, including preventing pregnancy and controlling the number and time between births (Belton et al., 2009; Wallace et al., 2018). Financial barriers, poor geographic access, lack of knowledge, and a shortage of health workers have contributed to Timor-Leste women not receiving family planning services (Kennedy et al., 2011), along with fear of contraceptive side effects, spousal disapproval (NSD, 2010; Wallace, 2014a) and high rates of spousal violence (Wild, et al., 2019). Further exploration of the broader determinants affecting discrepancies between knowledge and behaviour is needed to help policymakers and service providers enhance family planning services (Barrett et al., 2014). In Timor-Leste, knowledge of contraception has been relatively low (Wallace, 2014a;
2014b). Low literacy levels impede the understanding of health information (Kennedy et al., 2011). Rural Timorese women have had higher fertility rates, and there is an inverse correlation between fertility rate and levels of education and wealth (NSD, 2010). Empowering women concerning making informed decisions about family planning is multifactorial. It can include enhancing access to education and involvement in paid labour (Efendi et al., 2023) and enabling greater control over finances within the home (Htay et al., 2023).

Timor-Leste is a society with strong patriarchal practices. Women have less power and lower status than men (Wigglesworth & dos Santos, 2013, Efendi, et al., 2023), and men dominate public, political, and household decision-making roles (Niner, 2011). Cultural norms in patriarchal societies can include opposition to family planning by husbands (Belton et al., 2009; Wallace, 2014a). Strong patriarchal cultural attitudes often influence parents in rural settings to prioritise education for sons (Niner, 2011). Conservative attitudes contribute to increased maternal and child health risks; women miss school-based reproductive health education and begin childbearing relatively young. Sexuality education is an internationally promoted public health measure; historically, there have been fewer opportunities for implementation in Timor-Leste (Povey & Mercer, 2002; Wayte et al., 2008). While many Southeast Asian countries have developed adolescent sexuality education programmes, Timor Leste strategies have predominately focused on the health sector rather than education (Yaacob et al., 2020). Not only do schools face financial constraints, but often, teachers are inadequately equipped with the skills to teach sexuality education, leading to calls for cultural contextualisation of the sexuality curriculum (Iyer et al., 2014).

Furthermore, there is a lack of recognition of gender-based violence or gender inequality in Timor-Leste (Meiksin et al., 2015). Rural Timorese women often live with their husbands' families and rely on extended family, isolating them from other social support (Wild et al., 2022). Socio-culturally constructed gender discrimination has significant implications for maternal and child health and limits women's social and political participation (Niner, 2016). The Catholic Church (the Church) has a significant presence in Timor-Leste, especially the Church's conservative arm that directs couples away from modern methods of contraception (Richards, 2015). Over 97% of the Timorese population identifies as Catholic (Jacob, 2020).

## Methods

The primary researcher's background as a Timorese midwife with more than ten years of local and international experience sparked interest in this study. Using a qualitative descriptive methodology, the study focused on participants' views and experiences, thus providing an opportunity to amplify rural women's unheard voices. The setting for the study was the Suai district of Timor-Leste in 2017, 178 km from the capital, Dili.

The Auckland University of Technology Ethics Committee (AUTEC 17/40) and the Institute National Health of Timor-Leste provided ethics approval to conduct the study. The primary researcher piloted the interview questions locally. Purposive sampling resulted in the recruitment of women of reproductive age from two community health clinics via recruitment flyers and the support of a local midwife. The women participated in focus groups; a data collection method considered appropriate for understanding community perspectives and potentially more comfortable for those hesitant to be solely

interviewed (Creswell, 2013). Given the sensitivity of the research topic, women who had indicated an interest in participating were invited to a meeting prior to the focus group so they could ask questions, hear more about the study, meet the researcher, and assess for themselves their comfortableness with participating.

Each focus group comprised eight or nine participants, with a total of 25 women participating. The researcher discussed the importance of confidentiality, explained that names or identifying information would not be collected and reminded the women that participation was voluntary. They were free to withdraw at any time. Participants completed a consent form with a signature or inked fingerprint. Focus group discussions took place in the Tetum language and were semi-structured. Questions focused on current understanding and views of natural and modern family planning methods, their perceived benefits and barriers, and any intention for future use. Audio recordings were transcribed verbatim in Tetum and then translated into English by the fluent primary researcher. Notes were taken to augment the analysis of the recorded transcripts. The data was analysed thematically (Braun & Clarke, 2006). The first author initially analysed data and then discussed findings with other researchers, reaching a consensus for all identified themes.

## Results

Participant characteristics are summarised in Table 1. The age of the participants was between 18 and 45 years. Eleven were 18-25 years, seven were between 26-30 years, and seven were 31 years and above. All the women were married, and the majority (n=19) had their first child between the ages of 18 and 22. Eleven women had between five and seven children, ten women had between two and four, and the remaining four had one child each. The majority were Catholic (n=20), with five from other Christian denominations. Thirteen women had been formally schooled, with the remaining twelve having no formal education. None of the women worked for wages. All were dependent on their husbands' income.

**Table 1. Participant demographics**

| Focus group | No. of participants | Age range | Relationship status | Range of level of education | No. of pregnancy | No. of living children |
|---|---|---|---|---|---|---|
| Group 1 | 8 | 18 - 41 | All Married | Elementary - High School | 1 - 6 | 1 - 6 |
| Group 2 | 8 | 20 - 40 | All Married | Unschooled – High School | 1 - 6 | 1 - 6 |
| Group 3 | 9 | 18 - 38 | All Married | Unschooled – High School | 1 - 7 | 1 - 5 |

Our analysis identified two themes relating to influences on family planning service utilisation: gaps in knowledge and access, and the socio-cultural context.

***Gaps in knowledge and access to family planning services***

The participants' understanding of family planning was that its role was to space children effectively and, as a result, to enhance their own and their children's health.

> "We want to utilise family planning because it helps to prevent pregnancy, gives better health to the mother…. and it gives time for our children to grow a bit bigger and be healthy too." (P19)

The women also had practical knowledge from their experiences.

> "It is better to wait at least until the child has grown a bit older, particularly during the harvesting period; otherwise, it will be difficult for those of us who are needed to work in the rice field or gardening." (P25)

While the women understood the benefits of family planning, they had limited knowledge of specific types of modern methods of contraception, with most preferring injectable and oral forms. They had less knowledge of intrauterine devices (IUDs) or implants, with many unable to identify these by name. A lack of knowledge created a sense of fear or misunderstanding:

> "We are afraid, particularly when it is something inserted into our body." (P22)

> "Some people said to me that the insertion method, particularly the one inserted into the arm, is not effective as it does not enable us to do any work or lift heavy weights." (P27)

The majority of participants had little knowledge of natural family planning, with some considering it did not meet their needs. In particular, a number of the women noted that natural family planning required a high level of mutual understanding from both wife and husband. At times, it was not easy to compromise with their husbands during a fertile period with the consequences endured by the woman.

> "Natural family planning does really need a good mutual understanding, particularly from a husband. If not, it will be difficult for a woman to control the pregnancy because we need to fulfil our husband's sexual desires. In general, men often do not care if their wives are in a fertile period." (P24)

Access to health professionals was a key factor influencing the utilisation of family planning. The women reported finding it easy to approach midwives with family planning issues.

> "They do give good assistance. Whatever seems not right with us they would immediately advise us. Conversely, when things seem not right with us, we will immediately let them know." (P11)

However, despite this accessibility, some women felt their knowledge remained poor.

***Socio-cultural context***

The majority of participants considered it very important to discuss family planning with their partners. However, some husbands remained suspicious. Some participants spoke of men in their village being reluctant to learn about family planning, leading women to face difficulties explaining and convincing their husbands of the advantages.

> "Some men think when we use family planning, it is enabling us to cheat on them, that's why they refused their wife to use a contraceptive method." (P14)

Although challenges existed, women always looked for ways to discuss family planning. As it was a significant issue, avoiding misunderstandings and miscommunications was important.

> "We want to participate in family planning. So, we need to plan with our husband. If they refuse, we would have to remain patient and follow them. But as a woman, I really want to use it because I am concerned about my health and want to have a longer space. Because of the fear of our husband's disapproval, some women are often hesitant to use contraceptive methods. In the end, women bear the consequences of getting pregnant again." (P11).

Men were likely to dominate decision-making, creating conflict between husband and wife.

> "Men always make sure and insist their wife should not utilise family planning because they don't like their wife to use it. That's why still many women in my village haven't used family planning method, even though they had borne many children and in closer spacing." (P11)

However, husbands had some concerns regarding the side effects of modern family planning methods and possible impacts on the health of their wives. "Sometimes, my husband worries. He would think I can get sick after getting the contraceptive method. This is one of the reasons men often do not agree for their wife to use contraceptive methods." (P34)

Although there were challenges for women to change men's negative views towards family planning, some women considered it vital to feel confident to discuss its importance with their partner.

> "I think, as women, we should have the courage to talk to our men as we are the ones who give birth. Therefore, we should strongly speak to them that we need to participate in family planning and explain to men that when we use family planning

> methods, it is not to cause any harm or cheat on them, but it is for the benefit of our overall health to remain healthy and fit." (P11)

Furthermore, sometimes parents and in-laws were unsupportive of their family planning decisions.

> "My parents and in-laws always used to convince my husband and me not to use contraceptive methods because they believed modern family planning methods would stop me from conceiving and having another child." (P11)

Most participants considered the views of their parents and in-laws reflected common myths that still strongly influence Timor-Leste society. These myths centre on the belief that modern family planning methods may negatively impact women's future reproductive health, preventing them from conceiving or having a child. Most women stated that, even if parents disagreed with their decisions, this would not ultimately impact their use of family planning. Women considered that such choices were supposed to be for couples to make, not their parents.

While most of the participants were Catholic, participants from all three focus groups did not think the Church had influenced their decisions to utilise family planning. The women stated that it is up to each couple to decide whether to use modern or natural family planning methods, not the Church.

> "None of the Catholic Church here in Suai district had ever directly influenced us not to use the modern family planning methods. It was our rights and decisions to decide whether to use it or not." (P26).

## Discussion

In this study, low health literacy was an issue for women, with knowledge gaps about family planning methods and service access. This finding aligns with Cleland et al. (2006), who found low levels of education equated to a lack of family planning knowledge and Kennedy et al. (2011), who found that literacy levels in Timor-Leste remained considerably lower than in other developing Asian countries. More recently, it has been found that employment and the use of family planning were significantly correlated (Efendi, et.al., 2023). Given the low educational levels of women in the study with no one employed outside the home, poor health literacy is likely to have impacted perceptions of family planning, especially when misinterpretation of side effects was evident. Wallace (2014a) advises that information and education can positively shape women's perceptions and beliefs, which is critical to the equal functioning of women in society. Providing women and their partners with clear, culturally

contextualised family planning information tailored to their plans and needs may help better inform family planning decisions.

Some women in our study expressed negative experiences that they believed were caused by the contraceptives they used. Access to and a positive relationship with health service providers, especially midwives, is vital for women. Such connections help ensure reliable information, and timely assistance can inform decisions to begin or discontinue family planning. As Jay et al. (2017) suggest in their Fijian study, adequate information, counselling, and further assessment can be integrated within antenatal services, positively impacting women's attitudes and health practices. Women in our study stated that services and sources of family planning were more accessible because they were provided free of charge. Both governmental and non-governmental facilities were the leading sources of family planning services (NSD, 2016). Offering free family planning services encourages more women to utilise the services effectively.

The effects of Timorese patriarchal society and family influences were prominent in this study. In the traditional Timorese patriarchy, the man is considered the head of the family and responsible for household decisions. Shared decisions between husband and wife were viewed positively yet were not the norm among the women in our study. Most women would not use contraception without their husband's approval yet expressed a wish for the right to reproductive self-determination. By contrast, there are societal expectations that women will obey and respect their husbands and care for the children and the household routines (Niner, 2011; Wallace, 2014). These findings are similar to other Timorese-based studies (Wallace et al., 2018) along with research from India (Pegu et al., 2017), Tanzania (Schuler, Rottach, & Mukiri, 2011) and Bangladesh (Islam, 2014). Rural Timorese women reported that men could be suspicious and mistrusting women using contraception, creating a barrier to utilisation. Having men participate in family planning education would benefit men's awareness and knowledge and enhance communication between couples. Active participation may also decrease men's negative attitudes and perceptions of their wives' family planning use (Adelekan et al., 2014). The negative perceptions of men are part of existing socio-culturally constructed gender issues that need consideration.

The Church's position on modern family planning has challenged the implementation of contraceptive programmes in Timor-Leste (Belton et al., 2009; Richards, 2015; Wallace, 2014a; Wayte et al., 2008). However, the perspectives of women in this study are unique. Despite the assumption of religious dominance, women in the study used modern family planning methods, and they did not feel that the Church influenced their decisions. Although access to natural family planning was an option, women in this study lacked confidence and mistrusted it. Many reported that natural methods were ineffective, inconvenient, or unreliable to practice with their

partners. These women did not see religion as providing the most valuable perspective on women's roles and rights in family planning. More recent research suggests that religious leaders "sometimes" influence fertility preferences (Samad et al., 2022, p.240). It may, therefore, be that the influence of the Church is changing, or the influence of the Church may depend on the individual's degree of religiosity and traditionalism. Women were recruited from local health clinics and used modern contraceptive methods. Since they were all engaged with health services, it might be the case that the influence of religion or tradition may differ for women not accessing modern health services.

It is also possible to underestimate the impact of entrenched socio-cultural values on attitudes and practice. Therefore, family planning service providers need to understand better how religion could affect women's family planning decisions. Having strategies to involve Church leaders in family planning programmes could be beneficial to reduce negative interpretations and barriers to uptake (Richards, 2010). Furthermore, more natural family planning information and instructions could provide greater options for how and when couples could utilise these methods. Further research exploring the role of the Church in reproductive decision-making in Timor-Leste is warranted.

**Recommendations**

There is a continuing need to strengthen Timorese women's literacy skills and knowledge, helping empower women to develop socially and economically and embrace more independent and shared decision-making. However, both men and women need reproductive health education. Men play a dominant role in current family planning decisions but are not necessarily well-informed. Future family planning decisions need to be couple-oriented. Information, resources, and services must be more accessible to enhance family planning decisions. Family planning, both natural and modern, needs to be widely understood at the community level. It is perhaps aspirational that in the future, there could be a more open discussion or acknowledgement from the Church of the impact of both natural and modern family planning, strengthening its support in promoting a healthy family. Training family planning providers to keep abreast of new information is essential, thus helping to alleviate misconceptions and misinterpretations within rural communities. Potentially, training that also considers privacy, confidentiality and sensitivity of family planning may help encourage more couples to access and utilise family planning services. A limitation of this research is that we only studied one rural district. It may be that women from different rural Timorese locations have different perspectives and experiences. In addition, we only learned about men's family planning attitudes and practices from their wives. Further research encompassing broader rural populations would increase understanding of the factors influencing family planning decisions in

rural Timor-Leste. Including men will help understand their perspectives and perceptions of family planning, informing effective interventions.

## Conclusion

While rural Timorese women understand the role of family planning, their knowledge of a wide range of natural and modern family planning methods is more limited. Fear of side effects may not be well informed. Disapproval by family members, particularly husbands and in-laws, was a common factor affecting utilisation. While women in this study may not have perceived the Church's role and teachings as a barrier or influential factor, more generally, there is a need for community and Church leaders to be open to discussing family planning. Empowering rural Timorese families to be better informed may enhance confidence in recognising their reproductive health needs. Involving men to enable shared decision-making may help couples reach their family planning goals while improving maternal and child health.

## References


Adelekan, A., Omoregie, P., & Edoni, E. (2014). Male involvement in family planning: challenges and way forward. *International Journal of Population Research*, 2014, 1-9. https://doi.org/10.1155/2014/416457

Barrett, J. B., DaVanzo, J., Ellison, C. G., & Grammich, C. (2014). Religion and attitudes toward family planning issues among US adults. *Review of Religious Research*, 56(2), 161-188. https://doi.org/10.1007/s13644-013-0136-z

Belton, S., Whittaker, A. M., & Barclay, L. (2009). *Maternal mortality, unplanned pregnancy, and unsafe abortion in Timor-Leste: A situational analysis*. Alola and UNFPA. Retrieved from file:///E:/unfpa_east_timor_maternalmortality%20(2).pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Cleland, J., Bernstein, S., Ezeh, A., Faundes, A., Glasier, A., & Innis, J. (2006). Family planning: The unfinished agenda. *The Lancet*, 368(9549), 18101827. https://doi.org/10.1016/S0140-6736(06)69480-4

Creswell, J. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage.

Efendi, F., Sebayang, S. K., Astutik, E., Reisenhofer, S., & McKenna, L. (2023). Women's empowerment and contraceptive use: Recent evidence from ASEAN countries. *PloS One,* 18(6), e0287442.

Htay, Z. W., Kiriya, J., Sakamoto, J. L., & Jimba, M. (2023). Association Between Women's Empowerment and Unmet Family Planning Needs in Low-and Middle-Income Countries in Southeast Asia: A Cross-Sectional Study. *Women's Reproductive Health,* 1-16.

Islam, M. S. (2014). Determinants of contraceptive method choice in Bangladesh: Male perspectives. *South East Asia Journal of Public Health*, 3(1), 50-56. https://doi.org/10.3329/seajph.v3i1.17711

Iyer, P., Clarke, D., & Aggleton, P. (2014). Barriers to HIV and sexuality education in Asia. *Health Education,* 114(2), 118-132.

Jacob, F. (2020). Timor-Leste. In K. R. Ross, F. D. Alfarez, & T. M. Johnson (Eds.), *Christianity in East and Southeast Asia* (pp. 254-268). Edinburgh University Press.

Jay, L., Masoud, M., Sabiha, K., & Avelina, R. (2017). Knowledge, source of knowledge, and perceived barriers of family planning among women attending reproductive health clinics in Suva, 2017. *Open Access Journal of Gynecology*, 2(2), 1-5.

Kennedy, E., Gray, N., Azzopardi, P., & Creati, M. (2011). Adolescent fertility and family planning in East Asia and the Pacific: A review of DHS reports. *Reproductive Health*, 8(1), 11. https://doi.org/10.1186/17424755-811

Meiksin, R., Meekers, D., Thompson, S., Hagopian, A., & Mercer, M. A. (2015). Domestic violence, marital control, and family planning, maternal, and birth outcomes in Timor-Leste. *Maternal and Child Health Journal*, 19(6), 1338-1347. https://doi.org/10.1007/s10995-014-1638-1

National Statistics Directorate [NSD], (2010). Timor-Leste demographic and health survey (TLDHS). ICF Macro. Retrieved from https://dhsprogram.com/pubs/pdf/FR235/FR235.pdf

National Statisitcs Directorate [NSD], (2016). Timor-Leste demographic health survey (TLDHS), 2016. Key Indicators Report. ICF: General Directorate of Statistics GDS. Retrieved from https://dhsprogram.com/pubs/pdf/PR83/PR83.pdf

Niner, S. (2011). Hakat klot, narrow steps: Negotiating gender in post-conflict Timor-Leste. *International Feminist Journal of Politics*, 13(3), 413-435. https://doi.org/10.1080/14616742.2011.587371

Niner, S. (2016). Effects and affects: Women in the post-conflict moment in Timor-Leste: An application of V. Spike Peterson's 'gendering insecurities, informalization and war economies'. In *The Palgrave handbook of gender and development* (pp. 495-512). Springer.

Pegu, B., Gaur, B., P. S, Sharma, N., & A, S. S. (2017). Knowledge, attitude, and practices of contraception among married women. *International Journal of Reproduction, Contraception, Obstetrics and Gynecology*, 3(2), 385-388.

Povey, G., & Mercer, M. A. (2002). East Timor in transition: Health and health care. *International Journal of Health Services*, 32(3), 607-623. https://doi.org/10.2190/MAYX-00LX-D01V-RJDF

Richards, E. (2010). *The Catholic Church and the struggle for reproductive rights in post-independence Timor-Leste* (Unpublished PhD thesis). University of Leeds.

Richards, E. (2015). The Catholic Church and reproductive health and rights in Timor-Leste: Contestation, negotiation and cooperation. *Culture, Health & Sexuality*, 17(3), 343-358. https://doi.org/10.1080/13691058.2014.966255

Samad, N., Das, P., Dilshad, S., Al Banna, H., Rabbani, G., Sodunke, T. E., Hardcastle, T. C., Haq, A., Afroz, K. A., & Ahmad, R. (2022). Women's empowerment and fertility preferences of married women: analysis of demographic and health survey'2016 in Timor-Leste. *AIMS Public Health*, 9(2), 237.

Schuler, S. R., Rottach, E., & Mukiri, P. (2011). Gender norms and family planning decision-making in Tanzania: A qualitative study. *Journal of Public Health in Africa*, 2(2), e25. https://doi.org/ 10.4081/jphia.2011.e25

Wallace, H. J. (2014a). *Understanding family planning and contraceptive choices in Timor-Leste-an exploration of perceptions, misconceptions and realities*. Charles Darwin University.

Wallace, H. J. (2014b). *Perception of family planning in Viqueque & Dili (Timor Leste). Final report.* A collaborative qualitative research project between Marie Stopes International Timor-Leste and Menzies Schools of Health

Research, Darwin, Australia. Retrieved from https://mariestopes.tl/media/2024/eng-perceptions-of-familyplanning-in-viqueque-and-dili-timor-leste.pdf

Wayte, K., Zwi, A. B., Belton, S., Martins, J., Martins, N., Whelan, A., & Kelly, P. M. (2008). Conflict and development: Challenges in responding to sexual and reproductive health needs in Timor-Leste. *Reproductive Health Matters*, 16(31), 83-92. https://doi.org/10.1016/S09688080(08)31355-X

Wigglesworth, A., & dos Santos, A. B. (2013). Customary values and global influences in youth attitudes to gender and violence in Timor-Leste. http://www.tlstudies.org/pdfs/TLSA%20Conf%202015/online%20papers/onlinepaper01.pdf

Wild, K. J., Gomes, L., Fernandes, A., de Araujo, G., Madeira, I., da Conceicao Matos, L., McDonald, S., & Taft, A. (2019). Responding to violence against women: A qualitative study with midwives in Timor-Leste. *Women and Birth*, 32(4), e459-e466.

Wild, K., Young, F., de Araujo, G., Fernandes, A., Gomes, L., Kelly, L., & Taft, A. (2022). Healthcare responses to gender-based violence in Timor-Leste: women want empathy, information and safety from an integrated support system. *Journal of Interpersonal Violence,* 37(23-24).

World Health Organization [WHO] (2015). *World Health Statistics 2015*. Geneva Switzerland: World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/170250/9789240694439_eng.pdf;jsessionid=7A2B246DE6715C20876CBF3060B7D8E4?sequence=1

Yaacob, N. A., Abdul Rahim, A. F., Najid, N. A., Mohd Noor, R., & Zulkifli, N. (2020). Sex Education for Children: A Betterment Pathway for ASEAN Member States. Charting a Sustainable Future of ASEAN in Business and Social Sciences: Proceedings of the 3rd *International Conference on the Future of ASEAN* (ICoFA) 2019—Volume 1.