AN ASSESSMENT OF COMMUNITY-BASED DELIVERY OF FAMILY PLANNING SERVICES IN TIMOR-LESTE

Jennifer Berthiaume
Mary Anne Mercer
Susan Thompson
Marisa Harrison

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HEALTH ALLIANCE INTERNATIONAL

SCHOOL OF PUBLIC HEALTH
UNIVERSITY of WASHINGTON

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Table of Contents

Page

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List Of Abbreviations

CHC – Community Health Center

DHS- District Health Service

DHS- Demographic Health Survey

FP – Family Planning

HAI – Health Alliance International

HCSBS — Health Care Seeking Behavior Study

HNI – Health Net International

IUD – Intrauterine Device

MoH – Ministry of Health

MSI – Marie Stopes International

NGO – Non-Governmental Organization

PSF – Promotor Saude Familia

SHARE – Services for Health in Asian and African Regions

SISCa – Servisu Integradu Saude Communitaria

TAIS – Timor-Leste Asistencia Integradu Saude

Executive Summary

While the health of Timor-Leste's population has been impacted by a history of Indonesian occupation, conflict and great economic and social hardship, in particular, mothers and children continue to have poor health outcomes. Maternal and infant morbidities and mortalities are high and a third of all women of childbearing age have an unmet need for family planning. In 2008, the MoH implemented an integrated community health outreach service program, SISCa – *Servisu Integradu Saude Communitaria* - to address the lack of infrastructure that prevents the utilization of health services in rural communities and to increase the coverage of health programs, including family planning provision.

The aim of this assessment was to determine the effectiveness of SISCa in providing family planning services and counseling. Nine SISCa posts were observed in the regions of Ermera, Manatuto and Aileu. These sites were supported by NGO staff from Health Alliance International (HAI), Timor-Leste Asistencia Integradu Saude (TAIS), Services for the Health in Asian and African Regions (SHARE) and Marie Stopes International (MSI). At each SISCa post 1-2 semi-structured interviews were conducted with service providers and trained volunteers known as *Promotors Saude Familia* (PSFs) to ask about the provision of family planning services and 1-2 interviews were conducted with community women to ask about family planning preferences. Interviews with two District Health Services (DHS) staff members and four NGOs were also conducted. This assessment utilized observational data at each SISCa event that included a rough count of the number of people, the number of staff and providers, and services provided.

It was important to establish users' knowledge base at the onset: most women could identify at least one aspect of what family planning and/or define what child spacing was. Two women learned about family planning from a friend or family member, five from a midwife at a SISCa event, and six from the nurse or midwife at the CHC. Seven women could identify the benefits of at least one family planning method. While most of the women knew of family planning, many were not familiar with child spacing methods and fewer still had either the access or desire to use a family planning method.

Women expressed feeling afraid to bring up family planning with a midwife who might be judgmental. Negative interactions with midwives were an impediment to use of family planning. Women were also hesitant to discuss family planning with health workers without conferring

with their husbands and their in-laws. Other barriers included the distance to travel on poor roads with little transportation, lack of privacy at SISCa, insufficient funds, and lack of childcare.

SISCa successes included dissemination of family planning knowledge to communities far from the CHC, the use of SISCa as an entry point for discussions around family planning, and stronger relationships with women through monthly interactions.

The main factors cited by midwives and nurses that hinder the provision of family planning services at SISCa were lack of privacy and time at SISCa, stock-outs of methods, lack of consistent transport for staff and materials, unsatisfactory sanitary conditions to perform more complex procedures, lack of coordination between the CHC, the PSFs, the *chefe de suco,* and the pro-natalist influence of the Catholic church. All of the midwives stated that there was not enough time to provide counseling for women at SISCa and almost all identified a conflict in leaving and potentially having to close the CHC to attend SISCa due to lack of available staff.

Most PSFs expressed a desire for more comprehensive family planning training and believed that they could incorporate promoting family planning into home visits. Midwives and nurses supported the idea of having PSFs initiate family planning conversations with community members. Women were open to having conversations with PSFs in their homes. Challenges for PSFs included a perceived lack of recognition by the MoH for their work, inconsistent payment and scheduling of SISCa events. PSFs wanted to be more involved in SISCa planning and have more dialogue with the district health staff. Providing and monitoring incentives, monetary and non-monetary, to PSFs would help to strengthen this work force.

Women also said they often could not understand or retain family planning knowledge when speaking to midwives at health facilities or at SISCa, and so, were unable to explain it clearly to their husbands. Developing and providing take-home family planning materials could alleviate women's concerns in providing accurate and appropriate family planning information to family members.

Midwives expressed that having partner organizations available at SISCa to provide family planning services freed them up to provide other needed services to women. DHS staff members identified the strength of having organizations that emphasized direct services to women in the community as well as overall support to SISCa. Some mentioned that it is helpful when NGOs are based in the district because staff is easily accessible when issues arise.

Direct service and health systems strengthening are both important facets to providing family planning services to women. NGOs that support SISCa are complementary in providing both of these components. DHS staff, midwives, and nurses asserted that NGO support is imperative in SISCa implementation and desired continued collaboration. Greater use of NGO expertise in modeling family planning counseling and method provision to midwives could reduce the number of referrals needed to perform procedures and increase the number of procedures performed.

Women did not identify any one place that they preferred to receive family planning, but instead, mentioned SISCa, CHC, health posts and their homes as places that were accessible to them for various reasons. The data gathered in this assessment supports the need for provision of family planning in multiple settings and across many platforms to ensure more comprehensive care to women and their families.

Given the information gathered from this assessment, some of the recommendations to the Timorese Ministry of Health and other organizations working in reproductive health in Timor-Leste include:

1. Continue to provide family planning counseling and methods as a multi-site service at both the community and health centers level and integrate with primary health care services and with child immunizations visits;
2. Develop take-home information on the benefits of family planning and explaining the different methods available in Timor so that women could have a reference when discussing family planning with their husbands and family members;
3. Further encourage and motivate PSFs performance through greater programmatic feedback, coordination with SISCa scheduling, and dialogue, recognition and rewards by MoH health staff in the form of grant funds, loans and selection of the best national SISCa and PSF on a yearly basis;
4. Pilot a model of PSFs delivering family planning promotion during home visits, perhaps as a quality Improvement Collaborative in motivate and encourage PSFs;
5. Train PSFs to provide introductory information about family planning benefits and methods to community members on monthly home visits in order to encourage women and their husbands to attend services and speak to the midwives about family planning;
6. Consider utilizing district-based models for NGOs that support SISCa in order to enhance communication with CHC partners and to ensure sub-district logistical issues are dealt with efficiently.

Background

Timor-Leste is an island nation located in Southeast Asia that has been deeply affected by a history of Indonesian occupation, conflict and great economic and social hardship. While the collective, violent past has impacted all members of its population, the health of Timor-Leste's mothers and children has been particularly compromised. Indications of this are a maternal mortality ratio of 557 per 100,000 and an infant mortality rate of 45 per 1,000 live births. While there has been significant improvement in the overall total fertility rate since the 2003 Demographic and Health Survey (DHS), the recent 2009-2010 DHS shows that Timor-Leste still has the highest total fertility rate in all of Asia with 5.7 births per woman. On average, rural women have one child more than urban women (6.0 vs. 4.9 births per woman). A third of women have an unmet need for family planning, and there was a two-fold increase in the use of modern methods of contraception between 2002 and 2006 and a 50% increase between 2007 and 2010. Overall contraceptive use has increased from 10% according to the 2003 DHS to 22% in less than a decade, with 1 in 5 woman currently using a modern method.

In addition to the destruction of major health infrastructure throughout the country, part of the legacy of twenty-four years of Indonesian occupation is a scarcity of medical personnel with relatively low levels of training (Povey & Mercer, 2002). Recognizing these barriers to family planning provision, the MoH identified the need to upgrade the training of health workers (particularly midwives) to counsel and to distribute family planning methods as part of their National Reproductive Health Strategy for Timor-Leste. As Timor-Leste is predominantly Catholic, another significant barrier to family planning provision has been the hesitancy of the Church to promote the usage of modern methods. The MoH and NGOs that specialize in maternal and newborn health have worked hard to collaborate and dialogue with the Catholic Church to advance issues in reproductive health.

In 2008, the MoH implemented an integrated community health service program, SISCa – Servisu Integradu Saude Communitaria – in over 400 *sucos*, or villages, to address the problems of access that prevents the utilization of health services in rural communities and to increase the coverage of health programs, including family planning provision. SISCa is coordinated by and a product of community members, such as the *chefe suco* (village chief), *chefe aldeia (*neighborhood chief), community health volunteers, and other community leaders. Much research has been done to assess and promote the use of mobile health clinics to provide greater access to family planning and child spacing services. Among this research, Ogbeide and Edebiri (1984)

found that clinics implemented in Nigeria were successful in ensuring that less educated women were given sufficient family planning information. Molyneaux, Alimeoso, Lerman and Moeljodihardjo (1988) demonstrated in 1988 in Indonesia that mobile medical team visits significantly affected the growth of pill acceptance, and that clinics saw an increase in IUD and injectable contraceptive acceptance. In Colombia, Profamilia cited their mobile family planning program as one of the reasons for Colombia's contraceptive prevalence rate of 72%, which was one of the highest in Latin America at the time (Profamilia, 1995). Teela, Mullany, Lee, Poh, Paw, Masenior, Maung, Beyrer and Lee (2009) also described the importance of providing community-based delivery of maternal care through the implementation of the Maternal Obstetric Maternal Health Worker ("MOM") Project in conflict areas in eastern Burma.

The goals of the SISCa program include improving the health of communities through the reduction in mortality and morbidity rates, increasing utilization health services, the provision of health promotion and education, improving the nutritional status of the communities, advancing the conditions of the environment and engaging communities in improving their health (Ministerio da Saude, 2007). To that end, SISCa supports a broad range of health interventions through the use of a six table service system. The services provided at these six tables include: (1) population registration; (2) nutrition; (3) maternal and child health including family planning counseling and provision; (4) personal hygiene and sanitation; (5) general health care services and (6) health education.

SISCa is coordinated by trained volunteers known as *Promotors Saude Familia* (PSF), chosen by the community, who work to motivate the community members to attend SISCa every month, serve as positive examples of good health practices, coordinate and implement health promotion services including registration, height and weight measurements, and conduct health education at the SISCa events. According to SISCa guidelines, there should be at least three PSFs at each SISCa post and PSFs collectively should receive $25 as an incentive for their work every month at each SISCa event (Ministerio da Saude, 2007). Health staff from regional CHCs (Community Health Centers), including midwives, nurses and assistants, also staff the tables to provide health services such as immunization provision, ante-natal and post-natal care to women, family planning, and general curative services. If available, a doctor from the CHC will also attend SISCa events to provide basic curative services to patients. SISCa posts can be located anywhere

in the *suco* and their location is determined by community agreement. This location ideally should be easily accessible to community members and consistent over time.

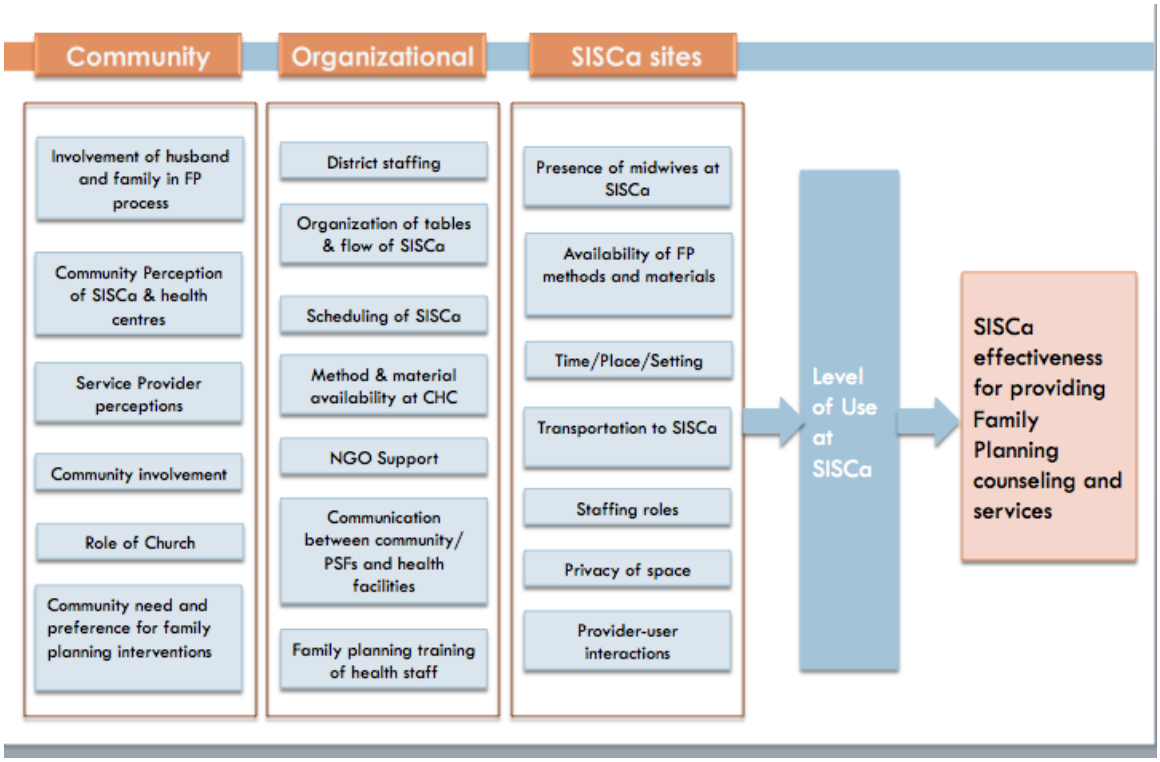
In addition, various NGOs, including Health Alliance International (HAI), Marie Stopes International (MSI), Timor-Leste Asistencia Integradu Saude (TAIS) and Services for the Health in Asian and African Regions (SHARE), have been working in collaboration with the MOH to support SISCa implementation as part of their work in promoting maternal and newborn child health in Timor-Leste. HAI promotes family planning and other services at SISCa through a supervisory program for midwives and supports overall SISCa functioning by working with district health staff to monitor the overall SISCa program. MSI provides oral and injectable family planning methods at SISCa and can also perform more complex procedures such as IUD and implant insertion, which would normally not be able to be provided at the community level. Typically, interested women must travel to a CHC or district-level health facilities for these methods. While HAI can also provide direct service support, staff will only do so in a supportive role when there is no midwife present or when the SISCa is very busy. SHARE and TAIS support SISCa through health promotion and logistical assistance such as transportation, supplies and support staff.

In 2010, key members of the MoH and representatives from HAI and TAIS attended an international conference on maternal and child health and family planning. Over the course of the conference, entitled "Reconvening Bangkok 2007-2010 – Progress made on Scaling-up FP/MCH Best Practices in Asia and the Middle East", stakeholders discussed what is commonly referred to as the "Bangkok Plan". Some of the goals for this plan include ensuring that 50% of SISCa posts have a private space for counseling and family planning services and that 80% of *sucos* will have a PSF doing family planning outreach by 2013 ("Country Team Action Plan: Timor-Leste, 2010). The current PSF cadre are responsible for basic health promotion, including nutrition, first aid, and vaccinations, but has had little or no initial training in family planning. Data from other countries presented at this conference demonstrated that PSF involvement in family planning might positively impact the delivery of services.

This assessment will help to identify the successes and challenges of a major MoH program, SISCa, in providing family planning counseling and services to the rural Timorese population in the three districts of Ermera, Aileu and Manatuto. This assessment used qualitative methods to identify community and service provider preferences and to provide a more contextualized interpretation of how SISCas are running in different settings.

A basic conceptual framework was created for the assessment (Figure 1). This framework was designed first to theorize the main factors that influence family planning provision at SISCa and subsequently to develop pertinent interview questions. Moving across from left to right, these factors are present at the community, organizational and site level. At the community level, involvement of service providers and community members in SISCa, overall perceptions of appropriate family planning provision, and community desire for family planning influence the utilization of SISCa. Environmental factors such as the Catholic Church, which has historically been opposed to modern methods of family planning, also influence the behavior of community members. At the organizational level, support by the MoH and various NGOs influence the implementation of SISCa on both a district level and site-specific level. Logistical considerations such as communication and the national availability of family planning methods and educational materials also impact family planning utilization at SISCa. At the site level, health staff issues, transportation, physical layout and the provider-user interface all influence how effective individual SISCa sites are in providing family planning counseling and services.

Figure 1. Conceptual Framework of Family Planning component within SISCa



[See Appendix A for larger version]

Main Objectives

The aim of this assessment was to answer the question: How effective are SISCas in providing family planning services and counseling? The effectiveness of SISCas is dependent on many factors including logistical and programmatic issues, availability of supplies, community involvement, health staff motivation, provider and user preferences and interactions as well as time, place and setting of these SISCa events. To answer this question, midwives and nurses, women and community health workers were asked about the provision of family planning services and counseling at SISCa. The following objectives were defined.

1. Observe at SISCa events the extent to which family planning counseling occurs and FP methods are distributed, tabulating the following measures of quality of service: available methods and materials; availability of a private space for counseling; presence of Table 3/Maternal and Child Health services; number and type of health staff; number of women at SISCa; provision of family planning counseling by midwife.

2. Identify strengths and barriers perceived by midwives, nurses, and community women to providing family planning services at SISCa events.

3. Identify preferences for the context in which community members would like to receive family planning services.

4. Observe the ways in which different NGO-supported SISCa posts provide family planning counseling and services and explore best practices in strengthening the SISCa model.

Methods

To assess the effectiveness of family planning services at SISCa, site visits at nine SISCa posts were conducted. The unit of analysis was the SISCa post. Purposive, stratified, multi-site sampling was used in order to compare nine SISCa posts, supported by staff from HAI, TAIS, SHARE and MSI, in the Ermera, Manatuto and Aileu districts. These four international organizations were chosen because they all support SISCa sites and all promote some form of family planning work through SISCa. Ease of transportation and availability were also factors in the selection of NGOs. Each SISCa post was visited once except for the SISCa in Assi, Letefoho, which was visited twice. Due to availability of time and transport, Assi was visited twice and three more interviews with women in the community were conducted. SISCa posts were stratified

based on the type of NGO support given in order to provide the maximum variation in data, to determine how SISCas are run overall and key differences between them (Bernard & Ryan, 2010).

At each SISCa post we conducted one to two interviews with service providers such as midwives and nurses, and with PSFs to identify the self-perceived barriers that they face in providing family planning services. One or two women were also interviewed at each site to explore in what context they would like to receive family planning services. Two staff members at a District Health Services (DHS) office were interviewed to provide insight on the overall SISCa program and one interview was conducted with each of the supportive NGOs to gather information about the general role of each NGO at SISCa. These interviews were semi-structured and included questions about the respondent's background, training, family planning knowledge and preferences. Throughout data collection some of the questions were amended or dropped if they did not seem pertinent to the experiences of the community or if the question did not seem to resonate with the informant. A translator was used for the interviews, which were conducted in Tetun language (and Mumbai in some instances).

Key informants at each SISCa event were selected using a convenience sampling method across all health services provided. In some instances midwives and other health staff solicited respondents to participate. MoH staff was helpful when women felt shy and needed assurance from a trusted and known health worker with ties to the community. Sampling women who were waiting for both family planning services as well as other health services ensured that women who were not already accessing family planning services at SISCas were also included in this assessment and thus providing greater representation of the experiences of women in the community as a whole.

The interview guides (see Appendix C) were translated into the Tetun language and pilot tested in an HAI-supported SISCa post. This ensured that the questions were accurately translated, properly phrased and well understood in order to elicit the right data in an reasonable amount of time. Foll0wing field testing the interview guides were prior to collecting data at SISCa events.

In addition to interviewing community members and service providers, this assessment utilized observational data from nine SISCa posts using descriptive field notes that included 1) a rough count of the number of people attending each SISCa event, 2) the number of staff and providers, 3) what services were being provided, 4) how many tables were active, and 5) any other observations that came up during the time that the SISCa event took place. A tally of some

quality measurements such as the number of family methods available, family planning materials used by midwives and nurses, and how many women received family planning counseling or methods was completed. This information helped to inform interviews with the service providers.

Table 1. Selected SISCa locations and number of interviews conducted

SISCa post	District	Sub-District	Suco	Aldeia	# Interviews			
					Midwife	Nurse	PSF	Women
1	Aileu	Remexio	Hautoho	Lilitei	0	2	0	1
2*	Ermera	Letefoho	Haupu	Assi	1	1	1	1
					0	0	0	4
3	Ermera	Atsabe	Tiarelo	Sede suco	1	0	1	1
4	Manatuto	Laclubar	Compubaro	Pualaka	1	0	1	2
5	Manatuto	Laclubar	Manelima	Lafulau	0	1	1	1
6	Ermera	Letefoho	Laucau	Assui Leten	1	0	1	1
7	Aileu	Remexio	Fadabloko	Lilitei Rai fatu	0	0	0	1
8	Aileu	Remexio	Tulatakeu	Aikurus	1	0	1	4
9	Ermera	Atsabe	Lemea Leten	Orbeto	0	0	4**	1

* SISCa #2 was observed on two occasions: July 8th & August 5th
** Interviews were done simultaneously in a focus-group setting

Table 2. Interview Key Informants

Informants	Number of Interviews
Midwife	4
Nurse	4
PSF	10
Community women	17
District Coordinating Staff	2
NGO staff	4
Total	41

Each interview was digitally recorded and uploaded into Transana, a qualitative data analysis program, and coded for themes (Spiers, 2004; Kumar & Kumar, 2005). Field notes and memos were written daily to provide descriptive information about SISCa and were coded. Contact summary sheets were written up after each interview and a site summary sheet was completed

after each SISCa visit. Data analysis was conducted using open coding to generate new themes (Miles & Huberman, 1995). While the original conceptual model was used as a guide for possible issues related to SISCa, themes were identified by the data itself and not a-priori. A codebook was developed that categorized the data based upon general themes.

This assessment was approved by the Ethics Review Committee at Health Alliance International and was also reviewed by the Technical and Ethical Committee within the Cabinet of Health Research and Development at the Ministry of Health, Timor-Leste.

Preliminary results were then discussed in a multi-disciplinary group of stakeholder during a presentation before leaving country. This forum helped to triangulate the findings, clarify meaning, perceptions and ensure no misunderstandings.

Results

Characteristics of the SISCas observed

Multi-site analysis of nine SISCa events was conducted to compare how family planning services were provided in various settings (see Figure 4). Six of these posts were supported by HAI, while TAIS, MSI and SHARE each supported one post. Three posts were supported by more than one organization: in Letefoho, the Assi SISCa was supported by HAI and Health Net International (HNI); in Remexio, the Fadabloko SISCa was supported by HAI, World Vision, and HNI; and in Remexio, the Aikurus SISCa was supported by SHARE and World Vision. In collaboration with HAI, HNI supports the CHC midwives through the provision of family planning counseling at some SISCa sites. Their staff is trained by HAI and shows a family planning video “Espaso Oan” (Child Spacing), created by HAI, in different communities in order to widen the population exposed to family planning information.

In total, seven SISCa posts had a midwife present who could provide family planning counseling and methods. MoH-employed midwives attended six SISCa and NGO-based midwives from HAI, HNI and MSI attended five SISCa posts. In Assi, Lacau, Aikurus and Lemea Leten, midwives from both the CHC as well as partner organizations were present.

Family planning methods as well as materials such as flipcharts, posters and patient family planning registration cards, were available at six sites. The most common methods available at SISCa were the pill, the Standard days method (a method that uses cycle beads to predict fertility

based on the length of a woman's cycle), and the Depo injection. The MSI supported SISCa in Lemea Leten, Atsabe, was the only site that had the capacity to provide IUD and implant insertion in a sterile environment in addition to providing one-on-one family planning counseling to women. A more conducive and sterile space within the SISCa site to perform IUD and implant insertion was achieved through the use of a sterile portable bed and equipment, and medical instruments that were brought to the site by MSI staff. Women received some form of family planning method at three of the observed sites: three women had implants inserted at the MSI-supported SISCa, two women continued to receive their Depo injections at another site and women received both the Depo injection and pills at the a third site in Letefoho on both occasions this site was observed.

All but one of the sites at which the midwife was present had available methods and materials. The midwife at the SISCa site where family planning materials and methods were absent did note that usually she brings them to SISCa every month, but on that day they were locked in a cabinet for which she did not have the key. This suggests that these family planning supplies accompany the midwife and are generally not brought to the SISCa if the midwife is not also present.

Family planning counseling - both in a group setting as well as with individual women - was conducted at four of the nine SISCa events. Statements from the midwives that family planning does not occur at SISCa in their absence supported this notion. All SISCa posts except Fadabloko had PSFs present. Some form of private space was available in seven posts, although there was some confusion in Assi as to whether the room or building used for family planning counseling was permanent. Many stated that the current place used for counseling was not adequately private enough for women to feel comfortable speaking about family planning in confidence with the midwives.

Figure 4. Multi-site comparison of SISCa

Suco, District	Support Org.	Midwife Presence	FP Counseling	FP Materials	Private Space Available?	FP methods	# Methods provided
Hautoho, Remexio	HAI	No	No	None	Yes	None	0
Assi, Letefoho	HAI	NGO MoH	Yes	Yes	Yes	Depo Pills Standard day beads	3-depo 4-pills
							2-depo 1-pills
Tiarelo, Atsabe	TAIS	MoH	No	None	Yes	None	0
Pualaka, Laclubar	HAI	MoH	Yes	Yes	Yes	Depo. Pills Standard day beads	0
Lafulau, Laclubar	HAI	No	No	Yes	Yes	Depo Pills Standard day beads	0
Lacau, Letefoho	HAI	NGO MoH	No	None	No	None	0
Fadabloko, Remexio	HAI, World Vision, Health Net	NGO	Yes	Yes	Yes	Depo Pills Standard day beads	0
Aikurus, Remexio	SHARE, World Vision	NGO MoH	Yes	Yes	Yes, Not permanent	Depo, Pills Standard day beads	2-depo
Lemea Leten, Atsabe	MSI	NGO MoH	Yes	Yes	Yes	Implants, Pills, IUDs, Depo, Standard day beads	3-implants

Community characteristics, knowledge, and use of family planning

Most of the women (13 out of 17) who were interviewed were able to identify the benefits of family planning and/or child spacing was, first learning it from a friend in the community or a family member (2), from the midwife at a SISCa event (5), or from the nurse or midwife at the CHC or health post (6). It is clear midwives are the primary providers for information on family planning. While many women recognized the concept of family planning, only seven of the 17 women interviewed could identify at least one modern method of family planning, and, of those women, only six had ever used some form of modern family planning. All of the women who had ever used a modern method were also currently using the same method when interviewed. This implies that while non-users may know the benefits of family planning, they may not be familiar

with specific child spacing methods. The most common modern methods used by the women were the Depo-Provera shot followed by the pill. Of these six women, two received either the contraceptive pill or the Depo-Provera shot at SISCa; three received the pill or the Depo shot at their closest CHC; and one woman's husband had a vasectomy in a Dili hospital. Five of the six women reported having talked to their husbands and/or family members about family planning.

Midwife and nurse perceptions

Ten service providers were interviewed in order to explore their views on the successes and challenges for providing family planning at SISCa. These informants included midwives, nurses and two DHS staff in Gleno, Ermera. Three CHC midwives, who consider themselves to be the main providers of family planning services, were interviewed at SISCa sites in Letefoho, Atsabe and Remexio. Additionally, a nurse from Health Net was interviewed at a SISCa site in Letefoho.

Some of the successes at SISCa in promoting family planning cited by midwives included greater dissemination of family planning knowledge to communities far from the CHC, and stronger relationships with women through sustained interactions on a monthly basis. Midwives recognized the need to provide services to women who are not able to access health facilities and feel that over the past two years, they have become a familiar figure to women at these SISCa sites.

Midwives identified a variety of challenges to providing family planning at SISCa ranging from a perception of community hesitation to discuss family planning to the logistical constraints of providing services. Referring to the perception that women are averse to asking about family planning at SISCa, one midwife stated,

> *"When SISCa goes to their suco, [women] want to ask the midwife about family planning, but they feel shy to ask. Most of the women go to CHC to meet with the midwife where they don't feel shy because the women feel this place is free and safe to ask the midwife". midwife".*

This quote also refers to issues such as perceived privacy and the women's comfort level at SISCa in discussing sensitive topics such as family planning. Other midwives and women who were interviewed echoed this woman's perception that midwives at CHCs were the predominant point of access for family planning services.

All of the midwives stated that there was not enough time to provide counseling for the women at SISCa due to the competing need to provide ante-natal and post-natal care and vaccinations for newborns and young infants. Another constraint was that almost all of the midwives identified a conflict in leaving the CHC in order to provide services at SISCa, knowing that in most instances, the CHC would have to be closed for lack of available staff. Most midwives did opt to attend SISCa, but did so somewhat reluctantly. One midwife explained,

> *"When it is time for SISCa, the Ministry of Health wants me and doctor to go to the community. We bring all the supplies and medicine with us. Because there is no one left at CHC and no medicine as well, we have to close the CHC for the day."*

While most SISCa sites had a designated private location to discuss family planning with women, the midwives expressed concern over how discrete these private rooms proved to be. Some felt that the CHC was a more appropriate place to speak to women one-on-one about family planning, as there was more time to speak thoroughly, as well as rooms that were completely private. However, one midwife also stated that SISCa is a good entry point to begin a discussion about family planning because *"women who do not understand family planning can hear about it at SISCa and then come back and talk with me about it later when they are ready"*.

Three midwives conveyed that greater involvement of PSFs in promoting family planning and in referring women to the midwives at SISCa would be beneficial; however, they expressed the need for greater PSF training in the area of family planning. According to one midwife,

> *"If the government did a training for the PSFs on family planning it would be better for us [midwives] because they could help to explain family planning when were are busy attending to pregnant woman and sick children at SISCa."*

Among all of the service providers there was a sense that only the midwives had the training to explain family planning clearly to the women, but that it would be helpful if all service providers including PSFs had at least a basic understanding of main family planning rationale and methods.

The four nurses interviewed in Remexio, Letefoho and Manatuto identified many of the same successes and challenges to providing family planning services at SISCa. While the scope of the nurses' work is much more broad than that of the midwife, which is primarily that of maternal and child health, women in the community also ask nurses to clarify and explain family planning. All of the nurses had basic training of family planning, but they reiterated that the midwives were

the most competent staff to provide family planning counseling. They all cited concerns over their background and training in family planning and stated that they commonly referred women to the CHC to talk to the midwives. Some expressed a desire for more training in order to provide accurate information to women and some believed that training PSFs to provide family planning counseling would also be beneficial when midwives were engaged in other services. One nurse stated that during Indonesian rule,

> *"…nurses used to come with midwives to the districts and go door-to-door especially to talk to women about family planning. This is better than talking to women at SISCa [about family planning] because there is more time and women feel more comfortable when they are alone…In the future, it would be better if health staff or PSFs went door-to-door again."*

Another major challenge that was identified by the nurses was the lack of coordination between the CHC, the PSFs, and the *chefe de suco* in which the SISCa event was being held. Miscommunication often resulted in poor community attendance, as they were unaware that a SISCa event was taking place.

Community perceptions

Throughout the interviews, there was a strong, and consistent desire to learn more about family planning: almost all of the women wanted to learn about family planning at greater depth. One woman explained,

> *"When I get check-ups for my pregnancies I always go to Letefoho. The nurse explains a little bit about family planning to me. I want to have four children and I told my husband that after we have our second child we will wait three or four months because I need to take care of my body and my baby. I want to use Depo [Provera] to stop having children."*

One woman, who did not wish to learn more about family planning, stated,

> *"The midwife has asked me at SISCa if three children is enough for me and if I want to follow family planning. Most women here want to learn about child spacing, but I do not want it. I want more children and will leave it up to God".*

While this woman was the only one who spoke of leaving the size of her family up to God during this assessment, past research has shown that the role of the Catholic Church in discouraging the

use of contraceptives is influential in the decision-making process of using family planning services (Timor-Leste Health Care Seeking Behavior Study, 2008)

Women generally seemed hesitant to discuss family planning extensively with health workers without conferring with their husbands and their mother and father-in-laws. Most expressed a desire to discuss family planning with a health worker in the presence of their husbands:

> *"I want to learn about family planning, but it is very difficult for me because I need to ask my husband first. I want bring my husband with me one day to SISCa so that when the midwife explains about family planning, we can do it together."*

None of the husbands of the women who were interviewed were present at SISCa either at the time of the interviews or when women spoke to the midwives. One woman reported that her husband traveled by himself to the CHC to speak with a midwife about family planning. One woman used the Depo shot without the consent of her husband and two women wanted to use family planning, but were discouraged by family members. As one woman reported,

> *"I tried to talk about family planning to my husband and asked if we could have two kids. My husband agreed, but my husband's father and mother did not agree. They want to have a big family; they do not want to be a small family."*

Two women explained that their husbands and their parents wanted a big family so that there would be more help on their farm. These findings support previous data that much of the decision-making surrounding family planning usage comes from the husband and his parents (HCSBS, 2008).

Women who previously had heard of family planning cited different preferences for where they wished to get more information in the future. Two preferred to receive family planning services at their home, six preferred to received services at SISCa every month and six preferred to go to the CHC to speak to the midwife about family planning. Women who cited the home as their preferred place of care valued privacy and discretion as well as the ability to easily involve other family members in the discussion. Lack of adequate child care – should the mother have to go to for a health facility – also made this option the most viable for some women. Midwives were cited as the primary desired health worker to provide family planning services in the home, although PSFs were also cited as possible providers of basic family planning information. One woman stated,

"I think PSFs should learn about family planning so that they can tell us about it when the midwife is not here. She [the midwife] does not come here often. It is better for women to learn from PSFs and then ask the midwife for more information at SISCa."

While PSFs were not seen as a potential primary source of family planning information and services overall, given adequate training, they were viewed as a potential avenue for learning about family planning at the home, where the environment would feel much safer, private and convenient. Women also viewed PSFs as more consistently accessible than health workers from the CHC.

Women who preferred to receive family planning services at SISCa cited the convenience of accessing the midwives at a closer proximity to their homes. Many also stated that as SISCa continues the events are being held on a more regular basis and because of this, they feel more comfortable receiving contraceptives at SISCa.

"Before SISCa did not come to Assi and I was getting depo in Letefoho. SISCa opened in July of 2009 and now I am ready to get [depo] injections every 3 months and maybe in the next three months I will get my sixth [depo] injection in Assi."

However, women also stated that a lack of privacy at SISCa dissuaded them from bringing up family planning with the midwives. Many women stated that although the CHC was not in close proximity to their home, they still preferred to speak to the midwife about family planning there due to a greater level of privacy from the rest of the community as well as the local church. Additionally, services and staff at CHC were reliably present and women were able to choose for themselves when they sought care as opposed to fixed days of SISCa events. Issues that dissuaded women to access care at the CHCs included the distance to travel on poor roads with little transportation, insufficient funds, and lack of childcare. As there were various factors that influenced where women preferred to obtain family planning services, ensuring a variety of options for women would provide communities with the best access.

PSF perceptions

In addition to interviewing CHC health staff, ten PSFs at seven different SISCas were interviewed to assess their role at SISCa and to identify their family planning knowledge. Four PSFs in Atsabe were interviewed in a focus group like setting due to the strong desire for each PSF present to express their views and concerns about SISCa in their community. As time to perform interviews was limited, questions were posed to these PSFs in a group rather than

individually. Most PSFs stated that they had a basic understanding of family planning, but many could not identify more than one method and none felt that they had enough knowledge to speak to women about family planning. All of the PSFs expressed a desire for more comprehensive training as most of what they had acquired was through the midwives and brief explanations during their introductory trainings when they first started working as PSFs. One PSF explained,

> *"The community here wants to know about family planning. They want to know about family planning because it is very important. If you don't want to have more children, it is very difficult for you without family planning. You don't have the ability to support them to go to school and you don't have money to buy their clothes. So, from this program [SISCa] they can know about it."*

While many stated that their current tasks at SISCa and those asked of them by various NGOs kept them quite busy, all ten PSFs believed that they could incorporate promoting family planning while they promoted other health activities door-to-door in their community. Indeed, over half of the PSFs were already being asked by CHC midwives to bring up family planning when they spoke to women and to refer women to the midwives to discuss family planning at SISCa. Because of this, the PSFs felt that they needed to be better equipped to answer questions that were being asked of them in the community. The PSFs conveyed a genuine desire to help their communities and to be given the tools to do so. Another PSF stated,

> *"First, the midwife explains a little bit about family planning to me and then she asks me to go door-to-door to give information about family planning to the community as well as information about SISCa…I want to learn more about family planning because it is very important. If I don't learn about family planning and tell it to my community, who will?"*

The PSFs also identified some challenges of SISCa as a whole. Some PSFs did not feel that they were rewarded enough for their efforts and that the inconsistency with which they got paid was a major challenge to their work. SISCa Guidelines outline the provision of $25 per monthly SISCa event to be used collectively as incentive for the PSFs (as well as transport and associated costs), but this did not seem to be the case for every PSF interviewed. Most PSFs interviewed identified that the incentive norm was seen to be $5 per SISCa event (regardless of how many PSFs were present in each suco) and while some received this incentive on a regular basis, others explained that they were given money weeks and even months late. Some felt the $5 to be an inadequate incentive or "salary":

> *"I work as a PSF to motivate and educate the community and also go door-to-door to explain what I have learned from the Ministry of Health as well as about SISCa…I don't feel satisfied with my salary as 5 dollars every month is not enough for me"*

As liaisons between the CHC and the community, many of them did not feel valued as part of the health staff team at SISCa. They conveyed frustration when SISCa schedules changed without being told in advance, as they were the ones held accountable by the community. PSFs reported that these misunderstandings ultimately created more work for them and that greater coordination between the CHC and the *chefe suco* would decrease disruptive scheduling changes. This issue was articulated by PSFs in all of the districts visited. Instead of performing interviews with these PSFs, a focus group-like discussion was held so that there was adequate time to speak to all the PSFs who wanted to be heard. One PSF, describing his frustration at times with SISCa scheduling, stated,

> *"When the government changes the date of SISCa without informing us, we have to go to the community and tell them to come very quickly when SISCa arrives here. This makes me upset because the community sometimes does not come to SISCa and also, the community gets angry because they do not know about it. Why does the government not tell us of these changes?"*

PSFs conveyed a desire to be more involved in SISCa planning and also expressed the need for greater feedback and dialogue with the district health staff. Some PSFs shared their appreciation for regular feedback discussion with health staff. In one district a PSF recounts,

> *"Every two or three months I go to the CHC and discuss what is happening at SISCa. They tell me how many people have gotten sick in my community and how many have died and we talk about things that we can do to make SISCa better."*

PSFs relayed a need to be given even more feedback about their performance. PSFs wanted their feedback sessions to also include feedback by PSFs to the district health staff on what is and is not working at SISCa. One PSF explained, *"When I have meetings…with the health staff I always discuss the problems that my community faces in this suco. They [health staff] never respond and then never listen to me."* In every region visited, PSFs expressed this desire to have feedback on their performances as well as the opportunity to give feedback to the district health staff.

Cross-Cutting Themes

Provider-User Rapport

During the interviews with women who wanted to learn more about family planning, the most prominent theme that arose when discussing barriers to care was the women's reticence to speak to the midwives, both at the SISCa site and the CHC. Women reported feeling afraid to bring up family planning with a midwife for a number of reasons. In communities that were geographically remote and far from the CHC, many women historically did not have much interaction with the midwife. Many preferred to send for the traditional healer or a local community or family member during the birthing process due to the distance that they would need to travel in order to give birth at a health facility, but also due to the lack of ties to health staff. One woman conveyed,

> *"I have never talked with a midwife [about family planning] and gave birth with assistance from a nurse in Maumeta. Once, the midwife came to Maumeta, [but] I didn't want to talk because I was afraid to ask the midwife about family planning."*

With the creation of SISCa, many women reported feeling greater rapport with midwives through sustained interaction and noted that this was beneficial when they needed assistance either during birth or in pre- or post-natal care. Women expressed appreciation that the MoH was providing much needed health services at the community level. Indeed, a number of women conveyed a deep affection for and closeness to the CHC midwife.

> *"When I talk to the midwife [from the health post], as a woman, I feel very comfortable. If you have health problems, you need to talk to the midwife. If you try and hide your problems, they will get bigger. I feel free to talk to the midwife because she supports me whether I choose family planning or not."*

Several women, however, still shared a hesitation to speak with the midwives even when they were easily accessible at SISCa and knew them well. They were fearful to bring up family planning themselves to midwives when visiting for other health reasons and stated that midwives did not initiate a conversation about family planning with them on their own accord. The midwives who were interviewed echoed this perception. Some stated that they did not have time to bring up family planning, but instead, waited for women to ask about it. One woman in Remexio conveyed an episode in her past where she was afraid to speak to the midwife about using family planning because she thought the midwife might become angry with her for ignoring her previous advice. This woman has a serious medical condition that impacted her reproductive

health and the health of her children, yet chose not to seek care for fear of reprisal. Women also reported feeling concerned about accessing midwives should an emergency arise outside of normal office hours. A few women recounted instances where the midwives were inflexible with their time and discouraged women from coming to the CHC unless they arrived in the morning hours. In one interview, a midwife conveyed frustration at having to attend to community members after hours.

> *"Sometimes people will come to the CHC after 4pm to talk to someone about their illness. When they see that the CHC is closed they will come to my house. When I go home every night I bring supplies and medicine with me so that I will have them if someone suddenly comes to my house. It is a lot of work and I never stop working!"*

Another barrier to family planning provision that was identified by women was their inability to either understand or retain family planning knowledge when speaking to the midwives. While there are many family planning materials, such as flipcharts, posters and videos, that aid midwives in describing family planning and which methods are available to them at the CHC, some women either were not shown these materials at the CHC or did not retain this information long enough to relay this information back to their husbands once they returned home. This created an information gap between health providers and those who make family planning decisions, husbands and their parents. One woman described her experience when talking to the midwife at CHC as confusing.

> *"When I went to the health center (CHC) to speak to the midwife I learned a lot about family planning. I wanted to speak to my husband about this plan, but when I returned home I did not know how to explain it to him. He didn't understand and I am fearful to go back to the midwife to ask again."*

Role of the Catholic Church

One of the barriers to providing family planning services to communities across Timor-Leste is the influence of the Catholic Church. Services providers and community members both spoke of the Church's role in discouraging the use of family planning and the stigma that is attached to it. One woman who was interviewed did not want to use family planning because she wanted to leave the number of children that she had up to God. Women who did want to use modern methods were afraid that people would tell the community priest if they spoke to the midwife at SISCa about family planning. A midwife spoke to this barrier:

> *"It is better for the community to learn about family planning at the CHC because the community is very close to the church. People can see when women get family planning at SISCa and might inform the priest about it."*

District health staff echoed this sentiment when discussing challenges to providing family planning at any location, but particularly at SISCa events. In the past district health staff have reached out to the Church to dialogue with priests about the benefits of family planning for maternal and child health with mixed results.

> *"A big challenge in providing family planning is the Church. When the Ministry of Health implemented SISCa, we talked to the priests a lot about the need for family planning, but they did not agree and told the community not to use family planning methods."*

Due to the close proximity of villages to the church as well as the lack of private spaces, there is little discretion when women seek out family planning information from midwives during SISCa events.

NGO-Support for SISCa

Midwives expressed that having partner organizations available at SISCa to provide family planning services freed them up to provide other needed services to women, as there is rarely enough time to provide both maternal care and family planning during a SISCa event. When asked where she prefers to provide family planning, a midwife explained,

> *"I prefer to talk to women about family planning at the CHC because there is no time at SISCa. At CHC I can talk clearly and slowly to women, which makes it easier for them to understand. At SISCa I have many other responsibilities and I do not have time…When an NGO like MSI comes to SISCa to explain and provide family planning, I have more time to do my other jobs. I like this."*

SISCa sites that were supported by HAI, TAIS, SHARE and MSI were visited to observe the ways in which these four organizations collaborated with district health staff to promote health services. One DHS staff member identified the strength of having organizations that emphasized direct services to women in the community as well as organizations that provided overall support to the SISCa program. She expressed the need for both logistical and technical support in order to provide comprehensive and lasting family planning provision.

> *"HAI, TAIS, and MSI all support SISCa here. HAI shows Espaso Oan [a family planning video] from village to village and provides supervision and monitoring, TAIS provides supervision and monitoring in other villages and MSI provides services and equipment*

for implants and IUDs…Now, HAI and TAIS help SISCa to work, but there are more [family planning] options for women when MSI comes to SISCa. Both are very good for family planning."

Each SISCa site visited had varying support from NGOs. Seven sites were supported by one NGO, one site was supported by two NGOs and one was supported by three NGOs. The SISCa site that was supported by three organizations had few community members in attendance and the PSFs were absent. Many of the NGO workers performed tasks designated for the PSFs, such as weighing and measuring infants, and it took longer than usual to set up the SISCa tables once the health workers arrived. Sites that were supported by one organization were not necessarily less organized and in some cases were very well coordinated, had many community members present and had very active PSFs.

DHS staff also mentioned that it is helpful when NGOs are based in the district because staff is easily accessible when issues arise and can help with day-to-day issues and logistics quicker than if they had to travel from Dili. Currently, TAIS and MSI travel to Ermera for one week at a time to perform various activities, while HAI travels to and from the district much more frequently.

"When there are some problems in the district, such as transportation, it is good when NGO are close by. When NGOs come to the district for meetings, but then return to Dili, it is very difficult to contact them for help and it takes a long time to fix some problems."

Discussion

The varied preferences of women as to where they would prefer to receive family planning counseling and methods demonstrate the need for provision of family planning in multiple settings and across many platforms to ensure more comprehensive care to women and their families. Interviews with women did not identify any one place that they preferred to receive family planning services, but instead, mentioned SISCa, CHC, health posts and their homes as places that were accessible to them for various reasons. This is consistent with results collected for the 2009-2010 DHS in which 45% of women preferred to get family planning services from the CHC, 20% from health posts, 17% from hospitals, 3.4% from SISCa and 2% from mobile clinics (Timor-Leste DHS, 2009-2010). Women were open to speaking with PSFs about family planning during home visits and health staff from District Health Services also believed that it would be worthwhile to train PSFs in family planning. Within each of these settings, families must be more involved in the family planning decision-making process. Research by Rimal

(2003) reported the need to include the broader family in family planning discussions when women lack personal agency in reproductive health matters. Incorporating husbands and their parents would alleviate the onus of women to relay complicated information to their families and would require fewer trips to the SISCa or CHC.

Other data gathered from this assessment concerning community knowledge and use of family planning are also somewhat consistent with the 2009-2010 DHS. Seventy-six percent (13/17) of the women who were interviewed were able to speak generally on the benefits of family planning and/or child spacing, however, only 41% (7/17) of women were able to identify one modern method of family planning. DHS results suggest that 78% of currently married women in Timor-Leste know at least one modern method of family planning.[1] This inconsistency might be explained by a lack of adequate sample size, discrepancy in the wording of this assessment's questions and those of the DHS and/or translational issues. Other results from this assessment are more consistent with DHS findings. Thirty-five percent (6/17) of the women interviewed had ever used a modern family planning method and injectables and the pill were the most commonly used modern methods. The DHS reported 30% of women having ever used a modern method of planning and injectables as the most commonly used method. Whereas the DHS suggests that the percentage of women who are currently using a modern contraceptive methods is lower (21%) than women who have ever used a modern method (30%), all six of the women interviewed for this assessment who have ever used a modern family planning method remain currently users. While results from this assessment may vary in orders of magnitude with current DHS findings, the trends in identifying gaps in providing family planning services are consistent. This assessment presents further qualitative data that while most women may know of family planning, fewer women have either heard of modern methods and fewer still have used some form of modern family planning.

One of the dominant themes that women raised was the quality of interactions between the women seeking care and midwives. Women discussed how difficult it was to travel long distances to seek care and how frustrating it became when midwives admonished them for not arriving during the CHC's normal operating hours. Midwives lamented that their duties carried over into the evening when community members would arrive at their houses. In addition to access to care, women felt that midwives could be judgmental or blame them for not having sought family planning methods in the past. Women who used family planning expressed having a positive relationship with the midwives and felt supported in their choices and needs. Negative

interactions with health staff, which was raised in Health Care Seeking Behavior Study (HCSBS), continue to be an impediment to providing regular and sensitive family planning services to women. The HCSBS found that women were discouraged from seeking care by health worker anger and blame and that the anticipation of a provider's anger could lead women to delay, or to not use services at all.[10] The information gathered from this assessment support the value of further support and supervision of midwives in providing family planning counseling.

Direct service and health systems strengthening are both important facets to providing family planning services to women. NGOs that support SISCa are complementary in providing both of these components. HAI, TAIS and SHARE provide implementation, coordination and training support for SISCa and CHC staff, while MSI provides direct family planning services in their respective SISCa sites. Informants from the DHS as well as midwives and nurses asserted that NGO support is imperative in SISCa implementation and desired continued collaboration. This assessment supports an even greater use of NGO expertise in performing hands-on reiterative training to midwives who have completed family planning training. In interviews, DHS staff stated that while midwives have had training in IUD and implant insertion, only three or four out of the eighteen midwives in Ermera felt comfortable inserting an IUD or implant. Low numbers of IUD acceptors within communities provides little opportunity for midwives to utilize and hone this skill set. Because of this, many midwives will refer women to other health facilities and health staff who have demonstrated stronger confidence in performing these procedures. Post-training modeling and skills checks by NGO midwives at SISCa could reduce time delays and the number of referrals needed to perform procedures and result in increased procedures performed.

While our observation at SISCa demonstrates that NGO support helps in the coordination and implementation of SISCa through transportation, monitoring, planning and technical assistance, those SISCa sites with support of multiple NGOs did not necessarily demonstrate better coordination or provision of health services. Indeed, in these instances there seemed to be less community involvement in coordination and planning. This was clearly observed at one SISCa site that was supported by three NGOs. This site had fewer community members in attendance, had no PSF involvement and was slower at providing services.

Because each SISCa post was observed only once (except for the SISCa post in Assi), it is difficult to assess other factors that might influence attendance and participation. However, these data suggest that promoting community involvement is critical in increasing interest in SISCa as well as providing greater communication between the CHC and *aldeia*.

Engagement of the PSFs as partners in the SISCa program is another vital component. Research by Coeytaux, Kilani, and McEvoy (1987), Dumidin (1986), and others have shown that use of family planning in rural communities significantly increases when mobile health clinics are paired with the health promotion activities by community health workers who transfer this knowledge at a household level. Providing and monitoring incentives to PSFs, monetary and non-monetary, would help to strengthen this work force. These incentives could be in the form of feedback, such as how their communities are doing on specific health indicators, vertical mobility and/or trainings. The SISCa guidelines mention possible PSF incentives such as presenting rewards in the form of grants, loans for business capital, revolving funds for those PSF with excellent performance, or awards presented by election to the best performing SISCa and best PSF on a national level each year. While many PSFs did cite poor and inconsistent incentives as a barrier in their work, most PSFs also cited social capital and love for their communities as main reasons for becoming a community health worker. Providing encouragement and recognition for their efforts could be motivating for the PSF workforce and potentially enhance SISCa coordination and communication efforts and improve their job satisfaction.

Additionally, observational and interview data support the current efforts to work with village councils on certain health topics, such as family planning, to improve communication between the *chefe aldeia* and other community leaders, the PSFs, health staff, and community members and empower *sucos* to coordinate and manage SISCa.

There are several limitations to this study. This qualitative assessment sought to contextualize community preferences and how family planning services are provided. It did not aim to provide a generalizable accounting of how the Timorese people view family planning across all regions and time nor did it discuss every eventuality of the successes and challenges to providing family planning services through SISCa. Additionally, observations recorded at one SISCa event were not necessarily indicative of how SISCa is run generally at that site. Circumstantial factors that might affect SISCa implementation were difficult to identify. Instead, this assessment attempted to provide relevant information from a sample of informants in order to deepen the knowledge base provided from previous studies.

One of the main limitations of this assessment was the language and cultural barrier both in data collection and in data analysis. While the use of a translator was absolutely essential during interviews and at SISCa in order to understand in real time people's perceptions and, later during

data analysis, it is possible that some information was lost or misunderstood despite attempts to mitigate these errors. The use of a male translator may have played a role in inhibiting women to speak freely about reproductive health. Using a non-Timorese woman as the main and interviewer potentially created issues in data quality through desirability bias. Informants may have felt a desire to answer questions posed during the interview in a 'desirable' way.

The second main limitation to this study was the availability of time at each SISCa event and with individual informants. The level of saturation for each theme might have become more complete at every level of analysis if more time was possible at sites observing and conducting interviews. Including other informants in the assessment such as traditional birth attendants, husbands of women accessing care, and health post staff would have given different perspectives on issues of family planning in Timor-Leste.

Recommendations

Given the information gathered from women and health workers, the following recommendations are made to the Timorese MoH and to other organizations working in reproductive health in Timor-Leste:

1. Continue to provide family planning counseling and methods as a multi-site service at both the community and health centers level and integrate with primary health care services and with child immunizations visits;
2. Develop take-home information on the benefits of family planning and explaining the different methods available in Timor so that women could have a reference when discussing family planning with their husbands and family members;

<u>SISCa coordination</u>

3. Assure that health staff (midwife or nurse) capable of providing family planning services attend SISCa events;
4. Support and foster more ownership and involvement of SISCa by the community through village councils in order to increase coordination on the CHC, NGO, *suco*, and *aldeia* level;
5. Carry out future research to clarify where time constraints when providing family planning provision and counseling occur at SISCas in an effort to promote more efficient use of time at each SISCa event.

PSF involvement

6. Further encourage and motivate PSFs performance through greater programmatic feedback, coordination with SISCa scheduling, and dialogue, recognition and rewards by MoH health staff in the form of grant funds and loans and selection of the best national SISCa and PSF on a yearly basis;
7. Monitor the monetary incentives given to PSFs on a monthly basis across all SISCa posts;
8. Pilot a model of PSFs delivering family planning promotion during home visits to motivate and spread good practices.

Recommended family planning trainings

9. Provide iterative trainings for and supportive supervision of district midwives to improve their skills to deliver proactive family planning counseling services;
10. Train nurses to provide family planning counseling and services to assure FP services are available at SISCa posts where midwives are not present;
11. Train PSFs to provide introductory information about family planning benefits and methods to community members on monthly home visits in order to encourage women and their husbands to attend services and speak to the midwives about family planning.

NGO partnerships at SISCa

12. Encourage with NGOs that support SISCa to provide greater skills transfer to CHC staff when family planning counseling and services occur at SISCa;
13. Continue to partner with NGOs that can provide both supervision and skill transfer as well as direct service delivery in areas where there is a lack of training or availability of staff and an expressed demand for long-term, permanent methods that the MoH are not able to currently provide;
14. Consider utilizing a district-based modes for NGOs that support SISCa in order to enhance communication with CHC partners and to ensure logistical issues are dealt with efficiently;
15. Maximize resources and efficiency and broaden the net of NGO-supported SISCa by having only one NGO support a SISCa post.

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