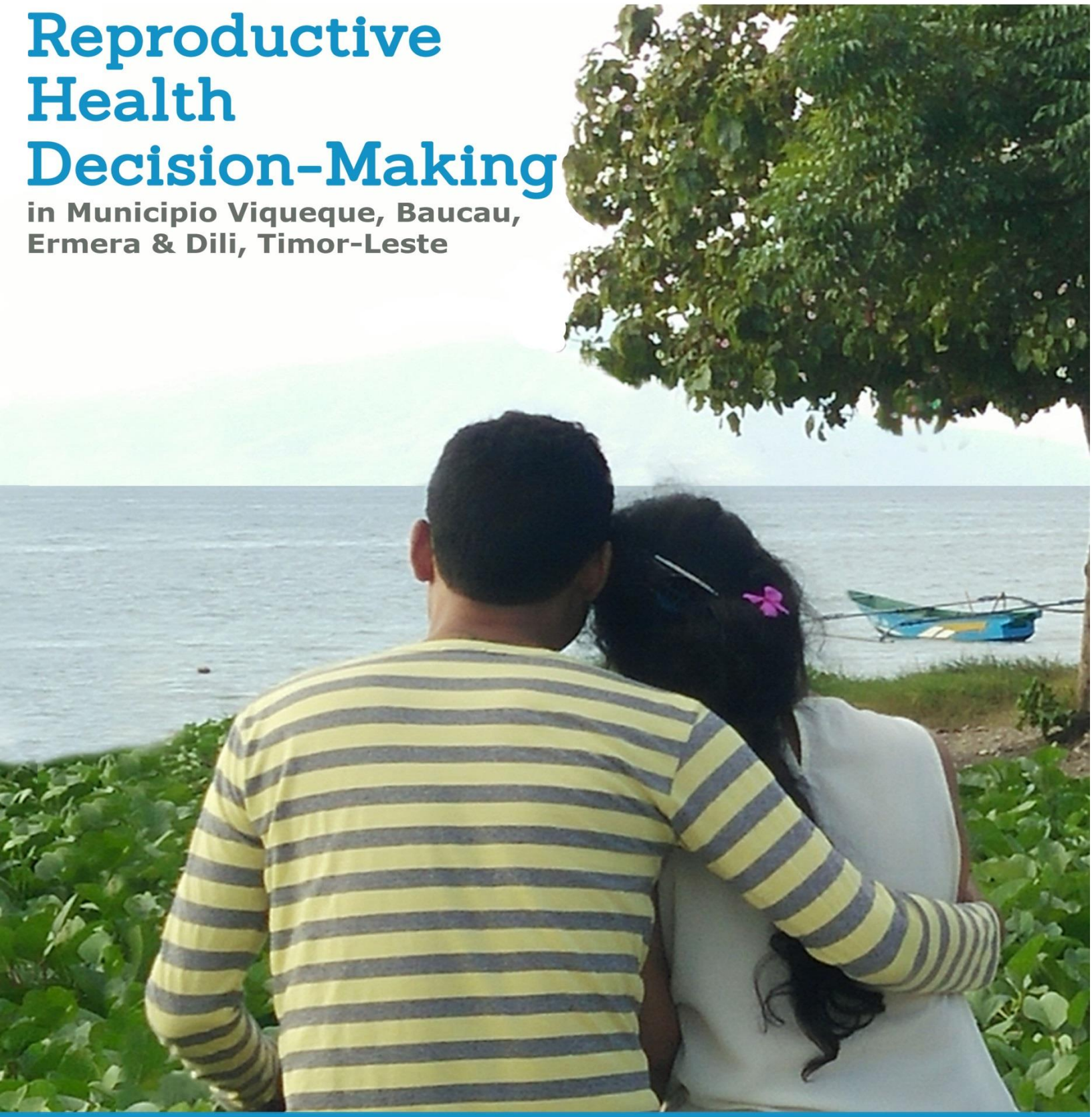
MARIE STOPES TIMOR-LESTE

LA TROBE UNIVERSITY

Australian Aid

Reproductive Health Decision-Making

in Municipio Viqueque, Baucau, Ermera & Dili, Timor-Leste



A collaborative qualitative research project between Marie Stopes Timor-Leste & La Trobe University, Australia

An exploration on how reproductive health decisions are determined between couples and how it is perceived to impact on women's and neonates' health

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REPRODUCTIVE HEALTH DECISION MAKING IN MUNICIPIO VIQUEQUE, BAUCAU, ERMERA & DILI, TIMOR-LESTE

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CITATION:

Wallace, H.J. et al, Reproductive Health Decision-Making in Municipio Viqueque, Baucau, Ermera and Dili, Marie Stopes Timor-Leste, 2016.

ACKNOWLEDGEMENTS:

Sincere thanks to the men and women of Viqueque, Baucau, Ermera and Dili who gave of their time to participate so willingly and openly in this research. I was humbled by your generosity and your welcome, and I so appreciate you speaking with us about such sensitive and private topics.

To Nicola Morgan and Kwesi Formson – thank you for the chance to work with MSTL once again. You have an incredible team doing an incredible job, and I feel extremely grateful to have been able to work alongside MSTL once more.

To the research team – Livio, Eurico, Agueda and Helen. Your dedication, commitment, passion and professionalism has been instrumental to the success of this project. I thank you all sincerely for your patience, your support and your friendship.

To the academic team – Angela, Sue, Suzanne & Lidia. Sincere thanks for your support, encouragement, guidance and wisdom. I feel truly fortunate to have such a team of experts guiding me in this process.

To the National Institute of Health - Research Ethics & Technical Committee (INS-RETC) Timor-Leste – thank you for your consideration, input and support of this project.

To the MSTL team – thank you for making me feel so welcome and for being so supportive of this research project. Special thanks to the Team Leaders in the Municipalities for recruiting our participants and organising focus group and interview locations.

To the Carmelite Madres in Fatu Hada – thank you once again for looking after me when I am in Timor. I so appreciate your care, your gentleness and your friendship.

TABLE OF CONTENTS

TABLES

DIAGRAMS

GRAPHS

REPRODUCTIVE HEALTH DECISION-MAKING IN MUNICIPIO VIQUEQUE, BAUCAU, ERMERA & DILI, TIMOR-LESTE

EXECUTIVE SUMMARY

This report discusses the findings from the collaborative research project 'Reproductive health decision-making in Municipalities of Viqueque, Baucau, Ermera and Dili, Timor-Leste'. This project explored how men and women negotiate reproductive health decisions, and how these decisions were perceived to impact on women's and neonates' health.

Data collection took place in these four Municipalities (Viqueque, Baucau, Ermera and Dili) during October 2015. This projects received ethical approval from the National Institute of Health-Research Ethics & Technical Committee (INS-RETC), Ministry of Health, Timor-Leste, and the La Trobe University Human Ethics Committee (LTUHEC), as well as written support from UNFPA, Timor-Leste.

This qualitative research project used de-colonising methodology to respectfully gain local (or Timorese) insight into the sensitive and personal arena of reproductive health decision-making. The aim was to identify influencing factors and to understand the cultural and contextual meanings men and women associate with these factors when making reproductive health decisions, and how such decisions are perceived to impact on health. Collaboration and consultation occurred throughout the research project, with the Timorese members of the research team instrumental to the design, implementation and success of this project.

The four municipalities were chosen based on their Contraceptive Prevalence Rates, Total Fertility Rate and Maternal Death Rate. Nine focus group discussions of 80 men of reproductive age were held across the four municipalities, and were facilitated by male members of the MSTL team who had received training in qualitative research. From these groups, 67 men took part in body mapping drawing exercises to gain insight into how these men believed the reproductive systems of men and women looked like, and how these and reproductive technologies functioned. In-depth interviews were conducted by a qualitative research trained Timorese female team member, and explored the perceptions of 17 women (of reproductive age) with regard to reproductive health decision-making and perceived impacts to health.

The reproductive health decisions explored included:

- The decision to have, or delay having, a baby;
- The decision to access family planning information and services;
- Decisions around number of children and child spacing;
- The decision to seek care during pregnancy, labour and choice of birth place;
- The decision to engage in sexual relations in general and postnatally.

The concept of 'understanding' as a means of couples regulating their fertility was also explored. The data was translated using a panel of 3-4 multilingual Timorese team members, transcribed verbatim, coded thematically, and analysis occurred across several dimensions, including sex, municipality, location (rural,

urban or peri-urban), marital status and age bracket. Clarification and validation of data occurred at the point of data collection, as well as during the translation, transcription and analysis phase.

We found that most participants perceived reproductive health decisions to be 'mutual' between husband and wife. The exception to this was with regard to seeking care during labour and the decision to have sexual relations in general – in both these domains it was generally perceived to be the husband's decision. While many participants spoke of the benefit of having a mutually agreed 'plan' regarding their reproductive health goals, they also acknowledged that in many instances 'reality' was very different to this 'ideal'. Perceived uncontrollable sexual needs, cultural factors and alcohol were all believed to contribute to the failure of the 'ideal'.

Financial considerations including land size, the age of the woman, the health of the woman, the sexual needs of the man, and cultural factors were all also perceived to influence many of the reproductive health decisions explored, as were issues concerning trust, including trust between a couple and access to trusted caregivers or health providers.

Knowledge was a particularly important influence, impacting on reproductive health decisions in a variety of ways. This included the knowledge a participant had regarding reproductive health, as well as knowledge imparted to participants by reproductive health professionals. Related to this 'knowledge' were a variety of myths, misperceptions and confusion surrounding many aspects of reproductive health, all which impacted on the reproductive health decisions made by men and women. A number of geographical and logistical factors were also identified as impacting on these decisions, as were beliefs regarding perceived consent, respect and entitlement.

The men spoken with described feeling responsible to provide financially for their families as well as taking responsibility for the health of their wives. However, men in their assumed positions as 'chief' of the family were also perceived to have numerous rights and entitlements, with these being prioritised over those of women. This linked to the notion of respect and consent, with research findings suggesting these concepts require urgent focus and exploration within Timor-Leste. So too does the acceptance of violence and conflict as an expected consequence for certain behaviours. For example, study results found it was perceived as acceptable for a woman to be subjected to violence if she refused to engage in sexual relations with her husband, or if she accessed family planning information or services without his permission.

Reproductive health decision-making in Timor-Leste is a complex, multifaceted phenomenon, influenced by historical, cultural, geographical, financial, political and physiological factors. Through identifying and exploring some of these factors it is hoped that both local and national stakeholders working on reproductive health will be able to target and direct their focus and resources on identified areas of need in culturally and contextually appropriate ways. Through such changes to policy and practice, it is hoped that women's reproductive health will improve, and the number of stillbirth, maternal and neonatal deaths decrease.

RESEARCH RECOMMENDATIONS:

1. **Improve access to quality, comprehensive sexual and reproductive health information and education**:
    - Advocate for the provision of reproductive health education across all municipalities of Timor-Leste, both within schools and outside of schools so to reach as many people as possible.
    - Stakeholders (including Ministry of Health, Ministry of Education, the Church, health care providers, community educators, teachers and parents) should continue to work together to ensure that all people across the age spectrum have access to age-appropriate and accurate sexual and reproductive health information and education. This should include information about: reproductive health anatomy and physiology, the fertility cycle, healthy relationships, consent, potential impacts from cultural practices on reproductive health, and methods available to assist couples meet their reproductive health goals including comprehensive information about modern and natural family planning methods.
    - Ensure young people (both in and out of school), have access to quality, comprehensive sexual and reproductive health information, including information about modern and natural family planning methods.
    - Stakeholders (including Ministry of Health, Ministry of Education, the Church, health care providers, community educators, teachers and parents) should work together to ensure that those delivering information and education about sexual and reproductive health are supported in being as up-to-date and accurate as possible, and are able to share information and education in an age-appropriate and understandable format.
    - Provide regular training and support to those delivering information and education, and conduct scheduled quality analysis to assess the accuracy and benefit of the messages delivered. This may involve working closely and in partnership with targeted populations to arrive at concepts, language and resources that are appropriate and understandable.
    - Consider engaging identified local champions who are trusted members of their community to assist in the delivery of reproductive health messages.
    - Continue to build upon respectful and trusting relationships with community/village/church leaders. Continue to acknowledge the influential positions *Xefe Suku* and *Xefe Aldeia* hold within their communities and positively engage these leaders and their wives to explore the impact of reproductive health decision-making and behaviour on the life and livelihood of their communities, for example, accessible and appropriate training that highlights the links between maternal health, financial situations, nutritional and educational opportunities for children, poverty reduction and healthy communities.

2. **Increase engagement and focus on men in sexual and reproductive health programming, including access to quality, comprehensive sexual and reproductive health information and services:**
    - Continue to recognise and acknowledge the significant role men play in making reproductive health decisions.
    - Ensure men have access to quality, comprehensive and age-appropriate sexual and reproductive health information and education to ensure that men have the opportunity to make informed choices.
    - Focus sexual and reproductive health education and information sessions for all men across the age spectrum, both within schools and outside of schools.
    - Support men to recognise the links between financial goals and reproductive health goals.
    - Explore with men the pervasive myths and suspicion that continue to surround modern methods of family planning.
    - Ensure men have access to timely and accurate information and services regarding sexually transmitted infections.

3. **Promote healthy relationships and decision-making between couples by challenging social norms and promoting gender equality and women's empowerment:**
    - Explore with men the concept of 'uncontrollable sexual urges'.
    - Explore with men concepts such as 'consent', and how this relates to sexual relations.
    - Explore with men how to translate the 'ideal' regarding family size, spacing and timing into everyday life.
    - Encourage men to discuss with their wives reproductive health goals, and support them to strategise about how best to meet these goals.
    - Celebrate and support young people in their belief in the importance of living harmoniously and respectfully with each other.
    - Acknowledge and promote the positive steps Timor-Leste has taken at a national level to promote women's rights and gender equality, for example, within the Timor-Leste constitution, or the recent Declaration of Maubisse (Government of Timor-Leste, 2015), and refer to national frameworks at relevant trainings, workshops, education sessions or service consultations.
    - Acknowledge the tension that potentially exists between the "rights" framework and "cultural/traditional" frameworks, and encourage the exploration of this tension by keeping women and children's safety as a guiding priority.
    - Continue to build and strengthen partnerships and coordination between government and non-government organisations working on sexual and reproductive health, gender and other relevant sectors in responding to the health needs of the women and men in Timor-Leste.

4. **Increase access and uptake of sexual and reproductive health services related to safe birthing:**
    - Promote and support women and couples in accessing antenatal care and making birth preparedness plans.
    - Help couples learn how to identify risk factors to the mother's or baby's health throughout the antenatal period.
    - Promote and increase access to sexual and reproductive health services and information in remote and rural locations, including access to available transport options.
    - Continue to work with communities to strategise with regard to community responses to women requiring emergency care or transfer, for example, the provision of a community vehicle for transportation.

5. **Strengthen links between the health sector and programs responding to violence against women (*Violénsia domestika*):**
    - Acknowledge the widespread existence of *violensia domestika* in Timor-Leste, and the link that appears to exist between some reproductive health decisions and violence.
    - Ensure access to sexual and reproductive health services and information are included in gender-based violence programs and campaigns.
    - Continue to work with stakeholders to devise culturally appropriate and safe strategies to reduce the acceptance and occurrence of *violensia domestika*.
    - Ensure individuals working in the sexual and reproductive health sector are familiar with relevant laws and policies about violence against women, and are well-supported and empowered to respond to the needs of women who have experienced violence.

6. **Strengthen and build relationships between the sexual and reproductive health sector and other health sector programs:**
    - Acknowledge the perceived and real link between nutrition and reproductive health.
    - Work with the nutrition sector to ensure they are engaged with reproductive health issues.
    - Collaborate with the water and sanitation sector in delivering and sharing information about menstruation.
    - Continue to support the link between different sexual and reproductive health projects in Timor-Leste, especially during pregnancy.

CHAPTER 1 – BACKGROUND & SCOPE

BACKGROUND

National policies and strategies in Timor-Leste echo the sentiments of those advocated for at an international level with regard to empowering women and encouraging the involvement of men in the reproductive health arena. However reproductive health remains a challenging domain within Timor-Leste as well as a priority research area. A need exists for the identification, exploration and examination of the socio-cultural, gender, power and historical factors that impact and influence reproductive health decision-making in Timor-Leste, and how these influences are perceived to impact on the health of women and babies.

AIM:

The aim of this study was to identify influencing factors, and to understand the cultural and contextual meanings men and women associate with these factors, when making reproductive health decisions, and how such decisions are perceived to impact on health.

This project has employed qualitative research methodology to gain insight into the following objectives:

- 1: how reproductive health decisions are determined between a couple;
- 2: what influences these decisions;
- 3: the concept of 'understanding' as a way of regulating fertility;
- 4: what men believe about women's reproductive health;
- 5: how these decisions are perceived to impact on the health and lives of women and neonates in Timor-Leste.

By gaining an understanding and insight into the cultural and contextual factors that impact on women's reproductive health decision-making, both local and national reproductive health service providers (eg. Marie Stopes Timor-Leste) will be able to target and direct their focus and resources on identified areas of need, in ways that are culturally and contextually appropriate.

Through such changes to policy and practice it is hoped that women's reproductive health will improve and the number of stillbirths, maternal and neonatal deaths decrease.

ETHICS:

This study was granted ethical approval from the National Institute of Health – Research Ethics & Technical Committee (INS-RETC), Ministry of Health, Timor-Leste and La Trobe University Human Ethics Committee (LTUHEC), Australia, and also received permission from MSTL and written support from UNFPA Timor-Leste.

METHODOLOGY:

De-colonising methodology has been used to respectfully engage with the participants and promote respectful, culturally considerate research. Collaboration and co-operation occurred throughout the entire research process. Discussions were initially held in Dili with key stakeholders to determine research priority areas. The MSTL members of the research team were instrumental in the design, implementation and analysis phases, collaborating on the design, research tools, data collection and analysis phases. The INS-RETC provided feedback and comment both at the design stage as well as attending field work observation visits during the data collection phase in Ermera. The findings from this project have been analysed through a de-colonising lens.

The methodology and aims of the research were explained to communities prior to commencing field work. Verbal permission to conduct the community-based research in a particular village was granted by the local community leader (Xefe de Suco). Introductions to the research team occurred at a community level.

METHODS:

Methods used included focus group discussions (FGDs) based on culturally appropriate vignettes, body mapping drawing exercises and in-depth interviews. These tools were developed in collaboration with the local research team and were piloted by the team prior to use. The following example illustrates one of the vignettes created (Please see Appendix A for the complete collection of vignette research tools).

> *Maria and Pedro are both 40 years old. They live in a rural area in the municipality of Ermera. They grow coffee beans and sell firewood, but it is sometimes difficult for them to make enough money to buy the things their family needs. They have been blessed with 4 sons, who were all born at home with the help of a neighbour. Maria's last labour was long and difficult. Maria and Pedro work hard on their farm. Maria gets very tired, and the health post staff have told her she has weak blood.*
>
> *Pedro is worried about how they will pay barlake for their 4 sons to get married in the future. He is also worried about how he will divide his land between his sons. Maria feels too tired to have any more babies but Pedro would like to have some girls so that they will get barlake in the future.*

The FGDs, body mapping exercises and in-depth interviews were conducted in the local language by the trained research team. They were all audio-recorded.

The FGDs and body mapping exercises with male participants were facilitated by the male Timorese research team, and involved the researcher reading out loud the vignette and then inviting the group to discuss the scenario. A number of prompt questions were also asked to stimulate further discussion. The researcher would clarify responses as the need arose, and summarise the group's perceptions back to

them at the conclusion of the FGD session. The male participants were then invited to take part in the body mapping exercise. This involved the men drawing or writing on a paper template of an outline of a male body and a female body their perceptions of what the reproductive system of each sex looked like, and where various methods of family planning were located within the body. The men then used these drawings to explain to the male researcher, in a private setting, how they believed reproductive anatomy and physiology to be, how conception took place, and where they believed various methods of family planning were located.

The in-depth interviews with female participants were facilitated by the female Timorese research team with support from Australian researcher Heather Wallace. The interview template used was based on a format proposed by Beall and Leslie (2014) and was further developed in collaboration with the MSTL team. It included questions covering multiple aspects of a woman's reproductive life, in order to gain insight into personal reproductive histories that illustrated the impact and consequences of reproductive health decisions on maternal and neonatal health.

At the conclusion of each research session, male and female participants were provided with a short sexual and reproductive health education session by a trained MSTL educator. This included answering questions that were raised by participants during the research activities. The communities were thanked for their time and participation, and were provided with contact details for the research team if further follow up was required.

Male and female representatives from INS observed the data collection process conducted in Ermera and were able to provide feedback to the research team as well as INS about this process.

SETTING:

This study was undertaken in four municipalities of Timor-Leste, based on their Total Fertility Rates, Contraceptive Prevalence Rates and reported numbers of maternal mortalities (please see Appendix B). These four municipalities are also municipalities in which Marie Stopes Timor-Leste is currently providing services in partnership with the Ministry of Health, and with support from the Australian Embassy in Timor-Leste.

The four municipalities were: Viqueque, Baucau, Ermera and Dili.

Research participants were provided private, safe and appropriate settings in which they were able to freely discuss their thoughts and perceptions. For the FGDs, this was often the community meeting place, which the research team ensured had only research project participants present. For the body mapping interviews, the male researcher ensured a private space away from the group where he and the participant could converse without being overheard. Similarly, for the in-depth interviews with female participants, the

researchers ensured that these took place in a private place, sometimes in the home of the participant, or else on a quiet verandah or under a tree away from other people.

PARTICIPANTS:

Participants were selected using purposive sampling strategies – we wished to speak with people who would be able to provide us with 'information rich' perceptions and experiences. Some of the participants were MSTL clients while others were not. MSTL team members working in the municipalities we wished to recruit from, received training with regard to this project and invited selected individuals to participate. Potential participants were informed of the nature of the research prior to giving informed consent, so that they were well aware of what topics would be discussed.

The FGDs consisted of 80 men in 9 different focus groups (2 of them were 'Youth' focus groups comprising generally of participants under 24 years of age who were mostly single). From these 9 focus groups, 67 men took part in the body mapping exercises. In-depth reproductive history interviewed were conducted with 17 women. All participants were of reproductive age (18-49 years), and all provided informed consent.

The following tables illustrate some of the demographics and characteristics of the participants:

TABLE 1: MALE FOCUS GROUP PARTICIPANT DEMOGRAPHICS AND CHARACTERISTICS

	Viqueque N=26	Baucau N=18	Ermera N=22	Dili N=14	TOTAL N=80
Age (mean)	28	32	26	25	28
Marital Status					
Married	92%	94%	41%	36%	69%
Single	8%	6%	59%	64%	31%
Educational Status					
No education	16%	0%	14%	7%	10%
Some primary	16%	28%	27%	7%	20%
Completed primary	20%	11%	4.5%	7%	12%
Some secondary	20%	33%	27%	14%	24%
Completed secondary	28%	28%	23%	57%	31%
More than secondary	0%	0%	4.5%	7%	3%
Range of number of pregnancies	0 - 9	0 - 10	0 - 9	0 - 6	0 – 10
Mean number of pregnancies	3.76	3.83	1.59	1.28	2.7
Range of number of living children	0 - 9	0 - 9	0 - 9	0 - 6	0 – 9
Mean number of living children	3.44	3.38	1.54	1.28	2.5

TABLE 2: FEMALE INTERVIEW PARTICIPANT DEMOGRAPHICS AND CHARACTERISTICS

Area	Int #	Age	Marital status	School	Age 1st period	No. of pregnancies	No. of babies	Comments
R	1	22	M	N	13	4	4-2	2 x Neonatal Deaths
R	2	28	M	SP	15	5	5-1	1 x Stillbirth (Fetal death in utero @ 8months)
R	3	29	M	SS	14	6	6	Wanting to stop but not using Family Planning
R	4	24	M	SS	15	1	1	Trying to get pregnant for 3 years
R	5	29	M	SP	15	3	3	Anaemia during pregnancy
R	6	34	M	SP	15	9	9-4	4 x Neonatal Deaths
P	7	40	M	SP	17	11-1	10-1	1 x spontaneous abortion; 1 x infant death @ 8months
P	8	38	M	SP	15	8	8	Tubal ligation
P	9	43	M	SP	15	6	6	3 x hospital births; 3 x home births
P	10	28	M	CS	14	1	1	Caesarean –now has implant for 5 years
R	11	35	M	CS	14	5-1	4	Miscarriage
R	12	38	M	CS	15	2	2	Retained placenta
P	13	24	S	MS	17	0	0	Traditional Family Planning
P	14	25	S	CS	18	0	0	Not using Family Planning
U	15	35	M	CS	12	2	2	Natural Family Planning (interview incomplete)
U	16	18	M	CS	14	1	1	Caesarean – now has implant for 5 years
U	17	19	S	CS	12	0	0	Not using Family Planning

Area: R=rural; P=periurban; U=urban; **Schooling:** N=none; SP=some primary; CP=completed primary; SS=some secondary; CS=completed secondary; MS=more than secondary. **Int #:** Interview number.

ANALYSIS:

Discussions from the FGDs, body mapping exercises and in-depth interviews were audio-recorded. The research team also made detailed notes during these sessions – the note taker in the FGDs used a pre-prepared template, while free hand notes were taken during the body mapping interviews and in-depth interviews. The researchers clarified participants' responses as each session was conducted, plus verbally summarised what had been discussed back to the participants at the conclusion of each session. The research team would meet together at the end of each day, and discuss the day's proceedings. Clarifications were again made and notes were taken. This was particularly useful for the non-Timorese members of the research team to gain insight into quintessentially Timorese perceptions.

All of the audio-recorded FGDs and interviews were translated using a translation panel. This involved the 4 bi-lingual members of the research team listening together to the audio-recordings and verbally translating. This also allowed for clarification and validation, and the audio-recordings were supplemented with the researchers' notes. Transcriptions of these translations were generated and again clarified by the Timorese members of the research team.

The transcriptions were then thematically coded, and the data compared and contrasted across the participants depending on municipality, age, marital status, education status and sex. The findings were discussed extensively by the whole research team to ensure culturally and contextually relevant interpretations.

CONTEXT:

This project was built upon 2013 research in Timor-Leste in 2013, in which women participants and reproductive health stakeholders recommended that greater insight into factors affecting women's reproductive health in Timor-Leste could be gained by speaking also with the men.

Therefore this study has sought the views of Timorese women and men of reproductive age their perceptions, understandings and priorities with regard to how decisions about women's reproductive health are made. The study recognises the diversity that exists across Timor-Leste, and has therefore spoken with women and men from a variety of municipalities and locations - rural, peri-urban and urban. This study also aimed to gain insight into choices made during the antenatal period and decisions determined with regard to place of birth – both of these concepts have been previously identified as research priority areas as stated by the National Institute of Health Training Department, Department of Health Research Timor-Leste (2015-2016).

Understanding the cultural and contextual meaning associated with factors within the reproductive health decision-making arena is crucial to being able to work collaboratively, respectfully, sustainably, successfully and in partnership within communities and populations (Cornwell, 1992).

KEY CONCEPTS & DEFINITIONS:

For the purpose of this study, the following applies:

Reproductive health decisions:

This study examined reproductive health decisions related to:

- Whether to delay or have a baby
- Issues surrounding family planning, including number of children, spacing of children, desired sex of children, methods of family planning, seeking family planning information, advice or services
- Seeking antenatal care

- Choice regarding place of birth
- Seeking care during labour and birth
- Engaging in sexual relations and resumption of sexual relations postnatally

Reproductive age:

For this project, reproductive age is defined as 18-49 years[1].

Youth:

For this project, 'Youth' is defined as 18-24 years (based on Belton et al's (2012) 'Choice Project Evaluation Report' for Marie Stopes Timor Leste)[2].

Modern methods of family planning:

Include oral hormonal pills, hormonal implants, hormonal injections, intrauterine devices, male and female condoms, male and female sterilization (WHO, 2015)

Natural or Traditional methods of family planning:

Include the withdrawal method (coitus interruptus), and fertility awareness methods including calendar or rhythm methods (WHO, 2015).

Domestic Violence – '*Violencia domestika'*:

"any act…by a family member against any other member of that family…which resulted in physical, sexual or psychological injuries or suffering, economic abuse, including threats such as intimidating acts, bodily harm, aggression, coercion, harassment, or deprivation of freedom" (Article 2 of the Law Against Domestic Violence, 2010, in Justice System Programme, UNDP, Timor-Leste, October 2013).

[1] Reproductive age is often defined as individuals aged 15 – 49 years. However, only participants aged 18 years and over were recruited in this study.

[2] The United Nations defines adolescents as aged 10 – 19 years, youth 15 – 24 years, and together adolescents and youth are referred to as young people, encompassing the ages of 10 – 24 years. However, only participants aged 18 years and over were recruited in this study.

CHAPTER 2 - FINDINGS

OBJECTIVE 1: HOW DO MEN AND WOMEN MAKE REPRODUCTIVE HEALTH DECISIONS?

- Mutual decision
- Having a plan
- "Ideal" as opposed to "real"

MUTUAL DECISION

Reproductive health decisions are perceived to be mutually made between husband and wife. Exceptions to this most notably include the decision to seek care during labour and birth, which is thought to be made by the husband or the woman's mother-in-law, and the decision to have sexual relations, which is perceived to be determined by the husband.

There is an overwhelming perception that there will be negative consequences for women, including conflict and violence, if she seeks family planning information or services without permission from her husband, or if she refuses to have sexual relations with her husband.

HAVING A PLAN

The majority of focus groups described having a mutually agreed upon plan, formulated collaboratively between the husband and wife regarding decisions to have a baby, family size, child spacing and timing of sexual relations:

> *"The timeof our ancestors is not the same as now. In the modern era, we need to think about forming a family in advance. First we need to think, then we can implement our plan with responsibility and not just imitate other people's lifestyles. We need to be conscious about what we are going to do and act responsibly" (Male Participant 8I, 42 years old (y.o.), - Focus Group 8 – 'urban').*

An opposing perception however was proposed by Focus Group 4:

> *"We should kompak [Bahasa Indonesian for 'co-operate'] on when and what number [of children] we want to have. Otherwise if I still need children and you decide to stop [having children], I will leave you and go and find another woman" (Male Participant 4H, 44 y.o., - Focus Group 4 – 'peri-urban').*

Although this statement was greeted by much laughter from other participants suggesting an element of humour, it highlights some of the potential consequences when there is disagreement within a couple with regard to reproductive health decisions.

Similarly, another participant from Focus Group 5 believed that if a wife opposed the husband's wish to have a baby:

> *"We better just obriga (force) her to have the baby" (Male Participant 5I, 40 y.o. - Focus Group 5 – 'peri-urban').*

This suggests that although many men and women perceive that reproductive health decision making and planning processes are mutual, for some couples "mutual" appears to contain an element of coercion. The wife should agree with the husband despite any wishes of her own, or face potentially adverse consequences and outcomes.

"IDEAL" AS OPPOSED TO "REAL" SITUATIONS

Men and women acknowledged that even though couples may have the best of intentions to mutually and responsibly agree on timing/number/spacing plans for their families, sometimes these plans were not fulfilled. Reasons for this included: perceived male physiological sexual needs, cultural factors including gender roles and reliance on fate to explain consequences, the effects of alcohol, and timing issues with regard to marriage and sexual relations:

> *"Sometimes in Timor we decide to have spacing of 2-3 years, but sometimes after 8 months the wife is pregnant with another baby" (Male Participant 4B, 38 y.o., - Focus Group 4 – 'peri-urban');*

> *"So it was just when we had sex and lived together – we were not expecting this pregnancy to happen and then it just happened…..it was all by destiny or fate" (Female Interview Participant 16, 18 y.o. – 'urban');*

> *"If man comes home in drunk condition sometimes man comes and has sex anytime he wants – that's just what happens" (Male Participant 6J, 39 y.o., - Focus Group 6 – 'rural').*

OBJECTIVE 2: WHAT DO MEN AND WOMEN BELIEVE IMPACT OR INFLUENCE THESE DECISIONS?

Our findings suggest that reproductive health decision-making is impacted on by a variety of factors, from individual and family level influences, community level influences and country level influences. These include physiological factors, cultural factors, financial factors, geographical factors and educational factors. The following table illustrates which factors are perceived to impact on which decisions.

TABLE 3: INFLUENCING FACTORS ON SPECIFIC REPRODUCTIVE HEALTH DECISIONS

Decision to delay or have a baby influenced by:	**Decision to access family planning information and services is influenced by:**	**Decisions regarding number of children or spacing of children is influenced by:**
- Financial considerations	- Support of the husbands	- Financial considerations
- Age of woman	- 'Understanding' between husband and wife	- Couple's autonomy
- Woman's health	- Desired number/sex of children	- Cultural factors
- Cultural & Familial factors	- Understanding the concept of spacing	- Woman's health
- Men's sexual needs	- Knowledge of family planning methods	- Knowledge of reproductive health & how to space.
- Knowledge of methods & sources of information	- Perceptions and misperceptions of perceived side effects from modern methods of family planning	
- Land – size and ownership	- Health professionals' advice	
- Geographical & physical barriers		

Decision to seek care during pregnancy is influenced by:	**Decision to seek care during labour & choice of place of birth is influenced by:**	**Decision to have sexual relations is influenced by:**
- Trusted caregiver	- Financial considerations	- Whether the woman has just had a baby
- Available transportation	- Available transportation	- Men's sexual needs
- Availability and provision of service	- Availability of ambulance	- Whether the woman is breastfeeding
- Men's availability and ability to take wife for antenatal care	- Distance to health facility	- Expectations of being married
- Health professionals' advice	- Past experience	- Woman's health
	- Constraints of health facility	- Perceptions of consent, respect and perceived rights
	- Others' experiences	
	- Where one feels most comfortable	
	- Mistake with predicting the baby's due date	
	- Expectation of health facility	
	- Perceived risks of birthing at home	

DECISION TO HAVE, OR DELAY HAVING, A BABY

Financial considerations

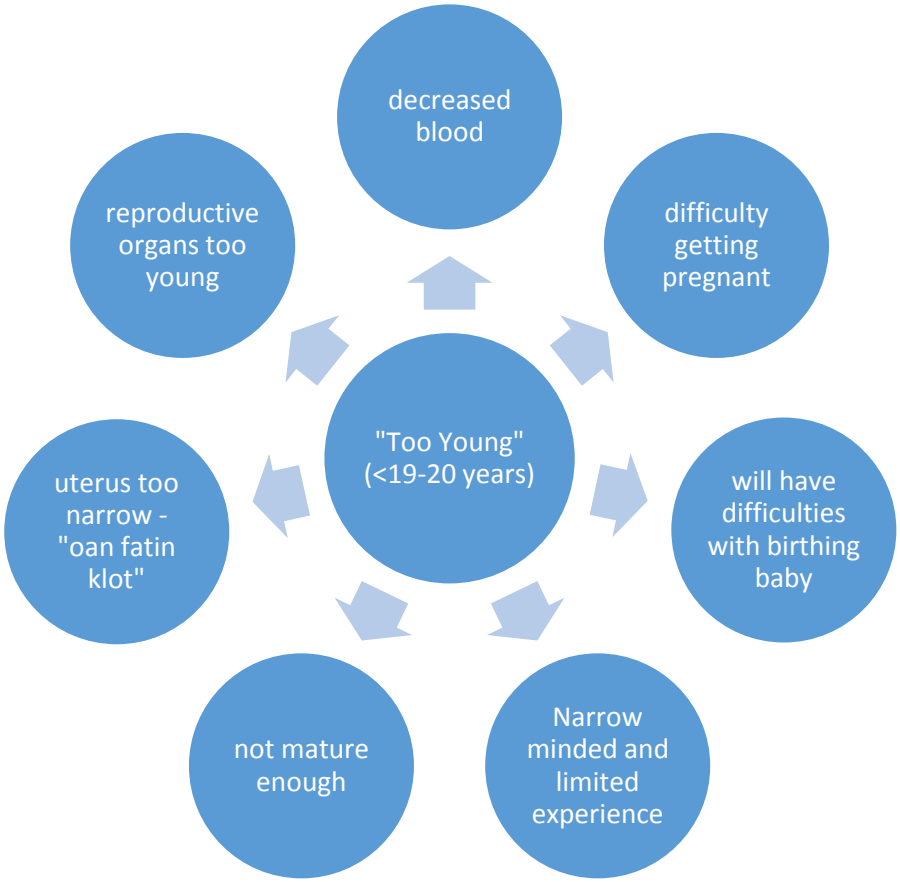
Many identified that it was the husband's responsibility to provide financially for the family, placing a burden upon men to ensure that they had sufficient income to meet their family's needs. However it was recognised that this burden may be reduced through child spacing:

> *"As a parent or a father we can lighten our work or the burden of our children by not having children born close together" (Male Participant 8I, 42 y.o., - Focus Group 8 – 'urban').*

Age of woman

Deciding to have a baby when the woman was "too young" or "too old" was viewed as detrimental. The physical and psychological characteristics of a young age perceived to impact on a woman's ability to conceive and birth successfully are illustrated in the following diagram:

DIAGRAM 1: PHYSICAL & PSYCHOLOGICAL CHARACTERISTICS RELATED TO "YOUNG AGE":



A number of the focus groups believed that a woman who was aged under 19, was physically not able to conceive or sustain a pregnancy:

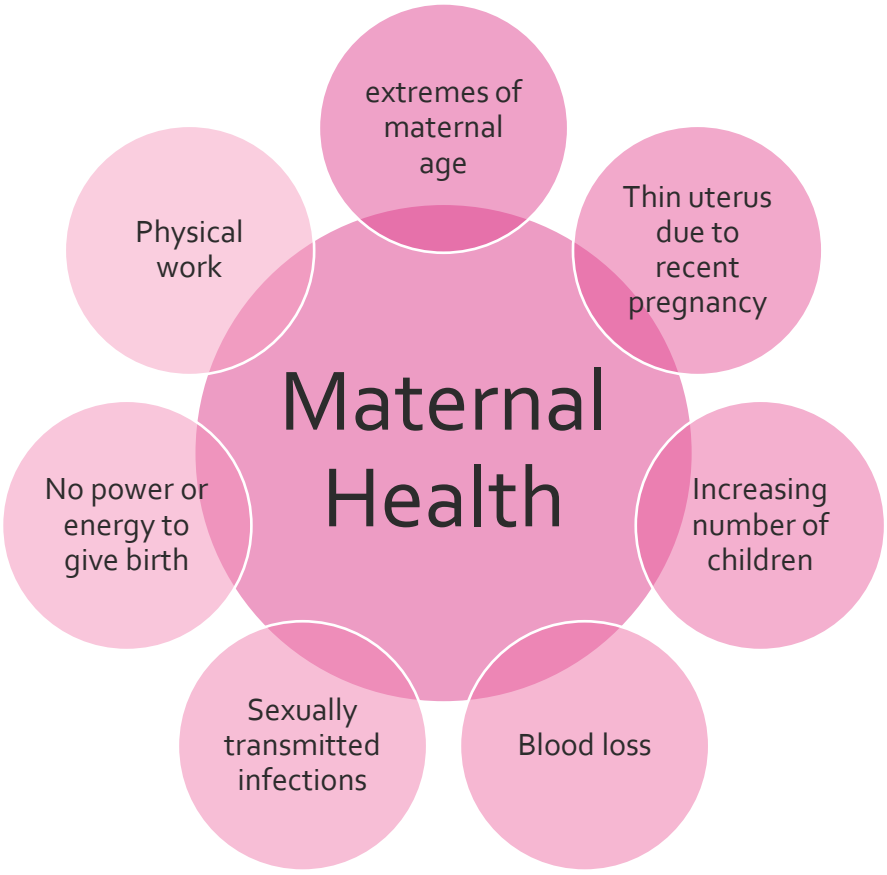
> *"the woman is only 19….as a woman of this age, her womb is not yet able to have a baby, "kandungan la bele tahan" [the womb is not ready yet]" (Male Participant 5D, 35 y.o., - Focus Group 5- 'peri-urban').*

This belief has consequences with regard to the perceived need for family planning – if the belief is that a woman is too young to get pregnant, it may be perceived as logical that there is no need for family planning.

Woman's health

Many men recommended prioritising the woman's health and delaying pregnancy in the presence of factors they believed impacted on maternal health. These risk factors are illustrated by the following diagram:

DIAGRAM 2: RISK FACTORS IDENTIFIED AS IMPACTING ON MATERNAL HEALTH:



Men explained that it was the responsibility of the husbands to seek care for their wife, and most agreed that if the wife expressed a wish not to be pregnant again due to health issues, the husband should accept

this. Not prioritising the woman's health or considering her wishes was believed to have dire consequences, including maternal death:

> *"If Pedro [husband] 'obriga' [force] Maria [wife] to have a baby, because of her situation of having lost much blood, it can affect Maria to die or pass away. So it sounds like Maria has no more power or energy to give birth but if Pedro insists or keep asking to have baby, then Maria will lose her life" (Male Participant 7I, 29 y.o.,- Focus Group 7 – 'peri-urban').*

Cultural and familial factors

Cultural influences are significant and impact on a couple's decision to have a baby. Many identified the importance of forming a family, and acknowledged that sometimes there was family pressure to marry at a young age. Also, once a man and woman were living together the expectation was that they would have children sooner rather than later.

A number of ethno-physiological factors were identified as impacting on the decision to have a baby, including the importance of "proving" fertility first and having a baby before engaging with any methods to delay. A concern was that if a couple used methods to delay, these practices may "close the way" to future pregnancies and result in infertility.

B*arlake,* while acknowledged as an important cultural custom, was not perceived to influence the decision to have a baby, and prioritising the woman's health ahead of any perceived reproductive obligations was identified as paramount:

> *"'Wain hira saude ladiak barlake la folin' [when there is no health barlake has no value]" (Male Participant 6I, 30 y.o., - Focus Group 6 – 'rural').*

While the 'Youth' focus groups perceived the important considerations to be respecting each other, living responsibly, peacefully and harmoniously, they also highlighted the importance of balancing the sexes when making decisions about the number of children, that is, having an equal number of sons to daughters. This may be seen as linked to traditional considerations embedded in *barlake* practices.

Men's sexual needs

Men's sexual needs were perceived as "high", "uncontrollable" and having utmost priority, with many men believing they were entitled to have these needs met whenever they arose, regardless of the circumstances or wishes of the women. This contradicts the sentiments expressed previously when discussing 'women's health', and these needs therefore override any mutual decision-making process with regard to having a baby.

If the wife did not meet these needs, her husband may seek sexual relations outside of the marriage, although it was acknowledged that this may bring disharmony to the couple:

> *"When the man wants or is in need of having sex, the woman should be able to calm the situation [fulfil his sexual needs]. Otherwise he may go outside [extramarital sex] to have sex that could cause a problem" (Male Participant 8A, 26 y.o., - Focus Group 8 – 'urban').*

Although the men believed that only God could diminish the man's uncontrollable sexual needs, a number of strategies were nominated to help decrease the likelihood of an unplanned pregnancy. These included reminding

each other of fertile periods, physical or geographical barriers and employing "KB" [family planning] methods. Groups advocated for the existence of a "plan" between the couple as a 'safety net' for preventing unplanned pregnancy, so no matter when a man's sexual needs arose, the woman would be protected from unwanted pregnancies.

However, it was acknowledged that if the husband came home drunk and insisted on sexual relations, any pre-negotiated family planning behaviours dependent on the husband's co-operation became null and void:

> *"if a man comes in drunk condition sometimes man wants to have sex anytime – that's just what happens…..If Maria [wife] doesn't want to get pregnant again she should inform her husband and they can have sexual relations but they should use a condom. But if Maria didn't inform him and the man comes in a drunk situation, then pregnancy can happen" (Male Participant 6I, 30 y.o., - Focus Group 6 – 'rural').*

The perception that men cannot control these sexual needs and urges has implications for other reproductive health doctrines and public health messages calling for people to 'control themselves' sexually.

Knowledge of methods and sources of information

The decision to delay or have a baby is influenced by people having access to trusted sources of information, including from the CHC [Community Health Centre], MSTL, midwives, doctors, nurses, nuns and teachers. Non health professional sources of trusted information were mothers and sisters, friends, neighbours or people at the market.

One of the Youth focus groups was adamant that one would not trust or consult with a '*Matan Dook'* [traditional healer] about methods to delay. However, others identified traditional medicine as a way to delay, or enhance, one's chances of having a baby, as were specific cultural ceremonies or blessings. If cultural considerations were not afforded appropriate importance within formal health care settings, people chose not to engage with such facilities, but rather sought care and advice from local people with health

care skills. One woman told the story of her infertility, which illustrates the blending of both formal health care and 'traditional' or 'cultural' health care:

> *"I have difficulty to get a baby right now. I feel sad because other people have many children already, but I don't have yet. My husband and I made the decision together to get help. I have been to the health site and had 'aimoruk' [medicine], and I've also had traditional herbs. I've also had a cultural ceremony, and have gone to the cemetery to pray to the ancestors to have more baby" (Female Interview Participant 4, 24 y.o., - 'rural').*

It is important to remember that such 'two-eyed seeing' or medical pluralism approaches exist, and influence the trust people have of health services and influence their health seeking behaviour.

Physical and geographical barriers

This is closely related to minimising the influence of men's sexual needs. This may involve the husband and wife staying in separate locations or simply sleeping separately in the same house:

> *"The way to prevent pregnancy, you want the first one to grow up before having the next. The wife should sleep separately from husband. If touching, have problem" (Female Interview Participant 3, 29 y.o., - 'rural').*

If sleeping separately is not possible, some of the men describe a process by which a long pillow is used to keep the husband and wife separated in the same bed.

Land

All of the focus groups except those conducted in Viqueque, believed that the amount/size of land owned by a family may impact of the decision to have a baby.

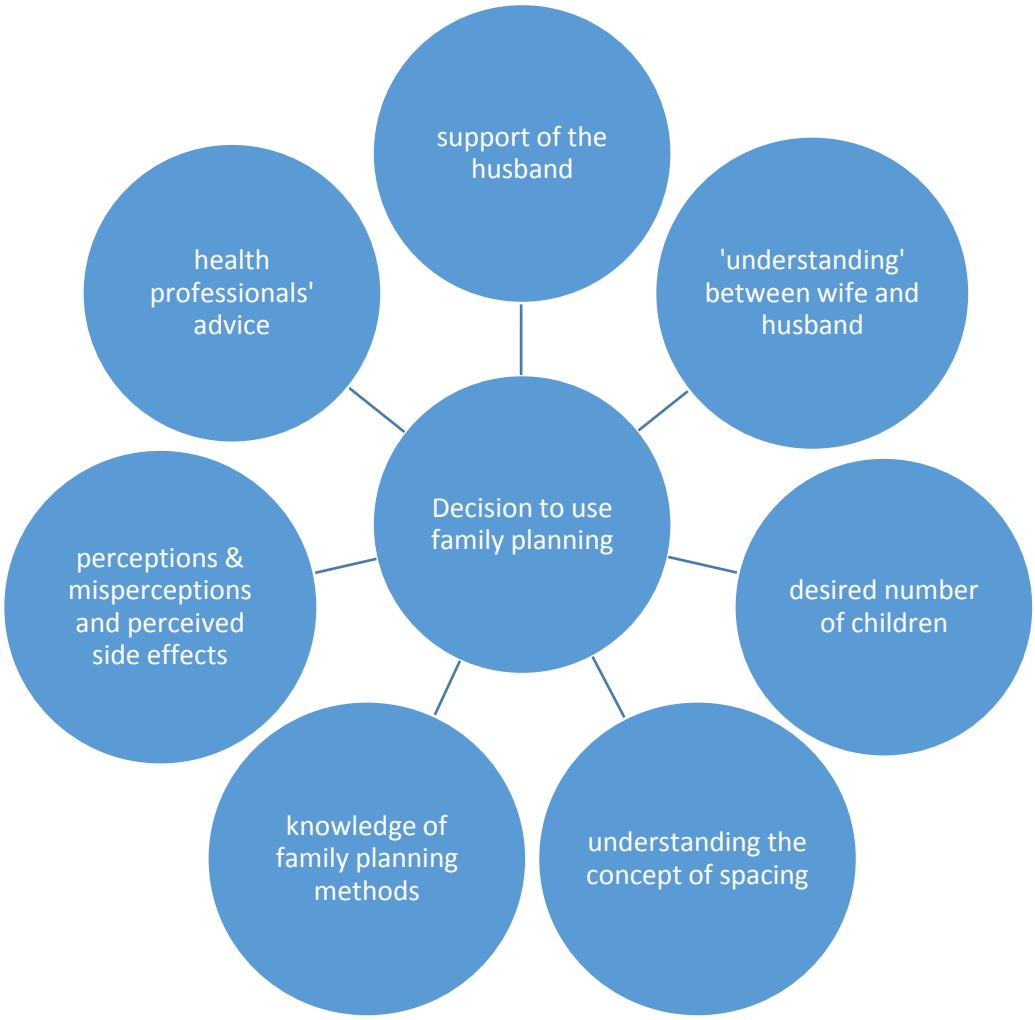
If there was only a small amount of land or a decreased ability to generate sufficient income from the land, the men strongly believed a couple should decide to delay having any more children. Both Youth focus groups saw the land as an important asset for the future, for providing both financial means for children to attend school, as well as being an important resource necessary for marriage. Sharing and dividing the land equally amongst sons is viewed as important to minimise potential conflict amongst the children, while it is accepted that daughters are not entitled to receive any portion of the family land. Similarly, some of the children in the family were chosen to stay and work on the land, while others were chosen to attend school.

DECISION TO ACCESS FAMILY PLANNING INFORMATION AND SERVICES

The decision to access family planning is overwhelmingly described as a "mutual" one between wife and husband. Also, the perception that women cannot independently decide to access family planning without first consulting with or asking permission of her husband, is consistent across most participants. How the

decision to use family planning is made, appears to be dependent on a number of factors, as illustrated by the following diagram:

DIAGRAM 3: FACTORS INFLUENCING DECISIONS ABOUT FAMILY PLANNING:



Support of the husband

Men stated that as "chief" of the family, they were entitled to be angry if their wife did not ask their permission to access family planning. Failure to seek permission from the husband could result in sickness, conflict and violence:

> *"'Wainhira ita la husu la'en ne'e ita bele hetan moras bele mate' [When we don't get permission from husband we can get sick or die" (Female Interview participant 5, 29 y.o. – 'rural');*
>
> *"When the woman doesn't listen to what the man wants, the result will be baku malu [fighting, slapping, beating]" (Female Interview participant 3, 29 y.o. – 'rural').*

Many men also spoke of a great deal of suspicion that a wife may access family planning 'in secret', perceiving a link between this and their wife engaging in extra marital affairs. The reasoning behind this stemmed from the perception that if a woman was secretly using family planning methods, she could have an affair, as the risk of pregnancy would be minimised, and thus the risk of her husband discovering her affair also minimised:

> *"The reason why men didn't support [family planning] – feeling jealous and worrying that the wife who has attended family planning may have an illegal affair – 'salingkuh', and because she is using family planning, potential pregnancy averted then no one will know about the affair" (Male Participant 8A, 26 y.o.,- Focus Group 8 – 'urban').*

Men and women stated that there would also be suspicion if the wife did not become pregnant despite sexual relations with her husband. In these circumstances, rural participants believed that the husband would be entitled to leave his wife and find another, in an effort to fulfil his reproductive goals.

'Understanding' between wife and husband

This concept of 'understanding' between wife and husband as a means of 'family planning' appears to have several elements, including physiological, cultural and behavioural components:

TABLE 4: COMPONENTS OF 'UNDERSTANDING'

PHYSIOLOGICAL	CULTURAL	BEHAVIOURAL
Men & women should know how the menstrual cycle works including when it is the fertile time	Once fertility obligations reached woman may stop having children	Understanding cannot occur if man is drunk
Women are responsible for informing the man of fertile time		Men should know themselves and control themselves
Men & women should be aware of their reproductive health		Collaborate prior to sexual relations and mutually agree on reproductive health goals
Be aware of each other's sexual libido & needs		Be open and honest with each other
Be aware of puberty and what it means physiologically		Sleep separately or practise abstinence
		Using withdrawal method
		Man using condom

The expectation was that collaboration and partnership underpinned this concept of 'understanding'. However, when men had perceived overwhelming sexual needs, or they were intoxicated, it was acceptable that any pre-established plan became null and void. In these instances it was viewed by many men as necessary that women had a 'back up' plan in terms of family planning, that is, one that did not depend on a man behaving in a certain way. Further exploration of 'understanding' is presented later in this report.

Knowledge of methods

Most male participants were able to identify at least one "natural" or "modern" method of family planning. "Natural" included the calendar method, withdrawal method, traditional herbs, *'kolar'* (counting method using beaded necklace) and 'sleeping separately' or avoiding each other. Knowledge regarding modern methods of contraception was collected during the body mapping exercise, and varied across focus groups and municipalities. Overall, half of the male participants who took part in the body mapping exercise (n=67), were able to accurately identify a male method and at least one female method.

The following table illustrates the number of men from each municipality who accurately identified male and female methods of family planning, that is, were able to name, or explain, or place that method accurately in the body [because of the ambiguity surrounding the 'female condom', this method was excluded from the analysis when it was placed at the female vaginal area; it was however included when it was deemed 'inaccurate', and placed on an incorrect body site, for example, on the female's arm]:

TABLE 5: NUMBER OF MEN ABLE TO ACCURATELY IDENTIFY A MALE METHOD OF FAMILY PLANNING AND A FEMALE METHOD OF FAMILY PLANNING

Municipality:	**Viqueque N=25**	**Baucau N= 16**	**Ermera N=22**	**Dili N=4**	**Total N=67**
Number of men who identified Male methods ACCURATELY	10/25; 40%	11/16; 69%	10/22; 45%	2/4; 50%	33/67; 49%
Number of men who identified Female methods ACCURATELY	18/25; 72%	10/16; 62%	7/22; 32%	0/4; 0%	35/67; 52%

As this is a qualitative study, we do not have a large sample size. However, these figures are included to give a sense of how many of the men from our study were able to accurately identify modern family planning methods. Of note is that almost the same number of men accurately identified a male method compared with those who accurately identified a female method. However, this is not the case when we highlight the Youth (18-24 year old) participants (n=25)[3]. Of these participants, 16/25 (64%) accurately identified a modern male method of family planning, while 9/25 (36%) accurately identified a modern female method.

[3] As we had demographic data including age for each participant who took part in the Body Mapping exercise, we were able to extract their data separately for comparison in this section.

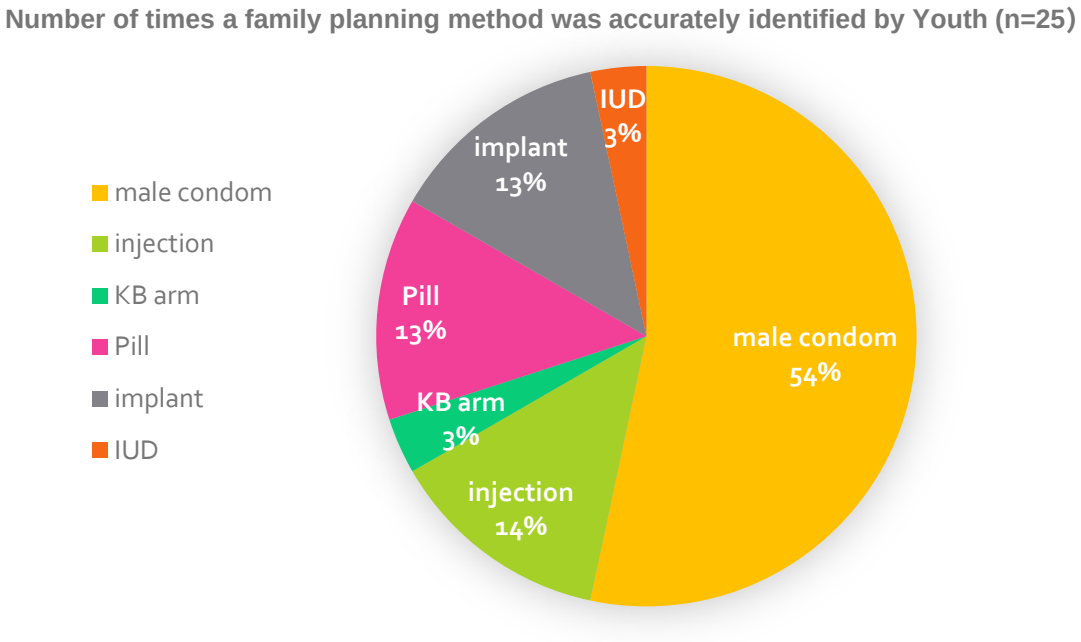
While the above table illustrates the number of men who accurately identified at least one modern method, the following table lists all the methods of family planning, both accurate and inaccurate, drawn and explained by the men during the Body Mapping exercise, and how often each method was nominated:

TABLE 6: NUMBER OF TIMES ACCURATE AND INACCURATE METHODS OF FAMILY PLANNING WERE IDENTIFIED

	Viqueque n=25	*Baucau n=16*	*Ermera n=22*	*Dili n=4*	*Total times identified*
Accurately identified male methods					
Condom	10	11	10	2	33
Inaccurately identified male methods					
Injection					3
Man can't use FP	3	0	0	0	2
IUD on penis	2	0	0	0	1
	0	0	1	0	
Accurately identified female methods					
Injection	14	2	0	0	16
KB – arm	3	0	1	0	4
Implant	4	6	2	0	12
Pill	11	6	2	0	19
IUD	2	3	7	0	12
Inaccurately identified female methods					
'Tie up mouth'					
Condom in arm	1	0	0	0	1
IUD in leg	2	0	0	0	2
IUD in arm	0	0	1	0	1
Menstruation	0	1	1	0	2
Vagina	0	0	2	0	2
	0	0	1	1	2
Ambiguous female methods					
Condom vagina					
	1	3	1	1	6

This table illustrates that men accurately identified the male condom (33 times) most often as a modern family planning method, followed by the pill (19 times), injection (16 times), implant (12 times) and IUD (12 times). Again, when we extracted the data for the Youth participants (n=25), they identified the male condom almost 5 times more frequently than any other method, as illustrated by the following graph:

GRAPH 1: NUMBER OF TIMES YOUTH PARTICIPANTS ACCURATELY IDENTIFIED A FAMILY PLANNING METHOD



When exploring whether participants identified multiple modern female family planning methods, we looked at the educational status of each participant (n=67) and how many methods they accurately identified.

TABLE 7: ACCURATE IDENTIFICATION OF MULTIPLE MODERN FEMALE METHODS, BY EDUCATION AND MUNICIPALITY

Number of men who accurately identified:	*Viqueque Prim or less* n=13*	*Viqueque Sec or more** n=12*	*Baucau Prim or less n=7*	*Baucau Sec or more n=9*	*Ermera Prim or less n=10*	*Ermera Sec or more n=12*	*Dili Prim or less n=1*	*Dili Sec or more n=3*	*Total*
***1 method** only*	3	4	3	2	2	1	0	0	15
***2 methods** only*	2	4	1	2	0	1	0	0	10
***3 methods** only*	2	2	1	1	0	2	0	0	8
***4 methods** only*	0	1	0	1	0	0	0	0	2
Total	7/13	11/12	5/7	6/9	2/10	4/12	0	0	35/67

*Prim or less = Some primary school education or less; **Sec or more = Some secondary school education or more.

Again, because our sample size is small, it is not appropriate to make comparisons based on education status; this table merely illustrates this status of our participants and how many of them were able to accurately identify one or more modern female methods of family planning. This table illustrates that 25/67 (37%) of our participants were able to accurately name one or two female modern methods of family planning, while 10/67 (15%) of our participants were able to accurately name 3 or 4. Of note is the low number of men from Ermera who accurately identified 1 method or more.

Interestingly, over 80% of the Youth participants had attained an educational level of 'some secondary schooling or more', however only a third of these participants were able to accurately identify a modern female method of family planning. It is important to note that this may have been due to the sensitive nature of the research topic –even though the Body Mapping exercise interviews took place privately between a male Timorese researcher and the participant, the participant may still have felt shy or embarrassed to discuss such issues.

Uncertainty and confusion exists with regard to many modern methods of contraception, while many methods remain unknown to many participants. Some of this confusion was illustrated by the different perceptions participants had with regard to condoms. The identification of specific condoms for men and specific condoms for women is not entirely clear - a number of participants in the 'Youth' focus groups explained that the condom used by females was different to that of males, while participants from other focus groups who named the female condom used in the vagina stated that it was the same condom used with males. Some of the confusion perhaps exists because the same male condom does in fact go into the vagina during sexual relations, but this is speculation.

Half of the focus groups contained participants who explained that male condoms on the penis were important for preventing pregnancy and preventing the transmission of disease by covering the penis.

Health professionals' advice

The advice and information provided by health professionals plays an important role in influencing the decisions couples make with regard to choosing family planning methods. Many participants also explained that it was important for husbands and wives to hear this information together.

However, the information retained is sometimes inaccurate from a biomedical perspective. It is impossible to know in the context of our study whether this is from the health professional passing on inaccurate information, or whether the participant has confused some of information heard.

A number of the women stated they had only been offered one method when they had attended the health clinic for family planning, and that there had been minimal information provided by the care giver as to alternatives or side effects:

> *"I didn't choose the other method because they didn't explain to me about the side effects. When I come and I don't know about the side effects, the midwife didn't explain it to me. I just went to clinic and they put it in me" (Female Interview participant 16, 18 y.o. – 'urban').*

Another participant explained that sometimes she did not understand the information provided by the health professionals, and would seek clarification from friends or neighbours:

> *"And if the information from the CHC staff is not very clear, then we can ask the people who have already received family planning. Sometimes the health people explain it in a different way to the people who have gone" (Female Interview participant 3, 29 y.o. – 'rural').*

Perceptions, misconceptions and perceived side effects

The participants expressed a variety of mixed perceptions, misconceptions and perceived side effects with regard to family planning methods. Many believed that the decision to sleep separately and practice abstinence were appropriate and effective behaviours to delay pregnancy, with 2 of the women stating that they could sleep separately from their husbands for 2-4 years and thus space their pregnancies accordingly. Many of the men however acknowledged the discordance between the 'ideal' and 'reality' of this situation, and cited examples of closely timed pregnancies resulting from transgressions.

Participants in 'Youth' Focus Group 9, stated that they believed natural family planning to be preferable, as it did not require visits to the health facilities for check-ups. One of the 'Youth' female interview participants stated that:

> *"If you are married you can use KB [modern method of contraception], but if you are single you use the 'wet season – dry season' Natural family planning" (Female Interview participant 13, 24 y.o. – 'peri-urban').*

Certainly the male youth we spoke with displayed limited knowledge with regard to modern methods of family planning, so expressing a preference for 'natural' methods may simply be due to a lack of awareness of different options.

A number of the women explained that they had decided to change contraceptive method based on a change in their circumstance or due to perceived negative side effects from a particular method:

> *"I had been using 3 monthly 'sona' injections for 6 years but felt not so good because I lost weight and had no menstruation and felt like a man. So I came for IUD insertion – I don't want to have a baby anymore, that's why I'm using this one" (Female Interview participant 9, 43 y.o. – 'peri-urban');*

> *"I choose natural family planning methods for spacing. I am scared that the other methods will not match me – will cause me to get too fat and fall sick" (Female Interview participant 15, 35 y.o. – 'urban').*

While the women believed some modern methods may cause general sickness, headache, an inability to work and infertility, **14 out of 17 of our female participants believed family planning to be generally beneficial for women's health**, providing effective means of spacing allowing women to recover from pregnancy and have the time to engage in other activities.

Two of the rural focus groups presented strong opinions with regard to the perceived safety of modern methods of contraception, expressing concern about the impact on the health and life of the woman:

> *"18 year olds have very high sexual needs and he can't control his sexual needs or urges…. I think the condom is good. Why can't the condom be distributed to youth who needs them, why can't they share them within themselves…. rather than women having injection that can make the woman have trouble getting pregnant or the second problem is if woman is pregnant you can die if you've used the injection" (Male Participant 2A, 40 y.o. - Focus Group 2 – 'rural');*

> *"KB formungu ['mungbean'; Pill]; the pill is black and yellow and regularly consumed. If consumed incorrectly the impact can be death" (Male Participant 2A, 40 y.o.,- Focus Group 2 – 'rural').*

There was also a perception that while spacing could be advantageous for women's health, perceived risks from longer acting methods of contraception were extreme. One rural focus group held the belief that there are more maternal deaths now compared to during Indonesian times. Part of the basis for this is that the long term methods of contraception offered by reproductive health providers now, which are believed to prevent pregnancy for 8-10 years, are perceived to be extremely strong medicine and therefore thought more likely to cause negative side effects for the women.

The men feel great responsibility for the health of their wives and they want to protect them. Due to persistent misinformation and myths in the community surrounding modern methods of contraception, many men are understandably fearful of engaging with such methods and potentially subjecting their wives to perceived negative side effects, including death.

DECISIONS AROUND NUMBER OF CHILDREN

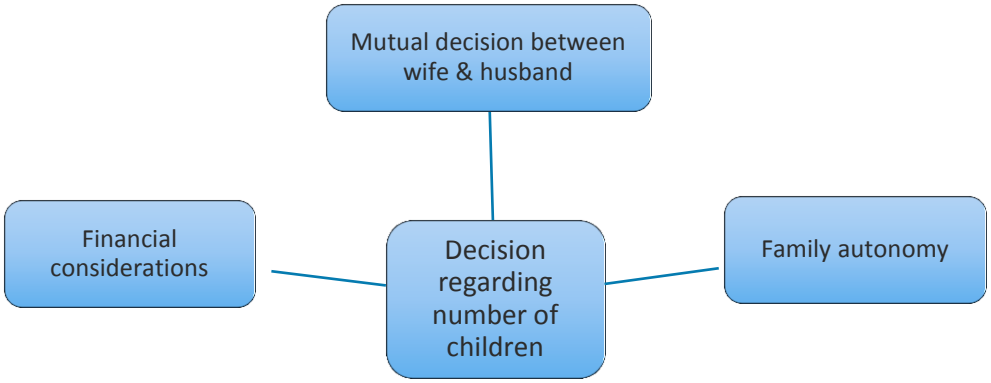
This decision was viewed by the majority of participants as a mutual one. Failure to communicate and collaborate may lead to problems:

> *"Certain women feel trauma. Good to have long spacing but because of the associated trauma they not feel comfortable with the long term method" (Male Participant 6H, 40 y.o.- Focus Group 6 – 'rural').*

For the men, the most consistent considerations impacting on the decision surrounding the number of children, were the influences of the family's financial situation and 'autonomy' at the family level:

> *"if couple does not plan and trust each other on these issues [deciding on number of children], it can lead to 'kria violensia iha familia' [domestic violence]" (Male Participant 6C,45 y.o., - Focus Group 6 – 'rural') .*

DIAGRAM 4: INFLUENCING FACTORS ON DECIDING HOW MANY CHILDREN



Men spoke of matching the number of children with income and perceived that family poverty could decrease by limiting the number of children. Also, children could provide labour on the family farm and care for their parents in the future.

The second important consideration was that of the autonomy of the couple to decide on the number of children they have - not something to be regulated by outside authorities:

> *"Commenting on other nations' regulations to limit with regard to number of children – in Timor there is no regulation. Sometimes people have 8-9 children. In my opinion, 5 is enough" (Male Participant 4B, 38 y.o., - Focus Group 4 – 'peri-urban').*

Having children is perceived as a desired expectation for many Timorese, and is also important from a cultural perspective. Additionally, one focus group described the ability of a couple to have many children being linked with a man's sexual prowess or 'virility'. A number of the women stated that because their husbands were 'sole children', their husbands wanted to have many babies. Men described seeking another wife if their current wife was unable to provide them with more children, or children of the desired sex.

Decisions around number of children are influenced by numerous factors, and while described as “mutual”, the consequences for women’s health and well-being are serious if she fails to agree with her husband’s wishes.

DECISIONS AROUND SPACING

The majority of focus groups and half of the women perceived spacing to be a mutual decision, while the other half of the women believed it to be a decision made by the husband.
Both men and women linked the decisions made around spacing with the health of the woman. For many participants, spacing was seen as a more important health consideration than number of children. The most consistent perception associated with spacing was that of the dangers of a thinning uterus from pregnancies too close together:

> *“If we keep having children like in a ladder, close together, then it destroys health. We should have an understanding of spacing. We should wait 2 years between children. There should be an understanding between wife and husband. A womb that is very thin, if we have to have a child every year, then we can die from having a thin uterus” (Female Interview Participant 1, 22 y.o., - ‘rural’).*

There was not a consensus as to what constituted adequate spacing. Some of the focus groups suggested 2 years as the participants believed that the uterus should not be ‘empty’ for too long. Others felt that 5 years was more appropriate, allowing the parents more freedom and the husband less economic burden. Some men believed that it was younger people who lacked knowledge about spacing and possible health consequences, while others felt that geographical barriers were at play with facilities offering reproductive health education and information too inaccessible. A number of the women felt that their husbands had not understood the importance of spacing and the impact to the woman’s health:

> *“My husband did not think. My husband makes me upset because he doesn’t understand well about my health and about spacing baby. It causes me stress. When men think like this I feel sad and stressed” (Female Interview Participant 6, 34 years old, 9 pregnancies – ‘rural’);*
> *“First and second child we decide together. Third child is because of my husband. My husband forced me to get another one” (Female Interview participant 5, 29 years old, 3 pregnancies – ‘rural’).*

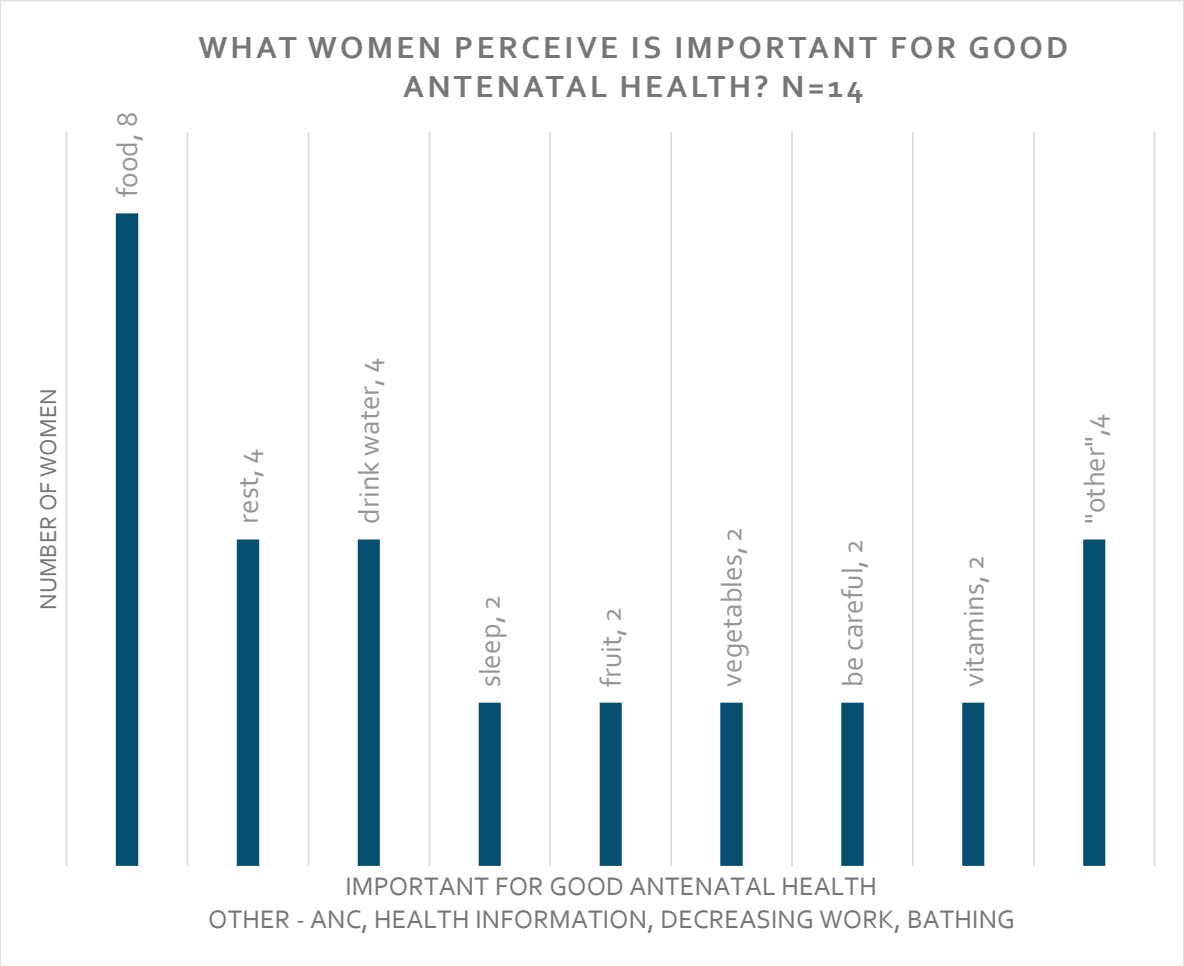
Both of these women disclosed that they had been pregnant when they did not want to be - their husbands had wanted another baby straight away, while they the women had wanted to space their pregnancies.

DECISION TO SEEK CARE DURING PREGNANCY

The majority of men and women agreed that seeking care during pregnancy – 'antenatal care' - was a mutual decision, and **79% (11/14) of the women who had been pregnant before had sought some form of antenatal care**. Three of the focus groups, including both 'Youth' groups, believed that the decision to seek antenatal care was made by the husband. The husband was also responsible for finding transportation to the health facility and for taking care of his wife during her pregnancy.

Men nominated good food, rest, vitamins and the husband not getting drunk as important for good antenatal health, while the women nominated a much more extensive list, as illustrated in the following graph:

GRAPH 2: WHAT WOMEN PERCEIVE IS IMPORTANT FOR GOOD ANTENATAL HEALTH:



The women believed that their health was intricately linked with that of their baby:

> *"'Wainhira inan isin diak, bebe mos isin diak' [when the mother's body is healthy, the child's body is healthy too]" (Female Interview participant 4, 24 y.o. – 'rural').*

Women stated that they sought antenatal care because they trusted their caregiver (43%), or because they believed that antenatal care was important for the health of the mother and her baby (29%). Midwives were the most frequently nominated trusted caregiver, with the CHC (Community Health Centre) the most frequently nominated site for antenatal care. The midwife's guidance in determining and communicating the frequency of antenatal visits (believed to be between 3-12 visits) to the couple was perceived to have an impact on the woman's health.

One rural community we spoke with expressed a great distrust towards health providers from outside of their area. Within their community they had a man who had worked for the Red Cross during Indonesian times, who had great experience caring for pregnant and birthing women. The faith this community had in this male health worker resulted in them seeking his care during pregnancy and birth. Identifying local champions such as this and ensuring that they feel supported to provide timely, accurate and safe care, as well as encouraging relationships between such champions and more formal avenues of health care, may contribute to the more trusted and acceptable care of women and babies.

Of the women we spoke with who had been pregnant before, 70% stated that they believed they had been in good antenatal health while of the remaining 5 women, 1 had experienced severe vomiting – '*muta'*, 1 had experienced anaemia – '*rann menus'* – which she believed was the result of not eating enough fruit during pregnancy, one woman had experienced a stillbirth at 8 months gestation, and 2 women had experienced miscarriages. One of these women experienced sudden, extensive vaginal blood loss at home when she was 2 months into her 4th pregnancy. She believed she miscarried due to working a lot. She asked her husband to help her but did not seek care from anyone else because:

> *"'Lakohi husu ajuda iha ema seluk tamba lakohi ema seluk hatene' [she didn't want to seek care from anyone else as she did not want other people to know about her situation]" (Female Interview participant 7, 40 y.o. – 'rural').*

The woman who experienced the stillbirth explained that she believed her baby had died due to a ghost:

> *"I walked during midday and certain ghosts touched me [described as touching or blowing bad air into the woman's uterus]. When the baby's body was born, the baby's body was totally black. I don't know why the ghosts touched me that day" (Female Interview Participant 2, 28 y.o. – 'rural').*

These examples illustrate the strength of ethno-physiological beliefs in explaining or understanding health outcomes, as well as the feelings of shyness or desire for privacy that may impede a woman seeking care.

They also demonstrate the perceived link between nutrition and reproductive health, and the perception that work may impact on a woman's reproductive health.

These ethno-physiological beliefs and links to nutrition were also evident when the women spoke of menstruation. Many women stated that during their menstruation, they should:

- Eat and drink enough so that their period comes;
- Not drink cold water;
- Not eat cool foods;
- Not take a bath;
- Not touch cold water;
- Not wash their hair.

Bathing and washing hair were believed to interfere with menstruation, and doing either when menstruating was perceived to be bad for one's health. Interestingly, one woman explained that now she had had children, she could bathe and wash her hair when menstruating, suggesting a possible link between such actions and fertility:

> *"I can take a shower or take a bath and wash my hair when having period because now I have many children" (Female Interview Participant 8, 38 y.o. – 'Peri-urban').*

For more detail regarding the menstruation data from this project, please see Appendix C.

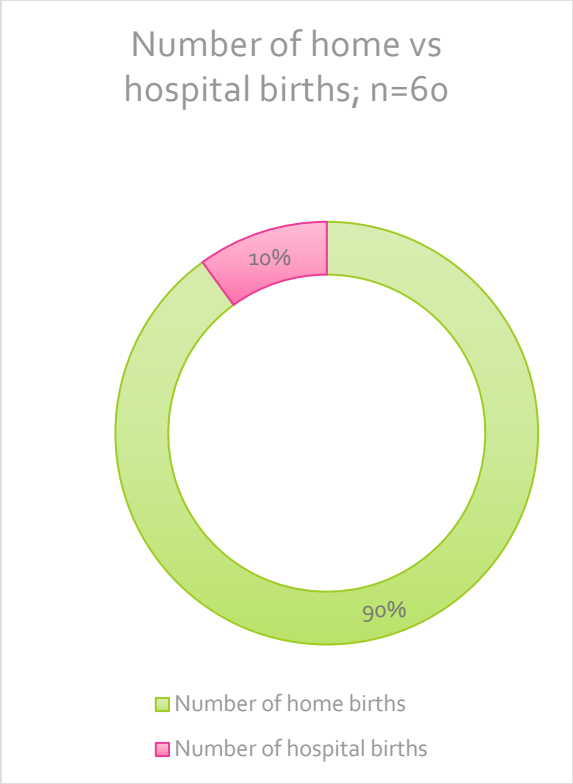
DECISION TO SEEK CARE DURING LABOUR AND CHOICE OF BIRTH PLACE

Over half of the focus groups and a third of the interview participants perceived it was the husband's decision to seek care for his wife during labour and decide on the place of birth. This was mainly believed to be because the woman was unable to focus on such decisions when she was in labour. This highlights the importance of encouraging couples to have the conversation about place of birth prior to the woman going into labour, so preparations are able to be made. A third of the interview participants also nominated their mother-in-law as the one to make the decision for them as to birth place:

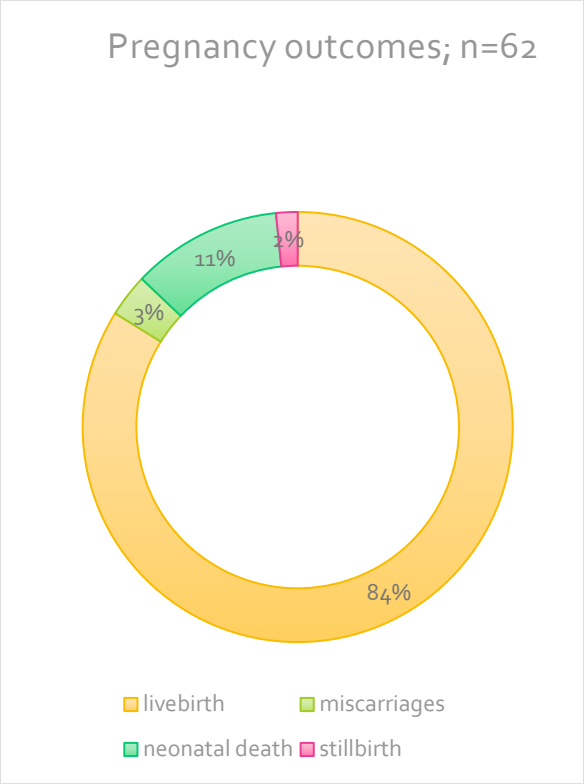
> *"For the third baby the mother-in-law decided for me to deliver at hospital because my health wasn't so good and because the first 2 babies had died after only a few weeks or months" (Female Interview Participant 1, 22 y.o. – 'rural').*

Of the women we spoke with for whom we have birth data[4], 13 had been pregnant before, they had had 62 pregnancies between them and had 52 living children (please refer to 'Table 2 – Female Participant demographics and characteristics') . The following graphs represents their babies' birth places and the women's pregnancy outcomes:

GRAPH 3: PLACE OF BIRTH



GRAPH 4: PREGNANCY OUTCOMES



At home, the women predominantly nominated their husbands and mother-in-law as the people who helped them with their labour and births. Even if the decision had been made that they would birth in the hospital, a variety of cultural, systemic, geographical, personal and financial reasons prevented this, as illustrated in the following table:

[4] 14/17 of the women we interviewed had been pregnant before, however Interview Participant 15 terminated the interview early due to her baby requiring feeding, so we were unable to obtain pregnancy, labour, birth and postnatal data for this participant.

TABLE 8: WOMEN'S REASONS TO BIRTH AT HOME & BARRIERS TO BIRTH IN HOSPITAL (N=14)

REASONS TO BIRTH AT HOME	BARRIERS TO BIRTHING IN HOSPITAL
No health problems so just stay at home	Money
Baby born faster because we can exercise or work	Ambulance not arriving
If you are hungry someone can bring food to eat	Difficulty with transportation
Home is better because at hospital many midwives watching	Distance to health facility
Able to call the midwife to come to the house to help	Mistake with predicting due date
Feel more comfortable at home	At hospital you are fully naked & have no clothes

One of the participants, in describing the trouble with finding adequate transportation to take her to hospital to birth, stated that:

> *"I was sick one week before all 6 children, but went to the hospital early for 3 children only. During sickness, I did not have the energy to deliver the baby, that's why I went to hospital. I had difficulty with getting transportation. They need to call the car that passes by. With the first boy, I just used a horse to get to the road" (Female Interview participant 9, 43 y.o. – 'peri-urban').*

The men acknowledged that they felt responsible for providing care to their wives, and while they sometimes recognized risk factors and realised their wife required help, were unable to get this help. As with the women, they identified money, transport and 'shyness' as barriers to their wives getting to hospital to birth:

> *"If you feel shy then you will die. That's why it's better to not be shy so you can still enjoy your life" (Male Participant 8A, 26 y.o., - Focus Group 8 – 'urban').*

Birthing in hospital where it was expected that there were trained caregivers, oxygen, equipment and medicine was perceived as a 'guarantee' of a good outcome.

Maternal death

Maternal death was acknowledged as a real possibility by the majority of focus groups, with a variety of factors believed to contribute to the risk of this occurring:

TABLE 9: MEN'S PERCEPTIONS OF POSSIBLE CONTRIBUTORS TO MATERNAL DEATH

POSSIBLE CONTRIBUTORS TO MATERNAL DEATH
Distance to facility
Condition of roads
Limitation of facility due to inexperience of staff
Distrust of health staff
Ignoring cultural considerations
Woman having no power or energy
Birth canal too narrow
Husbands not having skills or equipment at home
Infection

The men believed that infection was a real risk for causing maternal and neonatal death at home due to the practices of some particular caregivers:

> *"If Maria [wife] births at home it can cause infection because they will not use any medical equipment to help her during her delivery and at home the Matan Dook will use unclean equipment and not gloves. It can also lead to death" (Male Participant 6J, 39 y.o., - Focus Group 6 – 'rural');*

> *"At home there could be infection because the 'Abo Sira' [certain old woman in the community who helps women birth at home] who assisted the woman to give birth will use an unclean razor to cut the hussar [umbilical cord]" (Male Participant 6H, 40 y.o., - Focus Group 6 – 'rural').*

Labour and birth complications

The women described several complications they experienced during their labours and births, and acknowledged that these complications impacted on their health. They included:

- Large loss of blood after baby born;
- Retained placentas;
- Narrow pelvis and obstructed labour;
- One week of severe pre-labour pain;
- Undiagnosed causes of neonatal deaths;
- Failed induction of labour following possible rupture of membranes.

One of these women stated:

> *"Blood comes out and when tried to push hard I can't until I surrender. Doctor said I have a narrow pelvis and can't deliver normally. I don't think it is because of a narrow pelvis – I think it is because I ate lots of chilli at 3 months of pregnancy" (Female Interview Participant 10, 28 y.o. – 'peri-urban').*

This again highlights the importance of considering and acknowledging the influence of ethno-physiological beliefs as a possible explanation for pregnancy and health outcomes, the perceived link between nutrition and reproductive health, and the importance of timely and appropriate emergency care.

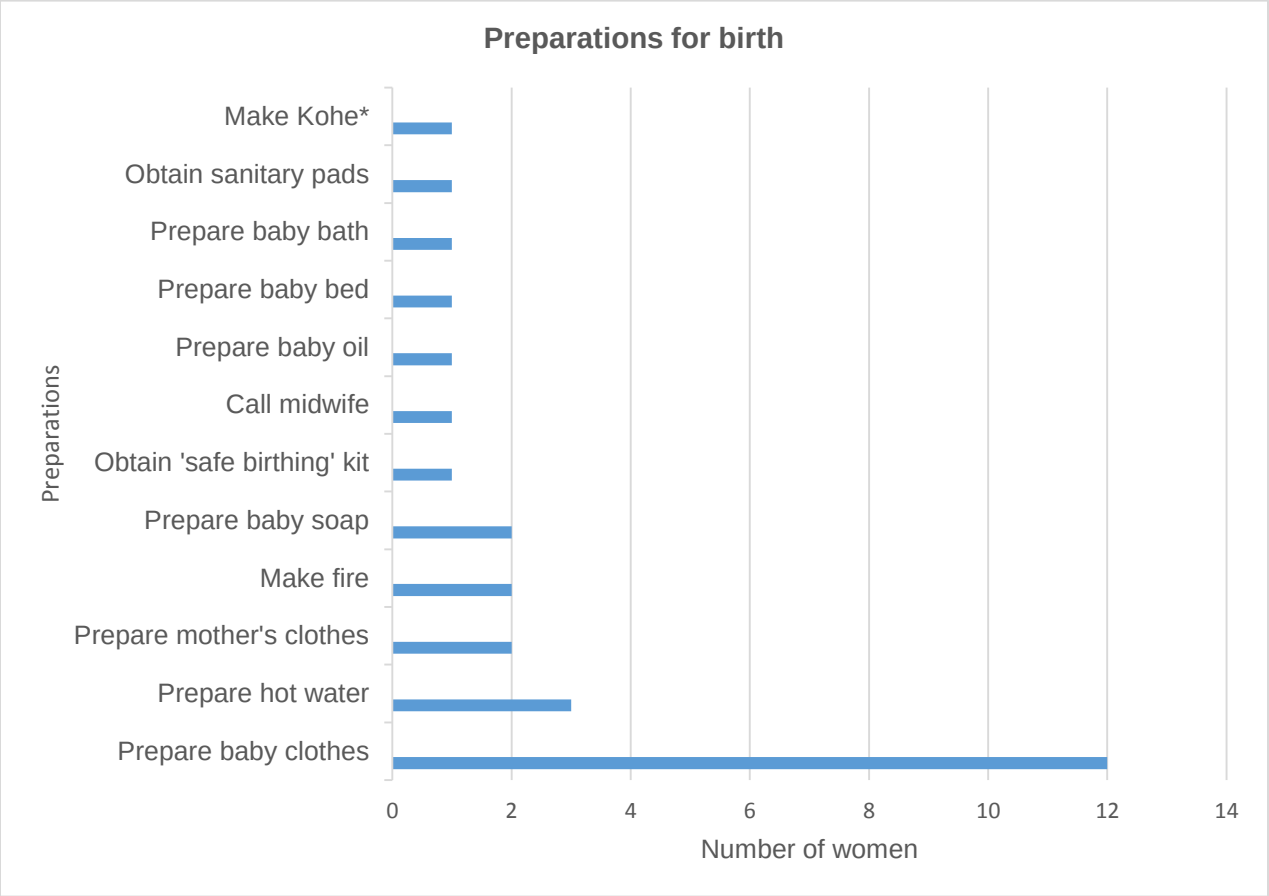
Neonatal death

Two of the women had experienced neonatal deaths - one woman had experienced **2 of her 4 babies dying**, while another woman had experienced **4 of her 9 babies die**. In both these cases, the women were unable to provide a diagnosis or cause of death for their children.

Preparations for birth

When asked what preparations had been decided to be made for the birth of the baby, the women described a number of practical items as well as a number of processes or behaviours:

GRAPH 5: PREPARATIONS FOR BIRTH



[**Kohe* – a bag made from palm leaves that the parents place the baby's placenta in and hang it from a tree].

This list is a mix of 'practical' and 'cultural' considerations, and highlights the opportunity to encourage women to include items necessary for a safer birth (for example, the 'safe birthing kit'[5] which a number of organisations have assembled and distributed) in their preparations. It is also a good reminder for reproductive health care providers of the importance of supplying and distributing such items, as well as using opportunities of contact throughout the antenatal period to discuss with the woman and her family the importance of birthing in a health facility, or at the very least, having access to a skilled birth attendant.

Husbands play an important role in deciding which preparations to attend to, so ensuring that husbands are aware of the importance of such factors is also vital.

[5] Safe birthing kits contain basic items including gloves, sterile scalpel blades and sterile cord clamps designed to assist women have clean and safe equipment to use when birthing their babies.

DECISION TO ENGAGE IN SEXUAL RELATIONS POSTNATALLY AND IN GENERAL

Men's perceptions as to who decides to resume sexual relations postnatally:

The 2 urban focus groups believed that it should be the wife who decided when to resume sexual relations postnatally. They believed that the husband should be understanding about his wife's circumstances, that the husband should prioritise his wife's health, and practise abstinence for 6 months.

The 3 focus groups who spoke about the decision being a mutual one, believed that the couple should discuss and consult with each other, and in doing so reduce the possibility of conflict and disagreement.

The 4 focus groups who believed this decision to be one the husband should make, all also emphasised the high, uncontrollable sexual needs of a man. One of these groups spoke of the requirement for men to balance their sexual needs, and to control themselves, with the health, situation and wishes of the women. However others did not believe the women's circumstances to be a major consideration, and believed that as the husband, the men could force or dominate the women to engage in sexual relations regardless of the women's situation, health or wishes:

> *"The man should decide to have sex because women are like a weak person because when we ask to have sex women mostly say yes ready all the time. Man sometimes need or insist to have sex – 'obriga' to have sex [force – persistent asking] – man cannot control his sexual needs" (Male Participant 5J, 33 y.o., - Focus Group 5 – 'peri-urban');*

> *"First of all Pedro [husband] should decide. Maybe Maria [wife] wants to have sex after 6-12 months, but it depends on Pedro – if Pedro says 'No' to this time, then sex could happen when the baby was only 4 months old" (Male Participant 6F, 26 y.o., - Focus Group 6 – 'rural').*

There was also a belief that women would never ask for or initiate sexual relations, and that it was therefore up to the husband to instigate such activity and for the wife to simply submit to her husband's wishes.

Two of the focus groups (a peri-urban and an urban group) spoke of the concept of the husband respecting his wife when making this decision. They believed this could be achieved through the husband prioritising the physical health of his wife, and not pressuring her to have sexual relations too soon after birthing her baby. The men believed this could be achieved by engaging in extramarital sex and employing the services of sex workers:

> *"If you want to enjoy sex just for fun you can go outside [extramarital sex] while in the period when your wife is in pregnancy or just recently delivered, so we should understand her situation" (Male Participant 4H, 44 y.o., - Focus Group 4 – 'peri-urban').*

Some of the men however acknowledged that this practice could harm their wives psychologically, through destroying the trust between the couple:

> *"For me and for the good health of my wife I can do abstinence for 6 months. If we don't do this we are destroying our wife, violating what our wife wants. If we go outside [have sex outside of the marriage] we will lose confidence from our wife" (Male Participant 8E, 27 y.o., - Focus Group 8 – 'urban').*

> *"[disagreeing with the idea of respect for your wife means engaging in extramarital sex] You slap her or beat her when you're angry – even if it's painful, it doesn't cause her to die. However going outside [outside the marriage for sex], it hurts her feelings softly [hurts her psychologically]" (Male Participant 4E, 38 y.o., - Focus Group 4 – 'peri-urban').*

Women's perceptions as to who decides to resume sexual relations postnatally:

For the majority of women who perceived the decision to be mutual, the resumption of sexual relations was linked with physiological processes. A number of the women believed that sexual relations could resume once breastfeeding had concluded. However, many of the women also acknowledged that even if they were breastfeeding and they resumed sexual relations, there was a risk that they could conceive:

> *"The first one – that baby was still only 2 months old when we had sex. That's why a baby came again after 9 months. Other times can be several months" (Female Interview Participant 7, 40 y.o. – 'peri-urban').*

If this happened, many of the women spoke of the perceived importance of ceasing breastfeeding straight away, as the breastmilk was now considered "dirty" and not good for the baby.

[The Timorese members of the research team explained that the idea exists if a woman gets pregnant while breastfeeding, the newborn baby and the baby in the uterus are consuming the same nutrients. That is, the quality of the breast milk is shared and not good quality for the baby who is breastfeeding. If a breastfeeding woman becomes pregnant, she will stop breastfeeding and feed her baby formula].

The women did not speak of feeling any degree of coercion or pressure from their husbands to resume sexual relations **postnatally**, although one participant did acknowledge the practice of men going "outside" of the marriage to fulfil their sexual needs:

> *"In my experience, when the baby is born I sleep separately from my husband for 2 years. In this situation, sometimes men go and find someone else – I don't feel angry or jealous – let him do it!" (Female Interview Participant 3, 29 y.o. – 'rural').*

Women's perceptions regarding deciding to have sex in general:

The perceptions about having sexual relations expressed by the women in a postnatal context differ to those expressed in a general context. The women spoke of this issue being influenced by expectations, perceived roles and perceived male sexual needs.

The majority of women we spoke with from Viqueque and Baucau, along with one third of the female Dili participants, all spoke of the need for wives to "follow" their husbands and to have sexual relations with the husband whenever he wanted:

> *"If we get married, we should have sex. This always happens – there is no other choice – when you get married you have sex" (Female Interview participant 4, 24 y.o. – 'rural');*
>
> *"When our husband wants to have sex with us, we should just obey, accept it" (Female Interview Participant 5, 29 y.o. – 'rural');*
>
> *"As a wife, we should serve him, it is part of our obligation. That means we are ready to serve him" (Female Interview Participant 15, 35 y.o. – 'urban');*
>
> *"If he wants, then we must follow – it is not possible to refuse" (Female Interview Participant 7, 40 y.o. – 'peri-urban').*

The women believed that if they did refuse, it would lead to negative consequences, including conflict, anger and violence:

> *"When the man has married us, we should just follow. If not, there will always be conflict or problems. If we don't follow our husband's needs, baku malu [fighting; physical fighting] will happen. This happens frequently" (Female Interview participant 3, 29 y.o – 'rural').*

A number of the women also believed that their husbands were suspicious of them having an affair if the wives refused to have sexual relations:

> *"If I don't follow him there will be domestic violence. Also, they may think we are having an affair with another man. When husband requests to have sex and wife refuses, then they might think we are having an affair with another man" (Female Interview Participant 10, 28 y.o. – 'peri-urban').*

Many of the women acknowledged that this perceived right of the husbands to have sexual relations whenever they wanted and the perceived obligation of the wives to fulfil these needs, often led to negative health consequences for the women. These included the risk of obtaining sexually transmitted infections, the risk of conceiving too soon after birth while the uterus is still "thin", and the perception that too much sex is detrimental for the female body:

"It seems like the impact will come for us the women. We never know, but if our husband ever go out and have sex with someone else, then we the women can get an STI quickly – 'Impaktu kayaknya iha ba ita feto, kadang mane la'o sai ba fatin ruma, no ita feto bele hetan moras lalalis'" (Female Interview Participant 15, 35 y.o. – 'urban');

"The impact to the health will be when the baby is too small and we have another one – the impact is on the womb as the womb is too thin and can become torn" (Female Interview Participant 3, 29 y.o. –'rural');

"When we have lot of sexual relations, it is not good for the female body" (Female Interview participant 13, 24 y.o. – 'peri-urban').

The women from Ermera all perceived a more collaborative and mutual decision making process between husbands and wives when deciding when to have sexual relations in general. They spoke of the need for husbands and wives to have an 'understanding', and of the importance of husbands respecting the decision of their wives not to engage in sexual relations.

OBJECTIVE 3: TO EXPLORE THE CONCEPT OF 'UNDERSTANDING' AS A WAY OF REGULATING FERTILITY

The concept of 'understanding' is frequently cited by men and women as a means of regulating fertility. As previously stated, a component of this is an understanding of the woman's menstrual cycle and recognition of her fertile period. Men and women believe that by having this 'understanding', couples are able to co-ordinate their sexual relations in order to meet their reproductive goals. This practice is therefore dependent on physiological knowledge and individual behaviour.

The participants believed it was important for both husband and wife to know about the wife's menstrual cycle. However, the women we spoke with had varied perceptions about the fertility cycle. Of the 10 out of 17 women who agreed that there was a time in their menstrual cycle when they were more likely to get pregnant, one woman was able to explain this with a fair degree of accuracy:

> *"I explain this by the 'wet' & the 'dry' season. It is easier to get pregnant during the wet season. If you want to delay, better to have sexual relations in the dry season. To work out the wet season – count the first day of menstruation to 14 days, and it is the 3 days before and the 3 days after the 14th day…. If you want baby you can do relations [have sex] during the wet season. If unmarried and not yet ready for baby, can have sex during dry season to prevent pregnancy" (Female Interview Participant 13, 24 y.o. – 'periurban').*

Other women had conflicting perceptions regarding when this most fertile time is:

> *"15 days after period if you have sex with your husband you will not get pregnant" (Female Interview Participant 5, 29 y.o. – 'rural');*
>
> *"[the most fertile time is] around 1-2 days before menstruation. Because the blood of the menstruation is ready to come, we can get pregnant" (Female Interview Participant 14, 25 y.o. – 'peri-urban');*
>
> *"Just stick with advice from the midwife – just 14 days after first menstruation [is the most fertile time]. If more or less than those 14 days, it cannot be. If more than 14 days, no longer the fertile period" (Female Interview Participant 15, 35 y.o. – 'urban').*

The women who did not believe in a more fertile time during their menstrual period, explained that living together with their husband meant that they engaged in sexual relations and could get pregnant no matter what the time.

The women stated that they were receiving the information pertaining to their fertility cycle from nuns, health professionals, teachers and relatives. This emphasises the importance of ensuring that those

teaching the community about reproductive health are as up to date as possible in terms of accurate and appropriate information, and that community members have the opportunity to consolidate or refresh their knowledge when necessary. Again, the importance of ensuring information conveyed to the community is appropriate and able to be understood is paramount.

OBJECTIVE 4: TO EXPLORE WHAT MEN BELIEVE ABOUT WOMEN'S REPRODUCTIVE HEALTH ANATOMY AND PHYSIOLOGY

The body map drawing component of this project was used to gain insight into what men believed about reproductive health anatomy and physiology. The majority of maps, although sparse in detail, were able to provide some valuable insights into men's ethnoanatomy and ethnophysiology pertaining to both female and male reproductive health:

- 24% of the men were able to identify that sperm from the man was important for conception, while 5% identified that a similar component was required from the woman;
- Sperm from the man as a component required for conception was identified by a much greater percentage of participants from the 'Youth' focus groups compared to the other focus groups;
- Many in the 'Youth' focus groups identified the man's knees as the site of spermatogenesis[6];
- There were varied perceptions as to whether the baby moved about while in utero or not, however the men identified a concept called *'bookan',* which is used to describe the little pokes and kicks made by the baby;
- Participants from Baucau believed that male babies have a gestation of 10 months and female babies have a gestation of 8-9 months
- Participants from Ermera believed that male babies have a gestation of 9 months and female babies have a gestation of 8 months
- Male and female babies may grow on a specific side of the uterus;
- Half of the focus groups contained participants who believed that the sex of a baby was not something a couple could decide or influence, that there was no guarantee that you would get a baby of a desired sex, and that this decision was up to God;
- Others believed that the sex of the baby was something that could be influenced or manipulated by deciding to engage in certain cultural practices, sexual positions or timing, or consulting the *matan dook.*

The following table presents the terms used by the men to describe or identify male and female reproductive health anatomy:

[6] When clarifying this idea with the Timorese members of the research team, they explained that they believed it to be a common myth amongst some people – they stated that operators have received many telephone calls to the National MSTL Youth Hotline 'Line Foin-Sae' asking about sperm and the knees. They stated that there was also a common joke that if a male has "weak knees" it means he has had lots of sexual relations and spread his sperm in many places.

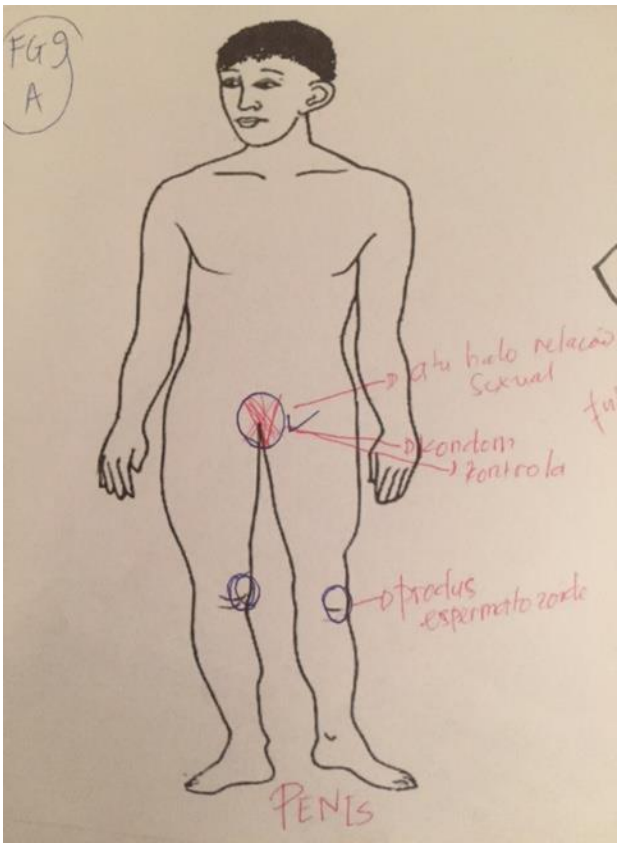
TABLE 10: TERMS USED BY THE MEN TO IDENTIFY REPRODUCTIVE HEALTH ANATOMY

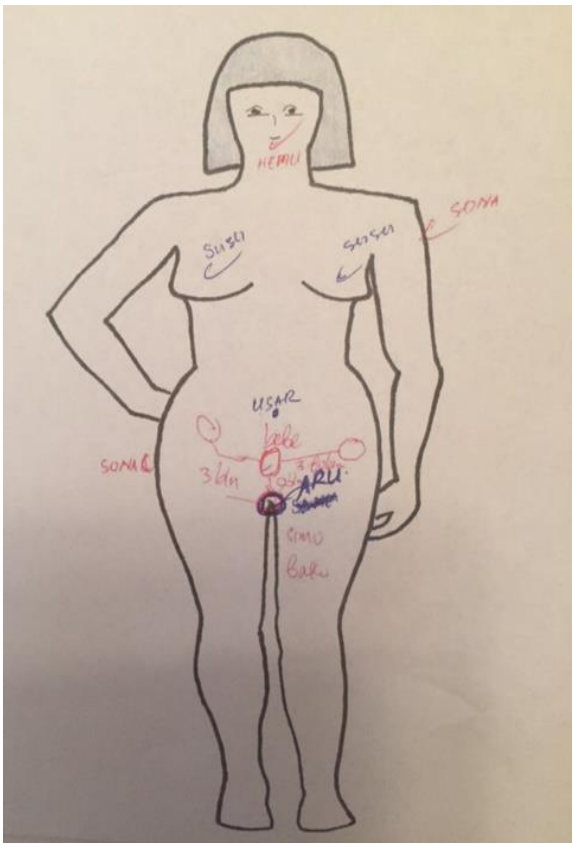
TERMS USED FOR "PENIS"	TERMS USED FOR "VAGINA"	TERMS USED FOR "WHERE THE BABY GROWS"	TERMS USED TO DESCRIBE SEXUAL RELATIONS OR CONCEPTION
• Pistol (pistol) • Lasan (Tetum – penis) • Uti • Asu (literal translation "dog") • Oin lulk mane (Tetum – Sacred place of male) • Utin • Vagina • Awa (Makasae – penis) • Samean (snake) • Samea ulun mean (red headed snake) • Jose Belo • Manuel • Kemaluen (Bahasa – something to make you shy) • 2 fuan (2 fruits – meaning testes) • Penis masculine • Sperma	• Bibi (literal translation "goat") • Oin feto (woman's space) • Huin (Tetum vagina) • Lulik • Oin lulik feto (sacred place of female) • Feto inia (belongs to woman) • Oiei • Aru (Makasae – vagina) • Pipis • Huin • Joesfa • Bibisiu (literal translation "goat meat") • Odamatan babe moris (literal translation "the door where the baby comes out") • Sasan lulik (something sacred) • Kemaluen (Bahasa – something to make you shy) • Oan fatin (baby space)	• Oan fatin (baby space) • Kabun (tetum – stomach region) • Kandungan (Indonesian – uterus) • Rahim • Perut (Indonesian – stomach) • Fatin labarik (child space) • Lambung (gastric) • Labarik moris falin (place where baby grows up)	• Het ("fuck") • Baku ba aru heun ona ('put the stick in the vagina to get baby') • Together with woman create the new generation • Relasaun sexual (sexual relations)

These terms demonstrate the varied ways men discussed reproductive health anatomy, with some men using terms such as ‘sacred place of the female’ to politely and respectfully identify ‘vagina’, while others used quite aggressive language to describe processes, for example, ‘put the stick in the vagina to get baby’.

Having an understanding of one’s own reproductive anatomy and physiology is vitally important. Addressing some of the knowledge gaps and misperceptions that exist at a community level may contribute to more positive reproductive health outcomes for men and women in Timor-Leste.

The following are examples of some of the more detailed body map drawings created by some of the participants:





OBJECTIVE 5: HOW ARE REPRODUCTIVE HEALTH DECISIONS PERCEIVED TO IMPACT ON WOMEN'S AND NEONATES' HEALTH?

As demonstrated throughout this report, men and women were able to identify numerous consequences for women's and neonates' health, as a result of reproductive health decisions. These consequences may directly impact, for example, the decision to have a baby while the woman is still perceived as "too young" may result in her being unable to birth her baby 'normally'. Similarly, these consequences may indirectly impact, for example, couples deciding to space by more than two years may result in the women being healthier and more able to provide direct care and supervision to her children, while also being able to contribute to the family economy.

The importance of a trusted caregiver and trusted reproductive health care facilities during pregnancy and birth were also linked with positive reproductive health outcomes.

The decision to use modern methods of contraception was perceived to have mixed impacts upon health. Some linked the use of such methods to sickness and even death, and if a woman used such methods without her husband's permission, the result may be physical violence. The antithesis to this was that the benefits of modern methods of contraception were perceived to be extremely positive for women's health, as well as improving health outcomes for children through having a healthier mother.

The decision by men to go 'outside' of the marriage for sexual relations was also perceived to have mixed impacts on the woman's health. On one hand it was viewed as respecting the woman's choice not to engage in sexual relations postnatally, while on the other hand it was identified that such a practice may impact psychologically on women, as well as physically through the risk of sexually transmitted infections.

Many of our participants were also able to identify numerous barriers to making positive reproductive health decisions and the subsequent impacts on health. These included barriers to getting to reproductive health facilities for professional care, as well as instances where decision making ability was hindered, for example, when men were drunk.

Breastfeeding

The majority of women (11/13) believed that breastfeeding impacted on the baby's health, and linked a healthy mother who has adequate nutrition to successful breastfeeding and a healthy baby. Many of the men who took part in the body mapping exercise also identified the breasts as important for breastfeeding the baby and giving strength or power to the baby. Only one of the women linked breastfeeding with impacting on the woman's health. (For more breastfeeding data from this project, please refer to Appendix D).

CHAPTER 3 – DISCUSSION & CONCLUSION

DISCUSSION

As Timor-Leste forges ahead as a new nation, forming its own unique identity and place in the world, the Timorese themselves face the challenges and uncertainties of molding self-identity and self-determination. When viewing or examining behaviours, beliefs and values, one needs to consider the very recent history of this nation, and appreciate how this history impacts on the story of contemporary Timor-Leste. Reflecting on 400 years of colonial rule, 24 years of invasion and occupation and then the task to completely 'rebuild' the country from the ground up, are important and significant considerations when thinking about the shaping of this nation and its people.

The responsibility men claim, their assumed role as "Chief" of their family, the passion with which they describe autonomous decision making, the distrust and suspicion they have – these all make a lot more sense when considered in parallel with Timor's recent history. During the Portuguese time, the Timorese existed under a colonising nation's rule and law, and many of their indigenous processes were eroded or shaped by the colonisers. The Timorese were told what to do and how to do it (Hicks, 2004; Molnar, 2010).

This happened again, but on a much more violent and aggressive scale, when Indonesia invaded and occupied Timor-Leste. The Timorese were dispossessed of their land and their culture, hundreds of thousands of lives were lost, and many men were absent as either part of the effort to fight for their nation, or as a direct result of assault or worse by the occupiers (Hill, 2012; Molnar, 2010). The suspicion, uncertainty, brutality and secrecy that permeated so much of Indonesia's actions in Timor-Leste, coupled with the inaction and disregard from the rest of the world to help the people of Timor, shredded any remaining feelings of trust (Wigglesworth, 2013). It is easy to see why the Catholic Church, who was one of Timor-Leste's only friends during this dark time, holds such a significant and powerful place in the Timor of today (Richards, 2015; Wigglesworth, 2013).

In the reproductive health arena, these circumstances shape and mold the decisions men and women make, and impact on whether a couple meets their reproductive health goals. This study gives a voice to men and women across 4 distinct municipalities of Timor-Leste, from a variety of locations, educational backgrounds, marital status and ages. The following themes emerged from our study as influencing factors related to reproductive health decision-making. They illustrate the complexity, diversity and challenges that exist in this often contentious and sensitive milieu in Timor-Leste.

RESPONSIBILITIES AND ROLES

The men have reclaimed positions of responsibility within their families – positions that within many families had been held by women during the Indonesian occupation. Men have assumed the role as financial provider for their family and they take seriously their role of responsibility for the health of their wife. The men also feel responsible for knowing where their wives are. They acknowledge the responsible position of having a plan for their family, which considers both financial aspects as well as practical aspects such as number and spacing of children.

The men also acknowledged a certain 'taking responsibility for being irresponsible'. They identify certain situations and circumstances whereby they are unable to fulfil their roles of responsibility. These situations include being drunk or being overcome by perceived uncontrollable sexual urges and needs. In these instances, the men acknowledge the almost covert roles of responsibility that women assume or need to assume, so that there is always a 'back up' plan in place. This hidden almost subliminal assuming of responsibility, has echoes of more ancient times in Timor-Leste, where part of women's defined positions and roles included responsibility for inner, sacred and private realms (Niner, 2011). This is in contrast to the roles and positions women assumed during the Indonesian time, when by circumstance they were required to head households, make decision and take responsibility for many aspects of daily life (Rimmer, 2007).

RIGHTS AND ENTITLEMENT

The men, in their position as Chief of the family, are perceived as having numerous rights and entitlements. One of the overwhelming rights demonstrated in this project, was the right for the husband to have sexual relations whenever the need arose. The right of the man was prioritised over the right of the woman, with many women in our study acknowledging that they just had to accept the wishes and desires of the man.

The concept of the husband being head of the household is linked with the conservative and patriarchal values supported historically during the Portuguese time in Timor-Leste (Belton et al, 2009). As Timor-Leste has tried to shape and carve out its identity, there has been much support for the return to these 'traditional' Timorese ways (Bye, 2005). Some of these 'traditional' ways appear to be in opposition or defiance of western ideals such as gender equality or women's reproductive rights, and put women in disempowered and disadvantaged positions (Rimmer, 2007). Timor-Leste as a nation has adopted and accepted the concept of reproductive and health rights at a national level; the challenge remains to assimilate such rights into the everyday lives of the Timorese people, or determine the appropriateness and desirability of such rights in this setting.

TRUST AND RESPECT

Suspicion and distrust were recurring themes throughout this project, with the men and women identifying several instances where these elements were of concern. The suspicion and distrust men have towards women accessing family planning methods without the permission of the husband, has been previously identified in the literature as stemming from the predominantly "woman focused" approaches of family planning services (Bankole & Singh, 1998). Such approaches have led men to perceive family planning as a means of male authority within the household being undermined (Wilson-Williams et al, 2008).

The concept of respect is a complex one in our study. During the postnatal period, the men perceived that they respected their wives by adhering to her wishes to not engage in sexual relations with her for a period of time. They believed that they were able to grant her this respect by going 'outside of the marriage' to a sex worker for sexual relations. Additionally, with regard to 'sex in general' (and not specifically in the postnatal period), the women we spoke with described a wife's wish to not have sexual relations with her husband as commonly being ignored and not respected. There appears to be a great need in Timor-Leste for some discussions and exploration focusing on the concept of consent, and this has been previously emphasised as a priority by Wigglesworth et al (2015).

'IDEAL' VERSUS 'REALITY'

The men and women we spoke with are able to acknowledge and identify many behaviours and circumstances that reflect an 'ideal' reproductive health decision-making process resulting in optimal health outcomes for women and neonates. This includes such concepts as mutually agreeable and collaborated plans, financial security prior to the responsibility of a family, and optimally spaced and intended pregnancies reflecting the reproductive health goals of the couple. It also includes the nebulous concept of 'understanding' that Timorese couples frequently cite as a way to control fertility and family size, whereby men and women are able to engage in partnerships and behaviours that have positive reproductive health outcomes in line with their goals and plans.

However, these same men and women concede that these reproductive health 'ideals' are often obliterated by 'realities', including closely spaced pregnancies, sexually transmitted infections, and impacts on the woman's health from a variety of barriers related to seeking care during pregnancy, labour and birth. These barriers stem from geographical, cultural, educational, financial and historical elements, across the spectrum of Timorese society.

Capitalising on the 'ideals' that men and women emphasise and recognise, and working with them to determine how to transfer these ideals into realities, may positively impact on the couples' reproductive health goals, as well as strengthening reproductive health systems and processes in Timor-Leste.

INFORMATION, MISINFORMATION AND KNOWLEDGE

Misinformation and myths pertaining to family planning persist across municipalities, ages and education status in our study. These myths contribute to the fear and distrust many people feel with regard to modern methods of family planning. Our study illustrated that even when people sought information and education about reproductive health issues, in many instances, the information they received was unable to be accurately recalled. This included information about family planning methods, information about men and women's reproductive systems, and information pertaining to conception, pregnancy and birth. This emphasises the need for focusing on not only the education and training offered to men and women in the community, but also that offered to the people providing the reproductive health services. Such information needs to be accurate and appropriate, delivered in such a way that is respectful of the audience, and able to be understood and reproduced.

Much reproductive health information needs to be accessible and directed towards males. It is clear from our study that men play a major role in reproductive health decision making, and it is not reasonable to expect them to make these decisions wisely if they have not had the opportunity to explore and learn about reproductive health in depth. Global research and policies, and indeed national policies and directives in Timor-Leste, advocate for and encourage men's involvement in the reproductive health arena (Dudgeon & Inhorn, 2004; Ministry of Health, Timor-Leste, 2004).

Being aware of the existence and influence of ethno-physiological and sociocultural factors on people's interpretation and engagement with reproductive health is also paramount, with our study demonstrating that such perceptions are powerful and persistent. Adopting approaches such as the 'two-eyed seeing' approach whereby one 'eye' sees things through a quintessentially Timorese lens focusing on the strengths and knowledge of this perspective, while the other 'eye' employs a western lens drawing on the strengths and knowledges inherent in this domain, may help create a way of knowing, blending both lots of strengths in a way that is palatable, appropriate and beneficial to the reproductive health of the Timorese (Bartlett et al, 2012).

EXPECTATIONS AND ACCEPTANCE

There were many expectations identified throughout our study, ranging from expectations pertaining to culture, expectations pertaining to behaviour and expectations pertaining to provision of services and care. For example, men and women were expected to have children as soon as possible once they were living together as husband and wife; maternal and neonatal outcomes were mostly expected to be optimal and guaranteed by seeking care from a health facility; and women were expected to consult their husbands before seeking family planning information or services.

There was also an acceptance of consequences from certain acts or behaviours. This was most amplified in the acceptance of violence and conflict as a consequence within the family if the wife either refused to

have sexual relations with her husband or if she sought family planning information or services without her husband's permission. Gender based violence is widespread within Timor-Leste, and has its roots in the historical and cultural aspects of this tiny nation (Taft et al, 2015; Meiksin et al, 2015). Global research demonstrates the link between violence and poor reproductive health outcomes for women exposed to such situations (Bourey et al, 2015). Gender roles, community values and societal norms all contribute to how violence is perceived, and for the men and women we spoke with, violence in viewed as an accepted and expected consequence of certain behaviours and attitudes. It is certainly a reality and an ever-present threat for many of the women we spoke with, impacting on their reproductive health and the decisions they can make in this arena.

CONCLUSION:

Reproductive health decision-making in Timor-Leste is a complex, multifaceted phenomenon, influenced by historical, cultural, geographical, financial, political and physiological factors. Men and women identify numerous roles, responsibilities and expectations that impact on these decisions, as well as identify barriers to 'ideals' that may hinder them achieving their reproductive health goals and may in fact contribute to Timor-Leste's high maternal mortality ratio. Much work remains in Timor-Leste to ensure quality, comprehensive sexual and reproductive health information is available and accessible to men and women across the age spectrum. There is need to explore and promote notions of respect, consent, gender equality and strategies for addressing conflict and violence towards women. There is also a need to ensure men and women across the age spectrum are aware of how the reproductive health decisions they make, potentially impact on the health and well-being of women and children.

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APPENDIX A

RESEARCH TOOLS

VIGNETTES:

Vignette 1: "Mausexta and Bikinta"

Bikinta (Joana) is a 19 year old girl living at Bairo Kafe-Laran. She recently finished Senior High School, in the last six months. After finishing school, Bikinta decided to get married with her boyfriend "Mausexta"(Tomas). They are now living together, but have not yet married.

Mauxesta is 21 years old and is attending a mechanical course in a training center in Aileu municipality. Mausexta hasn't found a job yet and thinks this will affect their economic situation in the future.

As a couple, they are sexually active but want to delay having a baby for a few years until they have a regular source of income.

Although they want to delay, they both don't know how to plan and where to get the information from.

Prompt questions:

1. What do you think about their decision to delay having a baby?
2. What can they do to delay having a baby?
3. Where could they get information about delaying having a baby? Who would be the most reliable source of information and why?
4. What could happen if Bikinta went to the CHC to ask about family planning without consulting Mausexta? In general, who makes the decision to use family planning?
5. Is it important for Mausexta to know about family planning? Why?
    - how would they make the decision about having a baby? Whose decision is it when to have a baby?
6. What is the best age for them to get married?
7. What is the best age for them to have their first baby?
8. How would they make the decision about how many babies to have?
9. How would they make the decision about spacing their babies?
10. If there is 'understanding' with regard to fertility decisions and behaviour between Bikinta and Mausexta, what does this 'understanding' involve? What does it mean?
11. In general, what are some of the reasons a man would NOT support his wife/girlfriend to use family planning?

Vignette 2: "Pedro and Maria"

Maria and Pedro are both 40 years old. They live in a rural area in the municipality of Ermera. They grow coffee beans and sell firewood, but it is sometimes difficult for them to make enough money to buy the things their family needs. They have been blessed with 4 sons, who were all born at home with the help of a neighbour. Maria's last labour was long and difficult. Maria and Pedro work hard on their farm. Maria gets very tired, and the health post staff have told her she has weak blood.

Pedro is worried about how they will pay barlake for their 4 sons to get married in the future. He is also worried about how he will divide his land between his sons. Maria feels too tired to have any more babies but Pedro would like to have some girls so that they will get barlake in the future.

Prompt questions:

1. What should Maria and Pedro do?
2. What could happen if Maria has another son? Is Barlake important to think about when deciding how many children to have?
3. How should Pedro divide his land between his children? Does this influence the number of children he decides to have?
4. How should Pedro and Maria decide if they are going to have more children? How many babies should they have? How is this decision made?
5. Is there anything they can do to ensure they have a baby girl?
6. What could Maria do to not get pregnant?
7. What could happen if Maria accessed family planning without Pedro?
8. What do you think about Pedro going to the CHC with Maria and getting information about family planning? Is it important for Pedro to know about family planning? Why?
9. If Maria does get pregnant again, should she seek care during her pregnancy? From who? How often? Why? In general, who makes the decision to seek care during pregnancy? Why this person? What needs to be considered when making this decision?
10. What do you think about Maria having her babies at home? Who makes the decision about where to have the baby? What influences this decision?

11. In general, who makes the decision about getting help when the woman is in labour? Why this person? What are some of the reasons that would make this person think that the woman needed help? How would they get help? What would stop them from getting help?

12. How do you think Maria and Pedro make decisions about their reproductive health? If they have an ‘understanding’, what does this understanding involve?

13. When can Maria and Pedro resume sexual relations after Maria has a baby? Who decides when this will happen?

APPENDIX B

CONTRACEPTIVE PREVALENCE RATES, TOTAL FERTILITY RATES AND REPORTED MATERNAL DEATH RATES

Table A: Classification of Municipalities based on TFR and CPR (DHS 2010)

Municipality A – Higher Fertility (>5.6) & Higher CPR (>18) • Ermera: TFR 6.6; CPR 18.8	**Municipality B – Lower Fertility (<5.5) & Higher CPR (>18)** • Dili: TFR 4.6; CPR 33.2 • Liquica: TFR 5.5; CPR 24.5 • Covalima: TFR 4.4; CPR 43.8
Municipality C – Lower Fertility (<5.5) & Lower CPR (<18) • Baucau: TFR 5.5; CPR 8.0	**Municipality D – Higher Fertility (>5.6) & Lower CPR (<18)** • Viqueque: TFR 5.6; CPR 13.1 • Lautem: TFR 6.7; CPR 17.7 • Ainaro: TFR 7.2; CPR 14.1

Table B: Number of reported maternal deaths 2008-2012 (NSRMNCAH, 2014,p.18) plus data from HMIS 2013/14

MUNICIPALITY	2008	2009	2010	2011	2012	2013	2014	totals
Aileu	4	2	1	3	0	1	0	**11**
Ainaro	5	1	2	0	1	1	4	**14**
Baucau	41	5	1	0	1	3	6	**57**
Bobonaro	0	4	1	1	1	0	0	**7**
Covalima	0	1	3	4	1	0	2	**11**
Dili	2	6	5	13	23	1	0*	**50**
Ermera	12	3	2	1	6	12	2	**38**
Lautem	2	1	1	3	0	2	2	**11**
Liquica	0	0	2	2	2	0	0	**6**
Manatuto	5	4	2	1	1	2	0	**15**
Manufahi	11	1	3	1	0	0	1	**17**
Oecusi	1	4	2	0	1	2	5	**15**
Viqueque	2	5	4	3	3	4	2	**23**
Timor-Leste	**85**	**37**	**29**	**32**	**40**	**28**	**24**	**275**

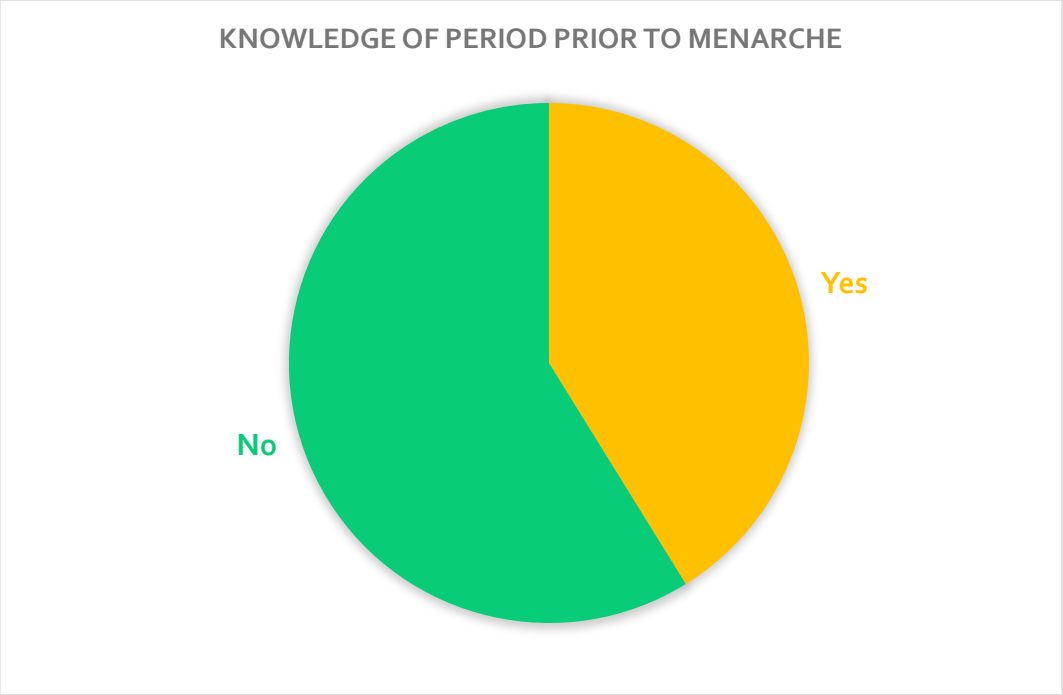
*Verbal statement from senior member of large NGO states that a health facility in Dili has had 13 maternal deaths in 2014 but these do not appear in official report.

APPENDIX C - MENSTRUATION

The average age of menarche for the 17 women we spoke with was 15 years old.

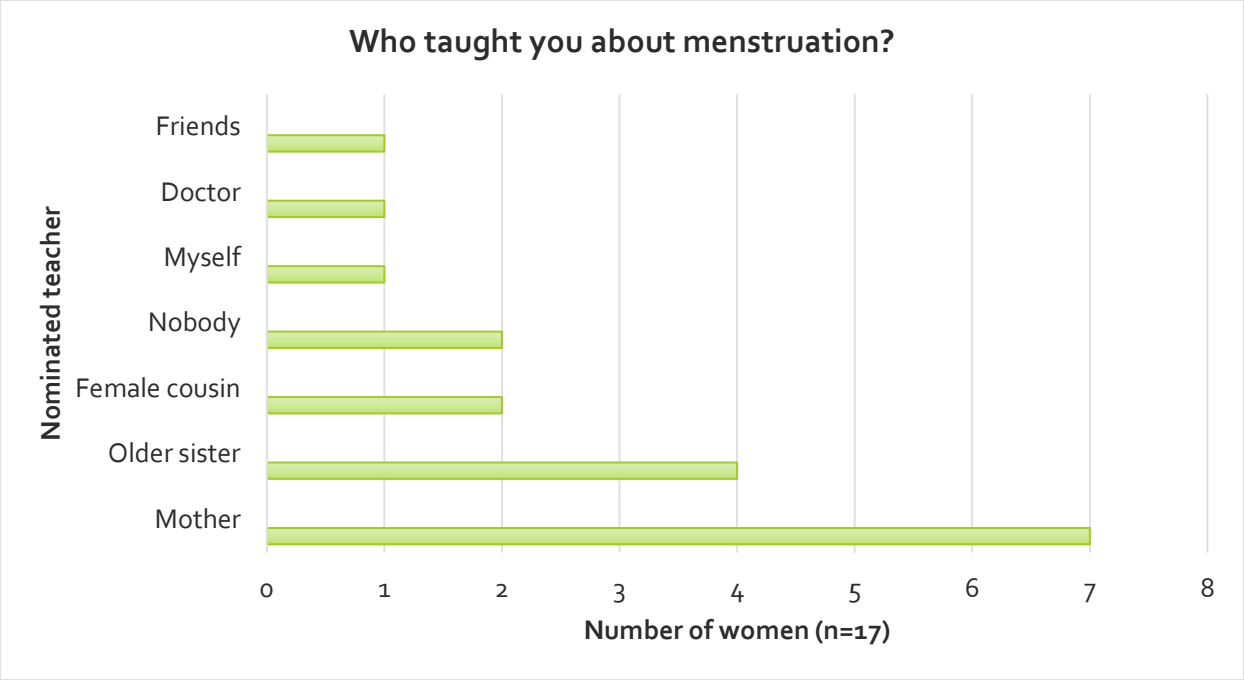
KNOWLEDGE OF PERIOD PRIOR TO MENARCHE:

Of these 17 women, 41% (7 women) had knowledge of menstruation prior to their menarche, while 59% (10 women) did not:



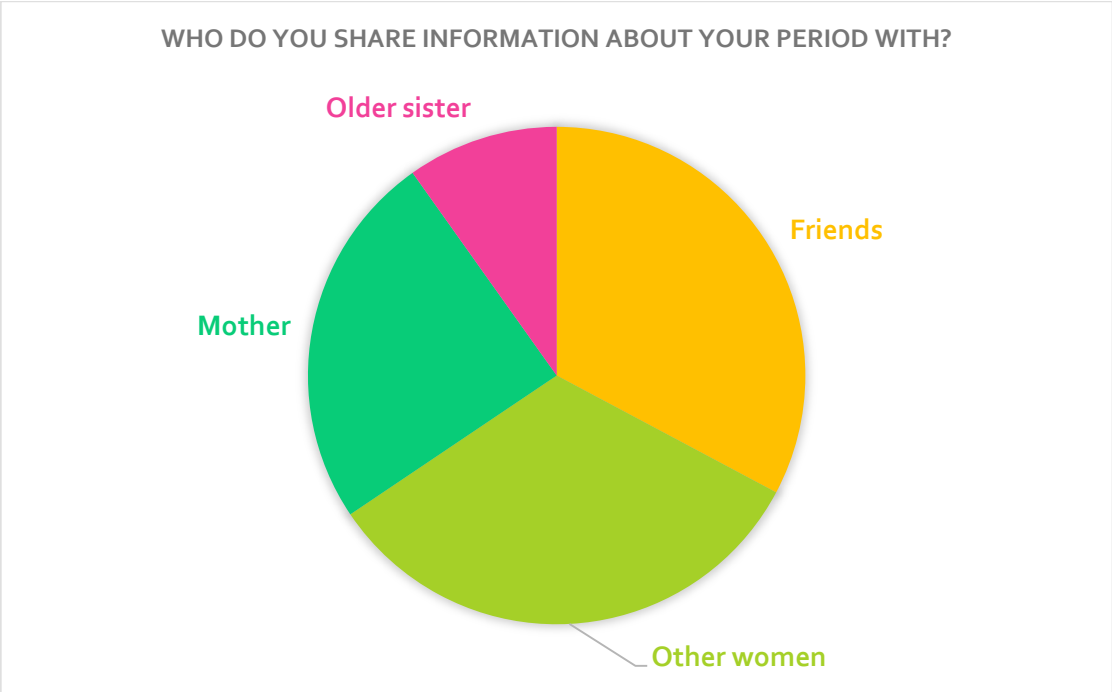
WHO TAUGHT THE WOMEN ABOUT MENSTRUATION?

For these 17 women, the most common person to have taught them about menstruation was their mother, followed by their sister. For 3 of these women, ‘nobody’ or ‘myself’ were given as answers to this question:



IS MENSTRUATION PRIVATE OR SHARED?

For 6 of the 17 women, menstruation was private; while for 11 of the women it was shared. The women stated that they shared information about their periods with their friends, other women, their mothers and their older sisters:



REGULARITY OF PERIOD:

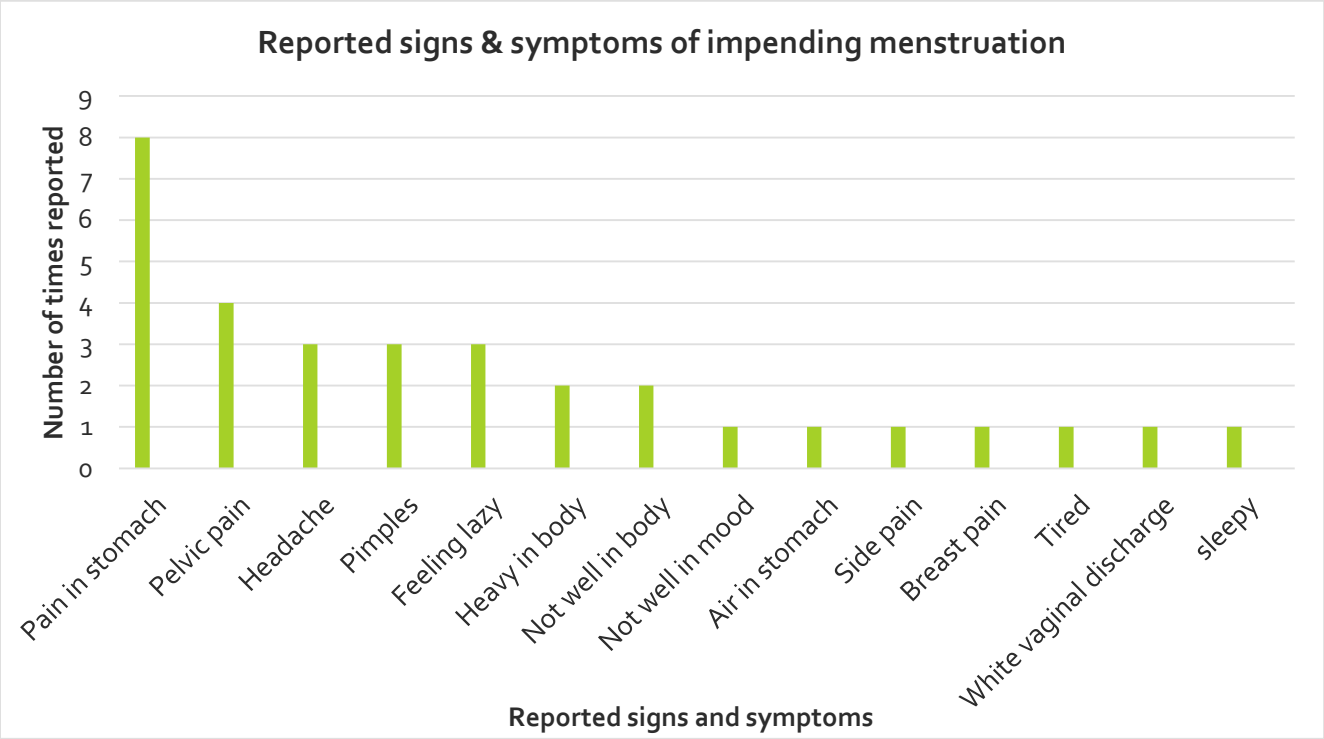
12 out of 17 women stated that their period came every month. Of these 12, 8 stated that it came regularly, although 2 pointed out that their menstrual pattern had been interrupted in the past by family planning methods.

Of the 5 women who stated that their periods came irregularly, they believed this to be influenced by their blood and how much water they had had to drink. They also believed that they could make their period more regular through drinking traditional herbs:

> *"Sometimes it comes for two continuous months, and then it stops. So I take traditional herbs to drink and that returns to normal. After taking the herbs, menstruation will go as usual", Female Interview Participant 11, 35 y.o.; Rural location.*

SIGNS AND SYMPTOMS OF IMPENDING MENSTRUATION:

When we asked the 17 women how did they know that they were about to get their period, they provided an extensive list of pre-menstrual signs and symptoms:



One woman reported that she did not know when her period was about to come, while another reported that she had no signs or symptoms.

THE PERCEIVED IMPACT TO HEALTH FROM MENSTRUATION:

The women we spoke with were almost unanimous (15 out of 17) in their belief that their period had the potential to impact their health.

Many of the women believed that having regular periods:

- Made the woman feel healthy;
- Made the woman feel that her body was good;
- Made the woman feel better;
- Made the woman feel more lively;
- Released the dirty blood.

A number of the women believed that if there was blood left inside the woman after her period, she could then get pregnant, and that menstrual blood was an essential component for conception.

There was also a strong perceived link between nutrition, bathing, temperature, menstruation and health, with many women stating:

- Don't drink cold water;
- Don't eat cool foods;
- Don't touch cold water;
- Need to eat and drink enough so that period comes;
- Don't take a bath;
- Don't wash hair.

Bathing and washing hair were believed to interfere with menstruation, and doing either when menstruating was perceived to be bad for one's health. Interestingly, one woman explained that now that she had had her children, she could bathe and wash her hair when menstruating, suggesting a potential link between such actions and fertility:

> *"I can take a shower or take a bath and wash my hair when having period because now I have many children" (Female Interview Participant 8, 38 y.o.; Periurban).*

Many women believed that there were negative consequences if their period did not come, including feeling sick, experiencing headaches, laziness, abdominal cramps and pain, as well as the suspicion of pregnancy.

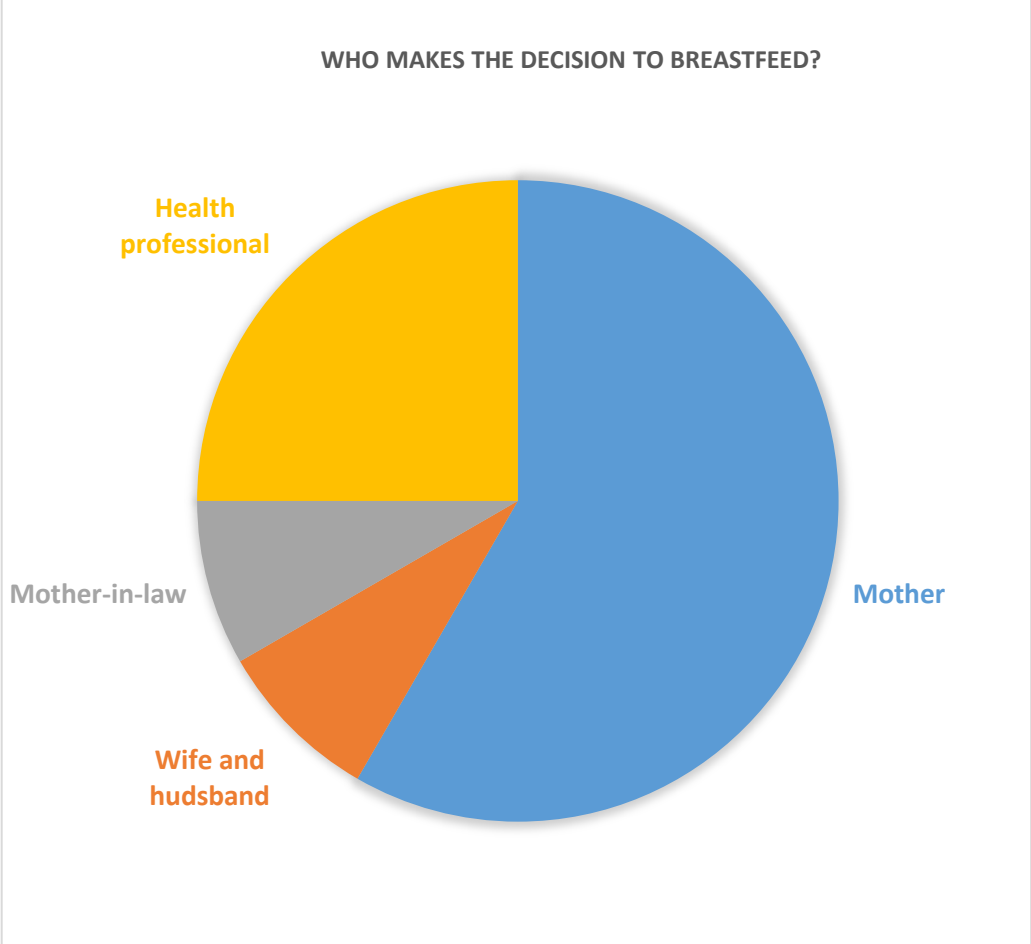
Traditional herbs were mentioned a number of times when discussing menstruation. Some women spoke of using the herbs to regulate menstruation, while other spoke of using herbs to induce menstruation, either when the woman's period had not occurred for several months, or when a woman suspected a pregnancy:

> *"When it didn't come for 5 months after taking a bath, I went to the nuns to get some medicine, but that didn't work. So I went and got some traditional herbs and got results – modern medicine no period, but period after traditional herbs" (Female Interview Participant 5, 29 y.o.; Rural);*

> *"Those young girls whose period doesn't come – it can be suspected that they are pregnant. They should get some traditional herbs" (Female Interview Participant 11, 35 y.o.; Rural location).*

APPENDIX D - BREASTFEEDING

Of the 13 women we have breastfeeding data for, 7 women stated they decided themselves to breastfeed their babies, 3 breastfed on the advice of health professionals, 1 stated the decision was mutual between wife and husband, another stated that it was her mother-in-law who made this decision and 1 did not specify.



Breastfeeding immediately after birth was nominated as the time to begin breastfeeding one's baby by 3 of the women while another 3 nominated 1 hour post birth; 2 women specifically stated that the first breastmilk is important and gives immunity to the baby. Four women nominated the timing of the first breastfeed to be approximately 2-3 hours after birth, and another 2 women stated that they did not begin breastfeeding their babies for several hours due to either the time of birth or the mode of birth:

> *"when I deliver at 9pm, then I wait until morning and breastfeed in the morning…..the baby has water with sugar overnight – this is what my mother-in-law decided" (Female Interview Participant 9; 43 y.o.; Periurban location);*

> *"I began to breastfeed my baby after one day, because I had the caesarean operation and was not able to move so I can't do breastfeeding on the same day" (Female Interview Participant 16; 18 y.o.; Urban location).*

One woman explained that after she had birthed her baby she had no breastmilk, so she found another woman who had birthed a baby and who could breastfeed her child as well. This participant was able to commence breastfeeding her baby after 2-3 days when she had breastmilk.

The bathing or washing before beginning to breastfeed was perceived by 5 women as important to decrease the risk of the baby getting sick. The majority of women (11/13) believed that breastfeeding impacted on the baby's health, and linked a healthy mother who has adequate nutrition to successful breastfeeding and a healthy baby. Many of the men who took part in the body mapping exercise also identified the breasts as important for breastfeeding the baby and giving strength or power to the baby. Only 1 of the women linked breastfeeding with impacting on the woman's health:

> *"When the child is breastfeeding again and again, the mother's body will get thin – mother will get thin, baby will get fat…….we should breastfeed for 2 years, but sometimes the baby will bite the nipple and stop breastfeeding early" (Female Interview Participant 11, 35 y.o.; Rural location).*