



The Indonesian national family planning program, Keluarga Berencana Nasional (KB), is consistently alleged to have violated internationally recognised standards for family planning and reproductive health care. In East Timor, where the KB program is set in a context of wide-scale repression and fear, there are concerns that the program has resulted in serious violations of women's human rights.

This report carefully investigates long-standing allegations that the Indonesian government has used both the KB program and the government health system to covertly sterilize East Timorese women. It also examines allegations that the KB program administers injectable contraceptives covertly and employs coercive recruitment practices.

Based on on-site fact-finding, witness interviews, and official government statistics, the report finds that the design and implementation of the KB program in East Timor have resulted in violations of fundamental human rights such as the right to bodily integrity, the right non-discrimination, and the right to freedom from violence. The abuses are magnified by the fact that they take place in an atmosphere of fear and intimidation, not only creating problems for East Timorese women and children, but also affecting the delivery of health services across the region.



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From One Day to Another: Violations of Women's Reproductive and Sexual Rights in East Timor

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East Timor Human Rights Centre

**From One Day to Another:
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INTRODUCTION

Indonesia has occupied the territory of East Timor for more than twenty years. Since Indonesian troops invaded in 1975, the Indonesian government has successfully sought social and cultural control over the half-island. It has done so through stern oppression and iron military rule. Men, women, and children have all been the subjects of human rights violations since the Indonesian invasion. Allegations of human rights abuses against women, although well known, have been relatively difficult to document. Reports have included persistent accounts of rape, sexual abuse, and torture, as well as violations of the right to life, security of person, and women's reproductive rights.¹

This report focuses on women's reproductive and sexual rights in contemporary East Timor. It does so by specifically examining allegations that human rights abuses are systematically perpetrated through the implementation of the Indonesian national population control program, *Program Keluarga Berencana*, (the 'KB' program).² The report also examines a variety of other issues associated with women's reproductive and sexual rights in East Timor.

Aims

There are long-standing reports of human rights abuses in East Timor committed during the implementation of the KB program.³ These are made against a background of continuing severe human rights violations in the region. Reports include allegations of forced sterilisation of East Timorese women, coercive recruitment practices, and of the widespread use of injectable hormonal contraceptives to deliberately limit the reproductive ability of the indigenous East Timorese population.⁴ If correct, this final allegation would constitute a breach of Article II (d) of the Convention on the Prevention and Punishment of the Crime of Genocide, which prohibits the deliberate limitation of births within a particular national, ethnic, racial or religious group.⁵

These allegations of abuses in East Timor have generally been made independently of those directed against the KB program in other areas of Indonesia.⁶ Restrictions on the activity of non-governmental organisations (NGOs) in East Timor have meant that those reports concerned with human rights in the Indonesian KB program as a whole have had little access to information concerning the situation in East Timor. This report therefore serves two purposes. The first is to investigate the allegations of human rights abuses that have accompanied the KB program in East Timor. The

articulated its commitment to the concept of economic and social rights. Indeed, the Indonesian government has long argued that its presence in East Timor is justified by the benefits of Indonesian development activities in the area. Thus, failure to accord with the spirit of the ICESCR would significantly undermine the credibility of such arguments.

In contrast to its position on other international human rights issues, Indonesia has recognised its responsibility to enhance and protect the human rights of women by ratifying CEDAW. This was subsequently incorporated into the domestic legal system as law number 7/1984. Indonesia played a prominent role in preparations for the 1995 Beijing Conference on Women, hosting the Second Asian and Pacific Ministerial Conference on Women in 1994. At this conference the government restated its commitment to women's rights in ministerial speeches, and also signed the Jakarta Declaration - publicly affirming that women's human rights are "inalienable, integral, and indivisible parts of universal human rights",¹⁷ and that it regarded the implementation of CEDAW as "crucial". The Indonesian government has also accepted international human rights norms and duties in relation to children by ratifying the Convention on the Rights of the Child.

Overview of Findings

Set in a context of wide-scale repression and fear, the KB program in East Timor consistently violates internationally recognised standards of family planning and reproductive health care as set out in Chapter 7 of the Beijing Declaration. The design and implementation of the KB program in East Timor have caused serious violations of women's human rights under both international and Indonesian domestic law.

Although complaints of human rights violations have been made against the KB program in other parts of Indonesia, those in East Timor differ in both nature and effect. These include breaches of such fundamental human rights as the right of security of person; the right to freedom from torture and cruel, inhuman and degrading treatment; the right to marry and found a family; and the right to life. The coercion and violence associated with the KB program constitutes physical and psychological violence against women. Because these abuses are suffered exclusively by women, the actions of the Indonesian government also violate the fundamental right to freedom from discrimination, which is enshrined in the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Social and Economic Rights (ICESCR), and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).

Specific violations include:

- Strong evidence of the covert, forcible injection of young women with hormonal contraceptives during 1987-1989. Such actions violate the fundamental rights to bodily integrity, security of person, and freedom from cruel, inhuman and degrading treatment contained in Articles 7 and 9 of the ICCPR, and Article 19 on the Convention on the Rights of the Child.
- Denial of treatment in life-threatening circumstances. This is a breach of the right to life enshrined in Article 6 of the ICCPR, and of Articles 6 and 24 of the Convention on the Rights of the Child. It is also a breach of Article 12 of CEDAW, which explicitly obliges states to provide women with appropriate services in connection with pregnancy.
- Ongoing breaches of the principle of informed user consent in KB recruitment and service practices, a breach of Articles 14 and 16 of CEDAW, as well as the right to marry and found a family contained in Article 23 of the ICCPR.
- Failure to provide KB users with basic follow-up care, violating the international family planning standards set out in Chapter 7 of the Report of the International Conference on Population and Development, and contained in Indonesian domestic law 10/1992.
- Continuing military involvement in both recruitment and service provision, contributing a strong element of structural coercion to the KB program and violating norms on user consent enshrined in CEDAW and Chapter 7 of the ICPD.
- A disturbingly high reliance on injectable contraceptives, which at 62% of all continuing family planning users is double that of the next nearest province, Irian Jaya. This pattern suggests that KB users in East Timor have highly restricted choice of contraceptive methods. It also raises larger questions regarding the likelihood of covert contraceptive usage, as well as the effects of such injectable hormonal contraceptives on women's health in East Timor.

These and other abuses have contributed to a strong belief on behalf of the local population that the KB program is used by the Indonesian government as a politically-motivated instrument to deliberately undermine the survival of the East Timorese as a national group, an activity expressly forbidden by Article II (d) of the Genocide Convention. Although there is insufficient evidence to judge that the KB program has been used with such intentions, widespread abuse of women's reproductive rights, poor communication, and insensitive administration - set against a background of intense political oppression - have undoubtedly contributed to this perception. The scale and severity of women's health problems in East Timor also indicate that the current

prevalence of injectable contraceptives has strongly negative health consequences for users.

Fear of the KB program has severely undermined the efficacy of the government health system in East Timor. According to statistics in the UN *World Population Report* (1996), the death rate in East Timor is double that in Indonesia and the worst in South-East Asia.¹⁸ Infant mortality in East Timor outstrips even that of Rwanda and Iraq.¹⁹ Yet women are unwilling to turn to the government health system for fear of covert injection or sterilisation, nor do they trust public health initiatives that rely on injections and tablets. These fears are compounded by linguistic difficulties and the attitudes of health care providers. High levels of distrust have created a situation in which the practical efficacy of a large part of the health system is open to doubt. Government indifference to this situation gives rise to serious questions regarding its commitment to fulfilling even the minimum content of the right to health in East Timor, a right enshrined in Article 12 of the International Covenant on Economic and Social Rights. Fear of covert injections through the medium of school vaccination programs has also had negative impact upon women's access to schooling. Other violations of women's human rights in East Timor include rape, forced marriage, and sexual servitude.

Given that the violations discussed in this report and their repercussions are suffered almost exclusively by women, this report concludes that they constitute discrimination against women as defined by Article 1 of CEDAW. Indonesia is a party to CEDAW, and has signed the Declaration on the Elimination of All Forms of Violence Against Women as well as the Convention on the Rights of the Child. It has incorporated international standards on reproductive issues and women's rights into domestic laws 7/1984 and 10/1992. These gestures towards international legitimacy will remain meaningless until the Indonesian Government ceases to tolerate the widespread violations of women's human rights in East Timor.

PART 1: CONTEXT

The history of East Timor is well-known. Since the Indonesian invasion of 1975, there have been gross violations of fundamental human rights throughout the half-island.²⁰ Although the scale of armed conflict has subsided in recent years, the inhabitants of East Timor continue to exist under conditions of intense repression and fear.²¹ In 1996, Amnesty International stated that it continued to receive reports of "disappearances", extra-judicial executions, arbitrary detention and of torture and ill-treatment²² in East Timor, while the UN Special Rapporteur on Extra-judicial, Summary or Arbitrary Executions noted that he remained "deeply concerned" about the level of ongoing unrest and violence in the area.²³ The level of tension is believed to have increased markedly since the award of the Nobel Peace Prize to Jose Ramos-Horta and Bishop Carlos Ximenes Belo in 1996.

Social Context

East Timor differs substantially from other parts of Indonesia in a variety of ways. It is the poorest of Indonesia's provinces, with substantially lower income and a higher percentage of families below the government poverty line than any other region.²⁴ Extreme poverty is common despite high relative levels of development spending by Jakarta, and illiteracy and education levels are by far the worst in Indonesia. The situation is generally worse than even other provinces in eastern Indonesia, which are generally poorer and have poorer social indicators than the rest of the country. Almost two-thirds of adult women in East Timor have never attended any kind of school, nor have half of adult men.²⁵ At 52.7%, illiteracy levels of people over 10 are almost double those of Irian Jaya, the next worst province.²⁶

East Timor is also distinguished by the fact that approximately 92% of the population is Catholic.²⁷ The Catholic Church in East Timor has played a crucial role in supporting the rights and welfare of its followers, and the religious identity of the East Timorese has particular significance in relation to family planning because of the Vatican's official disapproval of most kinds of contraception. Although women's behaviour in deciding to use family planning is not always determined by church policy, religious beliefs in this area are particularly significant for practising Catholics. The right to use contraceptive technology appropriate to one's religious and ethical beliefs is a fundamental element of the Cairo Declaration.²⁸

second is to supplement the information that already exists regarding KB and women's rights in other areas of Indonesia.

Reports of violations of women's sexual and reproductive rights in East Timor can be divided into two phases. The first phase is from 1975 to the mid-1980s, and includes allegations of rape, forced impregnation, killing and mutilation of pregnant women, and covert sterilisation. The second phase stretches from the late 1980s to the present, and consists of numerous allegations of coercive and coerced contraceptive use in the 1980s, as well as allegations of violations of the rights to information, contraceptive choice, and health. Reports of rape and other sexual abuse persist. This report investigates the second of these phases, with an emphasis on identifying and describing current patterns of human rights abuses.

Methodology

The work for this report was carried out in the U.S., Australia, East Timor, and Indonesia from May to September, 1996. Research was divided into three phases. In the first phase, demographic data and other relevant materials were examined to identify trends and provide an appropriate context for fieldwork. In the second phase, individual and group interviews were conducted with East Timorese women from a variety of different age groups, classes, and linguistic backgrounds, as well as with other relevant subjects. The third phase consisted of on-site fact-finding in East Timor and Jakarta. This was necessarily limited by the tight control that the Indonesian government exerts over the territory. The materials gathered, while checked and corroborated, most likely constitute a small proportion of the relevant information and incidents available under more open conditions.

This report recognizes the UN-defined status of East Timor as a dependent territory of Portugal. References to East Timor as a province administratively controlled by the Republic of Indonesia should not be taken as indicative of a legal or political opinion on the status of East Timor.

Reproductive and Sexual Rights

Women's reproductive roles have impact upon almost every aspect of women's lives, affecting health, social roles, and life experiences. Reproductive rights have therefore been accorded considerable attention as a "fundamental key entitlement to other human rights."⁷ Beliefs and conditions surrounding women's roles in bearing and raising children are often closely linked to actively discriminatory policies against women,

such as those which bar married women from participating in the labour force, or deny women access to social services if they do not participate in a state-sponsored population control program.

Women's reproductive and sexual rights are defined by a number of conventions and declarations. These include rights to life, liberty, and security of person as enshrined in the International Covenant on Civil and Political Rights (ICCPR),⁸ and also the right to health institutionalised in Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR).⁹ Infringements of women's reproductive rights often result in strongly discriminatory effects; hence, the right to freedom from discrimination is also relevant. Freedom from all forms of discrimination is a cornerstone of international human rights mechanisms, and exists in the ICCPR, ICESCR, and a variety of other binding treaties. The prohibition of all forms of discrimination against women has been reinforced by the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).¹⁰ Article 12 of CEDAW prohibits discrimination in the delivery of health care and binds states parties to provide appropriate services in connection with pregnancy, including free services where necessary. The right to life and state obligations to provide appropriate maternal medical services are reinforced by Articles 6 and 24 of the Convention on the Rights of the Child, as is the obligation to protect children from all forms of physical or mental violence, injury and abuse.¹¹

Women's reproductive rights therefore encompass a variety of rights and treaties. The content and definition of these rights have developed through international discussion,¹² and are represented most clearly in Chapter 7 of the Cairo Declaration of 1994, as well as in the Beijing Declaration of 1995.¹³ Women have the right to exercise free and informed consent in the use of family planning, as well as the right to adequate standards of health care and maternal/reproductive health services. These in turn involve the right to adequate information, the right to choice of methods, the necessity of voluntary consent, and the availability of appropriate follow-up care. Indonesia has incorporated many of these standards into domestic law number 10/1992, "Population Development of Happy and Prosperous Family."¹⁴

Indonesia is not a party to the ICCPR; however, the right to life and freedom from torture are increasingly being recognised as customary norms of international law and therefore binding on all states. Torture and ill-treatment are prohibited under the Indonesian Criminal Code, the Code of Criminal Procedure, and a variety of ministerial regulations.¹⁵ Indonesia signed the Torture Convention in 1985, but has failed to ratify it despite assurances to the UN Human Rights Commissioner to the contrary.¹⁶ Although Indonesia is not a signatory to ICESCR, it has consistently

East Timorese attitudes towards family planning are also affected by the events of recent history. Of a population of roughly 660,000 in 1975, approximately one third is believed to have died as a consequence of the invasion.²⁹ Population loss occurred either directly in fighting, or from starvation, malnutrition, lack of medical care, and other effects. The population is now approximately 857,000, 4.5% of whom are officially counted as transmigrants from other parts of Indonesia.³⁰ Government policy has encouraged population mobility to East Timor both through its military and administrative requirements, but also through its transmigration program. The transmigration program affects a number of Indonesian provinces. In East Timor it is strongly resented by the East Timorese people, who see it as a deliberate undermining of their ethnic identity and right to self-determination. The volume of spontaneous and unsponsored migrants is generally held to be considerably higher than that of the government program and is not well-reflected in official statistics.³¹

Status of Women

Women in East Timor have traditionally borne heavy responsibilities for both household and agricultural labour. Evidence suggests that these responsibilities have become more onerous as a result of the impact of the unrest and dislocation following the invasion.³² Women's familial responsibilities are central to traditional East Timorese kinship and social structures, and while women continue to be responsible for the household, many are also doubling as principle breadwinners for their families as a result of the disruption of war.³³ As in many countries, extended familial ties have been severely strained in coping with changes in family structure brought on by heavy population loss, increasing frequency of widowhood, and large numbers of orphans.

Although women in East Timor have gained access to increased educational and employment opportunities in the last decade, their social indicators remain sharply lower than both East Timorese men and women in other provinces in Indonesia. Both male and female interview subjects spoke of the very low status of East Timorese women. One nineteen year-old refugee commented that "Women are always second. Women are trusted only to have children and to feed them".³⁴ Women in East Timor are by far less likely to be literate or to speak Indonesian than in the rest of Indonesia. Almost two-thirds of women of child-bearing age have no schooling, compared to 39.6% in Irian Jaya and 15.2% in Indonesia overall.³⁵ For those East Timorese women who have attended school, the median duration of attendance is less than a year.³⁶ Only 54.7% are able to speak the Indonesian national language, *Bahasa Indonesia*, compared to a national average of 84.5%.³⁷ Given that the majority of government

activity occurs in Indonesian, these language difficulties have serious consequences in terms of women's access to government structures and services.

Interview subjects universally emphasised a desire for increased access to education, as well as strong concern over the difficulty of supporting their families under current conditions: "Life is harder now the Indonesians have come. It is difficult to find money and life is difficult."³⁸ A wide range of women reported that desperate economic circumstances led young women into prostitution or forced marriage. Many spoke of their fears and experiences of sexual abuse by Indonesian soldiers. Recent refugees, particularly older women, were often reluctant to discuss their own experiences because of strong trauma and associated feelings of shame.

Health

Reliable data on the health system in Indonesia is difficult to obtain. Many of the statistics are compiled from hospital records, which are seriously biased by a number of factors.³⁹ This scenario is complicated still further in East Timor. Hospital attendance rates in East Timor are extremely low, particularly in matters of pregnancy and childbirth. It is also a problem because the sample size for surveys such as the International Health and Demographic Survey is extremely small, meaning that the data collected is less reliable.⁴⁰ One doctor interviewed in East Timor complained that "we do not have any idea of the real death, mortality, and family planning figures at all," while another health worker with substantial experience in the province described the figures as "extremely misleading".⁴¹

Nevertheless, official statistics indicate extremely high levels of malnutrition compared to the rest of Indonesia, along with high relative levels of child mortality and sexually transmitted diseases.⁴² These findings are confirmed by health workers, as are high rates of tuberculosis, malaria, respiratory illness, and poor hygiene. Unofficial evidence suggests extremely high levels of infant and maternal mortality, as well as anaemia and other serious health problems. United Nations statistics indicate that in 1996 East Timor had a death rate of 17 per 1000, double that of Indonesia and the highest in East and South-East Asia. The infant mortality rate was recorded as 149 per 1000, almost three times that of Indonesia and one of the five worst in the world.⁴³

It is also difficult to assess the impact of the government's health program. The Indonesian government has substantially improved the health infrastructure in East Timor, but by Indonesian standards it generally continues to be low. The number of official hospitals and health centres is favourable compared to other provinces, although accessibility and actual staffing levels are less so. Half of all 121 doctors

work in the 10 provincial hospitals, and of 78 community health centres (*puskesmas*), 61 were counted as having available physicians in 1993.⁴⁴ Sixteen of these doctors are East Timorese. The situation is worse, however, for the substantial portion of the health delivery system that relies on volunteer support. The number of volunteers responsible for supporting community health posts (*posyandu*) is the lowest in Indonesia, leading to questions as to how many official community health posts exist in practice.⁴⁵ There is also a strong aversion to using the government health system amongst East Timorese people, who instead prefer to go to Catholic or other private clinics. These clinics are not always as well equipped as government facilities, but enjoy considerably higher levels of satisfaction and trust.

PART 2: THE KB PROGRAM

The Indonesian KB program in East Timor strongly resembles that in place throughout Indonesia. As is the case with much of Indonesia's development administration, program structures and implementation are devised by the central government and replicated throughout the country.⁴⁶ The manner in which these programs are actually implemented, however, usually differs from province to province according to local conditions, culture, and effects.

The Indonesian government has had a strong commitment to population control and family planning since the late 1960s. Fears that Indonesia's large population, and attendant rapid population growth would impede the nation's economic development led the New Order Government to institute a vigorous population program.⁴⁷ This consists of two elements: first, the family planning movement, designed to impede population growth; and second, the transmigration policy, which is intended to reduce population density. This involves the resettlement of citizens from areas with a high population density, such as parts of Java, to those with lower densities, such as Irian Jaya. President Suharto has twice won the UN Population medal in recognition of the success of Indonesia's population-related activities.

The KB Program and Human Rights in Indonesia

Since 1991, there has been consistent criticism of the Indonesian population control program on human rights grounds. There have been allegations of specific incidents of human rights violations perpetrated during program implementation, such as the forcible recruitment of Norplant acceptors.⁴⁸ There is also concern that the program contains a high degree of structural coercion.⁴⁹ Although definitions of coercion differ, this latter charge is widely accepted.⁵⁰ Critics have argued that the KB program consistently violates women's rights to free and informed consent of family planning methods by restricting choice of methods, by exerting great pressure upon women to participate in the program, and by failing to provide necessary information and follow-up care.⁵¹ Practices such as these actively endanger women's health and well-being, as well as violating rights to life, security of person, and health.

Three elements of the KB program have been singled out for particular criticism. The first is that the design and implementation of the KB program depends heavily upon the use of provincial and local targets. Targets represent the number of

contraceptive acceptors to be recruited by provincial governments in a given year, and success in achieving them is one of the means by which government officials are evaluated. The second cause of concern is the alleged involvement of the Indonesian military (ABRI) in recruitment of acceptors, a practice which, at a minimum, increases implied pressure for people to participate in KB. The third element is the use of intense large-scale events to recruit acceptors and deliver contraceptive services. These are most commonly called "safaris". Safaris often utilise ABRI assistance, and are also problematic because of danger they represent to acceptable health standards and informed consent.

Reports of safaris have described the forcible recruitment of KB users by police, and mass insertion of IUDs and other contraceptive mechanisms with neither information as to their effects, nor provisions for removal or follow-up care.⁵² Since 1993, the Indonesian government has moved to reduce official emphasis on the achievement of targets and large-scale recruitment drives, although Indonesian NGOs and family planning organisations criticise these changes as cosmetic.⁵³

The KB Program in East Timor

The KB program was introduced into East Timor in 1980,⁵⁴ considerably later than its introduction in most other provinces. Many of the standard health and demographic indicators from this period are missing, indicating that the program may be been introduced without coherent knowledge of local needs and problems. There are no accessible figures for fertility rates and population growth prior to 1980, nor are there official statistics on population loss. These kinds of information are fundamental in assessing the structures and desirability of family planning and population control programs. Recent data indicates that the projected Total Fertility Rate (TFR) in East Timor is 3.32 births per woman, which places it as similar to, but higher than, the TFR for other eastern provinces.⁵⁵ The population density in East Timor was calculated as 37 people per square kilometre in 1980, rising to 50 per square kilometre in 1990. These are roughly half the Indonesian averages for the same periods.⁵⁶

The promotion and administration of the KB program in East Timor closely resembles that in other provinces. The program is implemented by a variety of government agencies, although the National Family Planning Coordinating Board (BKKBN) has chief responsibility.⁵⁷ BKKBN offices are located in each administrative district, with officials, field workers and volunteers organising motivation and acceptance.⁵⁸ The Department of Health (*Departmen Kesehatan*) plays

a substantial role, and the military (ABRI) is also involved in its "dual function" of assisting the development process.⁵⁹ Family planning services are delivered in a variety of ways, particularly through KB clinics, health centres, and village health posts. Official statistics indicate that there were 92 registered KB clinics in East Timor in 1993, with approximately 144 professional staff and 627 volunteers.⁶⁰

Program Success and Local Attitudes

The success of the KB program in East Timor has been limited. With the exception of 1988/1989, the program has consistently failed to meet the targets set by the central government, even though these targets have been substantially reduced over time.⁶¹ Only 20.7% of currently married women reportedly use any contraception in East Timor, the lowest rate of usage in Indonesia. Given the religious convictions of the population, this is not surprising. It is important to note, however, that contraceptive prevalence in the neighbouring province of Nusa Tenggara Timur, which also has a high proportion of Catholics, is considerably higher at 37.3%.⁶² East Timorese society has traditionally valued extended families and many children, although family structures and roles have suffered great pressures since 1975.

This low rate of contraceptive usage may also be related to the extremely high degree of fear and distrust, which many East Timorese people display towards the program. Most East Timorese associate the KB with an explicit intention to prevent growth in the East Timorese population, identifying it with transmigration policies which bring in migrants from other parts of Indonesia. Many East Timorese resent the emphasis placed on the necessity of limiting births after the huge loss of population since 1975. The fact that the Indonesian government has promoted KB as a means of restraining growth and lessening population density has aggravated this problem: "We have lost so many people, it's not right."⁶³ This sentiment, along with resentment of the transmigration program, is particularly strong. Although individual, primarily middle-class women are willing to use family planning to limit their family size, the majority of East Timorese perceive the program as a politically-inspired means of undermining their continued existence by both covertly and overtly inhibiting their ability to reproduce:

*It's not good because East Timor is being controlled by a bigger country, and we have such a small country. They're trying to control us and silence our nation. It's not a good idea.*⁶⁴

This attitude has also been shared by the church, and priests have warned women to avoid the governmental health system where possible.⁶⁵ "Parents just give traditional medicine, and the ladies never go to hospital any more."⁶⁶ There is also a strong identification of the KB program with unhealthy side effects, in particular, a universal association with changes in body weight. "KB has unhealthy side effects. Some women become very thin. They lose their menstruation."⁶⁷ The fear of side effects is coupled with widespread accounts of birth defects and infant deaths associated with injections administered during pregnancy, as well as reports of ectopic pregnancies and cancer associated with the use of IUDs.⁶⁸

Many interview subjects also complained of the pressures involved in recruitment into the KB program. Often this was because women felt unable to refuse invitations to become acceptors, because of what might happen if they were seen to be reluctant in following a government program: "If you don't participate, your children might be persecuted or harm might somehow come."⁶⁹ Although many women would like to have access to some kind of family planning, there is little effort made by KB officials to offer contraceptive choices appropriate to East Timorese religious beliefs. One woman from Dili in her early 30s summarised the dilemma:

Why are we experiencing this? We are reluctant to go to clinics and talk about family planning because we are Catholic, because we are frightened we will be punished by God. But what is worse is that people are frightened of the Indonesians, and they are frightened of what will happen to their babies if they go to hospital when they have babies.⁷⁰

This unsavoury collision of religious principles and material fear breaches international human rights standards and norms of voluntarism in family planning. It is doubly undesirable because of the barriers it erects against women using the government system for any kind of health care.

Non-Catholic East Timorese share a similar distrust of the KB program. Although they have no religious reasons for their hesitation, many share in the suspicion that the program is politically and medically suspect. As one respected East Timorese official in Dili stated:

KB in the province is a good idea. But in this case, in the implementation, the people involved have their own agendas: religious, political, ethnic. It's the implementation; there's the feeling of suppressing the local population.⁷¹

Program Structure and Factors of Coercion

The KB program in East Timor contains elements of structural coercion similar to those criticized in other parts of Indonesia.⁷² Women routinely mentioned the pressure placed on wives of government employees to participate in the program as an example, with the threat of a reduction in wages for officials whose wives did not participate. Likewise, they also described a system of visits from members of the government-sponsored women's brigade, the Dharma Wanita, in which brigade members would systematically visit women's houses and invite them to attend the community hall to learn about KB. Pressure from authorities and respected figures to participate in family planning is common throughout Indonesia. In East Timor, however, the danger of not being seen to respond to the government invitation may mean that the implicit pressure to attend is considerably higher. As one young woman commented, "you just have to go".⁷³

Practices such as these seriously affect the health and rights of women, particularly the right to free and informed contraceptive choice. At a minimum, they represent systematic pressure from accepted authority figures to become involved in the KB program. This is not in itself coercive, but the pressure experienced by women subjected to these practices varies according to area, social status, and political situation. These kinds of recruitment practices can also become more overtly coercive. One group of women from a variety of eastern villages reported that women who failed to respond to the Dharma Wanita invitation to learn about KB would then receive visits from soldiers to require that they attend.⁷⁴ In this case, they said, women fear that

.... if we do not go, our fathers or brothers will be persecuted. They will call them and interrogate them about their background, opening old stories or making them up.⁷⁵

These reports cannot be confirmed, although the patterns of visits and pressure resemble those contained in complaints in other areas of Indonesia.⁷⁶ ABRI's role in development has led to its active participation in the KB program across many parts of the country. In the East Timorese context, however, where conflict is more overt and tensions considerably higher than much of the rest of Indonesia, ABRI involvement in such activities is more likely to be experienced as coercive.

Military Involvement

The military role and presence in East Timor is so pervasive that it would be unusual if it were not involved in carrying out most government programs. Each level of civilian administration has a corresponding level of military command, and ABRI officers are therefore present at many of the public events associated with family planning, including those organised to attract potential acceptors to the KB program.⁷⁷ Although there is no overt coercion alleged at these public events, their presence contributes to the strong identification between the KB program and Indonesian violence against the East Timorese people.

ABRI's development function affects the KB program in ways other than recruitment. Government documents indicate that at least 7 health clinics in East Timor are militarily operated,⁷⁸ and that some health facilities are located within military barracks. This is the case with Polyklinik 1827 in Dili, which is surrounded on either side by the barracks of Unit 167 on the Jl. Av. Marchal Carmona. Both factors substantially increase the likelihood of actual and perceived coercion. Many women believed that pressure to participate in KB was strong because no one could risk coming to the attention of ABRI, and that the military's involvement effectively prevented their ability to discuss problems that they might be having with any officials. "People don't feel free and they know it's government policy, so they just follow it."⁷⁹

Safaris

The Indonesian government describes safaris as special events designed to motivate women to become KB acceptors, "an intense media and service delivery blitz".⁸⁰ They are large-scale events, often one-day festivals, in which organisers seek to enrol as many people as possible into the KB program. The name and intensity of these events varies across Indonesia. There has, however, been strong criticism of safaris from a variety of human rights groups because of the allegedly intimidatory and coercive practices which they involve.⁸¹ Strong pressure tactics, including military recruitment, are used to sign up eligible women, and the contraceptive methods chosen are often long-lasting or irreversible. Women who are recruited via safaris often receive little or no information on the contraceptive methods they receive, and lack any means of follow-up care.⁸²

The Indonesian government has been sensitive to these criticisms, and the public emphasis upon and organisation of safaris has decreased from 1992. However, during interviews in 1996, family planning organisations and women's groups in Jakarta

emphasised their belief that this change is one of name only, and that the use and problems of safaris continue throughout the country.⁸³

Available information indicates that the KB program in East Timor continues to include the use of large-scale recruitment drives and mass rallies and festivals in order to recruit new acceptors. Government officials and military officers are present. In September 1994, nurses in Suai reported to another health professional their concern that a large-scale push had taken place to recruit women to sign up for tubal ligations, and had included a visit by an Indonesian general to mark the success of the campaign.⁸⁴ The nurses reported that women whose husbands had held official positions in companies or the bureaucracy would find that promotion would not be possible unless their wives participated. The nurses were also very concerned that the drive for acceptors had taken place with little information.

Sources in both Baucau and Dili also confirmed that large-scale events had taken place in 1995 and 1996 with military presence. This is consistent with complaints made concerning safaris in other parts of the country, although it is significant that tubal ligation, a long term and virtually irreversible method, is not commonly promoted at these events elsewhere in contemporary Indonesia.

Targets

The implementation of the KB program throughout Indonesia has relied on a system of local and provincial targets for the number of new and continuing acceptors, achievement of which is reviewed by the central government as an important performance indicator for government officials and departments. Within these targets there are also goals for the number of acceptors who adopt those kinds of contraceptive designated especially effective ("MKET") by the National Family Planning Board.⁸⁵ In Indonesia, MKET methods consist of hormonal implants such as Norplant, intra-uterine devices, and tubal ligation. Their desirability stems from the fact that they are highly effective and long-acting, although they are not easily reversed by the user.

The target system has been an efficient tool for assisting the growth of the KB program, but has been criticized for contributing to the falsification of data, and to serious charges of coercion as officials prioritize achievement of recruitment targets over stated goals of consent, information, and quality of care. These charges have been acknowledged by both donor agencies and the Indonesian government.⁸⁶ According to the World Bank, the desire to recruit acceptors led to "less-than-optimal attention" to quality of services. The Indonesian government officially renounced targets in February 1993,⁸⁷ although it is not clear that this change has been completely adopted.

Although official targets are no longer published, family planning organisations strongly believe that the practice continues to exist at the provincial and local level. For example, an official BKKBN booklet on program implementation published in 1995 continues to speak extensively of targets in the context of recruitment and motivation of KB acceptors.⁸⁸ An official interviewed in Dili confirmed the fact that targets continue in East Timor: "These may not be targets at the national level, but they're at the local level. There are still targets to meet, even now."⁸⁹

Government records suggest that targets may have been a significant factor in the history of KB in East Timor. Targets have abruptly fluctuated throughout the ten years for which there is data (*Appendix, Table 1*). In the early 1980s, targets were set relatively high, with achievement fluctuating between 31-41% of the numerical goal. Targets then dropped considerably, and the rate of achievement improved. Several large fluctuations occurred in data for 1988 and 1989, a period in which there were many rumours of contraceptive abuse. In 1988 targets dropped by half, and the provincial government was therefore able to record a 188% achievement rate. At the same time, the number of couples considered eligible for KB leapt by over 25,000 couples from 85,671 to 111,401.⁹⁰

Although there is no clear explanation for these variations, it is certainly possible that targets were set low in order to increase the appearance of a high achievement rate in reporting. These variations in the late 1980s also occur at the same time as a series of reports of abuse associated with covert use of hormonal injections in 1988-89. These will be discussed in the following section. If targets have led to bureaucratic pressures to recruit for achievement's sake, then the fluctuations in data suggest that such pressures may have resulted in the official manipulation of targets to improve achievement rates and in the covert use of injectable contraceptives on unknowing East Timorese women.

PART 3: SPECIFIC PATTERNS OF ABUSE

Injections

Every woman interviewed in relation to the KB program raised the problem of injections. Long-term hormonal contraceptives are an important part of the KB program, and in Indonesia they consist of Net-En, administered monthly, or DMPA, known as Depo-Provera, administered every 3 months. While the knowledge of older women was mainly anecdotal, younger women all spoke of injections as the primary form of contraceptive technology with which they were familiar; in particular, from Samé, Dili, Baucau, Venilale, and Lospalos.

While some middle-class women reported that they or their relatives were pleased with the injections they received as a part of the KB program in Dili, many others associated them with health problems and abuses. Almost all believed that injections of contraceptives were covertly given to women under the guise of vaccinations, or else during attendance at medical centres for another purpose. Many erroneously believed that these injections could permanently sterilise them, a fact that caused great fear. A variety of people reported that women were most likely to be injected if they or their families were suspected of disloyalty to the Indonesian government.

When the Indonesians know your parents are Fretilin, they give injections to your kids so they die. So parents do not let their children have any more injections.⁹¹

This association may be influenced from events in the early 1980s, when there was at least one case where the baby of a close relative of a Fretilin leader died under mysterious circumstances in hospital.⁹² At least four women believed that injections were also a means of killing those suspected of political disloyalty. This association between suspected disloyalty and harm inflicted through the medical system in East Timor is long-standing. After the Dili Massacre of 1991, for example, there were strong unconfirmed reports that those who survived the massacre in the Santa Cruz cemetery were later killed as troops entered the hospital and beat them and administered poison.⁹³

As well as the covert administration of contraceptives, people also attributed some of the distrust of KB injections to the fact that women were occasionally injected when already pregnant. Official clinical testing of injectable contraceptives has linked them

to a variety of birth defects caused to children exposed *in utero*,⁹⁴ and such exposure more than doubles the risk of neo-natal death. João, 23, had a friend in 1993 whose baby had grave birth defects. When asking the mother what might be the reason, she told him “they gave me the wrong injection and something happened to the child.”⁹⁵ Reports of pregnant women being injected with hormonal contraceptives were associated with reports that Indonesian doctors had covertly given abortifacients to pregnant women.⁹⁶ Other women also pointed that some nurses will give injections for abortion if sufficiently paid.

A number of young women interviewed described consistent accounts of being injected a series of times with unknown substances while in their final years of high school circa 1988-1989. There were also similar accounts from 1978-79. They had attended a variety of different schools, but each described a similar process, in which East Timorese students were separated from Indonesians, boys were either separated from girls or sent home, and the girls given injections for “vaccination”. This happened in Liquiça, Manatutu, and several high schools in Dili. One woman, who had attended the government high school in Manatutu, said:

*When they first came, I was happy. I thought it was maybe something to stop your period. But then I ran away.... We had the injections in 1988, and then my period stopped. Three or four months later it came back, but then it stopped for several years. That year we were injected three times in one year, then we finished high school. There were no injections after that, but I had problems with my period.*⁹⁷

Amenorrhoea (the cessation of menstruation) and disruption of bleeding patterns affects approximately one-third of women using progestin-only contraceptives.⁹⁸ The women injected in this manner distinguished these occasions strongly from the vaccinations they had been given throughout primary and high school, since they were organised differently, involved different officials, and in some cases, affected their menstrual patterns. Students were not informed of when these injections were going to take place, unlike with vaccinations at primary school, and the doors were locked to prevent escape. These incidents were repeated every three months during the school year. Another woman who attended Becora High School in Dili described it:

The injections were only for girls; they allowed the boys to go home. This was in Year 12. The boys asked why they didn't have to have them, but were given no reason. Everyone ran away if possible. No Indonesians came to

*school then, only Timorese. They made excuses why they were away. They used one needle for the whole class....*⁹⁹

When the boys returned from school and related what was happening, a woman from a prominent family went and told the Bishop, Carlos Ximenes Belo. Girls in the Catholic school in Liquiça were also injected in a similar “vaccination program” in 1987. The priest administering the school complained to the authorities that these injections were not in the parochial agreement, and asked why only the girls were given injections. No answer was given, although the government then discontinued the series in Catholic schools.¹⁰⁰ The church has continuously warned its parishioners to avoid accepting these kinds of injections and to avoid the KB program, and it is not clear whether these kinds of incidents continue to occur.

The fact that the majority of these incidents were reported at a time when there were significant fluctuations in the KB target and other statistics, may indicate that they were associated with a need to fulfil targets or otherwise to use up supplies. Indeed, there is little logical reason why the Indonesian government would wish to inject young women of high-school age, since they are well below marriageable age and, given strict norms in East Timor regarding pre-marital sex, unlikely to be sexually active. Family planning workers experienced in other parts of Indonesia had not heard of any similar incidents in other provinces, although several believed that it was most likely associated with the need for target fulfilment.¹⁰¹

The injection of young adolescents with Depo-Provera has potentially significant health implications, and is against both WHO and IPPF guidelines on safe injectable contraceptive usage.¹⁰² As well as breaching the right to security of person and well-articulated norms regarding information, communication, and consent, such practices also violate the government's obligation to protect children “from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation” as set out in Article 19 on the Convention on the Rights of the Child. It also violates state obligations to protect the health of children as defined in Articles 3 and 24 of the same Convention.

Whether or not the extensive rumours of coercive injections are justified, this series of incidents has rendered most East Timorese women extremely suspicious of any kind of injection, including those in the regular government vaccination program. In some cases, girls have been withdrawn from high school as a result. Both in Baucau and Lospalos, girls had been withdrawn from high school after incidents where Indonesian soldiers had arrived at their school, separated the girls from boys and East Timorese and from non-East Timorese, and taken the East Timorese girls off for

injections. In 1994, one girl was withdrawn from school when 13 and educated at home, whereas another withdrew at the age of 15.¹⁰³ Several lawyers in Australia commented that they had a number of asylum claims in which fear of injections and sterilisation played a significant role.¹⁰⁴ Other kinds of caseworkers also mentioned it as a significant issue for some women.

Safety, Consent, and Contraceptive Mix

The other significant issue in East Timor with regard to injectable contraceptives is the startlingly high use of Depo-Provera compared with other parts of Indonesia. Contrary to widespread perception, injectable contraceptives are not inherently dangerous or undesirable. They are often safe and convenient methods of contraception, and have the advantage of being simple to administer. This means that a wide range of people can administer the injections, not just medical personnel. In many population control programs, injectable contraceptives are often the preferred method of service delivery for women whose motivation for contraception is considered "low".

However, along with their benefits, critics have also pointed out the dangers of using injectable contraceptives: first, that they increase the danger of women being given contraceptives without proper information or follow-up; second, that they are the most easily administered contraceptives, in settings where motivation is weak; and third, that once administered, they cannot be reversed until their effects have fully worn off. This is usually a period usually of approximately 3 months, although the return to full fertility can be delayed for considerably longer.¹⁰⁵

Injectable contraceptives also have a relatively high level of side effects, including changes in weight, appetite, and bleeding. Women using injectable contraceptives recorded the highest proportion of health problems with their method in the Indonesian 1994 Demographic and Health Survey (IDHS).¹⁰⁶ Injectable contraceptives are also medically inadvisable for young women, pregnant women, and women with anaemia. Given the level of malnutrition in East Timor, levels of anaemia are said to be very high.¹⁰⁷

Many provinces have high levels of injectable usage for new KB users, although East Timor's is significantly the highest at 72.22% of all new users in 1993-1994 (*Appendix, Table 2*). The Eastern provinces in general have higher rates of injection usage than provinces in other parts of Indonesia. What is more startling is that 61.9% of continuing KB users in East Timor are using injections according to public government figures, and somewhat higher according to internal ones (*Appendix, Table 3*).¹⁰⁸ This figure is almost 50% higher than that of Irian Jaya, the province with the

next highest level of use of injectable contraceptives, and more than double the Indonesian average.¹⁰⁹ What is more, levels of injectable contraceptive usage, although consistently high, have also been increasing over time.

This is significant for a variety of reasons, even when leaving reports of covert injections aside. At the most fundamental level, it gives rise to questions as to why there is such an anomalously high level of injectable contraception usage amongst KB acceptors, especially in a population whose religious convictions emphasise other methods, such as periodic abstinence. The ability to make free and informed contraceptive choices is a fundamental reproductive right, and the extremely high level of injectable contraceptive usage in East Timor is worrying for this reason.

The high rates of Depo-Provera use also raise fundamental health questions. Depo-Provera can have strong adverse consequences in populations with high levels of anaemia and malnutrition, as is the case in East Timor. One local doctor was significantly worried by the high prevalence of Depo-Provera usage, indicating that "there is a big problem about that."¹¹⁰ Although he agreed that the populace in general had a high degree of respect for injections, he was concerned that Depo-Provera was administered with no concern for the health consequences, religious convictions, or follow up care.

*It's very bad. When they give injections and they give artificial contraception, they will not tell the people. There is no information about the side effects, no information. I see many cases of injections and side effects, and the patients do not know why.*¹¹¹

He too believed that injections were administered under the guise of medicine or vaccinations, although he, like others, knew that this charge was difficult to prove.

The issue of choice of method is a particularly pertinent one considering East Timorese religious beliefs. Given the strongly Catholic nature of the province, educating the population in those methods acceptable to the church would enable many women who may desire to limit or space their births but are hostile to "artificial" methods to do so. Various Catholic clinics had in fact made efforts to educate interested people in periodic abstinence (also known as the Billings or rhythm method), but since periodic abstinence is not included as part of the KB program, little effort has been made by the Indonesian government to provide information on this technique.

Critics have argued that the emphasis on MKET technologies has significantly constricted the available choice of family planning methods. Although injections are not an MKET technology, it is likely that the BKKBN's strong preference for the most effective methods has led to exclusion of contraceptive methods that may be more

acceptable to Catholic acceptors. Academics in a joint report of the Australian National University and Indonesian Academy of Arts and Sciences have commented:

*It is... strange and disturbing that virtually all of the women of Timor Timur reporting contraceptive use to DHS interviewers are recorded as using injectables or implants.... the concentration of users on these longer term hormonal methods gives rise to questions about the possible lack of information and services available to potential users of the IUD, pill, or sterilisation.*¹¹²

Some women interviewed referred to periodic abstinence as a means of limiting birth, but had no knowledge of what it involved,¹¹³ while health workers complained that they had received no information or training regarding periodic abstinence, and therefore were unable to assist those clients who wished to use it.¹¹⁴ Likewise, the ANU report also comments that the "extraordinarily low levels of periodic abstinence" in East Timor, revealed in the 1994 IDHS, "indicate either a remarkable lack of education in the method, or [a] lack of awareness that the DHS questions were meant to record such non-program methods."¹¹⁵ Religious and medical officials agreed that East Timorese health and socioeconomic conditions meant that limiting desired family size in the province was probably a desirable objective, but that a major problem was a lack of appropriate education in the most acceptable methods of doing so.

The BKKBN also designs projected contraceptive mix according to social analyses of each administrative region, rating socioeconomic conditions and user characteristics.¹¹⁶ While their promotion of Depo-Provera may be the result of such administrative predictions of contraceptive choice, it nonetheless breaches the right of choice and gives rise to serious questions regarding information, motivation, and quality of care in the KB program in East Timor.

Other Contraceptive Methods

There are also reports of human rights abuses involving IUDs, concentrated particularly in the Baucau area. Problems concerning IUDs focus on two main areas; first, the association between IUDs and side effects, including cancer and ectopic pregnancy; and second, the difficulty of having the IUD removed. Most women with experience of IUDs tended to be older, and their accounts may reflect the stronger emphasis placed on IUDs in the mid-to-late 1980s. One of the first acceptors of KB in the Baucau area, Donna C, was diagnosed by a nurse within the family as having cancer as a result of her IUD, and died in 1993-1994.¹¹⁷ Having been honoured by KB

officials and given a trip to Jakarta as a reward for her participation in the program, Donna C's death has contributed strongly to negative perceptions of IUDs in the Baucau area, although women in other regions also make the association.

Side effects were also a problem, particularly in the cases where women were unfamiliar with potential problems and were unsure whether to seek treatment. The lack of follow-up care was also reported to be a significant problem even in major towns, as women complained that users who sought treatment found it difficult and expensive to have the IUD removed, even when necessary.¹¹⁸

This was the case with Fernanda, a woman in her late 30s who suffered irregular bleeding and then Amenorrhoea after she had an IUD inserted in 1986. After feeling unwell for some time, she sought help from the doctor who inserted the device, but found that he had left the province. She also sought help from a relative who was a qualified nurse, whom she had had to pay but who could not help her. She then went to a second doctor in Dili Mandarin. He told her that the IUD had bent and become displaced, and that she could choose either to have a local anaesthetic and have it removed, or to seek treatment in Bali. Fernanda was upset because she had no money to go to Bali, and eventually paid the doctor approximately \$50 Australian dollars to have the IUD removed, as well as a further present of money as thanks. This is an extremely high sum by East Timorese standards. In her case, she said, there was nowhere else to go for help. "If you don't pay them, they won't treat you."¹¹⁹

Mrs A from Dili also complained that her cousin had used an IUD in the early 1980s, which bent and caused haemorrhaging. Like Fernanda, she had asked an East Timorese nurse to help take it out, without success, and therefore had had to pay a large sum of money to have it removed.¹²⁰ Caseworkers in Australia also indicated a number of instances where KB motivators had recruited women to accept IUDs while their husbands were away, only for their husbands to insist that they be removed.¹²¹

Tubal Ligations

Fear of covert sterilisation by tubal ligation is one of the primary reasons that East Timorese women - particularly older women - are reluctant to use Indonesian medical facilities. These are amongst the most long-standing reports of violations of women's rights in East Timor, the majority of which appear to stem from the early 1980s. Tubal ligations are not strongly promoted within the KB program. Instead, they tend to be subsidised by the government, but performed by the Indonesian arm of the Association for Voluntary Surgical Sterilisation.¹²² The frequency with which East Timorese women refer to tubal ligations suggests that they occupy a proportionately greater role

in East Timor than in other Indonesian provinces. This is not altogether surprising, since tubal ligation is a more acceptable form of family planning for Catholics than most other methods. What is unusual, however, is that there seems to have been no official promotion of tubal ligation in these terms.

Reports of covert sterilisations take two forms. The first consists of sterilisations conducted in tandem with Caesarean deliveries, in which women who had delivered their last child by Caesarean section would later find that they were inexplicably infertile. The second alleges that women in hospital for other kinds of operations, such as appendectomies, would leave the hospital and later find themselves unable to conceive. This was the case in 1989, when a woman in Dili, who had become infertile after an appendectomy, was told by her doctor that she had most likely been sterilised while under the anaesthetic.¹²³

Those women who voluntarily underwent tubal ligation also believed that covert tubal ligations were still occurring. A qualified health worker who frequently visits the province stressed that covert operations were not official government policy, but believed that there were incidents of "zealots" who had independently sterilised women without permission during the late 1970s and early 1980s.¹²⁴

Two nurses recently working in East Timor independently visited hospital wards comprised of patients scheduled for tubal ligation. Both were told by these women that the operation was voluntary, although both also commented that, since they were accompanied by Indonesian health officials, it might also have been difficult to suggest anything else.¹²⁵ After the 1994 safari mentioned above, one foreign nurse visited a hospital ward of 17 East Timorese women scheduled for sterilisation that afternoon. The nurse was told by hospital staff that this was one of several wards of women scheduled for sterilisation after a recent drive promoting participation in KB. The event had been organised by administered by ABRI.¹²⁶ Although she believed that some of the women were happy to participate in the program, she was also distressed by the age and demeanour of others: "many did not seem to know what was happening".¹²⁷ She was also concerned at the lack of patient-doctor communication. None of the patients spoke Bahasa Indonesia, nor did the doctors speak Tetum, the primary language of East Timor.

Communication, Consent, and Information

The difficulties involved in situations such as those mentioned in the preceding paragraph highlight the problems of health delivery in a setting such as East Timor. Set in an environment of repression, violence and mistrust, ordinarily complex

questions of consent and communication are intensified still further. More than half of all women of child-bearing years in East Timor cannot speak Bahasa Indonesia, a figure much higher than in any other province in Indonesia.¹²⁸ Given that few KB administrators, volunteers, and doctors speak local languages, this has significant implications.

Tensions between East Timorese inhabitants and Indonesian officials are exacerbated by language difficulties, which have reportedly led to misunderstandings over things such as permission for last-minute operations or explaining emergency situations.¹²⁹ This has meant that permission is not requested, or that patients and families do not understand what permission was given for, or that doctors believe that they have been given permission when this is not clear to patients. This has led to incidents where relatives believe a family member has been killed by doctors because the death seems otherwise inexplicable. Communication problems have also compounded structural difficulties inherent within the KB program itself. As expressed by one East Timorese medical practitioner, "there is no good informed consent of the people."¹³⁰

These difficulties in communication are not simply linguistic, but also a function of attitude. Most doctors in East Timor are recent graduates from Indonesia, serving 3-year terms in the outer provinces, and unfamiliar with East Timorese languages and culture. One doctor described the primary problem as being a

*lack of communication between health officials and the people. For the officials, citizens do not know how to be grateful, and the people feel that "this medicine is not for me." There is no communication or dialogue. That is what is crucial.*¹³¹

These difficulties include complaints from East Timorese women that Indonesian doctors have insulted them for having too many children,¹³² and a strong preference for Catholic and other privately-run clinics and hospitals "because of the way they treat us."¹³³ Women complain that Indonesian members of the medical staff are rude and dismissive, and believe they receive considerably different treatment to Indonesian patients. In particular, several complained that hospital staff members do not give East Timorese women anaesthetics during difficult labour, and will administer medications and injections without consent.¹³⁴

There are also more serious complaints of malpractice and denial of rights to health. East Timorese women most commonly give birth at home, although they will seek hospital assistance if matters seem urgent. Several cases were reported of women seeking hospital assistance for a difficult delivery, and being sent away again for lack

of funds. In April 1996, the sister-in-law of one woman had gone from Venilale to the hospital in Baucau to have her first child. When she went there, the doctor had asked whether she had enough money, and whether she could afford to pay to have the baby. She was upset because she did not have the money, but left. She and her baby then died in labour shortly afterwards.¹³⁵ Other women were refused treatment and then died in 1980 and 1993. Actions such as this violate the minimum standards for acceptable health care as defined by Article 12 of the Convention on the Elimination of Discrimination against Women.

There was a slightly different scenario with Fernanda, mentioned earlier, who suffered a miscarriage before she started using an IUD. She went to a clinic in Dili in 1982, having difficulties in her final stages of pregnancy:

They did nothing and then they sent me home. They said, "you knew you were going to have a baby, why didn't you have it at home, why did you come here?" So I went home and had the baby - but my belly was already all blue, all purple, my stomach felt cold like ice, and my legs were all bruised blue.

She returned home and went through an extremely difficult delivery, the foetus having died *in utero*.¹³⁶

Over 67% of women in East Timor give birth assisted only by relatives, a figure almost double that in Irian Jaya, which has the next nearest proportion, and approximately 5.2% of babies are self-delivered.¹³⁷ This is five times the average of family-assisted births in other islands of the area, and, although these proportions may be high for cultural reasons, they almost certainly reflect the extremely strong distrust East Timorese have of Indonesian medical facilities. It is important to note that East Timorese women do not suffer similar hesitation when dealing with alternative kinds of health care services. For example, there is an extremely popular privately-run women's health clinic in Venilale, and women will at times walk several days to get there.¹³⁸

However, the ability of East Timorese women to turn to Catholic clinics for assistance in reproductive health matters is inhibited by the Catholic opposition to most forms of contraception. Although some more educated women indicated that they would feel comfortable talking to nuns regarding problems with birth control, many said they would not. This then prevents many women from making use of the option that would otherwise be most comfortable to them if they needed follow-up treatment or advice: "No, there is no one to help them, and what's more, no one to say anything either."¹³⁹ Women were unanimous in reporting difficulties in follow-up treatment for all kinds of reproductive health issues, while doctors also confirmed that they had a high number of patients seeking assistance with contraceptive side effects.

*You can't go to the nuns and the priests to talk about family planning, even at Catholic clinics. The only place you can go is to Timorese doctors. Timorese doctors give you a choice of methods, and also information. What happens depends on what you want to do.*¹⁴⁰

Follow-up treatment is an essential factor in ensuring reproductive health and one of the basic rights of family planning users defined under the Cairo Declaration. Communication, consent, and access to information and follow-up treatment are the most basic constituent elements of successful and beneficial family planning programs, and are likewise part of a group of internationally recognised reproductive rights. The conditions and incidents discussed in this report indicate that the Indonesian government has consistently violated these rights, and in doing so, has contributed towards the fear and misery of the East Timorese in a manner that has significant, intimate, gender-specific effects.

The level of the problem is such that it affects not just the health of individual women, but delivery of health care services across the province as a whole. Whether or not the rumours of coercion and maltreatment can be proven, the situation in East Timor is undermining the implementation of the government health program itself, which is heavily dependent upon community participation and support, particularly in rural areas. Several health workers describe how women will routinely reject anti-malarial tablets and vitamins because they believe them to be contraceptive pills, which are also distributed via headmen and volunteers (*kaders*) in villages, and women themselves believe that it is safer to reject vaccinations and other injections than to accept them.

Official documents have reported the reluctance of the East Timorese to participate in health development,¹⁴¹ and also note that religious and political factors have inhibited the KB program from reaching its defined targets. There is little indication, however, that they have given any thought to the development or implementation of measures which might alleviate the situation. Subjects interviewed in Dili were unanimous that

the Government does not do much to solve this problem: they cannot mobilise the support of the people. In my opinion, it is to do with the political situation. Many patients after they have been treated by Indonesian doctors come to ask for a second opinion. Why? "Indonesians - you cannot trust them." This is because of both malpractice and political problems. There is also psychological trauma; people see Indonesian doctors as strangers. If

they can not find good nurses or [an] East Timorese doctor, then they go to traditional medicine.¹⁴²

Likewise, a senior religious official believed that

*Overall, the bigger picture in terms of health is the issue, and not the content. They [East Timorese] have problems with the KB program because of poor overall health. Especially when women give birth, they need good care and do not receive it. [There are also] the difficulties of the interface between the government and the local population. There is a lack of basic care and the perspectives are different: the government interest is in population control, and Timorese are more interested in their own health and that of their children.*¹⁴³

This difference in perspective is alleged to be a common one throughout Indonesia, although only in East Timor does it take place in such an overtly politicised setting. Violations of women's reproductive rights have contributed not just to health problems for individual women, but also to systematic weaknesses in the delivery of the health system which seriously question the government's fulfilment of the minimum content of the right to health. The fear generated by the political situation and by reports of reproductive rights abuses have led to the violation of other rights, particularly that of education. As women fear for their health, they are cut off from both medical programs and from schooling; a self-sustaining, destructive cycle of discrimination, abuse, and suffering.

PART 4: OTHER HUMAN RIGHTS VIOLATIONS

There are frequent reports of other kinds of violations of women's rights in East Timor, including persistent cases of rape, gross violations of the right to life, security of person, the right to marriage and found a family, and torture and cruel, inhuman and degrading treatment. Many of these cannot be substantiated due to difficulties of access to East Timor, and also because of the extremely strong sense of shame experienced by the victims. Nevertheless, accounts are varied, persistent, and detailed enough to indicate that there may be substantial patterns of sexual and other kinds of violence consistently perpetrated against women in East Timor.

During the research for this report, a surprisingly high number of women unilaterally raised the issue of prostitution as a significant problem. Many women associated prostitution with the need for money, especially in the context of money for education, or to support the family after the death of a male relative. According to one twenty-two year old woman, "Even if you are a good girl, you have to do it."¹⁴⁴ Accounts of forced marriage and prostitution were also common, in which soldiers force women into sexual relationships or to commit sexual acts under threat of violence or retribution.

*This is a way of surviving there, for them to survive. It's a very common thing in Timor, if the father has passed away and they have a family. It's not that they want to become prostitutes, but they are forced to do it because if they don't, the others are going to get killed. So they're forced to do certain things with them. If the mother doesn't do it, they go to the daughters, or to their younger daughters.*¹⁴⁵

Immigration lawyers in Melbourne reported a substantial number of forced marriages to Indonesian soldiers on duty in the province, in which women who refuse to "marry" the soldiers in question are subject to abuse. In one case, a woman was set on fire after such a refusal.¹⁴⁶ Women who are part of such relationships are then sometimes taken by a soldier to another part of Indonesia when they finish their duties in the provinces, or will be left with any children of the "marriage" in East Timor. The frequency of such incidents is said to be higher in the mountains and villages, where "there is no one to watch or to help." There are also a number of organised brothels in East Timor, such as those in Aspalgoren and in Bidau, mainly furnished with Indonesian prostitutes who arrive at fortnightly intervals by ship.¹⁴⁷ East Timorese

prostitution is instead said to be in the form of individual prostitutes or forced marriage and sexual slavery.

The militarisation of the province has been damaging to family structures and values in a number of ways, including the difficulties it causes for women who may have had free or forced relationships with soldiers, and then are abandoned when soldiers leave the province at the end of their duties:

*Many young women become prostitutes because of the army. They force them, to save their parents or because they've lost their virginity. At night in the country, they used to force the men to go on guard duty, and then come and abuse the women. In the countryside this is still happening. They make a girl choose between her parents and a soldier.*¹⁴⁸

One woman in her early 20's described the situation in these kinds of cases, and described the women who were known to have been sexually abused as "desperate":

*It's very bad, because we can't lose our virginity in our culture. The value of women in society is very low. No one will marry you, everyone will know you, [and] tease you, and there is no counselling for them, they just lead this life.*¹⁴⁹

New soldiers are stationed in East Timor every three months, and schoolgirls are particularly vulnerable to sexual abuse because of their visibility as they walk to school each day. All groups of women highlighted this as one of the most common means of sexual abuse, in which soldiers will follow a schoolgirl home and accost her immediately. More frequently, however, they organise for the subject's male relatives to be selected for guard duty soon afterwards, and take advantage of the absence of male relatives to force their way into the house:

*The soldiers go to schools looking for girls, [and] follow them home. Then the soldiers call the boys on watch duty, and the unit will go to the girls' house while the boys are away. They take the girls, go and rape them, and do all kinds of rape. Girls know they have to be quiet and can't tell anyone.*¹⁵⁰

In situations where parents complain about such incidents, sources said that the soldiers in question are either transferred to another area, or they argue that "he did it because she wanted him to."¹⁵¹ In order to prevent these kinds of incidents, boys will accompany their sisters to school to try and prevent any possibilities of harassment or violence along the way. Some families will pay monthly protection money.¹⁵² One woman who had arrived in Australia as a refugee in late 1995 said that she had wanted to leave East Timor because of these kinds of problems. If a man saw her and liked

her, they would invent something to hurt her husband and take her away. "There is no safety. From one day to another, we can lose our life."¹⁵³

Women also reported the singling out of women whose relatives were associated with the guerrilla movement for particular abuse, both immediately after the invasion and into the late 1980s. Women whose husbands were absent were moved to locations closer to the army headquarters and "then made them serve them, raped them, and would not let them live [at their former houses] because otherwise their husbands would come."¹⁵⁴ The women in this group identified this incident as happening in the area of the District Military Command (KODIM) in Samé.

In addition to these kinds of abuses, there is also direct evidence that the military uses rape as a weapon of torture and submission upon female prisoners in its control. During time spent in prison in 1995, João, a man in his early 20s, recounted that in addition to being tortured with electric shocks, and beatings, he was also forced to rape two female East Timorese prisoners. João's account supports other, similar reports of direct violence against East Timorese women in prison.¹⁵⁵ As well as the other effects on the women in question, such tactics may also constitute cruel, inhuman and degrading treatment of all three prisoners.

Very few organisations have been able to gather details of incidents of violence against women in East Timor, and much of what is known can not be officially corroborated. Human Rights NGOs are denied official access to East Timor, and alternative methods of information gathering are also inhibited by difficulties of access, shame, and the low status of women in much of East Timorese society. Partially because of these difficulties, these kinds of violations have largely avoided scrutiny. Until such a time as Indonesian practices in East Timor change, or international monitoring of the situation is allowed to become more efficient and concerted, women in East Timor will continue to suffer.

PART 5: CONCLUSIONS & RECOMMENDATIONS

The evidence in this report indicates that Indonesia has consistently violated the reproductive and health rights of the women of East Timor. Coercive patterns of family planning recruitment, consistent breaches of the right to information and contraceptive choice, and strong evidence of covert contraceptive procedures breach both international human rights standards and domestic Indonesian law. There is insufficient evidence to allege genocidal intent by the Indonesian government, however, the majority of East Timorese people perceive the KB program as a deliberate, politically-inspired means of controlling the local population in both literal and demographic terms. The resulting fear of violence and covert sterilisation has undermined the efficacy of the government health system, and has in a number of cases significantly affected women's access to education.

In creating and tolerating this destructive series of consequences, the Indonesian government is in breach of the obligations it has accepted as a signatory of the Convention on the Elimination of all Forms of Discrimination Against Women and the Convention on the Rights of the Child. It has also violated the rights to health, freedom from discrimination, and security of person enshrined in the ICCPR, ICESCR, and restated in the Declaration on the Elimination of all Forms of Violence Against Women. In order to redress this situation, this report makes specific recommendations.

Recommendations

1. Human Rights

- (a) The Indonesian government should end its tolerance of violations of women's human rights in East Timor and conform to its international and national obligations under the Convention on the Elimination of All Forms of Violence Against Women, and Indonesian domestic laws 7/1984 and 10/1992.
- (b) The Indonesian National Human Rights Commission (KomnashAM) should undertake a full and impartial investigation of the human rights violations alleged in this report. Perpetrators should be promptly brought to justice and removed from government service.
- (c) The Indonesian government should invite the UN Special Rapporteur on Violence Against Women to visit East Timor to examine violations of women's human

rights in East Timor and thereby assist the Indonesian government fulfil its international obligations.

- (d) Provincial military and health officials in East Timor should be fully informed of their human rights obligations in the provision of health and family planning services, and receive appropriate training and support.

2. Health and Family Planning

- a) The Indonesian government should substantively review and enhance health delivery services in East Timor. Such a review should prioritize improvements in the communication skills and attitudes of providers, and include a thorough re-assessment of the efficacy of the primary care system.
- b) The Indonesian government should ensure that coercive practices such as safaris, target-setting, and military recruitment of acceptors are immediately ceased in East Timor and that the covert administration of contraceptives is unambiguously prohibited. Regular program monitoring and evaluation should be instituted.
- c) Military involvement in the provision of health and family planning services should be immediately discontinued.
- d) The heavy use of Depo-Provera in East Timor should be examined and its health effects investigated. The appropriate provision of contraceptive technologies should be reviewed in accordance with local conditions and user preferences.
- e) The Indonesian government should remove barriers to family planning and health services by:
 - Redesigning the KB program to ensure health benefits;
 - Enabling user choice by incorporating of religiously-acceptable forms of family planning into the KB program. Private clinics should be supported in this task;
 - Enhancing communication skills and trust between users and providers; and
 - Increasing access to education for women, and promoting the greater involvement of men in family planning issues.

Indonesia's rhetorical commitments to women's human rights hold little value in the face of the ongoing discrimination and human rights abuses suffered by the women of East Timor. Instead, political and administrative factors have caused women to suffer a history of pain and humiliation at the hands of the Indonesian military and government. They have also created a climate of fear which itself substantially impairs women's ability to enjoy other basic human rights. If the claims of the Indonesian government to champion women's rights and development in East Timor are to have any credibility, then the government must address, and redress, the current situation.

Appendix

Table 1: Cumulative Targets of Contraceptive Acceptors, East Timor 1984-1991

Year	Target	Achieved	% of Target
1983/84	-	4,249	-
1984/85	12,888	4,730	36.7
1985/86	17,000	5,374	31.6
1986/87	12,000	5,000	41.7
1987/88	7,000	6,478	92.5
1988/89	4,333	8,147	188.0
1989/90	8,000	7,052	88.2
1990/91	-	8,854	88.15
1991/92*	-	-	58.7
1992/93*	-	-	68.5
1993/94*	-	-	53.7

Table 2: Contraceptive Mix: New KB Users, East Timor & Indonesia 1988-1994

Year	MKET			NON MKET		
	IUD	Ligation	Implant	Injection	Pill	Condom
1988/9	8.2	1.0	5.2	58.9	24.6	3
1990/1	8.9	-	7.2	65.1	14.3	2.1
1992/3	4.2	1.7	7.4	68.8	15.6	2.4
1993/4*	4.6	-	6.8	72.2	13.4	1.0

Table 3: Contraceptive Mix: Active KB Users, East Timor, 1988-1994

Year	MKET			NON MKET		
	IUD	Ligation	Implant	Injection	Pill	Condom
1988/9	11.8	1.7	8.9	52.3	23.4	1.6
1990/1	13.3	2.3	7.7	55.5	20.0	1.7
1992/3	11.3	2.2	9.4	59.5	16.2	1.4
1993/4*	10.9	9.8	2.2	61.9	13.8	1.4

Sources: BKKBN 1990; BKKBN 1992; *Indonesia Health Profile*, 1994, Annex IV.B.1, p. 96.

Endnotes

¹ Amnesty International, *Women in Indonesia and East Timor: Standing Against Repression*. London, 1995; East Timor Relief Association (ETRA), *Timor Woman. A Painful Road to Freedom*, Sydney, 1995.

² For an official introduction of the history and implementation of the program, see Kantor Menteri Negara Kependudukan/Badan Koordinasi Keluarga Berencana Nasional (BKKBN), *25 Tahun Gerakan Keluarga Berencana/25 Years Family Planning Movement*, Jakarta, 1995.

³ Taylor, John G., *Indonesia's Forgotten War: The Hidden History of East Timor*, Zed Books Ltd, London & New Jersey, 1991, pp. 157-160; Helwig, M., *Suharto to Receive "Population Control Award"*, British Coalition for East Timor Press Release, August 29, 1994; Scharfe, S., Parliamentarians for a Free East Timor, *Verbal Testimony before the Special Committee on the Situation with Regard to the Implementation of the Declaration on the Granting of Independence to Colonial Countries and Peoples*, 18 July, 1994.

⁴ Helwig, p. 1; Taylor, p. 81

⁵ Concerning the imposition of measures intended to prevent births within a particular national, ethnic, racial or religious group. See the Convention on the Prevention and Punishment of the Crime of Genocide, Art II (d), adopted December 9 1948, entered into force January 12 1951.

⁶ Hafidz, W., Taslim, A., & Aripurnami, S., "Family Planning Program in Indonesia: A Plight for Policy Reorientation", [sic] prepared for INGI Conference, Washington DC 29 April-2 May, 1991; Hull, T.H., "An Investigation of Reports of Coercion in the Indonesian Vasectomy Program", Australian International Development Assistance Bureau Appraisals, Evaluation and Sectoral Studies Branch, Development Paper No.1, Canberra, 1991; and Lawyer's Committee for Human Rights, *In the Name of Development: Human Rights and the World Bank in Indonesia*, Lawyers' Committee for Human Rights and the Institute for Policy Research and Advocacy (ELSAM), New York, 1995.

⁷ Cook, R.J. "International Human Rights and Women's Reproductive Health", *Studies in Family Planning*, Vol.24, No.2, March/April, 1993, p.78.

⁸ Articles 6 and 9 of the International Covenant on Civil and Political Rights, adopted 16 December 1966, entered into force 23 March 1976, G.A. Res. 2200A (XXI), UN Doc. A/6316 (1966), 999 United Nations Treaty Series 171.

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- ⁹ International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966, entered into force 3 January 1976, G.A. Res. 2200A (XXI), UN Doc. A/6316 (1966), 993 UNTS 3.
- ¹⁰ Convention on the Elimination of All Forms of Discrimination Against Women, adopted 18 December 1979, entered into force 3 September 1981, G.A. Res. 34/180, 34 UN GAOR, Supp. (No. 46), UN Doc. A/34/46 (1979) at 193.
- ¹¹ Set out in Article 19. See Convention on the Rights of the Child, adopted 20 November 1989, entered into force 2 September 1990, G.A. Res. 44/25, 44 UN GAOR, Supp. (No.49), UN Doc. A/44/49 (1989) at 166.
- ¹² Rahman, A. and Pine, R.N., "An International Human Right to Reproductive Health Care: Toward Definition and Accountability", *Health and Human Rights: An International Quarterly Journal*, (Special Focus: Women's Health and Human Rights), Vol.1, No.4, 1995, pp. 400-428.
- ¹³ *Report of the International Conference on Population and Development*, (Cairo, 5-13 September 1994), United Nations A/CONF.171/13, 18 October 1994; endorsed by the UN General Assembly G.A. Res. A/RES/49/120, UN GAOR, 29th Session. The Beijing Declaration is from the *Report of the Fourth World Conference on Women* (Beijing, 4-15 September 1995), United Nations A/CONF.177/20.
- ¹⁴ State Ministry of Population/National Family Planning Coordinating Board, *Indonesia Country Report: Population and Development*, Jakarta, 1994, p.11.
- ¹⁵ See Amnesty International, *Women in Indonesia and East Timor*, p.10.
- ¹⁶ Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted 10 December 1984, entered into force 26 June 1987, G.A. Res. 39/46, 39 UN GAOR, Supp. (No. 51), UN Doc. A/39/51 (1984) at 197. See *Report of the High Commissioner for Human Rights on his visit to Indonesia and East Timor*, 52nd Session of the Commission on Human Rights, E.CN.4/1996/112, 14 March 1996, paragraph 10.
- ¹⁷ c.f. Amnesty International, *Women in Indonesia and East Timor*, p.2.
- ¹⁸ United Nations Department for Economic and Social Information and Policy Analysis, *World Population Report 1996*. U.N. Secretariat, New York, 1996. The infant mortality rate in East Timor is surpassed only by those of Afghanistan, Sierra Leone, Mali, and Liberia.

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- ¹⁹ Ibid
- ²⁰ Human Rights Watch/Asia. *The Limits of Openness: Human Rights in Indonesia and East Timor*. New York, 1994.
- ²¹ For a recent summary see Amnesty International, *Indonesia and East Timor: When Will the Commission Take Action?* Amnesty International Country Report ASA 21/10/96, London, February 1996.
- ²² Amnesty International, *When Will the Commission Take Action?* p.1.
- ²³ Reproduced in E/CN.4/1996/56, Commission on Human Rights, 52nd Session, *The Situation in East Timor: Report of the Secretary General*, Question of the Violation of Human Rights and Fundamental Freedoms in any part of the World, With Particular Reference to Colonial and other Dependent Countries and Territories, 29 February 1996, Paragraph 16. Cited from *Report of the Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions*, E/CN.4/1996/4.
- ²⁴ Statistics vary between different government departments. For a thorough summary, see Jones, G.W. and Raharjo, Y., *People, Land and Sea: Development Challenges in Eastern Indonesia*, a Collaboration between the Centre for Population and Manpower Studies, Indonesian Academy of Sciences (PPT-LIPI) and the Demography Program, Research School of Social Sciences, Australian National University, Canberra, November 1995. See also Ministry of Health, Republic of Indonesia, *Indonesia Health Profile 1994, Attachments*. Ministry of Health Center for Health Data, Annexes II.B.1-II.B.7, Jakarta, 1994. The health department placed 36.84% of the population of East Timor below the poverty line in 1993.
- ²⁵ Ibid, Annex II.B.2. See also Central Bureau of Statistic [Indonesia] and State Ministry of Population/National Family Planning Coordinating Board and Ministry of Health and Macro International Inc., *Indonesia: Health and Demographic Survey, 1994*, Calverton Maryland, CBS and MI, 1995, pp. 14-19. This survey is subsequently referred to as the IDHS.
- ²⁶ *Indonesia Health Profile 1994 Attachments*, Annex II.B.4. p.34.
- ²⁷ This concentration of Catholics, although probably overstated as a result of census methodology, is rivalled only by that in some parts of the neighbouring province, Nusa Tenggara Timur. Catholics constitute approximately 2.1% of Indonesia's population overall. See Jones & Raharjo, p.90.
- ²⁸ Embodied particularly in Articles 7.3, 7.5(b) and 7.12. For full citation see note 13 above.

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²⁹ Aditjondro, G., *In the Shadow of Mt Ramelau: The Impact of the Occupation of East Timor*. Indonesian Documentation and Information Centre, Leiden, 1994, p.9. This figure is also cited by Taylor. Estimates as to the death toll vary and depend upon projections from both Portuguese and Indonesian census documents.

³⁰ Jones & Raharjo, p.48. Population projections are from Kantor Menteri Negara Kependudukan/BKKBN, *Kumpulan Data: Kependudukan & Keluarga Berencana Indonesia*, BKKBN, Jakarta, February 1995, p.197.

³¹ Jones and Raharjo, p.52. Interview, Dili, 6 August 1996. Transcripts of all interviews on file with author.

³² Mubyarto, Soetrisno, L., Hudyanto., Djatmiko, E., Setiawati, I., and Mawarni, A., *East Timor: The Impact of Integration, An Indonesian Socio-Anthropological Study*, Gadjah Mada University Research Center for Village and Regional Development in cooperation with the Bank of Indonesia and the Local Development Planning Board for the Province of East Timor, Yogyakarta, 1990 p.39. [Translated and published by the Indonesia Resources and Information Program (IRIP) Australia, December 1991].

³³ Ibid

³⁴ Interview, G III, Sydney, 25 July 1996.

³⁵ IDHS Table 2.5.4. p.18. The fact that the sample includes females from 5 years of age indicates this is a contemporary pattern.

³⁶ Ibid

³⁷ Hull, T. and Hidayani, T., "Family Planning and Achievement of Desired Family Size", in Jones and Raharjo, (Eds.) p.90.

³⁸ Interview, Melbourne, July 12 1996.

³⁹ Jones and Raharjo, pp. 7, 37.

⁴⁰ See note 24 above

⁴¹ Interview, Dili, 8 August 1996; Interview, Melbourne, 11 July 1996.

⁴² *Indonesia Health Profile Attachments 1994*, Annex III.A.1; Annex III.B.B.1-III.B.B.3 and Annex III.C.1.

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⁴³ United Nations *World Population Report 1996*. See note 18.

⁴⁴ *Indonesia Health Profile Attachments 1994*, Annex V.A.2. After climbing steadily in the late 1980s, this ratio declined in 1992-1993. East Timor has the highest per capita health budget allocation in Indonesia from 1988-1994 (Ibid, Annex V.B.2).

⁴⁵ The ratio is 2 kaders per post, with an official count of 927 posts. (*Indonesia Health Profile Attachments*, Annex V.C.1.2). Jones and Raharjo estimate that only 50% of posyandu in Eastern Indonesia are actually functioning (p.52).

⁴⁶ Tirtosudarmo, R. "Development Planning and Implementation in Eastern Indonesia", in Jones & Raharjo (Eds), pp. 23-35.

⁴⁷ See *25 Years Family Planning Movement*, pp. 17-33, as well as the IDHS pp. 4-5. Indonesia is currently the fourth-largest country in the world, with a population of roughly 200 million.

⁴⁸ Norplant is a highly effective long term hormonal contraceptive. It is inserted in the form of a number of small rods under the skin of the upper arm. Removal generally requires professional assistance and therefore is not always controllable by the user.

⁴⁹ *In the Name of Development* pp. 117-122.

⁵⁰ Ibid, and Hull, T. H., "An Investigation..."

⁵¹ Ibid, pp. 111-116, and Hafidz et al.

⁵² Ibid

⁵³ Interview, Jakarta, 20 August 1996; Interview, Jakarta, 21 August 1996.

⁵⁴ Taylor, *Indonesia's Forgotten War*, p.157.

⁵⁵ Kantor Menteri Negara Kependudukan/BKKBN, *Kumpulan Data*, 1995, p.8.

⁵⁶ For a summary of official statistics, see BKKBN, *Buku Saku Provinsi Timor Timur 1993*, Jakarta, Jan 1994, p.36. This was the most recent provincial fact book available in August 1996.

⁵⁷ *Badan Koordinasi Keluarga Berencana Nasional*

⁵⁸ Ibid

⁵⁹ Under the doctrine of "dwi-fungsi" (dual function), the Indonesian Armed Forces are

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officially accorded an important social and political role in society in addition to their military role. ABRI plays a dominant role in the political life of the country and is involved in a wide range of development activities. See *In the Name of Development*, p.36.

⁶⁰ Ibid, pp. 21, 61. There is no way of judging the number of actual volunteers, who are crucial in motivation and recruitment.

⁶¹ See BKKBN, *Kumpulan Data: Kependudukan & Keluarga Berencana Indonesia 1992*. BKKBN, Jakarta, 1993, pp. 20-21; BKKBN, *Kumpulan Data: Kependudukan & Keluarga Berencana Indonesia 1990*, BKKBN, Jakarta, 1991, pp. 21-24.

⁶² See IDHS 1994, p.76.

⁶³ Interview GIII, Sydney, 25 July 1996.

⁶⁴ Interview GI, Melbourne, 23 July 1996.

⁶⁵ Interview, Melbourne, 11 July 1996; Interview, GI Melbourne, July 23 1996; Interviews GII and GIII, Sydney, 25 July 1996.

⁶⁶ Interview, Melbourne, 20 July 1996.

⁶⁷ Interview, Darwin, 1 August 1996.

⁶⁸ Interview, Melbourne, 20 July 1996; Interview GI, Melbourne, 23 July 1996; Interviews GII and III Sydney, 25 July 1996.

⁶⁹ Interview GI, Sydney, 25 July 1996.

⁷⁰ Interview, Melbourne, 23 July 1996.

⁷¹ Interview, Dili, 7 August 1996.

⁷² See note 6 above.

⁷³ Interview GIII, Sydney, 25 July 1996.

⁷⁴ Interview GII, Sydney, 25 July 1996.

⁷⁵ Interview, Dili, 7 August 1996.

⁷⁶ Hafidz et al, *In the Name of Development*, p, 119.

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⁷⁷ Interview, Dili, August 7 1996; Interview, Darwin, August 2 1996.

⁷⁸ *Kumpulan Data 1993*, BKKBN 1992, p.29.

⁷⁹ Interview, Melbourne, 22 July 1996.

⁸⁰ Sumbung, P., *The Role of the IUD in the Indonesian National Family Planning Program*, Technical Report Series, Monograph No. 45, BKKBN, Jakarta, 1985, p.16.

⁸¹ *In the Name of Development*, p.120.

⁸² Ibid, p.119. See also Hafidz et al.

⁸³ Interview, Jakarta, 23 August 1996; Interview, Jakarta, August 20 1996.

⁸⁴ Interview, Melbourne, 16 July 1996.

⁸⁵ *Metode Kontrasepsi Efektif*, that is "Effective Contraceptive Method".

⁸⁶ *In the Name of Development*, p.127.

⁸⁷ Ibid, p.127.

⁸⁸ See Hamijoyo, S., and Chauls, D., *The Events in Which Community Members Participate in the Indonesian Family Planning Program*, Ministry for Population/National Family Planning Coordinating Board, Jakarta, 1995. Technical Report Series Monograph No. 80.

⁸⁹ Interview, Dili, 7 August 1996; Interview, Jakarta, 20 August 1996; Interview, Jakarta, 22 August, 1996.

⁹⁰ *Buku Saku Provinsi Timor Timur 1993*, p.55.

⁹¹ Interview, Melbourne, July 20 1996. FRETILIN is a political group dedicated to ending the Indonesian presence in East Timor.

⁹² Interview, Darwin, 2 August 1996.

⁹³ Interview, Melbourne, 20 June 1996.

⁹⁴ See "New Era for Injectables", *Population Reports Series K*, No. 5, Volume XXIII, No. 2, Population Information Program, The Johns Hopkins School of Hygiene and Public Health, USA, August 1995, p.13.

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- ⁹⁵ Interview, Melbourne, 20 July 1996.
- ⁹⁶ Ibid, and Interview, Melbourne, 17 July 1996; Interview GII, Sydney, 25 July 1996.
- ⁹⁷ Interview GII, Sydney, 25 July, 1996.
- ⁹⁸ "New Era for Injectables", pp. 9-13.
- ⁹⁹ Ibid
- ¹⁰⁰ Interview, Dili, 8 August 1996.
- ¹⁰¹ Interviews, Jakarta, August 20, 21, and 23, 1996.
- ¹⁰² See World Health Organisation (WHO), *Injectable Contraceptives: Their Role in Family Planning Care*. Geneva: WHO, 1990.
- ¹⁰³ Interview, Melbourne, July 19, 1996.
- ¹⁰⁴ Ibid, and Interviews, Melbourne, 15 and 22 July 1996.
- ¹⁰⁵ "New Era for Injectables", p.8.
- ¹⁰⁶ IDHS. Table 5.11, p.86. 22.3% of women using injections recorded particular health problems, with the next highest level coming from Norplant users at 19.5%.
- ¹⁰⁷ Interview, Dili, 7 August 1996; Interview, Melbourne, 19 July 1996.
- ¹⁰⁸ Figures from BKKBN *Kumpulan Data* 1994, p.20. For a presentation of figures, please refer to Table 2, *Appendix*. The internal figure that 65.07% of all acceptors use Depo-Provera is from *Profil Kesehatan Propinsi Timor Timur, Tahun 1994*, Dept Kesehatan, RI Kalata, Wilaya Propinsi Timor Timur, Dili, October 1995.
- ¹⁰⁹ BKKBN, *Kumpulan Data*. 1995. Table 18, p.20.
- ¹¹⁰ Interview, Dili, 8 August 1996.
- ¹¹¹ Interview, Dili, 8 August 1996.
- ¹¹² Ruharjo and Jones, p.97.
- ¹¹³ Interview, Melbourne. 15 and 20 July 1996; Interview, Dili, 7 August 1996.
- ¹¹⁴ Ibid

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- ¹¹⁵ Ruharjo & Jones, p.98.
- ¹¹⁶ Interview, Jakarta, 20 August 1996.
- ¹¹⁷ Interview, Darwin, 2 August 1996.
- ¹¹⁸ Interviews, Melbourne, 15 and 19 July, 1996; Interviews GI and GII, Sydney, 25 July 1996.
- ¹¹⁹ Interview, Sydney, 25 July 1996.
- ¹²⁰ Interview, Darwin, 2 August 1996.
- ¹²¹ Interview, Melbourne, 19 July 1996.
- ¹²² See Indonesian Association for Surgical Contraception (PKMI), *Strengthen and Expand Voluntary Surgical Contraception Service Delivery in Indonesia 1993-1994*, Jakarta, PKMI, April 1993. The service reported 10 urban and 2 rural units in East Timor in 1993, p.9.
- ¹²³ Interview, Melbourne, 16 July 1996.
- ¹²⁴ Interview, Melbourne, 23 July 1996.
- ¹²⁵ Interviews, Melbourne, 11 and 16 July 1996.
- ¹²⁶ Interview, Melbourne, 16 July 1996.
- ¹²⁷ Ibid
- ¹²⁸ Jones & Ruharjo, p.93
- ¹²⁹ Interview, Melbourne, 15 July 1996.
- ¹³⁰ Interview, Dili, 8 August 1996.
- ¹³¹ Interview, Dili, 8 August 1996.
- ¹³² Interview, Melbourne, 15 July 1996.
- ¹³³ Interview GIII, Sydney, 25 July 1996.
- ¹³⁴ Ibid
- ¹³⁵ Interview GII . Sydney, 25 July 1996.
- ¹³⁶ Ibid

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¹³⁷ IDHS 1994, p.163.

¹³⁸ Interview, Melbourne, 18 July 1996.

¹³⁹ Interview, Melbourne, 20 July 1996.

¹⁴⁰ Interview GI, Melbourne, 23 July 1996.

¹⁴¹ Daliyo, Bandiyono S., Handayani, T. and Hargiono, S., *Pengembangan Manusia di Propinsi Timor Timur: Partisipasi Penduduk Dalam Pembangunan*, Puslitbang Kependudukan dan Ketenagakerjaan Lembaga Ilmu Pengetahuan Indonesia, Jakarta, 1994, p. 18.

¹⁴² Interview, Dili, 8 August 1996.

¹⁴³ Interview, Dili, 7 August 1996.

¹⁴⁴ Interview, Melbourne, 20 July 1996.

¹⁴⁵ Interview GII, Sydney, 25 July 1996.

¹⁴⁶ Interview, Melbourne, 19 July, 1996.

¹⁴⁷ Interview GIII, Sydney, 25 July 1996. Interview, Dili, 7 August 1996.

¹⁴⁸ Interview GII and GIII, Sydney, 25 July 1996.

¹⁴⁹ Ibid

¹⁵⁰ Ibid

¹⁵¹ Ibid

¹⁵² Interview, Darwin, 1 August 1996.

¹⁵³ Ibid

¹⁵⁴ Interview GIII, Sydney, 25 July 1996.

¹⁵⁵ Interview, Melbourne, 18 July 1996.