

**CARE INTERNATIONAL TIMOR-LESTE**  
**HAMORIS project**

**MONITORING AND EVALUATION**  
**PRELIMINARY BASELINE REPORT**

**OCTOBER 2018**



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## List of Acronyms

ANCP	Australian NGO Cooperation Program
ANC	Ante-Natal Check
BFP	Breast Feeding Plan
BP	Birth Plan
BeMoc	Base Emergency Obstetric Care
CeMoc	Comprehensive Emergency Obstetric Care
CHC	Community Health Centre
CI	Care International
CITL	Car International Timor-Leste
CSC	Community Score Card
CCT	Comprehensive Care Timor
DHS	Demographic Health Survey
DPM	Deputy Program Manager
FSG	Father Support Group
FDG	Focus Development Group
GPA	Gender Power Analysis
IPP	Important Practice Promotion project
JSI	John Snow Inc
KII	Key Informant Interview
LILA	
MELF	Monitoring Evaluation Learning Framework
MoH	Ministry of Health
MSG	Mother Support Group
NGO	Non-Government Organisation
PNC	Post Natal Check
PLWD	People Living With a Disability
PQT	Performance Quality Team
SAA	Social Analysis and Action

SBA	Skilled Birthing Attendant
SICA	Integrated Community Health Services
SDG	Sustainable Development Goals
SRMHR	Sexual Reproductive Maternal Health Rights
TBA	Traditional Birthing Assistant

*HAMORIS Overview*

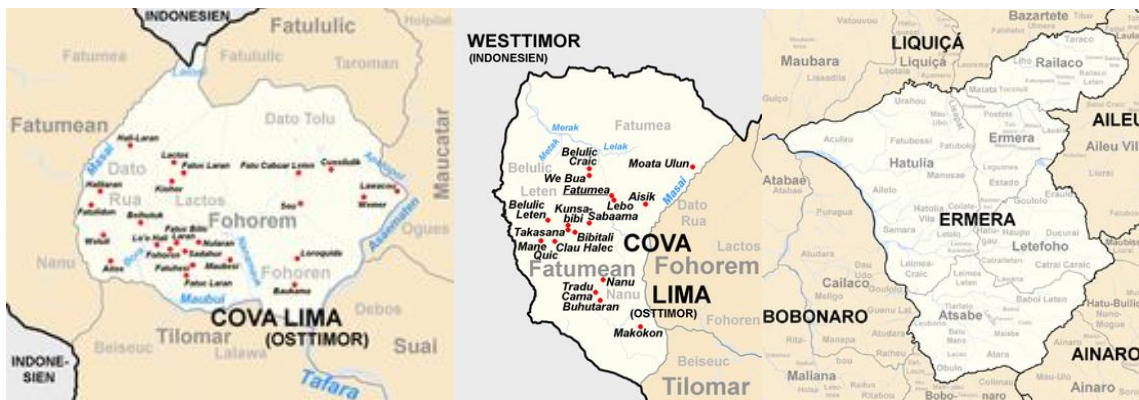
The HAMORIS project is managed and implemented by Care International Timor-Leste (CITL) and funded by the Australian aid program. The HAMORIS project goal is to contribute to lasting reductions in maternal mortality and morbidity by increasing the number of women in targeted communities utilizing appropriate and quality Sexual, Reproductive Maternal Health and Rights (SRMHR) services. The project aims to enable this by improving gender relations at the family and community level. HAMORIS started in July 2017 and will conclude in June 2021. It is based in two municipalities; Covalima and Ermera, across 3 Administrative Posts and 47 aldeias. HAMORIS builds on the success and work of CITL’s preceding investment; the Safe Motherhood Project (2015-2017). See the HAMORIS Theory of Change in Annex 1. The locations of the HAMORIS project are noted in the maps below.

Map 1: Timor-Leste: Location of Ermera and Covalima



\*Source: Wikipedia, Timor-Leste

Map 2: Administrative Post locations: Fohorem, Fatumea and Atsabe



\*Source: Wikipedia websites for Administration sites

**Purpose of the baseline study**

The baseline data has been collected to provide the team and key stakeholders to the project with a clear understanding of context at the initiation of the project. It will help the team assess changes in knowledge, attitudes and practice of participants and their approach to SRMHR services and changes in gender relations, social and power norms of participants and within the broader community.

The indicators for the HAMORIS Monitoring Evaluation Learning Framework (MELF) were derived from a series of consultations with the CITL team to derive the best measures for the outcomes of HAMORIS. The indicators support key areas of change investigated by the overall CITL country strategy, Care International (CI) and the Australian NGO Cooperation Program (ANCP) of which this project is funded.

### Data Sources

Data for the baseline has been collected from a range of sources. Table 1 provides a breakdown of sources used, populations engaged and timing of data collection.

Table 1: Data sources for the preliminary baseline

Source	Population	Timing of data collection
HAMORIS mother and father support groups program reporting	1,369 (699 women, 570 men) however data exists for 419 (including 302 women, 117 men)	Between June 2016-June 2018
Community Score Card program reporting	385	December 2017
Gender Power Analysis	233	July 2018
Municipal MoH statistics	Total populations for Atsabe, Fohorem and Faturmea Administrative Posts	Dec 2017- May 2018
HAMORIS mother support groups and father support groups extra data collection	279	Between August 2018-September 2018

### Extra Data Collection

During the first phase of data collection in July a number of indicators had been omitted which resulted in extra data being collected for the baseline in September 2018. Additional information was collected in 3 post administratives of ; Atsabe (Asio, Aliatu, Atu-Buti, Atu-Lara, Atupae and Obeto sub-village); Fatumea (Lebo, Halik Nain, Rai Oan, Nanu, Mane Ki'ik, and makokon); and Fahorem ( Au-Lulik, Lo'o Hali, Fatuklidun, Fatuk Laran (Lactos), fatuk Bitik Laran and Fatuk Laran (Fhorem).

Extra data was collected from 279 participants including 187 MSG and 92 FSG which responded to 15 indicators.

### Gender Power Analysis (GPA)

The study obtained a representative sample (233 including 105 women and 118 men) of the CITL HAMORIS project target population in Covalima and Ermera municipality, and included 2 control aldeias. This enabled CITL to identify key knowledge, attitudes and health-seeking practices of target communities for the project. The GPA uses the CI template approach to collect qualitative baseline data on gender equity and empowerment. This included 8 HAMORIS MELF indicators for the Social Analysis ad Action (SAA) component.

### Method

The GPA targeted 11 clusters (aldeias). This includes 9 HAMORIS clusters and a control sample of 1 cluster in both Covalima and Ermera (2 in total). The sampling frame related to *women between 15-49 years of age who have children under the age of 2 years old and their husbands/partners and stakeholders involved in structured community-level governance processes for improving access and utilization of SRMHR services.*

The study included the following activities:



1. Focus Discussion Groups (FDGs) s with the HAMORIS Mother Support Group (MSG) and Father Support Group (FSG).
2. FDGs with men and women not involved with the HAMORIS program;
3. Key Informant Interviews (KIIs) with community leaders, local and municipal government officials, and;
4. Field observations for all aldeias visited and meetings undertaken in the study.

### Survey tools

The GPA study included questionnaires that guide the sessions (see Annex 2). The questions were closed-ended and designed to assess knowledge, attitudes and practice related to gender roles in the household and community, SRMHR access and health-seeking behaviour. The anticipated duration of the FDG was between 3-5 hours for FDGs and 1-2 hours for KIIs.

### Field observation

Physical verification of the available health services in each cluster was observed. Field observation checklists were used during the study.

### Participatory tools

During the FDGs, several participatory tools were used. This includes Social Analysis and Action (SAA) techniques specific for exploring SRMHR issues as outlined in the CARE International manual, pile sorting, 24 hour exercise and visioning exercises (see Annex 2).

### Locations

The study was undertaken in the HAMORIS project municipalities (Ermera and Covalima) in in 3 Administrative Posts. Table 2 and Table 3 below provides detail of the Administrative Posts visited and the meeting schedule.

Table 2: GPA study locations

No	Location	Admin Post	# of Suco	# of FGD			# of KII
				Men/Women	MSG	FSG	
1	Covalima	Fatumea	2	1	1	1	8
		Fohorem	4	2	2	2	7
2	Ermera	Atsabe	3	2	2	2	5
	Control area	Atsabe and Covalima	1	2	N/A	N/A	4
3	Municipality level	Atsabe and Covalima					6
	Sub Total			7	5	5	30
	Total						47

### Sampling

The study used a self-weighted one- stage sampling method conducted through a multi-stage random sampling approach to obtain a representative sample of (i) men and women involved in HAMORIS and (ii) men and women in the cluster. Cluster sampling was used to identify representatives across five subgroups;



1. HAMORIS mother support group;
2. HAMORIS father support group;
3. Men not involved in the program,
4. Women not involved in the program, and;
5. Selected stakeholders including community leaders, government, development partners.

Stratified sampling was used to identify populations for sub-groups 3 and 4 (populations not involved in HAMORIS). The xefe suco of the identified HAMORIS aldeias and the control clusters (aldeias) were engaged. A total of 41 meetings were held with participants. The CITL team held 1-2 FGDs (MSG/FSG) in the HAMORIS clusters and joint man/women meetings were held in both the HAMORIS and control clusters. In total 30 KIIs and 6 meetings were held with municipal-level organisations such as development partners.

#### Size and selection

The GPA met best practice criteria for determining the appropriate size for the study and was representative of the target population. There were 233 participants in total, representing 16% of the total HAMORIS population (not including the control areas). With an anticipated confidence level of 95%, the confidence interval, or margin of error was approximately 0.642 (mean of 70 and a standard deviation of 5).

All clusters in Covalima and Ermera were randomly selected by the CITL Program Quality tea, (PQT) and gender teams. A total of 11 aldeias were chosen out of a possible 47, equating to coverage of 19% of the total HMORIS aldeias. Of the selected aldeias, all HAMORIS mother and father support group members were contacted, so all support group members have an equal opportunity to attend. The total list of aldeias is provided in Table 3.

Table 3: List of clusters (aldeias)

	Municipality	Administrative Post	Aldeia
1	Covalima	Fatumra	Nano
2			Be Lulik Kraik
3		Fohorem	Lorokida
4			Natar dik
5			Aitoos
6			Aululik
7			Bitis (control area)
8	Ermera	Atsabe	Obeto
9			Sorati
10			Atupae
11			Wabe (control area)

#### Program-level reporting

HAMORIS program team have been collecting data since the projects inception in July 2017. Information on the MSG and FSG participants have been collected including data on the number of participants, name, education session attendance, location of births, number of children, representation of People Living with a Disability (PLWD) and contraception usage. **It provides inconsistent and incomplete data for 419 participants out of a total of 1369 participants.**

The Community Score Card (CSC) program finalised three informative reports in December 2017 which outlines details on the engagement and method of the CSC process. It includes the action plans for each of the 10 CSC sites in Fohorem (4), Fatumea (3) and Atsabe (3). Meetings across the 10 CSC villages were held between February and April 2017. The report details the information gathered from the individual

meetings with the community including community leaders (men, women and youth) and service providers, a joint meeting to consolidate priorities and the development of action plans in each of the CSC villages.

#### Municipal-level data

The Administrative Post-level data is collected from two sources; (i) JSI who already has a pre-existing relationship with government to obtain the data, and (ii) data collected directly from the Ermera municipal government. The data collection is incomplete.

#### *Identified risks and limitations*

##### Data collection

The study undertaken in July intended to include the investigation of 43 indicators (34 MELF indicators and 9 supporting indicators) for the HAMORIS baseline report, as well as collection of data for the GPA analysis. The survey tools included tailored facilitation guidance and data collection templates designed to capture data relating to the key HAMORIS project indicators identified in the HAMORIS Monitoring Evaluation Learning Plan.

Once the team were in the field it was decided these templates would not be used. As a result the team did not undertake investigation of the specific MELF indicators, and instead focused on the data needs of the GPA. This resulted in gaps in data for a total of 19 MELF indicators and 9 supporting indicators. This included 8 indicators relating to the MSG/FSG profiles, 7 indicators relating to CSC activities, 4 indicators relating to SAA activities and 9 indicators focused on municipal-level data for Ermera (28 in total).

After the study was undertaken the team reconvened at the office in Dili in August 2018. Data collection for 8 baseline indicators was undertaken during this period. Data for these indicators is not completely accurate because the data was collected through indirect inquiry. Where possible secondary data has been used to address indicators not covered during the July study. This presents significant issues in duplicating the research and the quality and accuracy of the data.

##### Data samples and representation

The GPA study sample representation was limited due to the way participants were selected in the control areas. The xefe suco did not randomly select participants, resulting in the use of non-probability methods. Convenience or purposive sampling occurred because the populations were dispersed, lived in remote areas and because the pre-conditions such as disability were not known.

Of the 387 participants in the CSC activities, there is a proportion of cross-over of community members between the MSG, FSG and CSC activities. This has not been analysed in this study but it is acknowledged there is a risk of duplication that should be explored in future data collection.

For the overall baseline, there are significant differences in the sampling of population, and it is anticipated that this will create limitations when duplicating the research. Rather than the bulk of the baseline being undertaken within a targeted sample of the population, the data was collected from a range of sources, including:

- Targeted sample of 233 used for the GPA analysis;
- CSC program reporting which includes the collective input of all CSC participants; approximately 387 participants across the 10 CSC sites, and;
- MSG/FSG program reporting which includes data for 419 participants out of a total of 1369.

##### Availability of data for participants in HAMORIS activities

There is limited overall data available for the participants of the mother and father support groups. Of the 699 MSG participants, there is available data for 302. For Atsabe, out of 260 participants, data is only

available for 90, representing 34% of participants. For Fohorem, out of a total of 234 participants, data is available for 113 participants (48%). There is no reported data missing for Fatumea. Similarly for the participants of the FSG, out of a total of 570 there is available data for 117 (Fohorem; 2, 55 Atsabe, and 60; Fatumea), giving an overall total of data available of 419 or 30.6% of the total population. Of the data collected for 30.6% of MSG/FSG members, it is not complete and there is very limited data in some areas (such as PLWD).

For CSC activities, participant totals have been collected (387 participants including 194 males and 193 females) and there is informative information across all three Administrative Posts regarding CSC activities. However program reporting has limited data on engagement of PLWD, and there is currently no collection for CSC activities. The program faced challenges in trying to define disability amongst group members due to cultural sensitivities and no joint understanding on what it means to live with a disability. Moreover it is not clear what percentage of the population live with a disability in the broader community within target areas.

### Baseline results

Results of the baseline study are provided against each indicator in accordance with the HAMORIS Monitoring and Evaluation Learning Framework. Information relating to the limitations to data quality, collection and source are also provided. Recommendations for future data collection is also provided. Note the indicators are colour coded according to the area of work: **Member profile and SG/FSG**, **Social Action and Analysis** and **Community Score Card**.

Goal: CITL's HAMORIS project will contribute to lasting reductions in maternal mortality and disability by increasing the number of women in targeted communities utilizing appropriate and quality maternal health services

#### 4.1: Reduction in MMR\*\*

0 reported MMR

Data collected from meetings held for the CSC process in 2017 across 10 villages in Fohorem (4), Fatumea (3) and Atsabe (3) show that community members, leaders and service providers felt the high rates of maternal and child mortality rates were due to a number of infrastructure/services and socio-cultural issues. These include:

##### Infrastructure and services:

- Lack/no infrastructure within the health post including electricity, sanitation and clean water
- Limited access to CHCs and health services
- Limited ambulance and transportation services
- Limited/no activities in place for health personnel visiting nearby hamlets
- Lack of health promotion including malnutrition and information on safe birthing/delivery and danger signs

##### Social-cultural issues

- Use of traditional methods
- Lack of empowerment of women to visit the CHC (feeling shy, nervous)
- Lack of support by husbands and family
- Heavy housework
- Domestic violence
- Lack of participation in health services (for example ANC/PNC)
- Limited family planning experience
- Early marriage and empowerment issues related to traditionally defined male/female roles

\*Source: JSI data: Community Health Centre (CHC) Atsabe (Dec 2017—May 2018); CSC program reports, 2017

#### 4.2: 2136 beneficiaries reached

1,369 beneficiaries including 570 males, 699 females including eight reported participants living with a disability (2 females in Fatuk Laran; Fohorem and Traduk Ama; Fatumea, and 6 males in Suri-Ubu, Bili-Ubu, Aliatu, Airae, Ilat, Laku-Ubu; Ermera).

\*Source: MSG/FSG member profiles, CSC program reporting

#### 4.3: 196,366 indirect beneficiaries reached

Indirect beneficiaries that HAMORIS reached are 10,222 with 5,078 men and 5,144 women.

*Notes on data:* For HAMORIS activities involving the MSG/FSG activities, data will be collected regarding sharing information from the support group education sessions through the pre and post-test. It is estimated that each participant will share information to an average of 3 indirect beneficiaries. The figure therefore is 3,507 indirect beneficiaries.

The rationale for the target figure is primarily through the results of the CSC program. The results of the CSC program are anticipated to impact communities across entire sucos (for example, CSC intends to facilitate electrification or clean for the suco). These populations for sucos therefore are considered in the indirect beneficiary target. As the CSC action plans have not yet been monitored, the data is not available.

\*Source: MSG/FSG member profiles/CSC program reporting

#### **4.4: Change in adolescent birth rate (15-19y.o) -SDG: 3.7.2\*\***

11 including Fohorem (4) and Atsabe (7).

\*Source: JSI data: CHC Atsabe (Dec 2017—May 2018)

Outcome 1: Improving access and utilization of quality SRMHR services by men and women

#### **1.1: 20% increase from baseline on # MSG members who received a minimum of 4 ANC checks (disaggregated by ANC1, 2, 3 and 4)\* Agency and Structure**

From the extra data collected for the baseline in September 2018, it was reported that, of the 187 MSG members from 18 sub-villages, 84 or 45% of women reported that they have attended at least 4 ANC visits. Based on the GPA analysis. Husbands also pay attention to ANC for their wives although it is considered women's responsibility.

\*Source: MSG profile

#### **1.2: 20% increase from baseline on the # of MSG member who received a minimum of 2 PNC checks\* Agency and Structure**

In the follow up data collection in September, it was reported that of the 187 MSG participants, 85 or 45% of women reported that they have received a minimum of 2 PNC visits. The GPA analysis showed that husbands also pay attention to their wives accessing PNC, although it is the responsibility of women in their community.

\*Source: MSG profile

#### **1.3: 25% increase from baseline for the # of MSG members delivery with a SBA (disaggregated by health facility/at home/ BPP) - SDG indicators 3.1.2/CI CI2020 Agency and Structure**

Of a total of 699 MSG members there was data for 302 participants. Of these, 241 or 79% reported birthing (or planning to) at home (Atsabe-62; Fohorem- 111; Fatumea- 68). This compared to 61 or 21% (Atsabe-9; Fohorem- 22, and Fatumea 30 respectively) reported birthing in a CHC or referred to a hospital (see indicator 1.5 for hospital referrals). The data shows 87% of respondents in Atsabe chose to birth at home compared to 77% in Covalima, with Fatumea having the lowest home birth levels of 69%.

*Notes on data:* Data collected only covers the proportion of women giving birth at home or at a health facility and is not reflective of whether there was a skilled birth attendant present at the birth. Some of the women (it is suggested by field staff about 50/50) who birthed at home did so with a SBA present.

Data collection is the lowest in Atsabe with 77 (27%) respondents out of a population of 261. In Fohorem 98 (41%) responded out of 234 population and 122 (60%) out of 204 in Fohorem.

Of a total of 699 MSG members across 18 aldeas there was 187 members who participated in extra data collection in September. Of these, 37 or 20% reported birthing at home and were attended by an SBA (Atsabe 8; Fatumea 8; and Fohorem 21). This compared to 81 or 43% (Atsabe 43; Fatumea 21 and Fohorem 17) who reported birthing at home attended by a TBA. The comparison suggest that there is a preference by women to birth at home with a TBA and not an SBA. Traditions and access to SBA may contribute. Data from the GPA shows that husbands and mother-in-laws influence decision making on where to deliver the baby. There is a perception by the community that the TBA continues to be useful because of the distance from health centres making birthing in health services with an SBA more difficult.

\*Source: MSG profiles; program reporting

#### 1.4: # Improvement in nutritional status of pregnant and lactating women within MSG members - CITL: 1.2 Agency

In the baseline data collection of the 279 that participated (187 MSG and 92 FSG), it was reported that there were 10 pregnant women and 0 lactating women. 7 of the pregnant women reported that their MUAC > 23 and other > 23 with risk malnutrition.

*Future data collection:* It is recommended the attendance of a nurse/midwife/doctor from a local CHC is organised for the MSG/FSG meetings to do a nutrition assessment for each participant.

\*Source: MSG/FSG profiles-

#### 1.5: # of CHC completed referrals to BEmOC and CEmOC facilities through target CHCs and HPs Structure

Total number of referrals to hospital from June 2017 to September 2018 was 237 (Atsabe 167; Fatumea 30 and Fohorem 40) from the total population. The total number of referrals to hospitals reported for MSG members was 24. This included 6 in Fatumea, 9 in Fohorem and 9 in Atsabe.

*Notes on data:* Of a total of 699 MSG member there was data for 302 participants. Data collection is the lowest in Atsabe with 77 (27%) respondents out of a population of 261. In Fohorem 98 (41%) responded out of 234 population and 122 (60%) out of 204 in Fohorem.

\*Source: PO report

#### 1.6: # of CHCs in the target areas meet national quality standards (structure)

For CSC sites reporting suggests that all 10 CSC sites noted systemic issues and inadequate quality standards for CHCs and/or health services. Key issues are outlined in Table 4 below. Key issues impacting the majority of CSC sites include a lack of available health personnel (9 villages), poor infrastructure (8 villages) and access to CHCs (7 villages).

Table 4: CHC quality standards at CSC sites

Issue	Standard level (insufficient)	Standard level (sufficient)
-------	-------------------------------	-----------------------------

CHC availability	No CHC/poor access in 7 villages (Obulo, Lacro, Fatumea, Nanu, Fohorem, Dato-Rua, Lactoske)	2 village (Parami, Belulik Leten-except one hamlet)
Infrastructure functioning-sanitation, water, ambulances	8 villages (Parami, Lacro, Fatumea, Belulik Leten, Fohorem, Dato-Rua, Lactoske, Dato-Tolu)	
Medicine distribution	2 villages (Lacro, Obulo)	
Health staff at CHC	9 villages (Obulo, Parami, Lacro, Fatumea, Belulik Leten, Nanu, Dato-Rua, Lactoske, Dato-Tolu)	
SISCA activities	1 village (Fohorem)	5 village (Obulo, Parami, Lacro, Dato-Rua, Lactoske)
Outreach of health personnel to surrounding hamlets	5 villages (Parami, Fatumea, Dato-Rua, Lactoske, Dato-Tolu)	
Health information dissemination	8 villages (Obulo, Parami, Lacro, Fatumea, Fohorem, Dato-Rua, Lactoske, Dato-Tolu)	

*Notes on data:* The above table is not complete as it only provides evidence on the key priority issues for communities rather than a survey covering all issues.

*Future data collection:* It is recommended that the CSC team provides specific data which compares current health infrastructure resources at each CSC site with the government standard.

\*Source: CSC program report (2017)

### 1.7: # of men, women, youth and PLWD participants in CSC are satisfied with access to CHCs (agency)

Across all 10 CSC sites, all community representatives (men, women and youth) reported a low level of satisfaction in specific aspects of CHC access, infrastructure or services. (Refer to indicators 1.6 and 1.13). During the discussion with specific groups in the community, it was often the case that men would focus on issues related to infrastructure, while women would focus on behavioural/social issues.

*Notes on data:* The project has limited data on PLWD engagement in the CSC process with only one reported person represented that identifies with a disability.

*Future data collection:* It is recommended at the next CSC meeting across the 10 sites, the team asks participants about:

- (1) Disability rates in general within their community
- (2) How many CSC participants identify with a disability
- (3) How the CSC action plan will help PLWD in the community. It's important that the duty bearers in the CSC process understand it's their responsibility to represent all the needs in their community.

\*Source: CSC program report 2017



### 1.8: # of MSG members with access and control over quality SRMHR services- CITL: 1.1

Data collected shows that across all communities surveyed, a high number of women understand their rights to access health services. For example, they understand there is a CHC in their village (or surrounding village) with trained health personnel who provide health services for the community such as health checks, immunisations and checks for pregnant women and babies.

The study found that, even when understanding their rights to access services, a high number of women chose not to access the services. This is influenced by traditional values and norms to (i) prioritise traditional approaches to medicine rather than modern methods, (ii) rely on the broader community for support for sexual and reproductive health needs and (iii) a lack of empowerment by women to make decisions about SRMH needs; (iii) The GPA found that some health providers visit the households to provide health assistance during delivery; (iv) limitations of the health services provided and poor health facilities also make communities reluctant to go to health centers. Contributing to the disincentive is that health staff do not stay permanently at the health center; another finding of the GPA mentioned by participants was the bad road conditions and limited transportation to health centres as problems that the community faced in accessing the health center. A challenge for people with a disability who want to access public spaces is that the infrastructure is not set up to support their access.

In terms of ‘control’ over SRMH services, there were two key findings;

1. It was found there was a high number of women across aldeias who felt a lack of empowerment to access and control SRMH services as they did not feel comfortable making the decision for themselves or their children. This was considered in the GPA which found that the mother in law and men’s family also influence decision making around family size because they have provided the dowry. The study found a low number of women surveyed reported to have control over making their own informed decision over sexual relations (see indicator 2.3). This specifically relates to accessing contraception from health services.
2. It was found that across all aldeias there was a high number of women who felt they had control over attending ANC/PNCs (see indicator 2.10). It was found women felt they did not need permission from their husbands or his family to attend, however all domestic tasks still had to be undertaken (no support provided by husband/family).
3. KIIs held with health professionals found that health workers needed to encourage women to attend PNC/ANCs and use contraceptive services. It was noted that health professionals were bound by practicing standards (Saude Maternal Infantil- SMI) that after birth, women would be monitored and after a 40 day period the women would return and provide information regarding decisions around contraception methods.

*Notes on data:* Note that ‘access’ is not defined here as physical access. It relates to access to empowerment of women in the household and community.

*\*Source:* Pile sorting, GPA (quantitative data collection not undertaken).

Intermediate Outcome 1.1: Improved motivation of men and women in target communities to seek SRMHR services

### 1.9: # of MSG and FSG members satisfied with SRMHR services

*Future data collection:* It is recommended this data is collected and recorded in the member profile.

*\*source:* MSG/FSG member profiles- It will be collected on a monthly basis by using one of the SAA tools (vote with your feet).

#### **1.10: # of MSG members utilizing modern contraceptives (agency)**

Overall available data shows that 37% of MSG participants use contraceptives. In Fatumea, 72 out of a total of 204 participants report using contraceptives, representing around 35% of the population. For Fohorem, available data shows that of 113 participants (48% of overall population) 52 participants use contraception, representing 46% of the population.

This represents an overall contraception rate in Covalima of 39%. This compares to Atsabe where 29 report using contraception or 32% of the population. Contraception includes implants (16), injection (70), sona (12), kesi oan fuan (2) and the contraceptive pill (1). Interestingly, in Atsabe only sona and implants were reported to be used, while injection was commonplace in Covalima.

*Data note:* Out of a total of 599 MSG group members, data relating to contraception was available for 153, representing 26% of the total population. For Atsabe, out of 260 participants, data is only available for 90, representing 34% of participants. For Fohorem, out of a total of 234 participants, data is available for 113 participants (48%). There is no reported data missing for Fatumea.

*Source:* MSG member profiles

#### **1.11: 25 % of fathers and family members involved in developing the birth preparedness plan (relations)**

Data collection undertaken in September 2018 reported that out of the 92 FSG members surveyed 48 (or 52%) of group members reported that they (and/or their family members) were involved in developing the birth plan.

*Notes on data:* Data is based on 48 FSG members surveyed out of a total of 92, representing around 52% of the total sample.

*\*source:* MSG/FSG member profiles - data will be updated every month.

#### **1.12: # of fathers and family members actively involved and providing advice in BFP\* (relations)**

Of a total of 92 FSG member participants 48 or 52% reported that they are actively involved and provided advice in BFP during health education sessions related to breast feeding and through the SISCA program led by the Ministry of Health. The extra data collected found that 44% of FSG's in Fohorem reported that they were involved in providing advice in BFP. 25 % of FSG in Fatumea, including 31% of FSG in Atsabe are actively involved in BFP.

*\*source:* MSG/FSG member profiles

Intermediate Outcome 1.2: Increased capacity and commitment of duty bearers to respond to the needs of men and women related to SRMHR

#### **1.13: # of action plans that include SRMHR issues (structure)**

Nine CSC sites noted health services as a key priority out of a total of 10 sites.

Health services were noted as the top priority in **Obulo village** (Atsabe). It was noted the health services were good in the area and SISCA has been implemented effectively. However, it was a key priority in the CSC action plan to build a CHC in the village. A further priority in the action plan was the need for health

promotion services. Supply of medicines for serious illnesses were insufficient. It was noted by men, women and youth in the community that high mortality rates result from a lack of available doctors and nurses, and access to the health post is far away. Health promotion was also highlighted as a challenge.

Although health services weren't a key priority in **Parami village** (Atsabe) action plan, the priority for improving road access stemmed from the need to access health services. It was noted that the village has access to health services already and organisations such as CCT, Care and Frontline have facilitated the sharing of health information down to hamlets level. It was noted by the service providers that there was a need to ensure the CHC operated at full capacity and to increase the availability of ambulances. Men, women, youth and service providers felt high maternal and child mortality rates and complications for pregnant women stemmed from infrastructure issues (poor road access to health services, poor/low capacity of health services and health promotion and low levels of ANC/PNCs) as well as socio-cultural norms (limited support from husband/family, early marriage) and carrying out heavy household tasks while pregnant. It was also noted that malnutrition and limited information and knowledge of SRMH services and limited experience in delivery and family planning were contributing factors.

For the **Laclo village** (Atsabe) the need for a health post was a priority in the action plan, however electricity and road access took priority. Health services were considered unsuitable with very limited access to ambulances (1 for 12 villages) for pregnant women or women in labour. It was noted that Laclo village has access to health services however the services do not function well and community participation remains low with most women still undertaking traditional methods for birth. It was reported by men, women and youth in the community that the SISCA program operates monthly however, there was no opportunity for women to learn about breast feeding and other SRMH issues. Child and maternal mortality remains high due to poor road access to health services and the use of traditional methods.

In **Fatumea village** (Fatumea), the requirement for health personnel was the third priority for the CSC action plan. It was agreed by all stakeholders that although there is a health post, there is an issue with retaining health personnel. The distance to the next health post is far away and there is limited ambulance services and low distribution of essential medicines. It was noted by the women that high maternal mortality resulted from a low number of ANC/PNCs, lack of communication and information from health education, carrying out heavy household tasks while pregnant, a lack of resources and unfavourable roads. Limited access to electricity, ambulance and public transport and gender issues relating to an imbalance of household role tasks between man and women and domestic violence were also contributing factors.

For **Belulik Leten village** (Fatumea), resources (infrastructure and clean water) and personnel for adequate health services was a priority in the action plan, behind clean water and agricultural needs for the whole community. It was felt by stakeholders that health services had been well-delivered, and all but one health post in the area had access to electricity. In addition to health services, all stakeholders acknowledged the issue of barriers for women, an imbalance of household tasks and high levels of domestic violence. The security situation was also a key challenge including a lack of capacity for infrastructure, governance and human resources to handle the level of security threats.

**Nanu village** (Fatumea) noted the building of a health post as a lower level priority in the action plan. Community members felt that health services were not working well, and all stakeholders felt a health post should be constructed. Stakeholders differed in their views for the reason for high mortality rates. Service providers felt it was because of limited human resources at the health post, a lack of awareness from the community and the undertaking of heavy household tasks. Community members felt it resulted from the use of traditional methods and unstable health conditions for women. It was agreed by all stakeholders that the distance to accessing the health post was a key issue.

**Fohorem village** (Fatumea) noted health promotion and the construction of a health clinic as the top two priorities for the action plan. All stakeholders noted the key need for a health clinic in the village. Service providers also noted the need to improve malnutrition service systems, the need to implement the SISCA program at the Loroquida hamlet and limited community participation as key issues. Community members noted sanitation was a key issue, and information for pregnant mothers and health personnel was limited. Community members felt that infrastructure issues was the key issue contributing to high mortality rate. This included the distance to the nearest health clinic, poor roads and no ambulance, and limited information on health. Social norms impacting SRMH include the use of traditional methods, and women feeling inhibited and uncomfortable going to the CHC. Service providers felt women had a lack of awareness of dangers during pregnancy and low support from husbands also contributed.

**Dato-Rua village** (Fohorem) reported the need to conduct health education for community members, the construction of a health post and sanitation as the top three priorities in the action plan. It was acknowledged that health services have worked well. A health post was operating in the village, however it has since closed. The health and SISCA and malnutrition programs, as well as previous programs by World Vision on health promotion were key services working well in the community. Sanitation remained a key issue. All stakeholders saw headline challenges as being limited health personnel or outreach health activities, limited nurses and housing for health personnel. All stakeholders agreed the high rates of maternal and child mortality were due to a lack of access to health information, limited nurses available, the use of traditional methods, limited transportation services including ambulances and the distance away (particularly Aitos and Fatuklidun communities) from the health post. Service providers also noted a lack of support from husbands as a key issue.

In **Lactoske village** (Fohorem) noted the need to increase the number of health personnel as the second priority issue in the action plan. Issues regarding health infrastructure and services were a lower priority issue compared to other villages however, health personnel and availability of health information were highlighted as key issues for all stakeholders. It was noted that the health, SISCA and malnutrition programs were working well. Service providers noted the need to increase the number of health personnel and the establishment of a regular schedule for visitation of health personnel to each hamlet. Service providers considered that the high mortality rates were due to limited information and knowledge about delivery/danger signs, the use of traditional methods, low levels of empowerment to attend CHCs and limited support from husbands. The community also saw health information, low levels of empowerment and traditional methods as issues, as well as the distance from the CHC, irregular check-ups and limited nurses.

**Dato-Tolu** village highlighted the increase of doctors and nurses as the second priority (behind electricity access) in the action plan. Although it was noted that health services and programs are operating, an issue is the lack of health personnel and visits to other hamlets. Infrastructure issues impacting on the maternal mortality rates include limited ambulances and doctors/nurses and the distance to the nearest CHC. Social/cultural issues include the use of traditional practices, inadequate knowledge of health information and a lack of support from husbands.

*Source: CSC 2017-18 reports*

#### **1.14: Changes in responsiveness of local government to barriers of SRMHR in their communities (e.g. no. of midwives/doctors, frequency of SiSCa etc.) (structure)**

According to the Ministry of Health standard, each health post should have a doctor, a nurse, a midwife, a pharmacist and an administration staff member. But currently the Ministry of Health in the municipality lacks human resources. When implementing CSC in suco level, project staff found that all health post only have a doctor, a nurse and a cleaner. But in the CHC level they follow the standard.

Frequency of SISCA, in last year isn't going regularly because ministry of health stabilize **Vizita Na Familia Program**.

*Future data collection:* It is recommended that the CSC DPM provides a summary on current responsiveness of local government across each of the CSC sites.

*\*Source:* CSC program report

### **1.15: Change in baseline of the relationship between the community and service providers (relations and structure)**

Based on the available data (refer to indicator 2.13) coordination between community and service providers is at low levels in at least 8 village. It was noted by service providers across all 4 villages in Fohorem that there was a need for community to increase engagement and participate in activities and events. In 4 villages in Fatumea (2), Atsabe (2) service providers advocated for the lines of communication to be strengthened to allow community, community leaders and service providers to work together to solve problems. In terms of a joint understanding of issues, across all villages there was general agreement between community and service providers on the key health issues for the community and that this resulted from both infrastructure limitations and social-cultural issues.

*Notes on data:* The relationship between community and service providers has not been explored through direct inquiry and therefore the data quality remains low.

*Future data collection:* It is recommended the team provides further evidence based on previous observation.

*\*Source:* CSC reporting post-August 2018

## **Outcome 2: Improved gender relations at family and community level**

### **2.1: MSG and FSG members, xefe sucos, xefe aldeias and youth took the lead on actions to implement solutions to address social, gender and power norms (structure)**

The data collected across all aldeias reflects that communities focused more on leading change and problem solving on structural issues, and no specific interventions for implementing solutions to social, gender and power norms were undertaken.

It was noted across all aldeias in the interviews with community leaders that problems were solved via community governance processes. The problem is raised at the village council meetings and discussed within the community leaders and with health personnel. Where CSC activities reside, the issues are presented via the CSC process and discussed with health personnel. Examples of problems identified include systemic health facilities issues such as an ambulance on standby and increasing the health personnel in a neighbouring village.

It was noted that in some aldeias, community leaders will take forward issues raised in their communities such as improving health information sharing and increasing support from mother-in-law and families to support wives/women new to approaching the health facilities. The field team suggest about half of the community leaders in the aldeias studied (none in the control areas) supported SBA methods compared to TBA. The data collected also suggests that community leaders do support changes to social policy led by Ministry of Health (MoH) such as support for community members (a joint approach by husband and wife) to seek information and methods of contraception within CHCs.

*\*Source:* KIIs of community leaders

**2.2: Longitudinal study of 1 female and 1 male support group participants in Covalima and Ermera. The study measures the change in participants' knowledge and understanding of identifying social norms which hinder better SRMHR and changes made (if any) to adopt new behaviours and/or benefits resulting from transformative change CITL 3.3 (agency and structure)**

The purpose of the longitudinal study is to track changes in knowledge, practices and attitudes within targeted communities. The data for the baseline for the longitudinal study was conducted in September 2018 with 6 participants (2 men and 4 women) in 3 post administrative of; Atsabe (1 man and 1 women), Fatumea (2 women) and Fohorem (1 man and 1 women). The participants come from different ages, 46-60 (older) and 25-32 (youngest)). The aim is to measure impact for the different age groups over the life of the project. Participants involved in this study were identified by random sampling.

*Future data collection:* It is recommended that the HAMORIS and GPQ in Dili support the Ermera and Covalima field staff to collect data for the longitudinal study. This will require

- (a) Having meetings every 6-months and working with CI gender/SAA specialists to refining survey questions.

Intermediate Outcome 2.1: Increased support from men for women to access SRMHR services

**2.3: # 50 of MSG members aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care- SDG indicator 5.6.1 (agency)**

Of the 187 participants in the data collection, 20 women stated that they make their decision whether to have sex with their husbands. However, the larger proportion are not making that decision due to the cultural norms that have women beholden to men/husbands.

There is strong evidence that a low number of women surveyed reported to have control over making their own decision about sexual relations. Most women report that it is the man who makes the decision to have sexual relations. A low number of women across all aldeias report joint decision making.

Traditional thinking is that women must provide sexual relations when the man wants to, whether women want to or not. Data shows that even if the women do not want to (feeling sick or tired) they still do because they are shy, want to please their husband or they are scared. Evidence shows that across all aldeias this is culturally accepted behaviour for the man to seek sexual relations elsewhere or get angry with their wife/partner if they reject the man.

In the target areas CITL has already undertaken pile sorting and other activities and that data collected showed that in comparison to the control areas there was more joint decision making around sexual relations. In control areas, it is men (in the vast majority of cases) that makes decision on sexual relations.

In follow up data collection conducted in September 2018, it was reported that 20 members of MSG or 11% from 187 MSG members make their own decisions regarding sexual relations and 167 or 89% MSG members informed that women do not have power to say no to have sex even if they are tired or do not want to have sex. This suggests that men have the power and control over decision making and that women are not empowered to make decisions of an intimate nature.

For contraceptive use, it's reported a very low number of women have autonomous decision making around using contraception. It was reported that across most aldeias there was an understanding of the broader government messaging about contraception. As per the government directive, it was understood by most community leaders and MSG/FSG participants that joint decision from both the man and the women is required, and that both the man and woman need to visit the CHC to obtain contraception. It was noted



there is a potential risk of conflict (domestic violence) if the women attends the CHC by herself to seek contraception. It was also noted that the couples family and broader community would negatively judge the women for seeking contraception alone. This findings are applicable for both control and non-control areas.

As noted in indicator 2.10, current social norms limit women making their own informed choices about sexual reproductive health. Men are the primary decision-makers in the house for birth control and fathers determine if their daughters get married. Mothers are tasked with looking after their children. A key finding was that in some aldeias, the mother in-law and man's family also make decisions concerning family size because they have given the dowry. This was found in both matrilineal and patrilineal social structures. Traditionally, it is the responsibility of the man's family to make decisions about how the baby will be delivered.

In terms of decision-making on birth spacing, men decide on the planning of children (number and timing) and have for generations. This decision is strongly influenced by the husband's mother. It was reported there is some joint decision-making on planning (number and spacing) and this was reported in the HAMORIS aldeias as a result of the previous implementation of pile sorting and gender box (in all aldeias; 2017).

For the birthing process, it was reported across aldeias that many women do not have a birthing plan to birth at a CHC or at home. Traditional herbal methods would be used for labour and often little contact with the CHC unless there was an issue or complication during labour. In HAMORIS aldeias there was some joint decision-making however the decisions were also influenced by the man's family and available resources. Data from the CSC meetings also reflects that most of the target villages still use traditional methods.

As noted in indicator 2.10, there is evidence to suggest that across most aldeias, women had control over visiting the CHC for ANC and PNC checks. Women did not need permission from their husbands or family however all household duties were expected to be completed before attending the CHC.

According to the GPA KIIs with health professionals, the health professionals are bound by standard practice to follow-up all women birthing in CHCs at 1, 3 and 7 days intervals after birth. For women that don't birth at the CHC, it was found that women will bring the baby to the CHC (or a health professional will visit the mother and baby at home) after 1-day to do a PNC check. In contrast to this, it was noted in some CSC villages that irregular or no ANC/PNC check were undertaken, either because of the lack of access to health services or the women chose not to go.

*Source:* Pile sorting, KIIs; GPA; CSC report (2017)

#### **2.4 30% of men who report they support their partners to access maternal health and safe birthing practice (relations)**

Based on the extra data collection conducted in September 2018, it was reported that 57 or 62% of FSG support their partners to access maternal health and save birthing practice. In the longitudinal study conducted in September it was mentioned that men have to accompany their wife to go to hospital because of the condition of the roads and the distance.

During the CSC meetings (March-May 2018) it was noted in the majority of the 10 villages that communities and service providers felt a key contributing factor to high maternal mortality was a lack of support by husbands during pregnancy and labour. This included heavy household tasks being undertaken by women during pregnancy.



Low support from husbands was noted in some aldeias during the GPA study. However it was noted that in some KII it was reported that men will mostly accompany the women to the CHC for birthing. Men will mostly be the person that contacts the midwife during labour. The family can also have a role in supporting the pregnant women (for example during the rainy season when access to the CHC is difficult and public transport is not possible the family will take the pregnant women via motorcycle to a road where an ambulance is accessible (aldeia; Nano, Belulik Kraik).

\*Source: CSC report (2017); MSG/FSG member profiles-

Intermediate Outcome 2.2: Better sharing of household responsibilities and decision-making between men and women

## 2.5: Qualitative evidence of changes to sharing of household responsibilities (*relations*)

There is evidence that across all aldeias the roles of men and women were strongly guided by entrenched cultural norms and values. Women and men's roles were quite specific with not a lot of cross-over. Women did cooking, washing, cleaning, taking care baby, livestock, collecting water, sewing, food preparation. Most respondents reported men are responsible for working outside the home and providing for the family. Men did firewood collecting, farming, livestock care and planting.

Data collected across all aldeias reflect there was limited support for women from husbands and/or his family to share activities or change the roles. There was no reported difference between HAMORIS and control aldeias. This is in part due to traditional norms regarding the buying of women to perform these duties (*barleke*). It was noted that the women would be judged if they did not perform the required duties (listed).

In Fohorem, the social structure is matrilineal (the man marries the woman and moves into the woman's family). In Fatumea and Atsabe it is patrilineal (the woman marries the man and lives with the man's family). The jobs and perception of support for the women are the same across all social structures.

Social norms relating to the division of roles were socialized consistently across all cohorts. The study found that children learnt from their mother and fathers, and parents learn from their parents. Women were the main parent passing on gender roles as it remains their primary responsibility to take care of children. There was general acceptance by men and women regarding their roles and the break-up of duties.

It was noted by both men and women that women undertook the larger share of the duties (including heavy-lifting while pregnant). Women appreciate the man's job but only some men appreciate the women's work. Across the aldeias, most of the men do not see women's work as hard.

In specific situations the data collected shows that there could be some sharing of responsibilities when the woman is sick, attending community meetings or heavily pregnant or lactating. Where a man or woman has a disability or there is divorce, the activities are done by the man or woman most able/left in the household and there is support from family and the broader community.

\*Source: 24 hour activities in FDG; GPA

## 2.6: # of MSG and FSG members who report joint household decision making– CITL 3.1 (*relations*)

Data collected showed that across all aldeias most households are male-headed. In Fohorem it's matrilineal so it means that decisions about land and property is decided by the woman. In Fatumea and Atsabe it's patrilineal so these decisions are made by the man.

Data collected across all aldeias found that women can make decisions for smaller issues (nutrition and food buying, small animals such as chicken, dogs). In target areas bigger decisions such as buying/selling bigger animals are joint decisions. It was found that joint decision making did not occur for bigger issues in control areas.

\*Source: Pile sorting in FDG; GPA

Intermediate Outcome 2.3: Improved women's participation in formal and non-formal decision-making spaces

### **2.7: Qualitative evidence in changes in participation of women and PLWD in formal and non-formal decision making spaces (structure)**

There was strong evidence collected across aldeias that women have limited scope for influencing and shaping local planning and governance processes. There is strong evidence of rigid social norms which govern the way decisions are made within the community and that these structures (Suco Council) are predominantly male.

The GPA study reported some women in the community are involved in the socio-council (Aululik aldeia), but the decision-making process makes it difficult for women delegates to be heard. Data collected also reflected that the women delegates were unaware of their roles. Some community leaders noted they do have a gender policy. It was reported that across all aldeias there are MSG and FSG members involved in the Suco Councils. Although the MSG/FSG members don't represent the MSG and FSG directly, it was reported they have influence in decision making, particularly in the health sector.

When women do participate in community governance processes, it was reported that most women are comfortable participating but they don't engage fully. The limitations for women to engage stems from the cultural norm of being subordinated, the women feel shy and are unable to express ideas, even with the encouragement from men. Across all aldeias, women have low education and literacy rates.

It was reported some of the women require permission to attend community meetings from their husbands, and are allowed to attend so long as their household responsibilities are done first (there is limited support from husbands to share responsibilities). A small minority of women (1-2 in total) don't feel it's their role to attend meetings.

\*Source: Pile sorting, KII with community leaders; GPA

### **2.8: # MSG and FSG group members identified as effective decision makers and leaders in political, economic and social forums- CITL 3.2: ANCP (agency)**

The data collected focused on the broader role of women in decision making rather than specific MSG/FSG members.

*Future data collection:* It is recommended that data is collected on the number of participants who have run, or are planning to run in local, suco or municipal government at midline survey.

\*Source: KIIs with community leaders, GPA

### **2.9: 81 # of men, women, youth and PLWD participants actively participating in the CSC process (disaggregated by participant type) (agency and structure)**

There are a total of 387 participants (men: 194, women 193) across the 10 CSC sites. This includes 143 in Atsabe, 139 in Fohorem and 105 in Fatumea. There are 2 people with disability participating in CSC, 1 male in Covalima and 1 Fathumea.

*Future data collection:* It is recommended that the CSC team disaggregate the data according to PLWD and youth.

*\*Source: CSC program reporting*

Intermediate Outcome 2.4: Staff become active champions of gender equality

### **2.10: Qualitative evidence of challenging harmful traditional practices or a change in attitude or practices related to girls' and women's rights (including violence against women, HH and community decision making relating to SMRH)**

*Progress in counteracting traditional practices:* Evidence shows that in some communities (half of the aldeias studies) the community leaders note that traditional birth practices was prevalent 20 years ago and there is change to promote access to health services. However some (half of the aldeias studies) still undertake TBA and traditional medicine. By comparison, TBA was still undertaken in both the control areas. CSC data reflects that most of the 10 villages surveyed noted a reliance on traditional methods.

A key finding was that in some aldeias, the women will decide to go to the clinic and the man supports this, as long as the women does the housework duties (only for ANC/PNC).

In most aldeias, women want to seek information to ensure safe delivery. Women reported to share information to pregnant mothers to go to health facilities to receive proper care. Women reported interest in increasing their partner's health education skills to support mothers in health facilities. It was reported that women wanted to encourage families to participate in the activities to deepen knowledge.

Communities report participating in and learning from CITL activities in health, education and health promotion. Communities are also engaged with frontline and CCT services by LILA, SISCA activities. One control aldeia (Uabe) has a safe motherhood project (Important Practice Promotion Project: finished 2016-17). IPP was supported by community leaders and helped with health promotion.

*Context for the prevalence of unfavourable traditional norms:* In most communities social norms are strong and traditional values and practices are a central, accepted part of life within the communities. This can promote negative outcomes for women's sexual reproductive health outcomes. For example, several traditional practices were identified:

- Customary practice is for men to pay a dowry (*bileki*) for the women to marry into the husbands' family. The role of the women is to provide children for the husband's family and look after the children as well as performing specific household duties (see indicator 2.5 regarding gender roles in the household).
- Men are the primary decision-makers in the house for birth control and fathers determine if their daughters get married. Mothers are tasked with only looking after their children. A key finding was that in some aldeias, the mother-in-law and man's family also makes the decision because they have given the dowry. This was found in both matrilineal and patrilineal social structures.
- Traditionally, it was the responsibility for the man's family to make decisions about how the baby will be delivered.

- Men decide on the planning of children (number and timing) and have for generations. This decision is strongly influenced by the husband's mother. It was reported there is some joint decision-making on planning (number and spacing) and this was reported in the HAMORIS aldeias as a result of the previous implementation of pile sorting and gender box (in all aldeias; 2017).
- CSC data reflects that domestic violence was prevalent in at least 4 villages, and was considered a contributing factor to maternal mortality. No specific data was collected on domestic violence during the GPA. It was felt by the team that women may feel scared about retribution and judgement from the community and their families for talking about it. It was noted in one aldeia that when a women returns from a meeting without receiving money for attending the man will get angry. Also if the women doesn't fulfil domestic duties or if the women goes out at night the man will be angry. In these situations, the man's family and the community will judge the women.

\*Source: Pile sorting, and visioning activities in FDG, GPA; CSC report (2017)

### **2.11: Project management was effective; staff received sufficient training to facilitate activities effectively and staff actively advocate and become champions for transformative change**

Not measured in baseline

\*Source: Program management reporting for CSC, Social Analysis and Action (SAA) and member profiles

### **1.16: 50% of MSG and FSG members who report sharing support group education outcomes**

Initial data collected in September 2018 suggest that out of 540 support group members surveyed, 82 women and 69 men reported sharing support group education outcomes with others such as friends and family. This equates to 27% of all support group members surveyed.

*Notes on data:* Total support group members is 1,269 so the total number surveyed represents around 42% of the total population.

\*Source: MSG/FSG profiles

### **17: Evidence of changes in the broader community in attitude and/or behaviour regarding harmful traditional practices**

Evidence shows (refer to 2.10) that in some communities (half of the aldeias studies) the community leaders note that traditional birth practices was prevalent 20 years ago and there is change to promote access to health services. However some (half of the aldeias studies) still undertake TBA and traditional medicine. TBA was still undertaken in both the control areas.

In most communities social norms are strong and traditional values and practices are a central, accepted part of life within the communities. It was noted during the KIIs with community leaders that in about half the aldeias studies there is a move towards support for modern health methods, health promotion and support for women from the husband and family to support women who are new to accessing these services.

A key finding was that in some aldeias, the women will decide to go to the clinic and the man supports this, as long as the women does the housework duties (only for ANC/PNC) - See indicator 2.10. Across the broader community, leaders were promoting the government objective to promote the access of contraception from the CHCs (however it was required that the man and women attended the CHC together) - see indicator 2.3.

\*Source: Pile sorting, and visioning activities in FDG, KIIs with community leaders; GPA

Output 1.2: MSG+FSG members actively participate in their groups

**1.18: # of support group members (disaggregated by sex, disability)**

1,269 total MSG and FSG members which includes 699 women (651 women, 41 girls and 7 women with disability) and 570 men (530 men, 33 boys and 7 men with disability) compared to the expected target 2,136 for men and women (Male 801, female 728, boys 267, girls 259. Men with disability 33, female with disability 27, boys 11, girls 10). We can see that in the first year of the project we have reached 89% of the female target and 66% of the target men from total expected direct beneficiaries. For youth with disability if we compare this with the expected target it is low at 16 % girls, 12% boys and 17% with disability.

*Future data collection:* It is recommended data regarding PLWD and youth is collected by field staff.

*\*Source:* MSG/FSG profiles

Output 1.3: Awareness and knowledge of MSG+FSG members improved related to SRMH and safe birthing practices

**1.19: 30% MSG and FSG members with knowledge of one or more modern contraceptive method**

From both municipalities there is 74 women and 40 men (114) from a total of 540 with knowledge of one or more modern contraceptive method. In Emera there is 28 members (19 women and 9 men) and in Covalima 77 (32 men and 45 women).

In follow up data collection in September 2018, it was reported that 104 or 37% members (64 MSG and 40 FSG) have knowledge of modern contraception. Mostly participants were able to identify 3 types of modern contraception such; injection, implant and pill.

*\*Source:* MSG/FSG profiles

**1.20: % of support group participants who scored 75% or above on SRMH post test**

Of the 18 groups of total 44 groups who took part in the pre and post-test all scored above 75%. The pre and posts tests were for exclusive breast feeding and pregnancy danger sign health education sessions.

In the second fiscal year (FY2), pre-test and post-test have been done once in August and September. Pre- and post-test were done in 3 post administrative and 18 sub-villages. In Atsabe Post Administrative pre-post tests were conducted on pregnancy danger signs attended by 6 MSG and FSG with 110 total participant (76 women and 34 men). In Fatumea and Fohorem pre and post-test were conducted on exclusive breast feeding. There were 12 MSG and FSG with 169 total participants (111 women and 58 men).

*\*Source:* MSG/FSG profiles

**2.11:# of MSG+FSG members with knowledge of one or more social norm which hinders better SRMH outcomes**

**Data pile sorting and gender box**

*Future data collection:* It is recommended data is collected and included in the member profiles.

\*Source: MSG/FSG profiles

Output 2.1: Understanding of rights and duties related to health by service providers and community members

**2.12: # of CSC sites that clearly understand rights (responsibilities) and duties of each stakeholder.**

To be collected in November

*Future data collection:* It is recommended the CSC DPM provides information for all CSC sites regarding whether each stakeholder in the CSC process understand their roles, rights and responsibilities.

\*Source: CSC reporting post-August 2018

**2.13: Changes from baseline in the for community's aptitude to problem solve and facilitate change to improve the quality of health services**

Based on the available data it is suggested that communities in at least 8 village had low levels of coordination and participation rates when engaging in governance process, and activities and events to improve service quality in their community. By extension this could be a result of a low aptitude by communities.

During the discussions with all stakeholders regarding what could be improved, it was noted by services providers across all 4 villages in Fohorem there was a need for community to increase engagement and participate in activities and events. In 4 villages in Fatumea (2), Atsabe (2) service providers advocated for the lines of communication need to be strengthened to allow community, community leaders and service providers to work together to solve problems.

*Notes on data:* Data is of low quality as it was not collected through direct inquiry.

*Future data collection:* It is recommended the team provides further evidence based on previous observation.

\*Source: CSC monitoring report

**2.14:100% # of CSC sites where CITL provides support for assisting community advocacy for the CSC process**

Moved to collecting evidence at MTR

\*Source: CSC program reporting

Output 2.2: SUCOS action plan to improve health services developed jointly by members and service providers

**2.15:50% # of men, women, youth, xefes and service providers and PLWD satisfied with the contents of the action plan**

There are 385 in total participating in the CSC process.

\*Source: CSC program report, 2017

**2.16: Change in satisfaction of men, women, youth, and PLWD, xefes and service providers from baseline of the CSC process to improve governance**

Not collected in baseline

*\*Source:* CSC program report, 2017

**2.17: # of action plans developed**

10- for all CSC sites

*\*Source:* CSC program report, 2017

**2.18: # of action plans implemented**

Not collected in baseline

*\*Source:* CSC program reporting

**2.19: CSC phases held in all sucos on a 6-monthly basis**

Not collected in baseline

*\*Source:* CSC program reporting

Output 3.1: Regular reflection and identification of social norms that hinder better SRMHR conducted with staff and community members

**3.1: SAA reflections held in all sucos on a monthly basis**

Not collected in baseline

*\*Source:* FSG/MSG member profiles, program reporting

**3.2: SAA action plans implemented in a timely manner.**

Not collected in baseline

*\*Source:* FSG/MSG member profiles, program reporting

Output 3.2: Improved awareness and knowledge about harmful social norms and culture practice for staff, men and women in the targeted communities

**3.3: # of trainings by topic attended by support group members and community mobilisers**

Not collected in baseline

*\*Source:* FSG/MSG member profiles, program reporting

**3.4: Education sessions held on SRMH good practice on a monthly basis in all sucos**

Not collected in baseline

*\*Source:* FSG/MSG member profiles, program reporting



Annex 1: HAMORIS Theory of Change

Theory of Change for HAMORIS PROJECT

Reduce maternal mortality and morbidity

1. Improved access and utilization of quality SRMH services by men and women (FP, ANC/PNC, Safe birthing)

2. Improved gender relations at family and community level

1.1. Improved motivation of men and women in target communities to seek SRMH services

1.2 Increased capacity and commitment of duty bearers to respond to the needs of men and women related to SRMH

2.1 Increased support from men for women to access SRMH services

2.2 Better sharing of household responsibilities and decision-making between men and women

2.3 Improved women's participation in formal and non-formal decision making spaces

2.4 Staff become active champions of gender equality

1.1.1 Information and good practices around SRMH shared with other community members by MSG and FSG members

1.1.2 MSG+FSG members actively participate in their groups

1.1.3 Awareness and knowledge of MSG+FSG members improved related to SRMH and safe birthing practices

2.1.1 Understanding of rights and duties related to health by service providers and community members and service providers

2.1.2 Suco action plan to improve health services developed jointly by community members

3.1.1 Regular reflection and identification of social norms that hinder better SRMH conducted with staff and community members

3.1.2 Improved knowledge and awareness about harmful social norms and culture practice improved for staff, men and women in the target communities

Community Scorecard Process

Mother Support and Father Support Groups +Engagement activities

Social Analysis and Action Process

Annex 2- Gender Power Analysis training schedule, facilitators guide and data collection template, longitudinal study guidance

**HAMORIS Gender and Power Analysis: Staffs Engagement  
Training: July 2018  
Venue: Dili, Timor-Leste**

**Objectives:**

1. To surface staffs' knowledge, beliefs and attitude regarding gender, disability and power
2. To introduce the approach and tools to the gender and power analysis

**DAY 1: Surfacing staff attitudes, beliefs and knowledge and identifying capacity strengthening needs = Refresher session**

Time	Activity & objective	Guidance	Materials
9:00-9:30 Nell	<p><b>Introductions</b></p> <p>To get to know one another and begin reflecting on how we are all affected by gender norms</p> <p>Refresher experience using a SAA tool</p>	<p><b>SAA tool: Experience being a Man and Woman</b></p> <p><b>Follow instructions in the tool</b></p> <p>Go around the circle with each participant sharing their name and roles</p> <p>Each participant shares their response to the questions:</p> <ul style="list-style-type: none"> <li>• What is one thing you like about being a woman/man?</li> <li>• What is one thing you find challenging about being a woman/ man?</li> </ul> <p><b>Questions for the discussion</b></p> <p>Is this Gender or Sex? Why?</p> <p>Can we change this? if no, why? if yes why and how?</p> <p>How are you the same as the people in the community you are trying to serve?</p> <p>What challenges, problems, attitudes or beliefs do you share? How might these similarities help or hinder you from bringing about social change?</p>	<p>Colored cards</p> <p>Markers</p>

		<p>And how are you different from them? Are you from a different religion, ethnicity, tribe or economic group?</p> <p>How do these differences help or hinder you from bringing about social change?</p>	
<p>9:30-9:45</p> <p>Floriano</p>	<p><b>Establish group norms/rules</b></p> <p>To agree on rules for the training</p>	<p>Lead a brainstorming discussion to agree on rules of conduct for the training. Write the rules on flipchart, some rules includes:</p> <ul style="list-style-type: none"> <li>• Active listening</li> <li>• Respectful listening</li> <li>• Respecting diversity</li> <li>• Empathy</li> <li>• Confidentiality</li> <li>• Right to pass</li> <li>• Right to speak in your own language</li> <li>• Not judging</li> </ul> <p>Explain:</p> <ul style="list-style-type: none"> <li>• This is different from regular training. We will be encouraging a process of learning through personal reflection and discussion.</li> <li>• We will be exploring our own attitudes and values – not just those we expect from our communities.</li> <li>• The norms of respectful listening and confidentiality are particularly important given the sensitive nature of the material.</li> </ul> <p><b>Note:</b> This is challenging because participants are learning a new way of working for themselves while learning to facilitate a new learning process at the same time.</p>	<p>Flipchart</p> <p>Colored Markers</p>
<p>9:45-10:00</p> <p>Grishma / DPM</p>	<p><b>2-days overview</b></p> <ul style="list-style-type: none"> <li>• To introduce the objectives of the Gender and Power Analysis Mission</li> </ul> <p>To provide an overview of the 2-day agenda</p>	<p>Training objectives:</p> <ol style="list-style-type: none"> <li>1. To learn about our own attitudes, beliefs and knowledge regarding gender, disability and power, and how these impact on our work with community members</li> <li>2. To understand why it is important to address gender and power in the HAMORIS project</li> <li>3. To prepare for the field research to be conducted in the field</li> </ol>	<p>Workshop objectives written on flipchart</p> <p>Workshop agenda written on flipchart</p>

		<p><u>Explain:</u></p> <ul style="list-style-type: none"> <li>• Over the next 2-days we will explore our own gender and social values using participatory tools, some of which we will use during the field research.</li> <li>• <i>Don't worry if this is unclear now – we will explore these concepts more during our time together over the next week. We will learn more during the field survey in coming weeks</i></li> <li>• Through using participatory tools, we will develop personal experience and understanding of how our own attitudes influence both our lives and the work we do.</li> <li>• Then we will learn how to use these tools during the field research, and prepare for the research itself.</li> </ul> <p>It will be a busy two days!</p>	
10:30-10:45	<b>Break</b>		
10:45-11:45  Floriano and Zelia	<p><b>Values clarification</b></p> <p>To learn about ourselves through reflection and dialogue</p>	<p><b>SAA tool: <u>Vote with Your Feet</u></b></p> <p>This exercise focuses on the crossover between norms and values in our personal lives and how these reflect norms and values in our professional personal lives.</p> <p><b>Follow instructions in the tool. (8)</b></p> <p><u>Values clarification statements :</u></p> <ol style="list-style-type: none"> <li>1. A man should have the final word about decisions in his house</li> <li>2. It is a man's responsibility to provide for his family</li> <li>3. Menstrual hygiene is the responsibility of women</li> <li>4. It is a woman's responsibility to avoid getting pregnant</li> <li>5. A person with a disability could not perform public responsibilities</li> <li>6. A woman deserves to be beaten if she has an affair</li> <li>7. Women with a disability do not have right skills to be leaders</li> </ol>	<p>Signs with 'agree' and 'disagree' posted at opposite ends of the room</p>

		<p>8. A person with disability should be looked after by their family</p> <p>9. A man with disability shouldn't marry, he couldn't provide for his family</p> <p>10. Changing diapers, giving the kids a bath, and feeding the kids are only the mothers' responsibility</p>	
11:45-12:00 Floriano	Introduce data collection protocol	<p><b>Introduce:</b></p> <ul style="list-style-type: none"> <li>Objectives of the research</li> <li>Who we will be targeting and how (stakeholders, methodology)</li> <li>Roles and responsibilities of research team members</li> </ul>	PPT presentation
12:00-1:00	<b>Lunch</b>		
1:00-2:30 Sabitra	Introduce data collection tool	<p><b>Focus Group Discussion (FGD)</b></p> <p>Adult Men and Women, MSG and FSG</p> <p><b>It may be useful to probe:</b></p> <p>What information we expect from this research? What is our focus to collect primary data?</p> <p>Who are Key Informants for collecting data on Health?</p> <p>Who are specific group of peoples for FGDs and why?</p>	Tool Guide and Questionnaire
2:30-2:45	<b>Break</b>		
2:45-3:30 GPQU	<p>Practice on gender analysis tool</p> <p><i>To prepare for exploring the Aspiration and strategic interests of specific groups of people</i></p>	<p><b>SAA tool: Visioning Exercise</b></p> <ul style="list-style-type: none"> <li>Envision what we hope change looks like for the lives of women and men, girls and boys (menstrual hygiene practices, health services and facilities, toilet facilities etc)</li> </ul> <p>Ask the participants to close their eyes and imagine that they have gone to sleep and when they awake, 15 years have passed and we have really achieved social change. What does the attitude and behavior of the service providers look like for men, women, boys and girls to provide WASH services? for disable people?</p>	Tool guide with instructions

		<p>Ask the participants to split into two groups, include disabled people of each category in all groups</p> <ul style="list-style-type: none"> <li>• Men</li> <li>• Women</li> </ul> <p>Request each group to develop a poster with pictures and words to communicate their vision. Once completed, groups come together and share their visions.</p>	
3:30-5:00	Data Entry and Coding	<ul style="list-style-type: none"> <li>• Note-taking (note book, recording device, recording template)</li> <li>• Schedule, including daily debriefs</li> <li>• Data entry and coding</li> </ul>	Data Template
5:00-5:15 Grishma	Daily Reflection	<p>Ask participants to sit in a circle. Offer a special object to be passed around the room. Ask each participant to share just <b>one sentence</b> to summarize their feelings about the day.</p>	Special object

DAY 2: Preparing for field work & practicing facilitation skills			
Time	Activity & objective	Guidance	Materials
9:00-9:30 GPQU	<b>Day 2 introduction</b>	<p>Share the Day 2 agenda</p> <p><b>Explain:</b></p> <ul style="list-style-type: none"> <li>• Today we are going to start thinking more about the HAMORIS project's approach to gender, disability and power, starting with the scoping mission.</li> <li>• We will go over the approach to field work</li> </ul>	
9:30-10:30 Sabitra	Introducing additional data collection tools	Key Informant Interview and In-depth Interview (KII)	Tool Guide and Questionnaire
10:30-10:45	<b>Break</b>		
10:45-11:30 Sabitra	Introducing additional data collection tools	Continue KII	Tool Guide and Questionnaire

12:00-1:00	<b>Lunch</b>		
1.00 – 1:30 Sabitra	Introducing facilitation skills	<p>Facilitate a quick brainstorming exercise on the characteristics of good facilitation skills. Write participants’ contributions on a flipchart. These should include:</p> <ul style="list-style-type: none"> <li>• Active listening</li> <li>• Suspending judgement (make sure people know what this means)</li> <li>• Surface out the assumptions (ask questions)</li> <li>• Creating a safe space</li> <li>• Ensuring the space is accessible</li> <li>• Establishing trust</li> <li>• Asking probing questions (ask for examples of probing questions)</li> <li>• Confidentiality</li> <li>• Consent</li> <li>• Etc.</li> </ul> <p><b>Explain</b></p> <p>Facilitation skill is key for the research to explore knowledge. This is important to understand the facts, people are the source of knowledge and experiences. To understand this, value each member and provide opportunity to all to speak/communicate</p>	Flipchart, markers
1.30 – 1:45 Grishma / DPM	<b>Overview consent protocols for research</b>	<ul style="list-style-type: none"> <li>• Consent protocol (including for photos)</li> <li>• Child protection, Prevention from Sexual Exploitation and Abuse (PSEA)</li> <li>• What to do if people disclose violence</li> </ul>	
1:45 – 2:45 GPQU	<b>Practicing Facilitation Skill</b>	<p><b>GED Tool: Triad discussion : SEEKER, TELLER &amp; OBSERVER</b></p> <ul style="list-style-type: none"> <li>• Explain that we are now going to spend some time practicing the facilitation skills that we will be using during our field research.</li> <li>• Ask participants to divide into groups of three. Make sure the groups are as diverse as possible.</li> <li>• Ask participants to designate roles for each team member:</li> </ul>	Flipchart paper with Triad diagram and role written on it.



		<p>Teller: Will tell the seeker a real story about when they found themselves in a position where they felt powerless. They will describe the situation and what it felt like.</p> <p>Seeker: Will listen carefully, put judgements aside, keep the focus on the teller, avoid interruptions, ask probing questions and engage with curiosity.</p> <p>Observer: Must not speak, but just observe the interaction between the seeker and teller. The Observer watches for the following:</p> <ul style="list-style-type: none"> <li>• How well is the Seeker suspending judgment, putting his/her own stories and reactions aside?</li> <li>• Asking open-ended questions of curiosity?</li> <li>• Considering the teller is giving a gift and offering a precious treasure?</li> <li>• Not interrupting the Teller</li> </ul> <p>Tip: Ask each triad member to explain their responsibilities to ensure that they understand the activity</p> <ul style="list-style-type: none"> <li>• After the groups have assigned their roles, give the teller 7 minutes to tell their story, with questions from the Seeker throughout. After the Teller has told their story, the Observer gives feedback for 3 minutes.</li> <li>• After each round ask (5min), “How was that? How was it for the Teller? The Seeker? The Observer? What did you notice?” Tip: Ensure that people don’t share the Tellers’ stories during this plenary discussion.</li> <li>• Then switch new roles and follow the same pattern, so that each team member has a chance to practice in each role.</li> <li>• Close by asking, “How are these skills relevant for our field work this week?”</li> </ul>	
2:45-3:00	<b>Break</b>		
3:45-5:00	<b>Field Plan</b>	<ul style="list-style-type: none"> <li>• Finalize visit and field survey plan and responsible team for each district</li> </ul>	

Grishma / DPM	<b>Final clarifications &amp; logistics</b>	<ul style="list-style-type: none"><li>• Work through plan for each day of the research, or at least for the first day</li><li>• Confirm groups and the activities that they will each be leading on</li></ul>	
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**Gender and power analysis**

**Qualitative Data (Respondents' Profile)**

Date	Respondent/Organization	Number of Respondent				Comment/Observation <b>Position, age group... (how do you define respondents better ?? i.e. position, age group, who were speaking, who were silent, what the power dynamic was, way of dealing if you think this is important to reflect the attitude and behaviour of respondent, .....)</b>
		Total Female	Disable Female	Total Male	Disable Male	
<b>Total</b>						

**Key Findings; Major themes from research tools**

SN	Area of Enquiry	Stakeholder	Tool Type (FDG/KII)	Key Findings (statement with code i.e. Men_FGD_Village / Woman_KII)
1.	<b>Sexual/gendered division of labour</b>			

2.	<b>Access to public spaces and services</b>			
3.	<b>Claiming rights and meaningful participation in public decision making</b>			
4.	<b>Control over one's body</b>			
5.	<b>Aspiration for oneself</b>			

6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
1.				
14.				
15.				
16.				
17.				

**HAMORIS : Gender and Power Analysis**  
**FIELD GUIDE: Focus Group Discussion Guide for beneficiaries**  
**(Adult men and adult women)**

**HOW TO USE THE TOOL?**

Follow the steps outlined below and take notes from the discussion in the Recording Format.

Materials needed:

- Coloured cards
- Flip chart papers
- Markers
- Note book and recording template
- Camera and recording device

**WHO SHOULD BE INVOLVED?**

The focus group should involve a minimum of 4 and maximum of 15 participants. Focus group discussions should be held with women and men separately to ensure that they feel comfortable to speak freely. The focus group discussion should take 2 hours.

Focus group discussion roles:

- The facilitator makes sure everyone has a chance to speak and that the discussion stays focused
- The note-taker writes notes and takes photographs of the group (with the group's permission)
- If there is a 3rd person, this person observes what is happening and the dynamics of the group; takes photographs as needed etc.

**STEP 1: INTRODUCTION**

**Each member of the team introduces him/herself and clearly explain the purpose of the visit:**

- We are working for the implementation of HAMORIS project with aim to improve and increase knowledge of the community regarding HEALTH in this municipality.
- We would like to ask you some questions to help us make sure that our project meets your needs. Please do not be shy – there are no right or wrong answers and your opinions are very important!
- This discussion will take about 2 hours. Is this ok with you?
- **Ask participants if they have any questions.**

**STEP 2: INFORMED CONSENT**



Before starting the discussion explain the following to participants:

- All of the information that you share will be confidential. Our notes will be kept secure and we will not share personal details or personal views with anyone else. Is that okay?
- Because you will be sharing your thoughts and experiences together in a group, other people in the discussion will know what each person has said. So that other people in your community do not find out about what people in this group said, please do not talk about the details of this discussion once the discussion has finished. In this group, you should feel comfortable to speak openly. Is that clear?
- Some of the information you give me may be included in a report that will be used to design a new project to improve water, sanitation and hygiene in this district. It will not be possible from this report to identify you as individuals. Is that okay?
- Participation in the group discussion is voluntary. If you want to leave the discussion at any time, you can. After the discussion, you can tell us if you do not want us to use what you have said. You do not have to give a reason why. If you decide not to participate, we will not use any of the information you have given us unless you tell us you want us to. If there is anything you tell us that you do not want us to mention in the report, tell us and we will keep this confidential. Do you understand? Is this OK?
- If you have any complaints about the discussion, you can tell us. If you don't feel comfortable sharing your concerns with us, you or someone representing you can make contact with Grishma Bista, CARE International in Timor-Leste. Is this clear?
- Do you understand what we have told you? Can we start the discussion now?

### STEP 3: CONDUCTING THE FOCUS GROUP DISCUSSION - QUESTIONS



**Date FGD :**

**Venue :**

**Time begin:**

**Time finish:**

**Fasilitador:**

**LANGUAGE THAT USE IN FGD : (Please make a Circle)**

**1. Tetum 2. Tetum Terik, 3. Bunak 4. Bahasa, 5. Manbae, 6. Kemak**

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**Activity 1 : 24 Cloock (CITL GED Module) ( Focus on division of labour between mena and women)**

Introduction of the activity

divide participants to Two groups ( men and women)

Ask participant to prepara flipchart to write hours start from early morning until night

Facilitator will prepare coloring stone which difine each of household/ daily activity, and bring to plenary.



**Question for discussion**

Based on your idea, what are the work that mostly did by women / men?

what are the similarity and differences between men and women? Why this is ezist?

who provide this work to men and women? From where?

who did mostly and do less? Why ?

Women works get value in the community ? if yes why, it not why?

How women manage household activity and community works?

Who did women works/household/ domestic work when women participate in group meeting or community meeting?

**ose the session to thank community for their participation and time .**

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**Ativity 2: Pile Sorting ( CARE SAA tools) –**

- Introduction of the activity

- Facilitator prepare picture of men, women, and both (If we don't have picture, we can use coloring card that write men, women and both)
- Facilitator prepare statement iha the coloring cards as below; and continue to ask participant each of the statement ( mix group)

**EMENT :**

- *Go to clinic to access to the family planning*
- *Make planning and used of family planning*
- *Attend to antenatal and post natal*
- *Iniciate sex*
- *Delivery preparation*
  
- *Find information around contraception and family planning services*
- *Used of contraception*
- *Prepare nutrition food*
- *Decide to buy nutrition food*
- *Buy food at the market*
- *Feeding the baby/ kids*
- *Decide when to have baby*
- *Decide number of kinds*
- *Decide to bring kids to health post when they sick Bring kids to the clinic*

**Close the session to thank community for their participation and time**

**Activity 3: Visioning Exercise (Aspiration and strategic interests of specific groups of people )**

- Introduce visioning exercise, envisioning what we hope change looks like for the lives of women and men, (health services and SRMH )
- **BEFORE GO TO THE NEXT STEP, FACILITATOR NEED TO EXPLAIN CARE GENDER EQUALITY AND WOMEN'S EMPOWERMENT FRAMEWORK**
- Ask participants to imagine about women and kids health for 5 years coming in their aldeia ( Women can imagine their own health situation and men can imagine around women and kinds health in the future in their aldeia)

Participants will close their eyes to imagine health empowerment for women, men, boys, girls for five years coming in their aldeia/suco. What does empowerment look like for boys and girls in this new world?

Ask participants to keep in mind all that empowerment entails: change across **agency, structures and relations**. Ask them to focus on **inclusive health** issue

- Divide participant to Two groups : Men and Women
- Ask each of group to develop poster/ with pictures and words to communicate their vision of empowerment.

**Questions for discussion**

1. What are the aspirations of girls and boys that are articulated for themselves?
2. What limitations do they place on their dreams in terms of who they want to be, what they can achieve and what can change?
3. How social and culture norms affected to their aspirations? How do the environment around them changing within these aspirations or priorities?

*When finish the exercise, bring all the group to the plenary to share their imagination and ask some questions below:*

4. Based on the poster, what is the difference and similarity ?
5. What relations that influence the HEALTH establishment in your community ?
6. What is the key changing that need, to achieve HEALTH establishment in your community ?

**Focus on current situation:**

7. What are the challenges that women faced when they participate in meeting / discussion around health in their community? How you can access to the health facility and services ?
8. What are challenges for women and disable person to access to health assistance and services from the government ? How is the involvement of disable person and challenges they faced when participate in any meeting or discussion?
9. Key values, social norms, policy, tradition and custom that available in your society which not favorable to men and women in SRMH? Please provide list of health service providers in your suco/ aldeia?
10. What are the issues that discuss between men and women during pregnancy period ?  
 more:
  - Where they go for ante natal check (ANC)
  - where they want to delivery and why
  - When they start ANC and how often Mother nutrition
  - Pregnancy tradition
  - Preparation for the baby
  - Saving ( money) for emergency
  - Transportation planning to the hospital in case of emergency
11. How do you provide feedback/comment to the local governance and service providers around health issue?
12. How do you raise your ideas/ voice in the meeting?
13. Are the community encourage you to talk during the meeting ? ( how about women/ men)

**Close the session to thank community for their participation and time**

**STEP 4: ENDING THE SESSION**

**At the end of the session:**

- Give a brief summary of what has been said in case anyone has something to add
- Remind participants of the purpose of the discussion and explain how we are going to use the information – what the next steps are
- Thank participants for their time
- Check the written record has captured the main points and reflected the level of participants' involvement in the discussion.
- Check if participants have any questions
- Collect up materials

## **LONGITUDINAL STUDY INFORMATION GATHERING TEMPLATE FOR BASELINE**

### **Purpose:**

To track changes in knowledge, practices and attitudes within targeted communities, the HAMORIS project seeks to undertake a longitudinal study to measure a specific change. In the study, the HAMORIS baseline will identify one female and one male participant in Emera and Covalima. Over the life of the project, the participant will be interviewed several times to track change (midterm and endline). This is linked to the HAMORIS Monitoring Evaluation and Learning Framework (indicator 2.2)

### **What will be measured:**

The study aims to measure the change in participants' knowledge and understanding to identify social norms which hinder better SRMHR. The study will help to highlight:

1. Changes in participant's knowledge and understanding (if any) of harmful social norms which impact SRMHR (baseline)
2. Specific actions taken by participants (if any) to adopt new behaviours (baseline, midline and endline) and,
3. Benefits (if any) resulting from an increase in understanding and knowledge (midline and endline)

### **Tasking for baseline teams:**

- Identify at random one female and one male support group participant in each municipality
- Receive their permission to be a part of the longitudinal study
- Undertake interview

### **Identification of participants:**

Random sampling should be used to ensure the process is transparent. This is explained in the steps below. Here, the example of choosing a female participant in Covalima is used:

Define the population. How many participants will be involved in the MSD FDG discussion? For example, if there are 4 MSG FDGs in Covalima with 30 participants in each FDG then the total will be 120.

- Step 1: Assign numbers to each participant based on the registration list.
- Step 2: Randomly choose a number before the baseline begins. For example, Participant 22 on the registration list.
- Step 3: Select your participant.

### **Permissions:**

- You can use the CITL consent form to obtain consent. The participant should also understand:
- This is a long-term study to assist CITL to measure outcomes of the HAMORIS project. We would like to interview you in 12 months' time and then at the end of the project (May-June 2021). Are you comfortable with this?

### **Participant details:**

**Date of interview:**

**Venue :**

**Time begin:**

**Time finish:**

**Fasilitador:**

**Language(s) used: (Please make a Circle)**

**1. Tetum 2. Tetum Terik, 3. Bunak 4. Bahasa, 5. Manbae, 6. Kemak**

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**Guidance on discussion points for participants:**

We are very appreciative of your time and attendance in the meeting today. It helps us to better understand you and your community and will help to ensure we can align CARE's activities better with the needs of your community.

1. We would like to talk to you today about your experience of the culture and traditions that exist that can assist and/or prevent women from better accessing SRMH services. (*Ami hakarak kolia ho ita bo'ot kona-ba ita bo'ot ninia esperiensa liga ba iha kultura no tradisaun ne'ebe existe no prevene fetu sira atu asesu ba servisu SRMH ne'ebe diak*).
2. Based on your experience, tell me about the social practices in the community that help women to access health services. What are some examples (*for example, in some villages communities have develop their own transport networks for women to attend health services*)? (*baseia ba ita bo'ot nia esperiensa, hatete mai ami pratika social ne'ebe diak iha komunidadade hodi ajuda inan fetu sira atu asesu ba iha fasilidade saude*). Bele fo exmplu konkretu
3. What do you think the reason is for the high death rates of maternal mortality for women and children? (*Tuir ita bo'ot nia hanoin rajaun saida mak halo numeru mate ba inan no labarik sira sei a'as?*).
4. Tell me about the social norms that could have unfavourable outcomes for women or prevent them from accessing SRHM services (*for example, limited ability for women to make decisions, limited support from husbands, heavy household duties while pregnant or violence against women*). Are there any examples you can think of? (*Norma social saida mak la favorese fetu sira atu asesu ba servisu SRMH?*).
5. Tell me about the factors in the community make it hard to make changes to these social norms? (*Faktoreas saida deit mak sei difisil iha komunidadade hodi halo mudansa ba norma sosiais sira ne'e?*).
6. Tell me about the activities in the community that can help address any issues. Is there anything you or someone in your community has done to change ways of working to improve conditions and/or accessing SRMH services? (*Atividade saida deit iha komunidadade mak bele ajuda ita bo'ot sira hodi diskuti problema. Iha ema ruma kai ta bo'ot iha ita bo'ot sira nia sosiedade halo mudansa ruma hosi hadia servisu no kondisaun ba iha fornesimentu servisu saude*).
7. Saida mak ita halo atu bele tulun ita nia ferik oan bele asesu ba servisu saude?
8. Hahan saida mak ita/nia fen consume wainhira isin rua/fo susu?
9. Oinsa ita suporta ba ita nia fen durante nia isin rua?
10. Se deit mak halo servisu iha uma laran?
11. Se mak halo to'os/natar?
12. Oinsa halo desijaun iha uma laran (related to SRMH services)?
13. Karik hau bele husu ita ita nia familia uja PF?
14. Tuir ita nia hare komunidadade ita aledia ida ne'e uja mos PF? Laiha, tamba sa?

We are very grateful for your time. Thank you, I and my colleagues look forward to talking with you again in 6 months' time.