Mid-Term Review

Hamenus Mortalidade no Risku ba Inan (HAMORIS - 2017-2021)

CARE International in Timor-Leste

MTR conducted by External Consultant Julie Imron
March – June 2020

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ACRONYMS

ANC	Ante Natal Care
CHC	Community Health Centre
CITL	CARE International in Timor Leste
CSC	Community Score Card
DNSAS	Departamento Nasional Servisu Agua e Sameamento (National Department of Water and Electricity)
DPO	Disabled Persons' Organization
EoP	End of Project
FGD	Focus Group Discussion
FSG	Father Support Group
FP	Family Planning
GPA	Gender and Power Analysis
GBV	Gender Based Violence
GPQ	Gender and Program Quality
HF	Health Facility
HP	Health Post
KI	Key Informant
KII	Key Informant Interview
LFM	Logical Framework Matrix
MOH	Ministry of Health
MSG	Mother Support Group
MTR	Mid-Term Review
MUAC	Mid-Upper Arm Circumference
PLWD	People Living With Disabilities
PWD	People With Disabilities
PNC	Post Natal Care
PNDS	Programa Nasional Dezenvolvimentu Suco (National Program for Village Development)
SAA	Social Analysis and Action
SBA	Skilled Birth Assistant
SDG	Sustainable Development Goals
SG	Support Group
SRMH	Sexual, Reproductive and Maternal Health
SRMHR	Sexual, Reproductive and Maternal Health and Rights
STI	Sexually Transmitted Infections
TBA	Traditional Birth Assistant

EXECUTIVE SUMMARY

The HAMORIS project aims at contributing to lasting reductions in maternal mortality and morbidity by increasing the number of women accessing quality Sexual Reproductive and Maternal Health Services. The mid-term review of the HAMORIS project assesses the projects achievements from its inception in July 2017 to May 2020 (with the first 6 months of implementation mainly being used to design the project). The following tables present changes in value of project indicators for the two key outcomes: improves access and utilization of quality SRMHR services and improved gender relations at family and community level.

Progress achieved from Project Start to Mid-Term Stage[1]

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

Major improvement can be observed in the proportion of women giving birth with a Skilled Birth Assistant. Yet the proportion of MSG members with access and control over quality SRMH services is limited due to the proportion of women still not accessing modern contraceptives or not giving birth in a health facility. Progress related to nutritional status of pregnant women is difficult to observe given the limited amount of data available.

#	Indicator	Baseline result	Mid-term result
1.1	# of MSG members who received a minimum of ANC4 (disaggregated by ANC1)	84 women[2]	36% - 38 women
1.2	# of MSG member who received a minimum of PNC2	85 women	94% - 61 women
1.3	# of MSG member delivery with a SBA	31% - 37 women	78% - 35 women
1.4	Improvement in nutritional status among female group members - CITL: 1.2	10 pregnant women and 0 lactating women with MUAC>23.	12 pregnant women with MUAC>23
1.6	# of CHC that meet national standards for quality of care	NA	Quality of care acceptable in CHC Fohorem but undermined by limited water in Atsabe and Fatumea CHCs.
1.8	# of MSG members with access and control over quality SRMHR service	NA	56% - 34 women

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

Very significant progress is observed in men and women interest and understanding of the importance of seeking SRMH services. Use of contraceptives is the indicator for which the minimal change can be observed.

[1] All baseline and mid-term values are presented as proportions rather than numbers as suggested in Annex 3 of the report. And indicators statements in the tables here are the original statements.

[2] Baseline data doesn't indicate during which period/timeframe these 84 women (and 85 for indicator 1.2) were pregnant neither what % of all pregnant women this represents. Therefore, comparison with MTR is not possible.

#	Indicator	Baseline result	Mid-term result
1.9	# of MSG and FSG members satisfied with SRMHR services	NA	84% (122 cases)
1.10	# of MSG and FSG members utilizing modern contraceptives	37% (among MSG only)	57% (MSG only) 47% (MSG and FSG)
1.12	# of fathers and family members actively involved and providing advice in breast feeding plan	52% (48 cases)	96% (51 cases)
1.16	# of FSG and MSG members reported sharing support group education outcomes (disaggregated by sex)	27% (151 cases)	96% (146 cases)
1.19	# FSG and MSG members with knowledge of one or more modern contraceptive method	37% (104 cases)	86% (130 cases)

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

Duty bearers have responded positively to the project's efforts to engage them in providing better SRMHR services to the community (participation in CSC meetings at all levels, increased availability of medicines and SISCA activities). Yet, some key issues such as having sufficient personnel in health posts and building sufficient numbers of Health Posts are facing serious limitations linked to the government's financial resources and its ability to identify qualified human resources.

#	Indicator	Baseline result	Mid-term result
1.13	# of action plans that include SRMHR issues	9 action plans	9 action plans
1.14	Changes in responsiveness of local government to barriers of SRMHR in their communities (e.g. number of midwives/doctors, availability of medicine, frequency of SISCA)	- Increased availability of medicines and SISCA activities in some sucos. - Yet limited changes in number of health staff still undermines the overall responsiveness of local government.	
1.15	Change in baseline of the relationship between the community and service providers	- Improved relations with health personnel - but lack of human resources and limited infrastructures remain major barriers.	

Outcome 2: Improved gender relations at family and community level

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

Collected data reflects very significant changes in women's confidence to take decisions related to their Sexual and Reproductive Health Rights. Yet, data on men's support doesn't show asignificant progress. Accuracy of the collected data can be questioned here due to issues in enumerators understanding of the questions related to this indicator.

#	Indicator	Baseline result	Mid-term result
2.3	# 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	Sexual relations: 11%	Sexual relations: 76% All 3 decision making areas: 71%
2.4	# men who report supporting maternal health and safe birthing practice	62% (57 cases)	63% (32 cases)

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

#	Indicator	Baseline result	Mid-term result
2.6	# of MSG and FSG members who report joint household decision making– CITL 3.1	NA	59% (74 cases)

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

Women's participation in decision making at household level and public spaces is significant but yet far from being balanced with that of men's.

#	Indicator	Baseline result	Mid-term result
2.7	Qualitative evidence documenting changes in participation of women and PLWD in formal and non-formal decision-making spaces	- About one-fourth of MSG members holding decision making positions within the community and positive changes perceived by local leaders regarding their participation. - Still limited change observed among PLWDs, partly linked to the fact that they are not clearly identified.	
2.8	# Support FSG and MSG group members identified by community members as effective decision makers and leaders in political, economic and social forums;	NA	32% (48 cases)

Intermediate Outcome 2.4: Staff become active champions of gender equality

20% of the respondents were able to identify at least one social norm hindering women's access to quality SRMH services even though most of these specified this applied to other people in the community and not themselves as they now understand the importance adopting safe maternity and birthing practices. Yet, domestic violence was under-reported and under-estimated by a majority of respondents.

#	Indicator	Baseline result	Mid-term result
2.10 / 1.17	Qualitative evidence of changing harmful traditional practices related to girls and women's rights	Significant increase in knowledge of the importance of using SRMH services which has a direct impact on the proportion of women using safe birthing practices and of men supporting their wives to do so. Yet, acceptance of domestic violence still persists among a third of the beneficiaries.	
1.21	# of MSG and FSG members with knowledge of one or more social norm which hinders better SRMHR outcomes	NA	20% (27 cases)

CARE's 2020 Global Indicators

#	*Indicator*	*Baseline result*	*Mid-term result*
1	Demand satisfied for modern contraceptives among women aged 15-49 (SDG indicator 3.7.1)	NA	62% of health personnel and 84% of MSG members believe demand is met
2	Proportion of births attended by skilled health personnel (SDG indicator 3.1.2)	31%	78%
3	Adolescent birth rate (disaggregated by 10-14; 15-19 years) per 1,000 women in each age group (SDG indicator 3.7.2). Proxy indicator: Age at first delivery.	NA	At least 44 cases of adolescent births (15-19) in HAMORIS target health facilities since 2017.
4	Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (SDG indicator 5.6.1)	Sexual relations: 11%	Sexual relations: 76% Overall: 71%

Summary of recommendations

1	**Improved access to quality SRMH services**
(a)	Continuous advocacy to MoH to increase the number of health staff
(b)	Identify partner organizations to fill the gap in health infrastructure, including for (1) building Health Posts and staff housing; (2) access to water; and (3) providing for free second-hand medical equipment in good state.
(c)	Expand awareness raising on SRMH outside Support Groups through: (1) role models by leading MSG members; (2) training the PSF working in remote areas on SRMH activities; and (3) working with local radio channels to broadcast information on SRMH, interviews of Beneficiaries, success stories, etc.
(d)	Increase men support to their wives for using SRMH by identifying male role models who will participate in occasional events to share their experience with other men.
(e)	Increase information / awareness raising on male contraceptive (condom), especially during education sessions, as an alternative to female contraceptives when needed.
2	**Effectiveness of the Support Group approach**
(a)	Conduct some education sessions separately for FSGs and MSGs in order to enable discussing more openly specific or sensitive topics among men or women only.
(b)	Increasing men participation in FSG meetings by (1) inviting them officially; (2) setting meetings when men are more available (evenings, dry season); (3) men only meetings
(c)	Inviting health personnel during education sessions. For instance midwives to explain what happens during an ANC visit or a birthing, followed by questions and answers.
(d)	Targeting young men and women: (1) specific education sessions aimed to reduce adolescent birthing; (2) short interventions on contraception in high schools.

3	**Effectiveness of the CSC approach**
(a)	Advocate to MoH for prioritizing the action points in suco action plans which will best serve the objectives of the project. Use alternative ways: (1) mobile clinics; (2) rotating health staff; (3) community contribution for building health facilities / housing.
(b)	Regular reporting to communities on progress achieved: (1) having quarterly or 6-monthly progress meetings at suco level; (2) having some CSC meetings at aldeias.
(c)	Increasing women participation in CSC meetings at suco level: (1) use locations closer to communities; (2) provide children food incentives; (3) use official invitations.
(d)	Ensuring completeness of participants at each CSC meeting: invite well in advance the health authorities and local leaders, as well as health staff from local health posts.
4	**Effectiveness of the SAA process and promoting gender balance**
(a)	Increase socializing of Gender-Based Violence law: (1) work with the community police; (2) organize night events/short movies; (3) work with traditional/religious leaders
(b)	Involving religious and traditional leaders in Support Groups and during SAA sessions
(c)	Socializing the results of the GPA by organizing attractive events (theatre shows, or small movies) where the results of the 2018 GPA study could be socialized
(d)	Organizing awareness raising events around gender roles and SRMH, for instance short theatre sessions about daily family situations, written and played by local troupes.
5	**Inclusion of Persons Living With Disabilities (PLWDs)**
(a)	Pursue project efforts to identify PLWDs in HAMORIS target areas. Collaborate with local authorities to identify PLWDs based on the Washington Questions group.
(b)	Conduct project activities at aldeia level to ease PLWD participation and invite them.
(c)	If small theatre shows are developed, include messages on PLWDs inclusion
(d)	Conduct a case study to better understand PLWDs' specific needs in terms of SRMH services and their current access and use of SRMH services.
6	**Sustainability of Results**
(a)	Systematically involve health authorities into project activities so as to reinforce their engagement with the community and strengthen the trust of community in them: (1) have HPs/CHCs medical staff intervening during education sessions; (2) systematically invite all health personnel from HPs to CSC meetings at municipal and national level; (3) have them participating in local radio broadcasts, including health staff interviews and presentations. In return, provide CARE support for mobilizing Support Group members whenever local health authorities are organizing events (e.g. vaccinations).
(b)	Coordination with local leaders: systematically involve local leaders (both Chefe Suco and Chefe Aldeia) into all the activities implemented by CARE at suco and aldeia level.
(c)	Monitor progress made by MSG and FSG in relation to their engagement actviities and provide additional support to the weakest groups.
(d)	Promote active involvement of the PSF in each Support Group from now on and use them as a way to link groups with health personnel from nearest HPs.

1. Introduction

The HAMORIS project aligns with the first working area of CITL "Women and Girls in Rural Disadvantaged Areas" Program, which is: "Improving women's sexual, reproductive and maternal health, and rights, including access to supervised delivery and family planning". It also builds on the previous ANCP Safe Motherhood Project (2015 – 2017).

The 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 maternal health services. Two major outcomes derive from this: (1) Improved access and utilization of quality Sexual, Reproductive and Maternal Health (SRMH) services by men and women; and (2) Improved gender relations at family and community level. Under the first outcome, the project has also implemented a number of engagement activities with group members to reinforce the group cohesion as well as increase household income and knowledge on nutrition.

This DFAT-funded project was launched in July 2017 and has very recently been extended until June 2022. The first year of the project was mainly used to launch new groups of beneficiaries and revise the project Logical Framework Matrix (LFM) and detailed strategy. A Baseline Survey combined to a Gender and Power Analysis was conducted in mid-2018.

This Mid-Term Review aims to assess the progress of project activities since its start, using the Baseline and Gender and Power Analysis as markers, and provide recommendations to inform the future direction of the project.

2. Methodology

2.1. Evaluation approach

The main purpose of the MTR is to assess the progress of project activities from July 2017 to May 2020 (using the 2018 Baseline and 2018 Gender and Power Analysis as a marker) and provide recommendations to inform the future direction of the project. More specifically, this MTR is meant to:

- Identify challenges affecting progress and provide recommendations to address them.
- Identify opportunities to increase impact and enhance the project implementation.
- Assess the mainstreaming of cross cutting issues such as Gender Equality and Disability Inclusion.
- Orientate strategies and activities towards sustainability of results.
- Evaluate the contribution of the project towards the CITL's long term outcomes and the CARE international 2020 indicators.

To address these objectives, the MTR employed a mixed methods approach to data collection with part of the information being collected from primary sources and others from secondary sources. Secondary sources include project documents (project design document, annual reports, activity monitoring reports, baseline report, and Gender and Power Analysis report) as well the project's monitoring sheets and reports. Primary sources include data collected from

beneficiaries (interviews with MSG and FSG members) and project stakeholders at local and municipal level (Key Informant Interviews). Both quantitative and qualitative data was collected.

A reflection meeting was then facilitated with (1) the data collection team to cross-check some of the data analysis results, as well as with (2) a working group from CITL to reflect on the project achievements and implementation strategy.

Findings were structured to reflect the Key Evaluation Questions defined in the ToRs of the MTR (see **Annex 5**). Recommendations were finally structured around the project's key outcomes and main approaches used in the HAMORIS project.

2.2. Sample

The HAMORIS project covers 44 aldeias with one Mother Support Group (MSG) and one Father Support Group (FSG) per aldeia and 15 members in each group. The total number of MSG/FSG members for the whole project is therefore 1,320. The target project area also covers three Community Health Centres (CHC) and six Health Posts (HP). The number of interviewed beneficiaries and stakeholders from local government and health facilities were as follows:

Table 1. Number of interviewed beneficiaries and stakeholders

Category of respondent	*Details*	*Total target number*	*Actual number of respondents*
MSG/FSG group members	✓ 149 MSG members ✓ 149 FSG members	289	152 (96 MSG/56 FSG)
Local leaders	✓ 10 local leaders such as Chefe Suco and Chefe Aldeia or their representatives (one per target suco) ✓ 3 Administrators of Administrative Posts	13	13
Key Informants form health sector	✓ 6 health staff from the 6 target Health Posts ✓ 3 CHC Coordinators from the 3 target CHCs ✓ 3 Head of Reproductive Health Division at Administrative Post level ✓ 2 Head of Municipal Health Office ✓ 2 Head of Primary Health Department at Municipal level	16	15[3] .

The initial target of 289 FSG and MSG members to be interviewed corresponds to a sample size with 5% of error margin and 95% level of confidence[4]. Yet this target couldn't be reached as seen above. Indeed, due to the Covid-19 pandemic, the State of Emergency was declared in Timor-Leste just before starting data collection. The data collection team was then unable to travel to target sucos and all interviews had to be conducted via telephone. This significantly impacted on their ability to reach the number of respondents planned as not all respondents had access to a telephone or network. This reduced sample has then corresponded to a 7.5% error margin.

MSG and FSG members covered overall 20 groups randomly selected from all the 10 target sucos (1 MSG and 1 FSG per suco). The list of selected aldeia is provided in **Annex 1**.

[3] The Head of the Reproductive Health Division in Fohorem was contacted but asked to postpone the interview and finally wasn't reachable anymore.

[4] http://www.raosoft.com/samplesize.html

2.3. Data collection

Data collection was conducted electronically using the Open Data Kit collection system. Three questionnaires were used: 1 for MSG/FSG members, 1 for health Key Informants (KI), and 1 for local leaders. Questions were tailored to provide information on project indicators, identify constraints/challenges encountered over the course of the project and finally collect feedback on how to improve project implementation and increase its potential impact. Details on data collection tools are presented in **Annex 2**.

A one-day online training was conducted to train the enumerators in the use of these three questionnaires, followed by a piloting of questionnaires and a debrief session. Questionnaires were reviewed several times to include observations made during the piloting.

Data has been collected during 8 days, by a team of 12 enumerators (5 women, 7 men), of which most are part of the HAMORIS project team. To help respondents feel comfortable during the interviews, only women interviewed MSG members and men interviewed FSG members. Given the unusual situation related to the Covid-19 outbreak, data collection could not be conducted in the field directly but had to be done remotely, via telephone only.

As the questionnaire for MSG/FSG members included some very personal questions which could be uncomfortable to answer while being in a family environment, participants were always informed before each sensitive question and could decide whether they agreed to answer or not. If not, the sensitive question was skipped. Note that only few respondents refused to answer these questions.

2.4. Data cleaning and analysis

Data cleaning was done during the data collection period itself, which fastened the overall survey implementation. Note that 1 interview with an FSG member was removed from the overall sample as the interview had to be interrupted at an early stage. Data analysis was then conducted mainly using the SPSS (statistical analysis) and MS Excel softwares. Simple statistical tests (Chi-Square) were conducted to assess if differences between respondents were statistically significant. Whenever this was the case, it is noted in this report.

A reflection meeting was facilitated with CARE staff and the data collection team, so as to more deepen some of the MTR's finding. Feedback from this reflection meeting is also included in this report.

In order to provide a better understanding of the progress achieved by the project, most values related to project indicators are presented in the form of percentages instead of numbers (even though most statements for project indicators refer to a number).

2.5. Limitations

- The Covid-19 outbreak in Timor-Leste started just before actual data collection started. The whole study then was delayed and had to be adjusted to fit the new context: questionnaires had to be shortened, training had to be done online, interviews had to be conducted only via telephone, the initially planned Focus Group Discussions with FSG/MSGs were cancelled, and the questions which were part of these discussions were switched into the questionnaire used for MSG/FSG members.

- Conducting interviews by phone was very challenging:

  (1) Many respondents had poor network connections, which could cause interruptions in the interview.

  (2) Respondents had more difficulty to understand the questions, resulting in a longer duration of the interviews (up to 1 hour).

- Respondents were answering questions while they were in their family environment, a situation which had a number of consequences:

  (1) Women especially often had to interrupt the interview for a few minutes to take care of children or to do their housework.

  (2) As questions included sensitive points related to Sexual and Reproductive Health, domestic violence or relation between husbands and wives, it was more difficult for respondents to answer sincerely while still being in their house. Yet, respondents were always given the opportunity to reject some questions in order not to put them in a difficult position.

  (3) The unusual positive feedback from most respondents on questions related to men's support to their wives for example can be questioned for the same reason.

- The limited quality of the data presented in the HAMORIS baseline report makes it difficult to make conclusions on progress achieved since the start of the project. Indeed, quantitative project indicators are in significant number; however, the baseline information is often qualitative only. More over both the sources and data collection tools, which were used during the baseline are not clearly identifiable. Significant issues related to the overlap between the implementation of the Gender and Power Analysis and the baseline survey (team unclear on the data collection tools to use for each research) apparently explains why only few indicators could be addressed in the baseline report.

- A number of indicators required to extract information from project monitoring sheets (MSG/FSG profile sheets, pregnancy sheets, nutrition sheets, participant lists). Yet, these monitoring documents actually proved to lack clarity and completeness. Whenever possible, the data extracted from the MTR interviews will be presented instead. Recommendations for how to conduct clearer monitoring of the project outputs has been provided as part of this MTR (see **Annex 3**).

- A number of project indicator statements actually lacks precision (not being "SMART"[5]) which brought vagueness on the way data should have been collected and presented. Suggestions are provided in this report in order to better define such indicators (see details in **Annex 3**).

- Lastly, the team who collected the data was not external to the project, which could create some bias in the results. Yet, the MTR consultant insisted that enumerators should be allocated only to locations where they do not usually work and this condition was respected by the MTR team.

[5] SMART = Specific, Measurable, Achievable (or Attainable), Relevant, and Time-bound

3. Presentation of MSG/FSG members

As presented in ***Table 2***, 86% of the respondents are in reproductive age and therefore could provide an interesting feedback on most questions related to the Sexual, Reproductive and Maternal Health and Rights (SRMHR). It is to note that 21% of FSG members are above 49 years old, which is perhaps not an ideal target group for the project as these men are less likely to be in need of project inputs. Yet, they can help in disseminating/advocating project messages as some of them are holding lead positions in the community (lia nain, local leader).

Table 2. Presentation of interviewed MSG/FSG members

Description	*MSG*	*FSG*	*Total*
Overall	96	56	152
LOCATION			
Covalima	**74**	**43**	**117**
Fatumea	*21*	*17*	*38*
Fohorem	*53*	*26*	*79*
Ermera	**22**	**13**	**35**
Atsabe	*22*	*13*	*35*
Age			
- Average age	34	41	37
- Proportion of respondents in reproductive age (15-49)	91%	79%	86%
Respondent's status			
- Married	77%	96%	84%
- Single	7%	4%	6%
- Widow	6%		4%
- Divorced	9%		6%
Number of People with Disabilities (PWD)[6]	2	1	3
Respondent is the Head of Household	15%	95%	44%

Note that 21% of these group members have joined the Support Groups in 2019 or early 2020, which means the project had significantly less impact on these persons. For some of the results presented here, disaggregation by "old and new members" will be presented: "old members" meaning they joined support groups in 2017-18 while "new members" joined in 2019-20.

This sample also include 18% of members who are holding key positions within the groups (25 community mobilizers, 2 vice-group leaders and 1 treasurer).

Note that only 3 PWDs could be reached for this MTR which severely impacts on the ability for this review to get a better understanding of the project's impact in terms of disability inclusion and to provide recommendations accordingly.

[6] PWDs had difficulties seeing and/or hearing. All of them were 50 years old or more.

The following presents general questions asked to Support Group (SG) members on their participation in the group:

Table 3. Participation of Support Group (SG) members in meetings and Levels of satisfaction (MTR)

Description	*MSG*	*FSG*	*Overall*
How frequently do you join meetings?			
Always	64%	46%	57%
Sometimes	23%	45%	31%
Rarely	14%	9%	12%
How much are you satisfied of being a member of this group?			
Very satisfied	31%	29%	30%
Satisfied	67%	68%	67%
Neutral	1%	4%	2%
Not satisfied	1%	0%	1%

[Answers collected from 96 MSG and 56 FSG members.]

The proportion of satisfied and very satisfied Support Group members is very high which is a very positive outcome of the project[7]. Note that the participation of women in meetings is significantly higher than that of men. This suggests that some men might feel less engaged in the project activities. The detailed information presented in Chapter 3.3 actually provides further information on this aspect.

[7] Only 1 MSG members reported being unsatisfied because she wasn't involved in engagement activities and didn't receive compensation when attending meetings.

4. Findings

4.1. Improvement in access and use of SRMH services

This section assesses the progress achieved for the first project outcome: "Improved access and utilization of quality SRMHR services by men and women". This includes family planning, Ante-Natal Care (ANC), Post-Natal Care (PNC) and Safe Birthing.

4.1.1. Number of SG members utilizing modern contraceptives - indicator 1.10

As presented below, the project had significant impact already on the proportion of members utilizing modern contraception methods: increase from 37% to 57% among MSG members. This is also reflected in the difference in proportion of users among recent and older group members (significantly higher among older members). Awareness raising on family planning from the project (education sessions, group meetings) but also from the government definitely contributed to this evolution.

Table 4. Proportion of MSG/FSG members using modern contraceptives (baseline and MTR)

Description	*Proportion*	*Valid cases*[8]
Baseline (among MSG only)	37%	
MTR		
MSG	57%	92
FSG	20%	35
Overall	47%[9]	127
- Remote aldeias	39%	65
- Accessible aldeias	57%	62
- Old group members	55%	101
- Recent group members	15%	26

The overall proportion of members utilizing modern contraceptives among the only persons of reproductive age is 56% (74% among women, 21% among men).

When asked why they didn't use contraception, most married women of reproductive age explained that they were pregnant or were hoping to become pregnant. As for men, most respondents explained that their wives are the ones using contraceptives, or that they didn't know where to find male contraceptives (condoms). Some also expressed negative feelings related to men using contraceptives: as culturally not accepted, uncomfortable and/or inappropriate for men.

[8] The Valid cases column shows the total number of cases among which the presented proportions are calculated.

[9] This proportion might be slightly overestimated as a number of respondents during the first days of data collection could have meant that they used "natural contraception", not modern contraceptives.

4.1.2. Number of MSG members who received a minimum of ANC4 (disaggregated by ANC1) - indicator 1.1

Mid-term data was sourced from the project's pregnancy monitoring sheets. Among 107 pregnant MSG members recorded in those sheets, 38 were reported as having received 4 ANC check-ups, thus 36% of all pregnant women[10]. Note that these are pregnancies, which occurred since the project started.

The baseline report mentions that out of 187 MSG members surveyed, 84 received a minimum of ANC4. Yet, such data is difficult to interpret as it is not presented in the form of a proportion among all pregnant women and doesn't indicate the timeframe used to collect this data (i.e. any pregnancies before the baseline was conducted or among the last year only for example).

Therefore, it is not possible to make conclusion on whether women are more often accessing 4 ANC visits at mid-term than at baseline stage.

4.1.3. Number of MSG members who received a minimum of PNC2 (disaggregated by ANC1) - indicator 1.2

Similar concerns apply for this indicator. Mid-term data sourced from the project's pregnancy monitoring sheets suggests that overall, 61 women received PNC2 out of 65 women who had given birth since the project started. Thus 94% of the women having delivered since the project stated have been able to access at least 2 PNC visits.

And baseline report mentions that out of 187 MSG members surveyed, 85 received a minimum of PNC2.

4.1.4. Number of MSG members delivery with a Skilled Birth Assistant (SBA) (disaggregated by health facility/Home/Private Place) - indicator 1.3

Very significant progress has been achieved in the proportion of MSG members giving birth with the assistance from a Skilled Birth Assistant (SBA): from 31% at baseline stage up to 78% at mid-term stage.

Most of the women who reported not being assisted by a SBA since the project start explained that they were unable to access a health facility on time (far, night time) or were unable to call a midwife to come to their place. Very clearly, the project's education sessions on safe birthing practices were convincing to most MSG members as none of them reported giving birth with a Traditional Birth Assistant (TBA) by personal choice.

[10] It is very likely that these sheets underreport the total number of MSG members who have been pregnant since the beginning of the project given a much smaller sample as the MTR sample (96 women interviewed) already included 49 MSG members who have been pregnant since the project started.

Table 5. Proportion of MSG members delivering with an SBA (baseline and MTR)

Description	*Proportion*	*Valid cases*[11]
Baseline	31%	118
MTR	78%	45
- Births in health facility	100%	31
- Births at home/private place	29%	14
- Remote aldeias	74%	19
- Accessible aldeias	81%	26

This significant improvement was also reflected during interviews with Key Informants from the health sector who mainly explain this result by the increased access of communities to useful information through the SISCAs (Integrated Community Health Services) and HAMORIS project activities. The Chefe Divisaun Saude Reprodutiva in Atsabe even reported that the TBAs themselves are now advising pregnant women to go to a health facility to give birth.

Yet, feedback from some MSG members[12] revealed that, outside MSGs, some families still prefer to give birth with the local "Liman Badaen". This most likely concerns a small proportion of the community being more traditional.

4.1.5. Number of improvements in nutritional status among female group members – indicator 1.4

To improve nutritional status of women, the project has facilitated education sessions in Support Groups about nutritional needs of pregnant and lactating women as well as organized a cooking competition. Such innovative events are definitely interesting to draw women's attention on the importance of balanced nutrition for themselves and their families. Note that the cooking competition which was held on International Women's Day also involved men in order to draw participants' attention on joint household responsibility.

In terms of data to measure the impact on pregnant and lactating women, the MTR faced significant issues to observe improvements as the baseline and mid-term results are very limited for this indicator. Thus, no conclusion can be made regarding an improvement in pregnant women's nutritional status, even though the above activities most likely helped increase women's understanding on nutritional aspects.

The baseline study reports that 7 women (among 10 pregnant women) had a Mid-Upper Arm Circumference (MUAC)[13] of more than 23 and 3 others had similar MUAC but still presented risks of malnutrition.

As for the mid-term stage, only the data from the project nutrition monitoring sheet was available. Comparison was possible for only 12 pregnant women in Fatumea: MUAC measures increased between August 2019 and January 2020 for 7 women and stayed the same for the 5 others. All 12 women had MUAC of more than 23 in November 2019 (last data available).

[11] Number of births since the project start

[12] 8 cases including 3 in Suco Dato Rua.

[13] The Mid-Upper Arm Circumference (MUAC) is the circumference of the left upper arm, measured at the mid-point between the tip of the shoulder and the tip of the elbow. MUAC is used for the assessment of nutritional status for children and adults

4.1.6. Number of MSG/FSG members satisfied with SRMH services – indicator 1.9

During the MTR data collection, group members were directly asked how much they were satisfied with SRMH services. Note that baseline data was not collected for this indicator.

As shown below, the proportion of satisfied beneficiaries is overall very high: 84% of satisfied members, including 21% of "very satisfied" persons.

Table 6. Proportion of MSG/FSG members satisfied with SRMH services at mid-term stage (MTR)

Description	*Proportion*	*Valid cases*
Overall (MTR)	84%	146
- MSG	77%	91
- FSG	95%	55
- Remote aldeias	87%	71
- Accessible aldeias	80%	75

The reasons for not being satisfied were primarily linked to the difficulty to meet medical staff (15 cases) and the difficulty to access health facilities because of poor/no transportation and road access (11 cases). These respondents explained that there is not enough medical staff or if they are enough, they do not stay in the area where they are supposed to work or are not active enough. Five respondents also expressed their concerns related to the limited availability of medicines (contraceptives, anesthetises and/or vaccines), while three reported poor sanitary condition of health facilities.

This was also reflected in the Community Score Card (CSC) satisfaction survey the project team conducted in January 2020 among 94 participants across the project target area: 23% only believe the number of medical staff in Health Posts was sufficient (but 100% in Community Health Centres), 46% said their community could access a health facility in their suco (none in Atsabe) and 68% believed there are enough medicines in the health facility they are using.

4.1.7. Number of fathers and family members actively involved and providing advice in breast feeding plan – indicator 1.12

The proportion of FSG members sharing information on breastfeeding has increased drastically since the start of the project (from 52% to 96%) which reflects the very positive impact of the project's education sessions on men's understanding of the importance of breastfeeding. The use of IEC material messaging on breastfeeding (video featuring Timor-Leste's hero Xanana Gusmao) has also most likely drawn the attention of most male beneficiaries.

It is possible that the proportion at mid-term stage is overestimated as the beneficiaries often tend to respond positively to such questions. Yet, it is undeniable that participation of men in education sessions can only increase their understanding on the topic. The project's approach to have the same range of topics discussed within MSGs and FSGs is definitely one of the keys to ensure better understanding and support between husbands and wives.

Table 7. Proportion of FSG members sharing information on breastfeeding (baseline and MTR)

Period	*Proportion*	*Valid cases (FSG members)*
Baseline	52%	92
MTR	96%	53

Among the 53 FSG members who answered to this question, 44 reported that their wives have been breastfeeding since they became members of the FSG. All of them explained that they supported their wives during this period: giving them nutritious foods (20 cases), helping them with house chores (28), taking care of children (9), etc.

4.1.8. Evidence of change in baseline in the broader community in attitude and/or behaviour regarding harmful traditional practices – indicator 1.17

There is clear evidence of change in attitude and behaviour regarding harmful traditional practices between the baseline and project mid-term.

Firstly, the figures on actual birthing practices at baseline and mid-term stage show clear improvements among MSG members: from 31% up to 78%. Men also support their wives in attending health facilities and personnel for birthing, as reflected in the following table.

The majority of key informants also perceived this difference[14] and explained that this change of attitude is directly linked to the community's increased knowledge of the importance of using health services during birthing (project's education sessions, awareness raising from SISCA/health personnel). Women also have higher trust in health personnel and are less shy to be attended by a male doctor. Negative experience of birthing at home in the community also raised women's concerns on the risks.

Yet, several key informants also highlighted that some parts of the communities still have very limited access to health personnel and have no choice but to use TBA (Nanu Health Post, local leaders of Belulic Leten, Obulo and Fatumea).

Table 8. Support Group members' perception on statements related to harmful practices (MTR)

#	Item Description	Agree		Neutral		Disagree	
		MSG	FSG	MSG	FSG	MSG	FSG
1	It is better for a woman to give birth at home than in a health facility.	10%	9%	2%	5%	88%	86%
2	It is better for a woman to give birth with a traditional birth assistant than with a SBA.	7%	2%	1%	9%	93%	89%
3	There are times a woman deserves to be beaten.	23%	15%	7%	7%	71%	78%
4	If a married woman has been beaten up by her husband, it is okay for her to tell others.	58%	41%	3%	22%	39%	37%
5	If a husband beats up his wife, other people should intervene.	62%	33%	5%	30%	34%	37%
6	The husband (or his mother) should be the one deciding when to have children (spacing).	18%	15%	4%	24%	78%	62%

As evidenced by Asia Foundation's project ***Nabilan*** (DFAT-funded), intimate partner violence in Timor-Leste is among the highest in Asia. The Timor-Leste Demographic and Health Survey conducted in 2016 also showed high prevalence rates and proved that most women do not seek help from formal services.

[14] 52% and 71% respectively perceived a lot of change in the community's attitude related to (1) birthing in a health facility instead of home and (2) birthing with a SBA instead of a TBA. Others only perceived "little change" and 1 no change at all.

In this context, it is not surprising that feedback from Support Group members (statement 3, 4 and 5 of the above table) shows that there is still a significant proportion of persons believing women sometimes deserve to be beaten (23% of women and 15% of men). And about one third of MSG and FSG respondents do not think it is acceptable for beaten women to tell others about it or for others to intervene. Clearly, domestic violence remains a taboo in some areas. About half of the key informants believe there is only little change in this regard and only about one-fifth observed a lot of change. They explained that the community now understands that domestic violence is illegal and that husbands and wives should support each other. Yet, the Chefe Suco of Belulic Leten also recognized that there has been no change with regards to domestic violence since the project started but that this was mainly linked to poor economic conditions.

Lastly, baseline data highlighted how men sometimes hold a higher decision-making power as to how many children to have and the spacing between children. Part of this is being supported by the fact that the men's families are paying a dowry. Such practices still persist among a small proportion of the community as they are linked to deeply rooted cultural believes: only 78% of MSGs and 62% of FSG members disagreed that the husband should be the one deciding on children spacing (statement 6). However, all key informants believed that decision making within families is more balanced than before. The Coordinator of the CHC in Atsabe pointed out that women will systematically ask to their husbands if they want to use contraceptives. And in specific locations where the Kemak culture is more deeply rooted, men have more decision-making power (Chefe Suco of Obulo).

4.1.9. Number of MSG and FSG members with knowledge of one or more social norm which hinders better SRMHR outcomes – indicator 1.21

In order to assess this aspect, the Support Group members were asked if they knew of any norms/culture/traditions which could be barriers for women to access SRMH services. This question was complicated for many respondents and could have been misinterpreted in some cases. Note that baseline data had not been collected for this indicator.

Table 9. Proportion of SG members knowing at least one social norm hindering SRMH (MTR)

Description	*Proportion*	*Valid cases*
Overall (MTR)	20%	136
- MSG	10%	91
- FSG	40%	45
- Remote aldeias	23%	65
- Accessible aldeias	17%	71

Overall, only 20% of respondents who answered to this question reported knowing about the existence of such norms. This is probably underestimated due to some misunderstanding of the question. Yet, it does reflect the impact of the project's SAA approach used during specific education sessions where members are brought together to reflect on these social norms.

Most commonly stated social norms / cultural believes mentioned by the respondents were:

- ✓ To prefer birthing with a TBA or to still seek services from a TBA prior birthing in a health facility. (8 cases)
- ✓ The existence of prohibited foods during pregnancy or breastfeeding. Yet, such believes do not necessarily contradict the use of quality SRMH services. (8 cases)

- ✓ The use of traditional medicines. (7 cases)
- ✓ The fact that women are not comfortable giving birth with a male doctor (or their husbands not allowing them to do so). (5 cases)
- ✓ Believing use of contraceptives can cause permanent infertility. (4 cases)
- ✓ Magical believes around pregnancy. (3 cases)
- ✓ General belief in tradition rather than health services (uma lisan). (3 cases)

4.2. Improvement in gender relations at family and community level

This section assesses the progress achieved for the second project outcome: "Improved gender relations at family and community level". This includes reflection on men support to their wives when accessing SRMH services and on participation of women in household and community level decision-making schemes.

4.2.1. Number of MSG members aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care – indicator 2.3

Baseline data for this indicator is available only for the first type of decision-making: 11% of the 187 MSG members reported making their own decision on sexual relations. This proportion has significantly increase at project mid-term stage with 76% of women making such decisions. Yet it is unclear how the data was collected during the baseline and this important difference could also be caused by different data collection methods.

Table 10. Proportion of MSG members in reproductive age making decision on sexual relations, contraceptives and reproductive health care (baseline and MTR)

Description	*Proportion*[15]	*Valid cases*
Baseline (sexual relations only)	11%	187
MTR		
Overall	71%	61
- Remote aldeias	77%	26
- Accessible aldeias	66%	35
By type of decision:		
- Sexual relations	76%	61
- Use contraceptive	91%	61
- Use reproductive health services	92%	61

The project seems to have achieved very positive results at mid-term stage. Yet, it is likely that these figures do not actually reflect the complexity of the decision-making power mechanisms on these topics within the families.

[15] Proportions include women who reported making decision alone or together with their husbands.

4.2.2. Number of men who report supporting maternal health and safe birthing practice – indicator 2.4

FSG members' perception on each of the following safe maternal and birthing practices was collected: ANC, PNC, delivery preparation, birthing in a health facility and birthing with an SBA. Only the men supporting their wives in using all practices were considered for this indicator.

Table 11. FSG members reporting supporting their wives in safe maternal and birthing practices (baseline and MTR)

Description	*Proportion*	*Valid cases*
Baseline	62%	92
MTR		
Overall	63%	51
- Remote aldeias	59%	27
- Accessible aldeias	67%	24
By type of service:		
- Ante-Natal Care	98%	56
- Post-Natal Care	98%	55
- Delivery preparation	100%	54
- Birthing in a health facility	100%	55
- Birthing with a SBA	61%	54

Overall, there is no significant change between the baseline and MTR results. Men's support was significantly less regarding birthing with assistance from a SBA. Yet, this question might have been misinterpreted by some FSG members: in theory, they support the idea that their wives give birth with a SBA, but in practice, if a SBA is not available, their wives would have no choice but to give birth with a TBA. Thus, the overall proportion of men supporting maternal health and safe birthing practices at mid-term stage could be higher than 63%.

Men's support is also reflected in women's answers to the questions on access and control over SRMH services (indicator 1.8). Indeed, most women who have been pregnant since the start of the project declared that they were able to access to all basic SRMH services, and the decision to access these services was taken together with their husband. All MSG members also reported that their husbands supported them during pregnancy, delivery and after delivery by either helping them with housework (54 cases), or by taking care of children (22).

In 2018-19, the project has facilitated SAA activities with more than 1600 MSG/FSG members[16]. During these activities, women and men developed action plans to encourage more equitable household chore sharing. The impact of these activities is very much reflected in respondents' answers.

Interestingly, the project team itself is also starting to observe behavioural change among FSG members who are participating in Social Analysis and Action (SAA) activities. It was noted that Project Officers have received strong capacity building on gender balance and SAA facilitation skills. Most of the Project Officers have now been facilitating SAA sessions for 3 years and their capacity has been built on experience from the previous project.

[16] 2018-2019 ANCP Performance report.

4.2.3. Number of MSG and FSG members who report joint household decision making – indicator 2.6 & CITL 3.1

Five aspects of the household decision-making were assessed for this indicator: making big expenses, selling animals (big and small), spending money for ceremonies and deciding how many children to have. Overall, 59% of the 126 respondents who answered these questions reported that husband and wife share decisions on each of these 5 points. This proportion was slightly higher among FSGs: 63% vs. 56% among MSGs.

As shown below, decisions which are less commonly shared between husband and wife are: (1) making big expenses (mainly men); and (2) selling small animals (mainly women). Even though the baseline data do not include quantitative results for this indicator, it does explain that selling small animals can indeed be decided by women and that the sale of bigger animals is rather a joint decision.

Table 12. Sharing decision –making in households on 5 types of decision (MTR)

Description	*Husband alone*	*Wife alone*	*Joint decision*	*Valid cases*
- To make big expenses:	12%	5%	83%	125
- To sell big animals:	8%	1%	91%	127
- To sell small animals:	3%	15%	82%	127
- To spend money for traditional ceremonies:	8%	6%	87%	127
- The number of children to have:	5%	4%	91%	125

Note that, among the 111 respondents who said husband and wife are sharing the decision on the number of children to have, 14% also agreed that it is the husband (or his mother) who should decide on the spacing between children. This reveals the complexity of such questions and questions how sincerely respondents can answer to them.

4.2.4. Number of FSG and MSG members identified by community members as effective decision makers and leaders in political, economic and social forums – indicator 2.8

To assess this indicator, group members were asked if they were holding specific positions within their communities (in the suco council, municipal government or other key areas in the village such as the school, church or CARE Support Groups).

Table 13. MSG and FSG members holding decision-making positions within their community (MTR)

Description	*Proportion*	*Valid cases*
Overall	32%	152
- MSG	23%	96
- FSG	46%	56
- Remote aldeias	21%	75
- Accessible aldeias	42%	77

As a result, 32% of the interviewed group members reported holding such positions. This proportion is significantly lower among women, as they are less involved in activities occurring outside the house. Yet, when FSG members were asked if their wives were also holding a specific

position within the community, the only 5 FSG members who answered positively (their wives were youth representatives, Delegates in Suco Council or worked in a Health Post) also reported that their wives were members of a MSG. This could suggest that MSG members are more likely than other women in the community to take part in the suco life and development.

Note that no data was reported in the baseline study for this indicator.

The most common positions were: Chefe Aldeia, Delegate in the Suco Council or MSG/FSG Mobilizers. The MTR sample included an important proportion of MSG/FSG Mobilizers as they were more likely to have access to a telephone. For this reason, the overall proportion for this indicator might be slightly overestimated[17].

4.2.5. Qualitative evidence of changing harmful traditional practices or a change in attitude or practices related to girls and women's rights (including violence against women, household and community's decision making relating to SRMH). – indicator 2.10

This indicator is similar to indicator 1.17 discussed earlier.

4.3. Contributing to better quality of health service outcomes

This section discusses the project effectiveness in terms of enabling better quality of health services: number of Community Health Centres (CHCs) reaching national standards, number of action plans including SRMHR action points, and women's access to these quality services.

4.3.1. Number of MSG members with access and control over quality SRMHR service – indicator 1.8

To assess this indicator, the MSG members were asked if they had accessed the following services since the project started: family planning, ANC/PNC visits, delivery preparation sessions, and birthing in a health facility and/or with a SBA. If they did so, they were asked if they had taken part in the decision to access this service or not (control). Note that the data used here are only the answers from married women in reproductive age (15-49 years old).

As a result: 56% out of 61 women did have access and control over quality SRMH services at mid-term stage. This proportion was lower in remote aldeias (50% vs. 60% in other aldeias) which is mainly linked to the fact that less women in remote aldeias were able to give birth in a Health Post. Note that data for this indicator was not available in the baseline study.

As shown in the following table, the SRMH services which are the least accessed are: 1) family planning and 2) giving birth in a health facility. More than half of the women who have not used contraceptives since the project started explained that this was by choice (they wanted children or were already pregnant). Only 1 woman explained that her husband disapproved the use of contraceptives.

[17] The value for indicator 2.8 falls down to 20% if we exclude respondents who do not hold another position in the community than MSG/FSG Mobilizers.

Table 14. Access and control over quality SRMH services disaggregated by type of services (MTR)

Service	Access and control		Access		Control
	Proportion	Valid cases	Proportion[18]	Reasons for no access	Proportion[19]
Post-Natal Care	100%	38	100%		100%
Delivery preparation sessions	95%	41	98%	No information (1)	98%
Ante-Natal Care	95%	42	100%		95%
Using of SBA during delivery	79%	38	82%	No telephone number (1), remote (2), night (1), no transport (1)	97%
Giving birth in a health facility	71%	38	74%	Early birthing (5), far from HF (4), birthing at night (2), no transport (2)	96%
Contraception	66%	62	74%	Want more children (5), pregnant (6), infertile/menopause (2), tubectomy (2), natural FP (2), husband disapproval (1)	89%

4.3.2. Number of CHC that meets national standards for quality of care – indicator 1.6

A check-list was used to collect information on facilities and human resources in each of the three CHCs of the HAMORIS project target area (see **Table 15** overleaf). Clearly, some basic requirements were not being met in the CHC of Fatumea at the time of data collection (no water and limited human resources). Note that a separate CARE project was ongoing during the MTR period and has supported handwashing stations and water-tanks for health facilities in Covalima (Fohorem and Fatumea).

Table 15. Community Health Centre Check list (MTR)

#	Description	Fohorem	Fatumea	Atsabe
1	Doctor	1	1	2
2	Nurse	2	4	5
3	Midwife	1	1	2
4	Pharmacist	1	1	2
5	Nutrition Officer	1	1	1
6	Laboratory	1	1	1
7	Dentist	0	0	2
8	Malaria assistant	1	1	1
9	Medical record	2	1	1
10	Cleaner	1	1	3
11	Driver	0	0	1

[18] Proportions calculated among the only pregnant women, except for using contraceptives.

[19] Proportions calculated among the only women who access the service.

12	Security	1	0	2
13	Toilet	7	10	3
14	Maternity Room	1	1	2
15	IUC bed	0	1	0
16	Observation bed	6	12	1
17	Delivery bed	2	0	2
18	Drugs Availability	Sufficient	Sufficient	Sufficient
19	Water Availability	Sufficient	No water	Insufficient

Given that the minimum requirements to reach national standards couldn't be identified, the MTR team also asked the question directly to the CHC Coordinators and to key informants from the health sector at municipal and post level. Only the Coordinator of the CHC in Fohorem believed the CHC was currently reaching national standards. The Coordinators of CHCs in Fatumea and Atsabe explained that the limited (or no) access to water, the difficulty to reach communities living far away from the CHC and the limited human resources were major problems in their CHCs. Similar feedback was collected from KIs at Health Post and municipal level. The Head of Covalima Municipal Health Department added that CHCs still lacked equipment. Surprisingly, the Head of Municipal Health in Ermera considered that the CHC of Atsabe had already reached national standards. This suggests that more standardization in the way CHCs are classified is probably needed.

4.3.3. Number of FSG and MSG members reporting sharing support group education outcomes (disaggregated by sex) - indicator 1.16

The proportion of Support Group members sharing what they have learned during education sessions with other people has drastically increased from 27% (September 2018[20]) to 96% at mid-term stage (with no difference between MSG and FSG members). This very high proportion of people sharing information reflects the strong interest and satisfaction of SG members about their involvement in their respective Support Groups.

The Respondents reported that they primarily share information with family members (98%), followed by friends (66%). The topics which they most commonly talk about are:

- ✓ Pregnancy: ANC (75 cases), contraception (51), PNC (46), generalities (19), and "alert signals" (16).
- ✓ Child care: breastfeeding (44), health/immunisation (8).
- ✓ Health in general: nutrition (12), Sexually Transmitted Infections (STI) (11), "familia saudavel" (healthy family) (8).
- ✓ Gender: domestic violence (8), gender balance (6).

These results also give some indications on which topics the group members have been the most interested in. Clearly, the community is in great need of quality information about SRMH services.

Even though only a small proportion of group members reported sharing information on gender balance and domestic violence, it is interesting to see that an equal number of men and women reported sharing information about this topic.

[20] By that time, only 3 to 4 education sessions had been facilitated by the project.

4.3.4. Number of action plans that include SRMHR issues – indicator 1.13

The results for this indicator remain the same since the baseline survey: 8 out of 10 sucos have clear health related action points (health in general but not directly related to SRMHR issues).

Note that among the two other target sucos (Parami and Belulic Leten), Parami has a part of its action plan aimed to improve road access. The baseline study explains that this action point directly draws from the community's need to better access health services. Parami was therefore included as part of the sucos with SRMHR issues in their action plans. Key informants during the MTR also suggested that the community had requested for more health staff in their Health Post and increased SISCA activities.

The Belulic Leten suco in Fatumea therefore remains the only suco where no action point related to SRMHR issues was identified.

4.4. Appropriateness: project addressing identified needs

4.4.1. Number of FSG and MSG members with knowledge of one or more modern contraceptive method – indicator 1.19

The project has already achieved important progress in this matter as the proportion of Support Group members with knowledge of at least one modern contraceptive has increased from 37% to 86%, as detailed in the Table overleaf.

Table 16. Proportion of Support Group members knowing of at least one modern contraceptive (baseline and MTR)

Description	*Proportion*	*Valid cases*
Baseline	37%	
MTR	86%	152
- MSG	87%	96
- FSG	84%	56
- Remote aldeias	85%	75
- Accessible aldeias	86%	77
- Old group members	88%	120
- Recent group members	75%	32

Interestingly, the older group members (members since 2017-18) have a better knowledge of contraceptives, an element which could reflect the project's impact.

The most well-known contraceptives are injections 92%, implants (78%), pills (66%), tubectomy (19%), condoms (15%) and Intrauterine devices (IUDs) (5%). The fact that only 15% of the respondents mentioned condoms suggests that Family Planning (FP) is often considered as a woman's responsibility.

Note that even though the question specified "modern contraception method", some respondents also gave examples of non-modern contraception methods: counting calendar days *("tersu"*), "natural FP" or breastfeeding.

4.4.2. Qualitative evidence documenting changes in participation of women and PLWD in formal and non-formal decision-making spaces – indicator 2.7

As reported by the results of indicator 2.8, about one-fourth of MSG members are holding specific positions within the community, a situation which already provides evidence of women's participation in decision-making spaces. Apart from this fact, all interviewed local leaders felt positive changes in women's involvement in decision-making for the community[21]. Local leaders of Parami, Lactos, Fatumea and Dato Tolu explained that women are now more active during meetings (asking questions, sharing their opinion and taking part in decision making). The Chefe Suco of Nanu specified that women also participate in Community Score Card (CSC) meetings for example. Yet, in some areas like Dato Rua, women join meetings but are not participating in discussions.

Regarding disabled people (PLWD), the MTR sample included three MSG/FSG members having some deficiencies (for hearing and/or seeing). All 3 persons were 50 years old or more. One person among them is a member of a Suco Council as "Lia Nain".

Only half of the 10 interviewed local leaders believed there has been some positive change in the participation of PLWDs in the decision-making spaces. They stated that the PLWDs in the sucos do participate in meetings, especially those linked to CARE activities. Yet, several local leaders explained that limited infrastructures, especially in the more remote areas, impacted on how much PLWDs are actually able to participate in community meetings. They also noticed that there were no programs targeting specifically PLWDs in their suco (Dato Tolu, Obulo).

The project team also recognized that they faced major difficulties trying to identify PLWDs as these people are often under-reported by the local authorities because they mainly consider the people with obvious physical deficiencies (one-legged persons for instance) as being part of PLWDs, and not the deaf or low-hearing persons. HAMORIS is already in the process of improving this situation by coordinating with DPOs. The team also plans to use the Washington Group[22] questions to better identify PLWDs within their target area.

4.4.3. Identifying and addressing project's unintended consequences

- **Risks of conflicts within households**

The baseline study reported that some husbands were angry if their wives came back from meetings without bringing back money or without having completed house chores before attending the meeting. However, no such feedback was collected during the MTR. In fact, none of the interviewed local leaders believed that project activities could present risks in terms of domestic violence.

The project team reported that they never had to face such problems with group members as members who join meetings were coming voluntarily. SRMH issues discussed during education sessions are also linked to households' economic situation: family planning for example is presented to participants as a way to ensure parents can better meet their children's needs.

[21] One half of them perceived "a lot of change" and the other half "a little change".

[22] The Washington Group is a United Nations Statistics Commission City Group formed of representatives of national statistical offices working on developing methods to better improve statistics on persons with disabilities.

Yet, 14% of MSG/FSG members said their families are not happy that they are part of a Support Group[23]. They explained that meetings sometimes take too much of their time, which is even more a problem whenever both husband and wife are attending a meeting.

- **Unbalanced participation of men and women in Support Groups**

The project intends to have a balanced number of FSG and MSG members. Yet, the number of FSG members has reduced since the start of the project as men consider they have less time available compared to women to join such meetings.

This tendency was also reflected in the MTR data: about two-third of the interviewed MSG/FSG members had their husband/wife also being a member of a Support group but this was more often the case for FSG members. In most cases, MSG members explained that their husbands could not be member of a FSG because they were too busy working (89%) or simply not interested (11%). This was confirmed by local leaders who explained that men are busy and many still believe the topics discussed during education sessions are targeted to women only.

To overcome this situation, the project is facilitating engagement activities within the FSGs about agriculture and saving and loans in order to attract men to join the meetings.

- **Meeting community's expectations during the CSC process**

Another working area where the project had to address unexpected consequences was the CSC process. Indeed, suco level CSC meetings were an interesting opportunity for communities to address their concerns to local governments. Thus, a significant number of action points raised during these meetings are related to areas which are not under the MoH scope of work: road infrastructure, electricity, water, as well as agriculture. Yet, as several of these action points do have an impact on the communities' ability to access quality SRMH services, the project team had to innovate and initiate coordination with other categories of stakeholders such as DNSAS (National Department of Water and Electricity) and the PNDS National Program for Village Development) programmes. This was also made possible thanks to the close collaboration of project staffs with the Staff of Administrative Posts.

Some very positive results of this process is for example the fact that following the CSC process, 40 HHs in suco Halik Na'in and Nanu were given solar panels from a collaboration between Government and NGOs[24].

4.5. Sustainability

One of the keys to ensure sustainable outcomes is the role that is given to government and community leaders within the project implementation strategy to sustainably improve the community's access to quality SRMH services. This is discussed in this section.

[23] Similar proportions among men and women.

[24] 2018-2019 ANCP Performance report.

4.5.1. Changes in responsiveness of local government to barriers of SRMHR in their communities (e.g. number of midwives/doctors, availability of medicine, frequency of SISCA) – indicator 1.14

The Community Score Card (CSC) approach was used by the project to help the communities to express their needs to local government and for local governments to engage more specifically on a number of priority issues discussed during CSC meetings.

About half of the interviewed Support Group members reported that they had participated in such CSC meetings (especially men) and explained what had been their main requests during these meetings. In first position came the need for more health staff. Yet, the response of local governments was reported to be very low (only 17% of group members said that this action point had already been fulfilled). The Chefe Sucos in Belulic Leten and Dato Tolu also believed no or very little progress had been achieved in terms of SRMHR in their communities mainly because they still do not have sufficient health staff and are unable to respond to health emergencies. The Chefe Suco of Fohorem for example explained that there is only one nurse covering 4 villages.

Building a health facility closer to the community was the second point most often raised, and this was achieved in Suco Nanu in 2019 as well as in Fatumea[25]. Note that health staff has yet to be appointed to this Health Post and staff houses to be provided. In Suco Laclo, Obulo and Fohorem (Aldeia Loroquida), the community is still expecting for Health Posts to be built. Some aldeias of Obulo for example are located more than 10 kilometres away from a health facility.

Other barriers which were raised by SG respondents were the lack / shortage of ambulances, SISCA activities and medicines. To date, ambulances are still rarely available in the target areas of the HAMORIS project, but SISCAs are more frequently happening and medicines significantly more available. The Chefe Suco of Dato Tolu explained that since there is still no ambulance in their area, CARE has been helping pregnant women to reach health facilities by using project cars. Note that this was only done in exceptional circumstances. As highlighted by the Chefe Suco of Fohorem, having ambulances is also important in order to be able to respond to emergency situations at night time for example.

This was consistent with the feedback from key informants of the health sector, who reported:

- ✓ An increase in personnel only in CHC Atsabe and HP Parami but not yet in other health facilities of the HAMORIS target areas. A nurse in HP Nanu for example explained that she is working alone in the Health Post, she is unable to provide ANC services to pregnant women and thus has to direct them to the CHC instead.
- ✓ An increase in SISCA activities (CHC Atsabe and HP Parami).
- ✓ Higher availability of SRMH medication in CHC Fatumea and Fohorem as well as in HPs Nanu, Dato Tolu, Fatumea, Parami and Lactos.

A number of them also mentioned: increased number of beds in maternity rooms, more equipment and better skills of the health personnel to treat STIs.

Limited rural infrastructures also have a direct impact on communities' access to quality SRMH services. The most striking point is the poor road infrastructure but also simply having water and electricity within the HPs and CHCs. Collaboration with the PNDS program for example, resulted in the building/rehabilitation of a number of rural roads and small bridges between Sucos and Aldeias, some of which are leading to HPs.

[25] 2018-2019 ANCP Performance report

In conclusion, thanks to the CSC process, the local health departments are now well aware of the community's priorities and significant progress has been achieved in some areas like availability of medicines and increased SISCA activities. The building of two health posts and additional personnel in CHC Fohorem and HP Dato Tolu are also significant improvements which should be highlighted.

Yet, for some of the most striking action points [(a) increasing the number of health personnel in health posts, (b) building health posts, (c) availability of ambulances], the MoH is facing major challenges related to limited financial and human resources. Identifying doctors, nurses and midwives willing to work in rural areas is very challenging and often requires to build complementary facilities (houses) for the health personnel to be willing to stay in the suco. The sensitive political context is also somewhat undermining the ability of MoH to rapidly attend the community's expectations.

4.5.2. Change in baseline of the relationship between the community and service providers – indicator 1.15

Significant changes were observed in this area as well. Indeed, the baseline study indicated that coordination between the community and service providers was at very low levels in at least 8 villages, especially in Covalima. Since then, the project has facilitated 3 rounds of CSC meetings at suco and municipal levels during which community representatives, local leaders and health department representatives were present. All KIs interviewed during the MTR believed this process to be a very good way to improve relations between communities and health staff.

When asked the question directly[26], more than 90% of respondents believed the situation has improved. Yet, the Chefe Suco representative in Obulo for example deplored the fact that health personnel are not reaching remote communities like Aldeia Malitada and Ailisu and, in such places, pregnant women in need of urgent care are not being attended.

Support group members were also asked specifically if they were able to meet health staff each time they needed to. As a result, 89% answered positively. Several reasons were given by the 16 respondents who did not agree[27] with this: 1) "health personnel come to the health facility only if we call them first"; 2) "they do not follow standard working hours"; 3) "there is limited/ no personnel here"; 4)"health personnel lives in town"; 5) the nurse comes only twice a week"; 6) "we live far from the HP", and 7) "they are directing us to hospital instead of attending us at the HP".

In conclusion, progress has been achieved but the lack/shortage of human resources and poor infrastructure remain major barriers to be able to respond to the demand in SRMH services. In some locations, limited accountability from some health personnel also impacts on the quality of the provided services.

4.5.3. Sustainability of MSG and FSGs

The sustainability of the Support Groups beyond the project life could be questioned if the only link that members have to keep together would be the educational activities monthly facilitated by the project. This is one of the reasons why the project introduced "engagement activities" within each Support Group. Such activities also help to ensure the active participation of women and especially men during education sessions. Engagement activities range from kitchen gardens,

[26] "Is the community having better relations with health personnel since the project started in 2017?"

[27] Number of cases by suco: Dato Tolu (4), Belulic Leten (3), Fohorem (3), Dato Rua (3), Lactos (2), Obulo (1).

tais weaving, small livestock raising, fish ponds as well as saving and loans. A one-time contribution to each group was made in 2018-19 (seeds, weaving material, chickens, etc.). The project also linked groups to local government authorities to receive technical assistance. The benefits made as a group are expected to be reinvested in the group.

As no data was available on actual progress made by these groups in relation to their engagement activities, it is hard to tell if these will indeed be successful in keeping groups together beyond the project life. Saving and loan activities for example require groups to have a solid organization and members to build trust among themselves.

4.6. Assessment of contribution towards CARE 2020 global indicators

4.6.1. Satisfied demand for modern contraceptives among women aged 15-49 (SDG indicator 3.7.1)

No official statistics on demand for contraceptives are available. Therefore, this indicator was assessed by asking directly MSG members and health personnel if: (1) they believed all the women in the community who needed contraceptives were able to get contraceptives; and (2) If not, what were the main problems women encountered in this regard.

As a result: 84% of MSG members believed the demand for modern contraceptives was met vs. 62% among health personnel[28].

The main reasons why some women in demand of contraceptives were unable to use them include: (1) being unable to access a health facility; and (2) limited access to information on contraceptives. A nurse in the HP of Parami for example explained that the "Promotor Saude Familiar" (Family Planning Promoter) does not have sufficient skills to be able to sensitize the community. Some MSG members specified that women who are not in a MSG or living far away from other MSG members are also not getting information on Family Planning.

Note that only 3 MSG members also said that some women would like to use contraceptives but their families are forbidding them to do so. One of them explained that the culture of "barlake" (dowry) contributes to this situation as men's families are expecting the wives to give them many children in return.

4.6.2. Proportion of births attended by skilled health personnel (SDG indicator 3.1.2)

As reported previously, the proportion of women giving birth with the help of SBA has increased from 31% at baseline stage to 78% in HAMORIS's target communities.

[28] 89 MSG members and 13 health KIs respectively answered to these questions.

4.6.3. Adolescent birth rate (disaggregated by 10-14; 15-19 years) per 1,000 women in each age group (SDG indicator 3.7.2). Proxy indicator: Age at first delivery.

As no official statistics were readily available from local health authorities for this indicator, the HAMORIS team contacted health personnel in each of the HAMORIS target health facilities and asked them the number of births from girls under 19 years old since 2017. The following summarizes the data collected:

- In Fatumea: 1 case in aldeia Mota Ulun, 2 in aldeia Fatumea and 1 in aldeia Raioan.
- In Fohorem: no information could be collected from the CHC.
- In Atsabe: 36 cases in CHC Atsabe and 4 cases in HP Parami.

So overall 44 cases of adolescent births were reported since the project started (all were above 15 years old). Unfortunately, not all records were found by the health personnel. Also, data on the total number of women aged 15-19 years old in HAMORIS project area during this period is not available. It is therefore impossible to calculate the value of this indicator.

Yet, the data collected proves the existence of a significant number of adolescent births and thus, highlights the importance to target the young women as well.

4.6.4. Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (SDG indicator 5.6.1)

As reported previously, the proportion of women in reproductive age making their own informed decision about sexual relations, contraceptive use and reproductive health care is 71% in HAMORIS's target communities.

5. Recommendations

As reflected in this report, very significant progress has been globally achieved in raising the awareness of MSG and FSG members on the importance of using SRMH services. At this stage of the project implementation, the priority is to ensure that this higher demand can now be responded by the health authorities. Most recommendations in this section are discussing this.

Note that recommendations related to monitoring and evaluation are presented in **Annex 3**.

5.1. Access to quality SRMH services

- **Continuous advocacy to MoH to increase the number of health staff**

All respondents were unanimous about the need to overcome the serious lack/shortage of health personnel in sucos and aldeias. It is therefore recommended to continue advocating this issue at national level. Yet, identifying health personnel willing to work in the more isolated parts of the countries is a major challenge.

- **Identify partner organizations to fill the gap in health infrastructure**

Here also, the government faces significant challenge mainly related to limited financial resources. Yet, in order to fasten the government response, the HAMORIS project should consider working with other partners such as:

- Organizations with infrastructural mandates to support the building of health facilities in Suco Obulo, Fohorem (Aldeia Loroquida), Laclo or Dato Rua (Aldeia Aitos). Building of health staff housing is also important in Fatumea and Nanu, Dato Tolu as this could significantly help the MoH to identify health personnel willing to work in those areas.
- Organizations in the water sector to support a number of existing health facilities for accessing water.
- International Organizations able to provide second hand medical equipment in good state in order to support health facilities with missing equipment.

- **Expand awareness raising on SRMH outside Support Groups**

As shown in this MTR, the access to quality information is the first level to increase women access to SRMH services. HAMORIS has been very successful in filling this gap within Support Groups already. And as reported by respondents at all levels, it is now mostly in remote areas that information on SRMH is still lacking. The Chefe Suco of Dato Tolu for example insisted that CARE should now expand its awareness raising activities outside of the Support Groups.

For the last implementation phase of the project, HAMORIS could reach these other parts of the communities. Several strategies could be put in place, as follows:

- ✓ Work with leading MSG members to act as role models in such remote areas. Occasional events where leading MSG members are sharing their experience with other women could be organized for example. Using role models from the community itself would also be a more convincing method for the more traditional families.
- ✓ Continue to work with Promotor Saude Familiar (PSF), especially in the more remote aldeias. A nurse in Parami explained that these persons often lacked skills and knowledge on SRMH. If resources are available, capacity building in basic SRMH issues (safe maternal

and birthing practices) could be provided to these persons. This can be done by systematically proposing them to become FSG/MSGs members (as already happening in some groups) but also by providing them additional support given their specific role in the aldeia.

- ✓ Work with local radio channels to broadcast information about the project and SRMH, interviews of key participants, success stories and other project-related topics.

- **Increase men support to their wives to use SRMH**

Men support to women is also a key condition for women to be able to access SRMH services. Male role models could be identified among the most active FSG members and invited to participate in occasional events to share their experience with other men. To attract enough participants, such events could be combined with activities related to HAMORIS engagement activities or competitions (e.g. quiz on health care with prices to winners with best scores).

- **Access to information on male contraceptive (condom)**

Knowledge and use of male contraceptive were significantly low among the MTR sample. More awareness raising on male contraceptive / condom during education sessions could help the beneficiaries to have a more balanced perspective of family planning and alleviate the cultural barriers related to the use of male condoms. The use of male condoms can be suggested to FSG members whenever their wives are unable to use female contraceptives for example: medical contraindication or temporary inability to access their usual contraceptives. This point is also important to avoid pregnancies outside of marriage as it can have dramatic consequences on young girls' future. An FSG member actually reported having used condoms before marriage.

5.2. Effectiveness of the Support Group approach

- **Conduct some education sessions separately for FSGs and MSGs**

The MTR has proven very positive results in terms of increased understanding and support between men and women. Joined education sessions for men and women have certainly participated in this process.

Yet, starting to facilitate some of the education sessions separately for MSGs and FSGs would also enable discussing more openly specific or sensitive topics among men or women only. For example, men and women could feel more open to share their experience and thoughts regarding domestic violence if they are only among them.

This would also avoid having to ask both husband and wife to attend meetings at the same time and thus, leaving their children alone at home.

- **Increasing men participation in FSG meetings**

Local leaders recommended project staff to coordinate with them as they can support to mobilize more men. They also advised that the project team visits the men in their houses to "invite them officially".

Facilitating meetings at times men are more available (during evening and during the dry season when there are less agricultural activities) could also be proposed to FSG members.

Men often believe that topics discussed during education sessions are "for women only". The project could organize education sessions only for men during which the first part of the discussion is more specifically targeted to men's sexual health (male contraceptives, male STIs)

but then followed by other messages to increase men's understanding of women needs in terms of SRMH services.

Continuing facilitating engagement activities related to agriculture (for instance on attractive crops, plant diseases, or health care to large animals) is also definitely needed.

- **Inviting health personnel during education sessions**

A number of Key Informants in the health sector recommended CARE to involve them when facilitating events in the sucos such as education sessions in Support Groups. This could be a very interesting opportunity to improve relations between the community and health staff from local health facilities.

CARE could for example organize group meetings during which midwives explain what happens during an ANC visit or during birthing followed by "questions and answers sessions". This could help to make things look more concrete, break taboos around SRMH, and increase women and men trust is nurses and doctors.

- **Targeting young men and women**

Data show that there is a significant number of adolescent births in HAMORIS project areas. For this reason, it is important for the project to also specifically target young men and women. Specific engagement activities for young beneficiaries could be facilitated (e.g. dancing show / competition, sport game) followed by education sessions only for this group of beneficiaries. The team could also work with health personnel to organize short interventions in high schools to discuss contraception methods.

5.3. Effectiveness of the CSC approach

- **Implementation of the suco action plans**

A significant number of action points have not yet been achieved. As it is unlikely that all these action points can be implemented by the end of the project life, it is recommended to prioritize the action points which will have the highest impact on the access of community to the SRMH services. Further advocacy to the MoH on these most urgent action points will be required to be able to respond to the community's expectations.

The project could also work with the Municipal Health Department on possible alternatives for some of these action points. For example, organizing mobile clinics instead of building a health post or having health personnel rotating between different sucos. These are not ideal solutions but would still be an improvement to the current situation.

For action points which require simple construction work or bringing water to a health facility, the project could facilitate an active collaboration between municipal health authorities and the communities: communities providing some of the workforce and construction materials locally available and health authorities providing the remaining material, medical equipment, etc. This can also be done in the form of "Food for Work".

For future projects, it is also important for the team facilitating CSC meetings at suco level to be able to manage the community's expectations and agree on a limited number of action points that the project can reasonably expect to achieve by the end of the project life.

- **Regular reporting to communities on progress achieved**

Most local leaders were very enthusiastic about the CSC process but expressed their frustration of not seeing most of the action points being implemented and not being informed of the progress achieved.

CARE organizes yearly meetings at suco level which seems to be insufficient in frequency. The project should consider quarterly or 6-monthly progress meetings at suco level.

A number of KIs also suggested to conduct the CSC meetings at aldeia level in order for more community members to be able to reach local governments. This could also be an opportunity to mobilize community members around small construction projects as suggested previously.

- **Increasing women's participation in CSC meetings at suco level**

It was noted that the participation of MSG members in CSC meetings was significantly lower than that of FSG members. In order to increase women participation, the project could organize meetings in locations closer to the community and also provide incentives such as food for children during these meetings.

Local leaders also advised to officially invite women to participate in CSC meetings by sending them invitation cards.

- **Ensuring completeness of participants at each CSC meeting**

A number of KIs deplored the fact that health authorities or local leaders are sometimes not attending CSC meetings because they were not informed. It is important to ensure that all relevant parties are invited well in advance to the CSC meetings in order to avoid creating such frustration among key stakeholders. Health personnel from local health posts also insisted to participate in CSC meetings.

5.4. Effectiveness of the Social Analysis and Action (SAA) process and promoting gender balance

This is very likely the area for which changes are the most difficult to observe during a project lifetime as it takes generations to have a significant impact on men and women attitude and behaviour. Yet, it is by sowing seeds (at school, church, home, ceremonies, meetings, etc.) that changes will appear in the long run.

Besides from recommending the project to continue its regular SAA activities with Support Group members, a number of more specific recommendations can be made.

- **Gender-Based Violence**

Further efforts to socialize the Gender-Based Violence (GBV) law is highly recommended as the MTR result have shown that a significant part of the community still finds domestic violence to be legitimate in some cases. This could be done together with the community police people or by organizing night events to show short movies on GBV.

Working together with traditional and religious leaders could also help enforcing the messages.

The Chefe Suco of Belulic Leten also explained that raising the community awareness on family planning would have a positive impact on domestic violence as GBV is often closely related to the economic conditions of families.

- **Involving religious and traditional leaders in Support Groups**

A number of social norms are still persistent as they are deeply rooted among some of the more traditional families. Also, important family decisions are often still taken by men only. In order to give more weight to the project strategy, it is important to involve religious and traditional leaders during the Social Analysis and Action sessions. Involving the *Lia Nain* in education sessions was also recommended by a nurse in the HP of Dato-Tolu.

- **Socializing the results of the GPA**

A lot of community members often participate in surveys. Yet, they are very rarely informed about the results of these studies. It is recommended to organize some attractive events (theatre shows, or small movies for instance) where the results of the GPA study conducted in 2018 could be socialized. This could be combined with a presentation of the MTR results to show how the Support Group members have evolved since the start of the project.

- **Organizing awareness raising events around gender roles and SRMH**

To reach out to families outside the groups but also to reinforce HAMORIS message among project beneficiaries themselves, the project could find a partner to help prepare short theatre sessions about daily family situations related to men and women attitude around SRMH. For example, the first time a woman goes for a check-up with a male doctor; a young couple starting their lives together and making choices on how to build their family; families with a lot of children vs. families with 2 children; attitude of in-laws when paying expensive dowry, etc. Making these small scenes interactive and funny would help spread the message in an informal and relaxed atmosphere. Organizing such events requires significant preparation time which might be available if the project is being extended. Note that theatre groups capable to write and play such small scenarios in rural areas are already existing and active in Timor Leste.

5.5. Inclusion of PLWDs

As reported by CARE, there is evidence that PLWDs are underreported by national and local level authorities. Efforts have already been made by the project team to identify PLWDs in HAMORIS target areas and need to be pursued. The project could work with local authorities to identify PLWDs based on the Washington Questions group.

Local leaders also recommended to conduct project activities at aldeia level to facilitate PLWD's participation and to "officially invite" them with invitation cards.

If small theatre shows are developed, including message on PLWDs inclusion would definitely be interesting.

Note that limited information is currently available regarding how PLWDs are accessing and using SRMH services and how the different types of disabilities they have are impacting on this. The project could consider conducting a case study specifically on PLWDs in HAMORIS target areas to understand what their specific needs are and provide information on how they currently access and use SRMH services. This could form the base of a more targeted approach.

5.6. Sustainability

One of the keys to ensure sustainable outcomes is the sufficient government responsiveness to the Suco Action Plans. Among the most striking action points there are: (1) the need for more health personnel (doctors, nurses and midwives) which was repeated several times by almost all respondents; (2) the necessity to build health posts in a number of sucos and remote aldeias, and (3) better access to these health facilities (road infrastructure). Recommendations related to these points were already presented in part 4.1 and 4.3.

- **Systematically involving health authorities into project activities**

Providing a legitimate role to the local Health Department within CARE activities is crucial to reinforce their engagement with the community and strengthen the trust of the community in the health personnel. Several things can be undertaken: (1) propose to medical staff from HPs or CHCs to intervene during education sessions or one-time events; (2) systematically invite all health personnel from HPs to CSC meetings at municipal and national level; (3) having them participating into local radio broadcasts, including health staff interviews and presentations.

In return, a local leader suggested that CARE provides support to the health department by mobilizing Support Group members whenever local health authorities are organizing events (such as vaccination for example).

- **Sustainability of Support Groups**

It is highly recommended to monitor the results of the engagement activities to assess how successful are each group in their own activities. If needed, further support could be provided to the weakest groups or VSLA groups as these involve complex trust issues between members to be sustainable.

And again, providing a legitimate role for duty bearers within these groups will help sustain the SRMH component of the groups later. PSFs can play a key role in this process by keeping the link between health personnel from the nearest HPs with group members. Engaging PSFs in this dynamic from now on in each Support Group is required.

- **Coordination with local leaders**

It is recommended to systematically involve local leaders (both Chefe Suco and Chefe Aldeia) into all the activities implemented by CARE at suco and aldeia level. The Chefe Suco of Dato-Tolu for example explained that he was barely aware of the project activities because he was rarely invited to participate into them.

ANNEXES

Annex 1 – MTR Terms of Reference

Annex 2 – List of selected Aldeias

Annex 3 – Data collection tools

Annex 4 - M&E recommendations

Annex 5 – MTR team composition

ANNEX 1 – Terms of Reference

Terms of Reference for the Midterm Evaluation of HAMORIS
(Hamenus Mortalidade no Risku ba Inan Sira)

CARE International in Timor-Leste

Project:	**HAMORIS (Hamenus Mortalidade no Risku ba Inan Sira)**
Position Title:	**Mid-term Review Team Leader**
Duration:	**17.5 days**
Place of Assignment:	**Dili, Timor-Leste**
Reporting to:	**Alison Darcy (Assistant Country Director, Programs)**
Project Duration:	**FY17/18 – FY20/21**
Donor:	**DFAT (Australian Department of Foreign Affairs and Trade)**
Budget:	**AUD 2,470,761**
Expected Start Date:	**Early March 2020**
Completion Date:	**Mid May 2020**

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1. Background

CARE International in Timor-Leste

CARE International in Timor-Leste's (CLTL) 15-year Long-Term Program, 'Women and girls in Rural Disadvantaged Areas', seeks to address underlying causes of poverty through direct programming, partnerships (with civil society, government and private sector) and advocacy, in the following key areas.

1. Improving women's sexual, reproductive and maternal health, and rights, including access to supervised delivery and family planning.
2. Improving women's economic empowerment, including skills, linkages to markets and services, and ability to withstand shocks.
3. Improving quality and access to education, with a particular focus on supporting girls' decision-making and leadership.
4. Strengthening women's voice, meaning enhancing women's decision-making and leadership role within families, communities, institutions and the wider society and addressing gender-based violence.

The HAMORIS project aligns with key area 1 of the Long-Term Program: *Sexual, Reproductive and Maternal Health (SRMH).*

Project

The HAMORIS project builds on the previous ANCP Safe Motherhood Project (2015 – 2017) with an overall goal to reduce maternal mortality and morbidity. The project focuses on increasing demand for quality maternal health services in 44 aldeias (hamlets) in 10 sucos (villages), 7 sucu (villages) in Covalima Municipality and 3 sucu (villages) in Ermera, Timor-Leste. The project continues to follow the Mother Support Groups (MSG) model to engage women, provide information and raise awareness, and facilitates change to harmful beliefs and practices through CARE's Social Analysis and Action (SAA) process. Engaging men and boys is a critical component of CARE's gender equality strategy, and this project engages men through establishing Father Support Groups (FSG), that have a similar focus as the MSGs. The project also continues to refine an inclusive governance approach, (i.e. CARE's Community Score Card (CSC)), that complements the SAA process, and empowers services users and service providers to address service quality issues in maternal health.

Goal

CITL's HAMORIS project contributes to lasting reductions in maternal mortality and morbidity by increasing the number of women in targeted communities utilizing appropriate and quality maternal health services.

Project Outcomes

End of Project Outcomes:
1. Improved Access and utilization of quality SRMH services by men and women
2. Improved gender relations at family and community level

Intermediate Outcomes:
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

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

2. Purpose and audience

The main purpose of the MTR is for the MTR Team Leader to work with the HAMORIS Team/Gender and Program Quality Unit (GPQ), to assess the progress of project activities from 1 July 2017 to 31 of March 2019 (using the 2018 Baseline, and 2018 Gender and Power Analysis as a marker), and provide recommendations to inform the future direction of the project (1 of April 2020 – 31 June 2021).

Sub-purposes:

1. Identify constraints/challenges/issues affecting progress and provide recommendations to address them
2. Identify opportunities to increase impact and enhance the implementation and management of the project
3. Assess the mainstreaming of cross cutting issues including Gender Equality and Women's Empowerment and Disability Inclusion
4. Orientate strategies and activities towards sustainability of results in the post-project period
5. Evaluate the contribution of the project towards the Country Office Long Term Program Change Outcomes[29] and the CARE international 2020 indicators (specified under section 3).

The primary audience of this MTR are HAMORIS and GPQ Unit staff who will use the findings to inform project improvements for the last year of the project. The key results and recommendations from the MTR will be shared with DFAT Post/Canberra, relevant Government of Timor-Leste departments (such as the Ministry of Health), project partners, and relevant International non-governmental organisations and local non-government organisations. Finally, CITL will share the findings with project participants.

[29] *SRMH and Rights:* % increase in access and control over quality SRMH services; % improvement in nutritional status among the impact group (IG). *Women's Voice:* % increase in IG as effective decision makers and leaders in political, economic and social forums.

3. Evaluation questions[30] and MTR Scope

Level	Key Evaluation Question	Indicator[31]/Area of Inquiry	Do we need to collect this data at MTR stage – Yes/No.	1. How will data be collected? 2. With whom? 3. By whom?
Outcome	Has the project made improvements in access and utilization of quality of SRMH+R services?	1.10: # of MSG and FSG members utilizing modern contraceptives 1.1: # MSG members who received a minimum of ANC4 (disaggregated by ANC1) 1.2: # of MSG member who received a minimum of PNC2 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 1.4: # improvement in nutritional status among female group members - CITL: 1.2 1.9 # of MSG and FSG members satisfied with SRMHR services 1.12 # of fathers and family members actively involved and providing advice in breast feeding plan 1.17 Evidence of change in baseline in the broader community in attitude and/or behaviour regarding harmful traditional practices 1.1.2 # of MSG and FSG members with knowledge of one or more social norm which hinders better SRMHR outcomes	1.10: Yes	1. Mothers and Fathers Profile Form 2. Mothers Support Group and Fathers Support Group. 3. HAMORIS Team or GPQ Team
			1.1: Yes	1. Pregnancy Monitoring Form 2. Mothers Support Group 3. HAMORIS Team or GPQ Team
			1.2: Yes	1. Pregnancy Monitoring Form 2. Mothers Support Groups 3. HAMORIS Team or GPQ Team
			1.3 Yes	1. Mothers Profile Form 2. Mothers Support Group 3. HAMORIS Team or GPQ Team
			1.4:Yes	1a. Nutrition Form 2a. Mothers Support Groups 3a. HAMORIS Team or GPQ Team 1b. Key Informant Interviews 2b. Doctor, midwife or other medical staff. 3b. HAMORIS Team or GPQ Team
			1.9 Yes	1a. Focus Group Discussions (using SAA tools, such as 'Vote with your Feet') 2a. Mothers Support Groups and Fathers Support Groups 3a. HAMORIS Team or GPQ Team 1b. Participant Survey 2b. Mothers Support Groups and Fathers Support Groups 3b. HAMORIS Team or GPQ Team

[30] The Evaluation Questions table is adapted from the HAMORIS MEL Plan. The KEQ at "Effectiveness" and "Goal" levels were not added to the MTR TOR as these areas were deemed not appropriate to measure at mid-point stage.

[31] The indicators in the table were also measured as part of the Baseline/GPA (expect, indicator 1.9, indicator 1.12, indicator 2.8, indicator 2.2, and the areas for inquiry on: result and challenges, unintended consequences/project assumptions and innovations).

			1.17 Yes	1a. Key Informant Interviews 2a. Local Leaders (e.g. Chief of Village, Administrator of Post Administrative) 3a. HAMORIS Team or GPQ Team 1b. Stories of Change from Longitudinal study 2b. Mothers and Fathers (4 women and 2 men) 3b. HAMORIS Team or GPQ Team
			1.1.2 Yes	1. Focus Group Discussions 2. Fathers Support Groups and Mothers Support Groups 3. HAMORIS Team or GPQ Team
			1.12 Yes	1a. Focus Group Discussions 2a. Fathers Support Groups and Mothers Support Groups 3a. HAMORIS Team or GPQ Team 1b. Key Informant Interviews 2b. Doctor, Midwives, health centre staff. 3b. HAMORIS Team or GPQ Team
Gender and transformative change	Has the program made improvements in gender relation at family and community level?	2.3: # 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 2.4: # men who report supporting maternal health and safe birthing practice 2.6: # of MSG and FSG members who report joint household decision making– CITL 3.1 2.8 # Support FSG and MSG group members identified by community members as effective decision makers and leaders in political, economic and social forums; 2.10 qualitative evidence of changing harmful traditional practices or a change in attitude or practices related to girls and women's rights (including violence against women, household and community's decision making relating to SRMH).		
			2.3:Yes	1a. Focus Group Discussions 2a. Mother Support Group members 3a. HAMORIS Team or GPQ Team 1b. Key Informant Interviews 2b. Doctor, midwifes, medical staff. 3b. HAMORIS Team or GPQ Team
			2.4:Yes	1. Focus Group Discussions 2. Father Support Groups 3. HAMORIS Team or GPQ Team
			2.6:Yes	1. Focus Group Discussions, SAA tool: 'Pile Sorting'. 2. Father Support Groups and Mothers Support Groups 3. HAMORIS Team or GPQ Team
			2.8 Yes	1. Key Informant Interviews 2. Community leaders such as Village Chief, local authorities, Doctors. Chief of each group. Community mobilisers.

				3. HAMORIS Team or GPQ Team
			2.10 Yes	1. Key Informant Interviews 2. Father Support Groups and Mothers Support Groups; Local Authority. 3. HAMORIS Team or GPQ Team
Effectiveness	What key changes has the program contributed to enable better quality of health service outcomes?	1.8: # of members with access and control over quality SRMHR service 1.6 # of CHC that meets national standards for quality of care 1.16: # of FSG and MSG members reported sharing support group education outcomes (disaggregated by sex) 1.13: # of action plans that include SRMHR issues Project is achieving expected results, and challenges to effectiveness were managed. How effective are key project approaches (SAA, CSC, F/MSG, behaviour change programs) in achieving expected results	1.8: Yes	1. Focus Group Discussions 2. Father Support Groups and Mothers Support Groups 3. HAMORIS Team or GPQ Team
			1.6:Yes	1a. Key Informant Interviews 2a. Medical Staff, doctors, midwives 3a. HAMORIS Team or GPQ Team 1b. Observation of the CHC facilities 2b. Review facility and staff to assess if national standards are met (against checklist) 3b. HAMORIS Team or GPQ Team
			1.16:Yes	1. Focus Group Discussions 2. Father Support Groups and Mothers Support Groups 3. HAMORIS Team or GPQ Team
			1.13:Yes	1a. Key Informant Interviews 2a. Chief of Village and other community leaders (as part of CSC activities) 3a. HAMORIS Team or GPQ Team 1b. Review the CSC action plan documents 2b. CSC action plans developed at community level (with providers and communities) 3b. HAMORIS Team or GPQ Team
			Project is achieving expected results and challenges to effectiveness were managed: Yes	1. Project reflection workshop with staff 2. Hamoris Team and GPQ Team 3. HAMORIS Team or GPQ Team
			Effectiveness of key project approaches: yes	1. Focus Group Discussions 2. Father Support Groups and Mothers Support Groups 3. HAMORIS Team or GPQ Team

Appropriateness	Does the project address the identified needs?	1.19: # FSG and MSG members with knowledge of one or more modern contraceptive method 2.7: Qualitative evidence documenting changes in participation of women and PLWD in formal and non-formal decision making spaces Project assumptions and/or any unintended consequences were monitored, identified and managed in a timely manner	1.19:Yes	1. Focus Group Discussion 2. FSG and MSG members 3. HAMORIS Team or GPQ Team
			2.7:Yes	1. Key Informant Interviews 2. Local authority, women and women with disabilities. 3. HAMORIS Team or GPQ Team
			Project assumptions and/or any unintended consequences were monitored, identified and managed in a timely manner: Yes	1. Project reflection workshop with staff. MEL working group (internal). 2. HAMORIS Team and GPQ Team 3. HAMORIS Team or GPQ Team
Sustainability	Has the project provided a legitimate role for government, community leaders and community members to improve SRMH+R? What changes will transcend the lift of the project?	1.14: Changes in responsiveness of local government to barriers of SRMHR in their communities (e.g no. of midwives/doctors, availability of medicine, frequent) 1.15: Change in baseline of the relationship between the community and service providers Project innovations to improve efficiency, effectiveness or sustainability of the project were identified and implemented	1.14: Yes	1a. Key Informant Interviews 2a. Midwives and doctors, and local authority and community leaders. 3a. HAMORIS Team or GPQ Team 1b. Field observation of CHC facilities 2b. View facilities 3b. HAMORIS Team or GPQ Team
			1.15: Yes	1. Key Informant Interviews 2. Local authorities, MSG, FSG, community leaders and service providers. 3. HAMORIS Team or GPQ Team
			Project innovations to improve efficiency, effectiveness or sustainability of the project were identified and implemented: Yes	1. Project reflection workshop with staff. MEL working group (internal). 2. HAMORIS Team and GPQ Team 3. HAMORIS Team or GPQ Team
CARE's Global indicators 2020	Can results achieved be measured against CARE 2020 global indicators?	1. Demand satisfied for modern contraceptives among women aged 15-49 (SDG indicator 3.7.1) 2. Proportion of births attended by skilled health personnel (SDG indicator 3.1.2) 3. Adolescent birth rate (disaggregated by 10-14; 15-19 years) per 1,000 women in each age group (SDG indicator 3.7.2). Proxy	Yes	1. Focus Group Discussion 2. FSG and MSG members 3. HAMORIS Team or GPQ Team

		indicator: Age at first delivery. 4. Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (SDG indicator 5.6.1)		

Note: All data and information must be disaggregated by sex and age (and other factors, if possible, such as disability).

4. Approach and methods

Following an initial desk review and briefing, the MTR Team Leader should develop an Evaluation Plan and evaluation tools, to be approved by CITL before commencing the evaluation. In the Evaluation Plan, the MTR Team Leader should explicitly describe how their approach will ensure gender sensitivity. In addition, the evaluation approaches and tools must consider the reasonably high incidence of illiteracy among project participants, and the ability of people living with disabilities to input into the evaluation.

The MTR Team Leader is expected to define and carry out an evaluation approach that is most appropriate and relevant to the context. Potential data collection methods are articulated in the KEQ and MTR Scope table above (see the last column).

The evaluation approach (as articulated in the Evaluation Plan) must consider the safety of participants at all stages of the evaluation. The MTR Team Leader will need to demonstrate how they have considered the protection of participants, including people with disabilities, through the different evaluation stages, including recruitment and training of evaluation staff, data collection and data analysis and report writing. The MTR Team Leader will be expected to adhere to CARE's Code of Conduct, Child Protection policy and Prevention of Sexual Harassment, Exploitation and Abuse policy.

The Team Leader is expected to build the capacity of the MTR Team in evaluation design, planning, implementation, analysis and reporting through specific evaluation guidance and on-the-job mentoring.

5. Responsibilities

The overall role and responsibilities of the MTR Team Leader:

- Review relevant secondary data to be included in midterm evaluation (desk review)
- Draft an Evaluation Plan (in English) to be shared with CITL/GPP for one round of comments, including:
    a. timeline
    b. proposed approach (including ethical considerations)
    c. detailed methodology and sample frame
    d. MTR report structure
- Develop data collection tools to be shared with CITL/GPP for one round of comments
- Develop training materials for fieldwork training, and train the Dili-based HAMORIS/GPQ staff who will deliver the fieldwork training to CITL field level staff
- Lead the data and information analysis
- Draft an evaluation report (in English language) of no more than 30 pages, not including annexes (draft and final), for at least two rounds of comments by CITL/GPP. This should include a 4-6 page summary of the report's key learnings and recommendations (Executive Summary)
- Update the draft MTR report based on CITL/GPP feedback
- Present the final key findings and recommendations to CITL/GPP.

The overall role and responsibilities of HAMORIS Project Team and GPQ Team:

- Agree on a final document review list and support the consultant in accessing relevant documents from CITL
- Lead on the translation of data collection tools (into Tetum)
- Deliver the CITL field staff fieldwork training
- Organise field travel logistics for travel and the booking of meetings, and accommodation and meals for the MTR team
- Plan, coordinate and undertake fieldwork
- Support the MTR Team Leader with data and information analysis
- Organise logistics for the data validation workshop
- Facilitate a data validation workshop to inform the preliminary analysis
- Provide timely feedback on draft MTR products e.g. Evaluation Plan, fieldwork tools, draft and final MTR report

- Arrange for the final MTR report (including Executive Summary) to be translated into Tetum (either through an external translator or translation by HAMORIS/GPQ Team).

6. Schedule[32]

Activity	Tentative Timeframe[33]	Number of Days	
		MTR Team Leader	HAMORIS/ Program Quality and Gender Unit staff
Verbal briefing of the key issues and priority information by CITL/GPP	Late February 2020[34]	1 hour	1 hour
Review of project documents	2 March 2020	1 day	-
Submit Evaluation Plan for review and approval	4 March 2020	2 days	2 hours to review
Submit data collection tools for review and approval	13 March 2020	2 days	2 hours to review
Field staff training preparations / training of trainers	23-24 March 2020	1 day to prepare training material 1 day delivery of training of trainers workshop in Dili	1 day
Training of field staff to undertake fieldwork	25-26 March 2020	-	2 days to deliver the training to field staff
Fieldwork	30 March – 12 April 2020	-	10 days (5 days in each location)
Data and information analysis	13 – 15 April 2020	3 days	2 days
Presentation of initial findings to CARE for validation purposes	17 April 2020	-	1 day preparation. Facilitate a 4 hour validation workshop
Submission of Draft Evaluation Report	24 April 2020	4 days	-
Submission of Final Evaluation Report	8 May 2020	2 days	-
Presentation of findings and recommendations to CARE (and other interested NGOs, DFAT Post)	15 May 2020	1 day preparation. 1 hour presentation.	Participation in the 1 hour presentation
TOTAL		17 days, 2 hours	17 days, 3 hours

7. Reporting arrangements

Alison Darcy, Assistant Country Director: Programs, will be the primary focal point and will supervise the MTR Team Leader. Alison will provide all the relevant information for the consultancy and will arrange for support from other staff where required. The MTR Team Leader will also be expected to interact with the CITL GPQ Unit, and the Hamoris project team.

[32] Note: 3rd March 2020 is a national holiday (Veteran's Day).

[33] To be confirmed by the MTR Team Leader in the Evaluation Plan.

[34] Note: CITL Monitoring and Evaluation Officer, mana Junita Castanheira will be going on parental leave from March onwards for 3 months. Therefore, the verbal briefing will need to be conducted before then.

8. Selection criteria

Education:

- Master's Degree in Social Science or a relevant field
- Excellent report writing skills and effective communication skills in English; written and spoken Tetum abilities are highly desirable.
- Good interpersonal skills
- Sound knowledge and understanding of community empowerment, gender equality, participatory research and workshop facilitation
- Strong knowledge of development issues, especially in Timor-Leste

Experience:

- Experience in conducting evaluations, preferably in the maternal/sexual reproductive health sector
- Experience with gender responsive evaluations and projects where gender equality is a principal objective
- Experience in working with international organisations or NGOs, including abiding by their child protection, and prevention of sexual harassment, exploitation and abuse polices
- Experience in quantitative and qualitative data collection
- Experience in gender-sensitive and participatory evaluation approaches
- Experience in training, coaching or capacity building of staff on evaluative processes

Language:

- Fluency in spoken and written English and written and spoken Tetum abilities are highly desirable

9. Contact and Further Information

Alison Darcy
Assistant Country Director: Programs
CARE International in Timor-Leste
alison.darcy@careint.org

ANNEX 2 - List of Selected Aldeias

Sampled aldeias for interviews with MSG and FSG members

District Sub-District Suco	MSG		FSG	
	Aldeia	Number of respondents	Aldeia	Number of respondents
Covalima				
Fatumean				
Fatumea	Lebo	4 + 1 from rai Oan	Rai Oan	4
Belulic Leten	Mane Kik	7 + 1 from Baleo	Baleo	7 + 1 from Mane Kiik
Nanu	Nanu	8	Tradu Kama	5
Fohorem				
Fohoren	Lo'o Hali	15	Fatuk Bitik Laran	6 + 2 from Loo Hali
Lactos	Au-Lulic	10	Kakaut	3
Dato Rua	Fatulidun	9	Fatulidun	11
Dato Tolu	Natardic	19	Fatuc Kabuar Craic	4
Ermera, Atsabe				
Paramin	Aliatu	5	Aliatu	3
Obulo	Biliubu	8	Lacoubu	3
Laclo	Malitada	9	Ailisu	7

Note: In Suco Fatumean and Suco Belulic Leten, the aldeias that were initially randomly selected to conduct interviews with MSG members did not actually have telephone access and therefore had to be switched to other aldeias in order to be able to reach respondents.

ANNEX 3 – Data Collection Tools

Sequences of questions in data collection tools

All Questionnaires were coded in order to be used with the Open Data Kit (ODK) survey system software. Therefore, the choices of answers, skipping logic, hints given to enumerators and other features of these electronic questionnaires are not reflected in the below sequences of questions. For further understanding of the questionnaire and Tetum translation, please refer the Excel form of the questionnaires Also, note that final modifications in the formulation of some questions were sometimes included only in the Tetum version of the forms and might not be reflected here.

1. Questionnaire for FSG/MSG members

INTRODUCTION AND CONSENT The HAMORIS team is collecting data to assess the progress achieved since the beginning of the project. Because of the State of Emergency situation in the country, we are unfortunately not able to visit you right now so we are contacting people by phone only. Your opinion is very important to us but you can decide not to be interviewed or to answer only some questions. You can also ask to stop the interview whenever you would like to. Some questions are sensitive so please tell us if you are not comfortable answering those so we can skip these questions. The information that you will share with us will remain confidential. Do you agree to participate in this interview?
SECTION 1 - GENERAL
RESPONDENT DATA
Name:
Age:
What is your marital status?
Does the respondent have disabilities?
Type of deficiency:
Other deficiency:
Are you the head of the household?
So who is the head of household?
Are you a member of the suco council (Xefe aldeia/suco/other)?
Specify the position:
Are you a member of municipal government?
Specify the position:
Are you holding any other specific position in the community?
Specify the position:
Is your wife a member of the suco council (Xefe aldeia/suco/other)?
Specify the position:
Is your wife a member of municipal government?

Specify the position:
Is your wife holding any other specific position in the community?
Specify the position:
Since when does your wife hold this role/position?
SECTION 2 - BEING A MEMBER OF THE MSG/FSG
When did you become a member of the MSG/FSG?
What is your position in the MSG/FSG?
Other position:
How often do you join the group meetings?
How much are you satisfied of being a member of this group?
Is your wife a member of the MSG?
Why is your wife not a member of the MSG?
Other reason:
If you both go to meetings at the same time, who takes care of the children while you are outside the house?
Is your husband a member of the FSG?
Why is your husband not a member of the FSG?
Other reason:
Do you think your husband is more supportive of your health needs during pregnancy, delivery and after delivery since he is a member of the FSG?
What does your husband do to support you?
Is your husband supportive of your health needs during pregnancy, delivery and after delivery?
What does your husband do to support you?
If you both go to meetings at the same time, who takes care of the children while you are outside the house?
Do you usually share things you learn during education sessions with people outside the group?
With whom?
What topic more specifically are they interested in?
Have you shared the breastfeeding information with your wife and extended family?
Have you shared the breastfeeding information with your extended family?
Has your wife been breastfeeding since you joined the FSG?
How have you supported your wife during the breastfeeding stages?
SECTION 3 - SRMHR SERVICES
Do you know any modern contraceptive method?
Which modern contraceptives do you know about?
Other answers provided:
Do you use contraceptives or have you used contraceptives in the last 12 months?
Have you used contraceptives before (since the project started)?
Why not use contraceptives?
Why not use contraceptives in the last 12 months?
Do you use contraceptives or have you used contraceptives in the last 12 months?
Who decided that you should use contraceptives?

Do you think all the women in this community who needed contraceptives were able to get contraceptives?
What problems did women encounter? Why not all women can get contraceptives (no medicine, leave to far from health centre, etc)?
Have you been pregnant in the last 12 months?
Already delivered or not yet?
Have you been pregnant before (since the project started)?
Did you attend ANC visits?
Why not attend?
Who decided that you should attend ANC visits then?
Did you attend delivery preparation sessions?
Why not use attend delivery preparation sessions?
Who decided that you should attend delivery preparation sessions?
Where have you given birth?
Why did you not deliver in a health facility?
Who decided that you should deliver in a health facility?
Have you given birth with an SBA or a TBA or none?
Why did you not get assistance from an SBA?
Who decided that you should get assistance from an SBA?
Did you attend PNC visits?
Why not attend?
Who decided that you should attend PNC visits then?
If your wife is pregnant, do you:
… agree that she completes all ANC check-ups?
… agree that she completes all PNC check-ups?
… accompany her to complete these check-ups at the health facility?
... agree that she joins delivery preparation sessions?
... accompany her to delivery preparation sessions?
... agree that she gives birth in a health facility instead of giving birth at home?
... accompany her to give birth in a health facility?
... agree that she gives birth with a SBA instead of a TBA?
How much are you satisfied with SRMHR services?
Why are you satisfied?
Why are you not satisfied?
SECTION 4 - RELATION WITH HEALTH PERSONNEL AND CSC PROCESS
Do you think the community has better relations with the health providers since the HAMORIS project started?
Are you able to meet with health personnel each time you need to?
Why not/what is the problem?
Do you have good communication with them when you go to the CHC or health post?
Why not/what is the problem?
Have you already participated in CSC/Community Score Card Meetings?
Were health personnel also present in the CSC meetings?

Were you able to inform health personnel about the community's needs during the CSC meetings?
What did the community request for?
Do you have any recommendations to improve the CSC process?
SECTION 5 - DECISION-MAKING
In your family, who usually decides:
To make big expenses:
To sell big animals:
To sell small animals:
To spend money for traditional ceremonies:
The number of children to have:
Explain other:
Now I will ask you a sensitive question about your personal relation with your husband. Is it ok for me to ask this question to you now?
Is it usually you alone, your husband alone or you AND your husband together who:
- Decide to initiate sex
- Decide to use or not to use contraceptive
- Decide to use or not to use health reproductive services
SECTION 6 - SOCIAL NORMS
Here, are there cultures or traditions that can prevent women from better accessing SRMH services?
Give examples:
>
>
Now I will ask you sensitive questions about domestic violence. Is it ok for me to ask this question to you now?
Do you agree or disagree with the following statements?
There are times a woman deserves to be beaten.
If a married woman has been beaten up by her husband, it is okay for her to tell others.
If a husband beats up his wife, other people should intervene.
It is better for a woman to give birth at home than in a health facility.
It is better for a woman to give birth with a traditional birth assistant than with a SBA.
The husband (or his mother) should be the one deciding when to have children (spacing).
Are people in your family complaining that you are a member of the GSI/GSA?
END OF INTERVIEW: THANK YOU! Would you like to add something?

2. Questionnaire for Health Sector Key Informants

INTRODUCTION AND CONSENT The HAMORIS team is collecting data to assess the progress achieved since the beginning of the project. Because of the State of Emergency situation in the country, we are unfortunately not able to visit you right now so we are contacting people by phone only. Your opinion is very important to us but you can decide not to be interviewed or to answer only some questions. You can also ask to stop the interview whenever you would like to. Do you agree to participate in this interview?
SECTION 1 - GENERAL
RESPONDENT DATA
Name:
Position
Other position:
Sex:
Does the respondent have disabilities?
Type of deficiency:
Other deficiency:
SECTION 2 - RESPONSIVENESS OF HEALTH SERVICES
1. Are there more health personnel since the project started?
2. Are there more SISCA activities about SRMHR since the project started?
3. Are there more medicines for SRMHR since the project started?
4. Do you agree that health facilities are providing better SRMHR services since the project started?
What has improved for example?
Why do you not see any improvement?
5. According to you, what are the key points that still need improvement in order to be able to provide better SRMHR services?
Do you think all the women in this community who needed contraceptives were able to get contraceptives?
What problems did women encounter? Why not all women can get contraceptives (no medicine, leave to far from health centre, etc)?
SECTION 3 - RESPONSIVENESS OF HEALTH SERVICES
1. Are there more health personnel since the project started?
3. Are there more medicines for SRMHR since the project started?
5. According to you, what are the key points that still need improvement in order to be able to provide better SRMHR services?
Do you think all the women in this community who needed contraceptives were able to get contraceptives?
What problems did women encounter? Why not all women can get contraceptives (no medicine, leave to far from health centre, etc)?
SECTION 4 - CHC checklist
NUMBER OF PERSONNEL IN THE CHC:
Number of doctors:
Number of nurses:

Number of midwives:
Number of pharmacists:
Number of nutrition officers:
Number of laboratory personnel:
Number of dentists:
Number of malaria assistant:
Number of medical record personnel:
Number of cleaner:
Number of drivers:
Number of security persons:
NUMBER OF FACILITIES IN THE CHC:
Number of toilets:
Number of maternity rooms:
Number of patient beds in ICU rooms:
Number of patient beds:
Number of patient beds:
Enough drugs?
Enough water?
Is the CHC meeting national standards for quality care?
What are the main problems faced by this CHC?
Are the CHCs of HAMORIS's area meeting national standards for quality care?
What are the main problems faced by these CHC?
SECTION 5 - RELATION BETWEEN HEALTH SERVICE PROVIDERS AND COMMUNITY
Do you think the community has better relations with the health providers since the HAMORIS project started.
Do you think the community is able to meet with a health personnel each time they need to?
Why not/what is the problem?
Does the community have good communication with the health personnel when they come to a CHC or health post?
Why not/what is the problem?
2. Did you participate in CSC meetings?
3. Do you know if the community shared information about their health needs during these meetings?
What did the community request for?
5. Do you think the CSC process is a good way to improve relations between health personnel and the community?
Why do you not think the CSC is a good way ?
Do you have any recommendations for the project to improve the CSC process?
SECTION 6 - CSC PROCESS
2. Did you participate in CSC meetings?
3. Do you know if the community shared information about their health needs during these meetings?
What did the community request for?

5. Do you think the CSC process is a good way to improve relations between health personnel and the community?
Why do you not think the CSC is a good way?
Do you have any recommendations for the project to improve the CSC process?
SECTION 7 - SOCIAL NORMS
2. Can you see a change among your community regarding domestic violence since the project started?
What change?
Why?
2. Can you see a change regarding the community's practice to give birth at home instead of a health facility since the project started?
What change?
Why?
2. Can you see a change among your community regarding women's habit to give birth with a TBA instead of an SBA since the project started?
What change?
Why?
2. Can you see a change among your community regarding who usually decides about children spacing since the project started?
What change?
Why?
3. Do you have any recommendations for the project to be able to have more impact on the negative effects of these social norms/traditions?
The interview is finished. Thank you very much! Do you have comments?

3. Questionnaire for Local Leaders Key Informants

INTRODUCTION AND CONSENT The HAMORIS team is collecting data to assess the progress achieved since the beginning of the project. Because of the State of Emergency situation in the country, we are unfortunately not able to visit you right now so we are contacting people by phone only. Your opinion is very important to us but you can decide not to be interviewed or to answer only some questions. You can also ask to stop the interview whenever you would like to. Do you agree to participate in this interview?
SECTION 1 - GENERAL
RESPONDENT DATA
Name:
Age:
Sex:
Does the respondent have disabilities?
Type of deficiency:
Other deficiency:
SECTION 2 - HEALTH SERVICE PROVIDERS IN YOUR SUCO
1. Do you think the health facilities in this community are providing better SRMHR services since the project started?
What has improved for example?
Why do you not see any improvement?
Why do you think services have worsen?
2. Do you have any recommendations for the project regarding what to do to help health services provide better SRMHR services?
SECTION 3 - RELATION WITH HEALTH SERVICE PROVIDERS AND CSC PROCESS
Do you think the community has better relations with the health providers since the HAMORIS project started.
Do you think the community is able to meet with a health personnel each time they need to?
Why not/what is the problem?
Does the community have good communication with the health personnel when they come to a CHC or health post?
Why not/what is the problem?
Are the health personnel able to respond to all the community's need when they come to a CHC or health post?
Why not/what is the problem?
2. Did you participate in CSC meetings?
2. Do you think the CSC process is a good way to improve relations between health personnel and the community?
Why do you not think the CSC is a good way?
3. Do you have any recommendations to improve the CSC process?
SECTION 4 - MSG and FSG MEMBERS
What do you think about men's participation in health education sessions: do they participate a lot or not?
Why do you think there are less men than women joining group meetings?

Other reasons:
What could the project do to have more men join the meetings?
Do you think there is a risk that project activities could increase domestic violence due to conflict between traditional and more modern social and gender norms?
Please explain what type of risk and what more precisely are sensitive issues:
Do you have recommendations for the project to avoid such risks?
1. Can you see a change in how women of your community participate in decision making since the project started?
Can you explain what has changed?
Why do you think there is no change yet?
2. Can you see a change in how PLWDs of your community participate in decision making since the project started?
Can you explain what has changed?
Why do you think there is no change yet?
3. Do you have any recommendations for the project to help women and PLWDs be more active in decision making in the suco?
2. Can you see a change among your community regarding domestic violence since the project started?
What has changed?
Why is there no change?
2. Can you see a change regarding the community's practice to give birth at home instead of a health facility since the project started?
What has changed?
Why is there no change?
2. Can you see a change among your community regarding women's habit to give birth with a TBA instead of an SBA since the project started?
What has changed?
Why is there no change?
2. Can you see a change among your community regarding who usually decides about children spacing since the project started?
What change?
Why?
3. Do you have any recommendations for the project to be able to have more impact on the negative effects of these social norms/traditions?
The interview is finished. Thank you very much! Do you have comments?

ANNEX 4 – M&E Recommendations

This Annex presents in a tabular form the current statements for the different progress indicators of the LFM (left column), the proposed new statements for these indicators (middle column) and related recommendations where applicable (right column). The proposed new statements will be rendering the indicators more specific and relevant for evaluating the progress made. The recommendations, if considered in the M&E process, will increase the accuracy and validity of the collected M&E data by avoiding confusions and misunderstandings on the data collection methods to be followed by the project staff and the End of Project (EoP) survey enumerators.

Indicator statement	***Proposed new statement***	***Recommendation***
1.10: # of MSG and FSG members utilizing modern contraceptives	Proportion of MSG and FSG members in reproductive age having utilized modern contraceptives since the start of the project (disaggregated by sex).	The MTR only asked if the respondent was using a contraceptive but did not ask which one. For the EoP survey, it is recommended to also ask which one as some respondents might actually refer to "natural contraception" (and such cases should not be counted for this indicator).
1.1: # MSG members who received a minimum of ANC4 (disaggregated by ANC1)	Proportion of MSG members who received a minimum of ANC4 (disaggregated by ANC1) among women having been pregnant since the start of the project.	The MTR did not include the question on the number of ANC visits attended per pregnancy. This should be asked at EoP stage.
1.2: # of MSG member who received a minimum of PNC2	Proportion of MSG members who received a minimum of PNC2 among women having been pregnant since the start of the project.	The MTR did not include the question on the number of PNC visits attended per birth. This should be asked at EoP stage.
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	Proportion of births with a SBA among MSG members having given birth since the start of project (disaggregated by health facility/at home)	The previous target at EoP (25% increase of the proportion) may be kept or revised according to the excellent result obtained at MTR stage (from 31% up to 78% therefore a 250% increase)
1.4: # improvement in nutritional status among female group members - CITL: 1.2	Proportion of MSG members with MUAC >23 among MSG members having been pregnant since the start of the project.	Project Officers could measure the MUAC of pregnant women during each education session and record these in a simple monitoring sheet.

Indicator statement	*Proposed new statement*	*Recommendation*
1.9 # of MSG and FSG members satisfied with SRMHR services	No change.	For the EoP survey, it is important to use the same question as in the MTR to ensure results can be compared.
1.12 # of fathers and family members actively involved and providing advice in breast feeding plan	Proportion of FSG members sharing information on breastfeeding with their wives and families.	Consider dropping this indicator as results are very similar to that of indicator 1.16 on sharing support group education outcomes.
1.17 Evidence of change in baseline in the broader community in attitude and/or behaviour regarding harmful traditional practices	No change.	Consider dropping this indicator as it is very similar to indicator 2.10.
1.1.2 # of MSG and FSG members with knowledge of one or more social norm which hinders better SRMHR outcomes	Proportion of FSG members sharing information on breastfeeding with family or outside persons.	For further data collection: cross-check with people outside Support Groups to see if they have received such information from FSG members.
2.3: # 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	Proportion of married MSG members aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.	
2.4: # men who report supporting maternal health and safe birthing practice	Proportion of FSG members who report supporting maternal health and safe birthing practice (ANC, PNC, birthing in a health facility and/or with assistance from a SBA).	
2.6: # of MSG and FSG members who report joint household decision making– CITL 3.1	Proportion of married MSG and FSG members who report joint household decision making (sale on big and small animals, big expenses and expenses for ceremonies, number of children).	
2.8 # Support FSG and MSG group members identified by community members as effective decision makers and leaders in political, economic and social forums;	Proportion of FSG and MSG members holding specific positions at suco or municipal level.	
2.10 qualitative evidence of changing harmful traditional practices or a change in attitude or practices related to girls and women's rights (including violence against women, household and community's decision making relating to SRMH).	No change.	

Indicator statement	*Proposed new statement*	*Recommendation*
1.8: # of MSG members with access and control over quality SRMHR service	Proportion of married MSG members in reproductive age with access and control over quality SRMHR services.	For the EoP survey, SRMHR services considered for this indicator should remain the same as in the MTR: contraception, ANC, PNC, birthing in a health facility and/or with a SBA, delivery preparation session.
1.6: # of CHC that meets national standards for quality of care	Number of CHCs with increased health personnel, improvement in basic health care facilities (number of beds, toilets, etc.) and minimum infrastructure requirements met (water, electricity).	No national standard for quality of care was identified during the MTR. Therefore, this indicator should simply be a comparison between data collected for the CHC checklist at MTR and EoP stages.
1.16: # of FSG and MSG members reported sharing support group education outcomes (disaggregated by sex)	Proportion of FSG and MSG members sharing support group education outcomes with people outside support groups (disaggregated by sex).	A very simple survey can be done at EoP with non-group members to ask them if they have heard/ received information about things discussed during group education sessions. If yes, what did they learn?
1.13: # of action plans that include SRMHR issues	No change.	
1.19: # FSG and MSG members with knowledge of one or more modern contraceptive method	Proportion of MSG and FSG members with knowledge of one or more modern contraceptive method.	
2.7: Qualitative evidence documenting changes in participation of women and PLWD in formal and non-formal decision-making spaces	No change.	
1.14: Changes in responsiveness of local government to barriers of SRMHR in their communities (e.g. number of midwives/doctors, availability of medicine, frequency of SISCA)	No change.	
1.15: Change in baseline of the relationship between the community and service providers	No change.	Specific questions should be asked at EoP to assess this point: being able to meet a health personnel whenever needed, knowing the phone number of health personnel, having used this phone number, number of times meeting a health personnel for SRMH in the last 6 months, etc.

General recommendation for the EoP

- ✓ It is generally recommended to use the same tools / indicators as those used in the MTR to ensure that results can be compared.
- ✓ Do not source data from project monitoring sheets for indicators that are cumulative since the start of the project as the project monitoring sheets are not cumulative (besides for pregnancy sheet but this sheet was incomplete).
- ✓ Also, it is good practice to set targets that should be reached for each indicator by the EoP. Yet, given the HAMORIS baseline study did not include sufficient quantitative results, it is understandable such targets were not set.
- ✓ Missing baseline data for a number of indicators will limit the ability to see the progress achieved thanks to the project's intervention. What could be doen to compensate this would be to interview a control group outside of the project;s target area to provide comparison with
- ✓ Add questions on number of children, spacing between children and year of marriage in the questionnaire for FSG and MSG members, as behaviour and attitude might be different among families with more children for example (more traditional families).

Cross-checking of some of the results obtained during the MTR

As mentioned in this report, the unusual positive feedback from most respondents on questions related to men support to their wives is, for example, likely to be linked to the unusual interviewing circumstances: interviews conducted by phone while respondents were in their family environment which makes it difficult for women especially to be honest about sensitive questions.

The project team informed being willing to collect extra data later (when the situation in Timor Leste would be back to normal) to cross-check some of the MTR more suspicious data. This could be envisaged for indicators 2.3, 2.4, 2.6 and 1.12 as these indicators relate to how husbands and wives support each other and share decisions within the family. Such questions should only be asked to respondents during one-to-one interviews in a private place. Yet, this is also assuming that women and men will be willing to answer honestly to questions. Better indicators of change in behaviour and attitude are actual changes in the number of children families have, spacing between births, number of domestic violence cases reported to local authorities, etc. Yet, it is unlikely that significant progress can be observed in this regard in a 3-4 years period.

The very high results for indicator 1.12 and 1.16 (sharing information with people outside the group) could be cross-checked by conducting a very short random survey outside the groups to see if other community members have indeed received information from MSG/FSG members.

General recommendation for the project monitoring forms:

- ✓ There should be only 1 sheet for each member where all his/her data are recorded: general profile including month of joining the group, participation in education sessions and engagement activities, information related to use of contraceptives, to pregnancies and nutritional status since they joined the group. For SRMH information.

- ✓ Data can be collected at the end of each education session and recorded on simple index cards as those used to record patients information in health facilities (1 card per member). For nutritional status, if possible, project officers could measure the MUAC of pregnant MSG members at each education session and record this on the index cards as well.
- ✓ Group mobilizers should be responsible for these cards and support project officers to update the information regularly (at each education session for example). Project Officers could then update the HAMORIS M&E Officer every quarter (participation and SRMH information). The updated information should be entered in new columns by the M&E Officer (not updating existing columns) so that changes/progress can be observed along the year.
- ✓ There is no need to collect information on whether the person shares information about education sessions with others (this is rather something to assess during a survey and not in a project output monitoring sheet).
- ✓ It is also recommended to rigorously monitor the progress on each point of the Suco Action Plans (Excel sheet showing for each action point, the steps taken by the project to advocate to MoH or search for partners, the number of new health personnel appointed to each health facility, etc.). This is important as the project has engaged the community into this process and should therefore regularly report to local leaders on the progress.

ANNEX 5 – MTR Team Composition

Name	Responsibility as part of the MTR	Position within CARE
Julieta de Araujo	Overall coordination of MTR team Enumerator for MSG members	Program Quality Project Manager
Isac da Gama	Overall coordination of MTR team Enumerator for KIIs	Deputy Project Manager for SRMH
Julio Ribeiro	Enumerator for FSG members	Project Officer for Fohorem
Plasido Soares	Enumerator for FSG members	Project Officer for Atsabe
Yolanda P Gusmao	Enumerator for MSG members	Project Officer for Fohorem
Lasaro Lelan Sila	Enumerator for FSG members	Interim Project M&E Officer
Cipriano Soares	Enumerator for KIIs	CSC Team Leader
Fortunato Gusmao	Enumerator for FSG members	Project officer for Fatumea
Celestina Pereira	Enumerator for FSG members	CSC Project Officer
Tereja Soares	Enumerator for MSG members	Project Officer for Atsabe
Olimpia Baptista	Enumerator for FSG members	Senior Project Officer-Gender and Program Quality
Julieta de Araujo	Enumerator for MSG members	Program Quality Project Manager
Lucia Viana Branco	Trainer and overall support to MTR consultant	External to CARE
Julie Imron	MTR Team Leader - consultant	External to CARE