HAMORIS Project
(Hamenus Mortalidade no Risku ba Inan Sira)

FINAL EVALUATION

FINAL REPORT

JUNE 2022

Acknowledgments
This preliminary report was prepared by Ethos of Engagement (EoE) Consulting for CARE International Timor-Leste. The authors wish to thank the implementing partners, stakeholders, staff and individuals who gave up their time and CARE International Timor-Leste for their generous support to conduct the final evaluation. CARE would like to acknowledge the support of the Australian Government through the Australian NGO Cooperation Program (ANCP).

About Ethos of Engagement Consulting

Ethos of Engagement Consulting (EoE) is a values-based, women-owned and led consulting firm which prioritizes advancing women, girls' and other marginalized voices' rights by bringing together a network of diverse, virtual and human rights-minded consultants, academics and practitioners from across the globe.

We actively build country partnerships to support implementing effective research projects, training and evaluations which include targeted capacity-building to support national plans to implement the UN Sustainable Development Goals and hire country partners as part of our team.

EoE's Mission is to provide monitoring and evaluation, organization development, coaching, capacity development, and research services that support individuals, communities and organizations to thrive using gender analysis, systems thinking, participatory and intersectional approaches.

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Abbreviations

ANC	Antenatal Check
CHC	Community Health Centre
CITL	CARE International in Timor Leste
CSC	Community Score Card
DAC	Development Assistance Committee
DHS	Demographic and Health Survey
EoE	Ethos of Engagement Consulting
FGD	Focus Group Discussion
FSG	Father Support Group
GBV	Gender Based Violence
HAMORIS	*Hamenus Mortalidade no Risku ba Inan Sira*
IPV	Intimate Partner Violence
ISE4GEMs	Inclusive Systemic Evaluation for Gender Equality, Environments and Marginalised voices
KI	Key Informant
KII	Key Informant Interview
MEAL	Monitoring, Evaluation, Accountability and Learning
MoH	Ministry of Health
MSG	Mother Support Group
MTR	Mid-Term Review
PNC	Postnatal Check
PWD	People With Disabilities
SAA	Social Analysis and Action
SISCA	Integrated Community Health Services
SBA	Skilled Birth Attendant
SRMHS	Sexual, Reproductive and Maternal Health services
SRMHR	Sexual, Reproductive and Maternal Health Rights
TFFV	Towards a Future Free from Violence Program
TBA	Traditional Birthing Assistant

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Executive Summary

This report is an end-stage evaluation of CARE International Timor-Leste's HAMORIS project. 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 (SRMHS).

Ethos of Engagement Consultants was commissioned to undertake the evaluation between April and June, 2022. The evaluation team was headed by Dr Anne Stephens and Dr Ellen Lewis with field support from Senior Research Consultant, Ms Amina de Araujo.

The aim of this report is to provide an analysis, findings, conclusions and recommendations based on data and information collected and analysed for the evaluation. The main users of the evaluation are CARE International in Timor-Leste and Australia, Timor-Leste government stakeholders, project program participants and Australia's DFAT. This final report is presented in five sections and two appendices.

- Section 1 Background and Purpose of the Evaluation
- Section 2 Methodology
- Section 3 Findings
- Section 4 Conclusions
- Section 5 Recommendations

The HAMORIS project had a preliminary baseline report (2018) and Mid Term Review (MTR) in 2020. Both documents have been consulted in the formulation of this report's findings and conclusions. Where possible, lessons learned through the COVID19 pandemic are reported.

The objective of the baseline was to:

- Consolidate existing information in relation to SRMHS indicators, gender inequality indicators and information on protection risks associated with accessing primary health care services.
- Compliment incomplete or data of poor quality relevant to the activities being implemented within the context of the HAMORIS project.

The purpose of the Mid-Term Review (MTR) was to:

- Assess the progress of project activities from 1 July 2017 to 31 of March 2019 against the baseline.
- Provide recommendations to inform the future direction of the project (1 of April 2020 – 31 June 2022).

Purpose, Objectives and Scope of the End-Stage Evaluation

The purpose of the end-stage evaluation is to: Assess the project's progress and impact from 2017 to 2022 against the DAC criteria; relevance, coherence, effectiveness, efficiency, impact and sustainability. Two additional criteria have been included in this report because of their relevancy to the HAMORIS project: gender equality and disability inclusion.
Gender equality, women's rights, access to quality health services and women's safety are core

components of the project, and the evaluators have assessed the extent to which the project has

progressed gender equality and inclusion of people with disability (PWD). The evaluators have also reviewed the data collected to comment on other marginalised communities including progress for people with disability.

There are four sets of conclusions drawn from the findings:

- There is increased access and utilization of improved quality SRMHS by women and men in the targeted communities of the HAMORIS project
- Normative changes towards acceptance of Gender Equality and less tolerance for GBV, have been produced as a consequence of the project
- There are unintended consequences for marginalised voices, including PWD
- Many of the recommendations of the MTR were followed but further time, resources needed to implement them all.

The evaluation team provide two recommendations drawn from stakeholder interviews.

Recommendation 1: Continue to provide key components of the HAMORIS project, advocating for government support to strengthen Sexual, Reproductive and Maternal Health services (SRMHS)

Beneficiaries overwhelmingly request that the HAMORIS project be continued. Noticeable change in behaviours towards using modern day health care maternal and child health suggests that the work conducted by CITL and its partners has started to culturally shift cultural norms, and should be continued. CITL should consider:

- Continuing the program, even if in some reduced manner by finding donors and funding support
- Supporting the training of midwives and other SRMHS personnel
- Continuing to assist infrastructure improvements at health services including access clean water and target areas that have the most difficulty accessing SRMHS
- Advocating with government to continue the provision of services, as well as reducing the barriers to access of services, particularly in rural and remote areas
- Supporting nutrition and immunisation projects to continue to reduce childhood malnutrition and improve the health of pregnant and lactating mothers
- Continuing working with men and boys, to improve their knowledge, awareness of gender norms and continue to nudge gender-based violence (GBV) behaviour change
- Supporting and expanding CITLs involvement in women’s leadership and participation including savings and loans groups.

Recommendation 2: Increase advocacy for SRMHR for Youth, Unmarried and Divorced Women and People with Disabilities

Community Leaders recommended the following to continue to help women and PWDs be more active in decision making in the suco and aldeia levels.

- Implement specific projects to enable and build capacity for PWD to have equal rights
- A specific program for women and girls with disabilities to encourage their full participation and appreciation of their SRHMR

- Continue to advocate for the facilitation of PWD needs at SRMHRS.

1. Background and Purpose of the Evaluation

The end-stage evaluation provides an assessment of the HAMORIS *(Hamenus Mortalidade no Risku ba Inan Sira)* project from 2017-2022. Findings are reported against the Development Assistance Committee (DAC) criteria with attention to cross-cutting themes including gender equality and disability inclusion.

The HAMORIS project had a preliminary baseline report (2018) and Mid Term Review (MTR) in 2020. Both documents have been consulted in the formulation of this report's findings and conclusions. Where possible, lessons learned through the COVID19 pandemic are reported.

The objective of the baseline was to:

- Consolidate existing information in relation to Sexual Reproductive and Maternal Health Services (SRMHS) indicators, gender inequality indicators and information on protection risks associated with accessing primary health care services.
- Compliment incomplete or data of poor quality relevant to the activities being implemented within the context of the HAMORIS project.

The purpose of the MTR was to:

- Assess the progress of project activities from 1 July 2017 to 31 of March 2019 against the baseline.
- Provide recommendations to inform the future direction of the project (1 of April 2020 – 31 June 2022).

Purpose, Objectives and Scope of the End-Stage Evaluation

The purpose of the end-stage evaluation is to: Assess the project's progress and impact from 2017 to 2022 against the DAC criteria; relevance, coherence, effectiveness, efficiency, impact and sustainability. Two additional criteria have been included in this report because of their relevancy to the HAMORIS project: gender equality and disability inclusion.

Gender equality, women's rights, access to quality health services and women's safety are core components of the project, and the evaluators have assessed the extent to which the project has progressed gender equality and inclusion of PWD. The evaluators have also reviewed the data collected to comment on other marginalised communities including progress for people with disability. The impact of COVID19 on the project is also considered where supporting data was provided.

The evaluators also report where appropriate, relevant and applicable on any unintended consequences (positive or negative) and the extent to which the mid-term review findings and recommendations are addressed.

Project Logic Model and Theory of Change

Since 2017, CITL has operated the HAMORIS project as an intervention to create lasting reductions in maternal mortality and morbidity by promoting appropriate and quality SRMHS for lasting Sexual Reproductive and Maternal Health Rights (SRMHR). The intended outcomes of the HAMORIS project are:

- Increased access and utilization of quality SRMHS by women and men and people with a disability, and
- Improved gender relations at family and community levels.

The project logic model and theory of change is provided in Appendix 1. It was reviewed and informed the discussion and recommendations.

Methodology

The overarching evaluation approach for the end-stage evaluation for the HAMORIS project is the *Inclusive Systemic Evaluation for Gender Equality, Environments and Marginalised voices (ISE4GEMs).* This approach is used for the evaluation of complex social issues where multiple intersections between different social groups and their environments, influences the project's implementation and outcomes.

Research methods included a participant survey, key informant interviews (KIIs) with health professionals, workers and community leaders, and focus group discussions (FGDs) with project beneficiaries. Instruments for each method are provided in Appendix 2.

Quantitative and qualitative data was collected and monitored by the CARE International Timor-Leste project team. The evaluators commenced with a review of the project's documents. These included the baseline and MTRs and was used to report documented changes in service usage and program participation.

Methods

- Final evaluation quantitative survey was distributed to members of the Mother Support Group (MSG) /Father Support Group (FSG) (Instrument: *MSG/FSG Questionnaire*)
- FGDs (Instrument: *FGD Guide for MSG/FSG*)
- 24 Hour Clock activity (Instrument: *24 HOUR CLOCK GUIDE)*
- KII with health workers, administrators and senior post administrative leaders (Instrument: *KII HEALTH V2*)
- Community Leaders (Instrument: *KII LOCAL LEADERS V2*)
- CARE International project staff KIIs (6 males).

Table 1 Field Work Sample

Method	Stakeholders	2022 Total Target #	Actual Number of Respondents	Male Female
Focus Group Discussion and questionnaire	Father Support Groups (FSG)	135	72	
	- Mother Support Groups (MSG)	140	100	
	-			
Participant surveys	MSG-FSG Members		TBD	89 F:49 M:40
Total		**275**	**261**	
Key Informant Interviews Community Leaders	Chefe Suco and Chefe Aldeia or their representatives (one per target suco)		10	10 F:0 M:10
	Administrators of Administrative Posts		3	3 F:0 M:3
Total		**13**	**13**	
Key Informant Interviews Health workers & administrators	Health Staff	6	5	F:0 M:5
	Community Health Centre Coordinators		3	3 F:0 M:3
	Head of Reproductive Health Division at Administrative Post level		3	3 F:3 M:0
	Municipality Health Office	2	2	F:1 M:1
	Primary Health	2	2	F:1 M:1
Totals		**16**	**15**	

Table 2 Key Informant Interviewees Targeted and Interviewed (√)

- Chefe Suco and Chefe Aldeia or their representatives: one per suco ✓
- Administrators of Administrative Posts: one per sub-district ✓
- Health Staff of health posts: midwives (3), nurses (4), doctors (1) ✓
- Community Health Centre Coordinators: Fatumean, Fohorem, Atsabe ✓
- Head of Reproductive Health Division at Administrative Post level: Fatumean, Fohorem, Atsabe ✓
- Municipality-level health: one interviewee from Covalima and Ermera ✓

- Primary Health Department Head: Covalima and Ermera ✓

Table 3 below provides target locations and sample sizes. 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 initial target of 275 replicates the targets of the MTR FSG and MSG members to be interviewed but like the MTR this target was not reached as seen below, with 172 participants across all FGDs conducted. This is due to enumerator team size and the limited timeframes available.

Table 3 FGD Target Locations and Actual

Municipality	Covalima					
Post	Fatumean	Aldeia	Target MSG	Target FSG	Actual MSG	Acutal FSG
Sucus	**Fautume**	Mota Ulun	15	10	8	4
	Belulic Leten	Mane Kiik	20	25	15	9
	Nanu	Nanu	15	10	6	7
Sub-Totals			**50**	**45**	**29**	**20**
Post	**Fohorem**					
Sucus	**Fohoren**	Loroquida	20	10	11	6
	Lactos	Au-Lulic	10	10	8	5
	Dato Rua	Aitos	10	25	9	11
	Dato Tolu	Natardic	20	10	10	8
Sub-Totals			**60**	**55**	**38**	**30**
Municipality	**Ermera**					
Post	**Atsabe**					
Sucus	**Paramin**	Asio	10	10	12	8
	Obulo	Obeto	10	10	10	6
	Laclo	Sorati	10	15	11	8
Sub-Totals			**30**	**35**	**33**	**22**
Grand Totals			**140**	**135**	**100**	**72**
			275		**172**	

Limitations of the study

There are several important limitations to this study concerning, particularly concerning the data collection phase. CITL provided an enumerator team, trained by EoE, but not supervised by the Consultants. Enumerators knowledge of the program and the subject area was not found to be high. Therefore, their capacity to execute the surveys and facilitate discussion groups may have reduced the number of responses received.

Cultural perceptions and asking of sensitive questions may have affected the quality of the interview and data collected. This is despite the training provided, several surveys have gaps in responses by respondents and some FGDs did not probe participants for their explanations about their views, attitudes or practices, due to their limited knowledge of the subject and TFFV

program. This resulted in data not being as rigorous in providing in-depth understanding of social issues being discussed.
The qualitative data transcripts were affected adversely by language barriers. All field work was conducted in Tetun, and CITL's team translated all data from the surveys and FGDs into English. This process effected the quality of the data collected and some material was re-transcribed by EoE's in-country Senior Consultant. All FGDs used in the final collection were reviewed by EoE's Tetun-fluent Consultants to ensure their usability and reliability for the analysis phase.

The sample selected for completion of the Final Evaluation Survey was random sampling of FSG/MSG participants. The surveys do not represent the general population. This may bias the results. Bias limits the potential for generalizability. The instruments used between the MTR and end stage evaluation are highly compatible, however the total number of participants sampled for both FGDs and the survey, is smaller than the MTR samples. Limitations on the total sample size is due to time and resource constraints.

The evaluators supplemented this with a higher number of targeted KIIs for health post administration chiefs, Community Leaders and health workers, in order to better triangulate quantitative data with descriptive data. This strategy provided greater insight into the extent of structural and social changes occurring in the communities targeted by the HAMORIS project. This does not omit the potential for KIIs to provide bias responses as people may be motivated to say what they think the evaluators want to hear. For this reason over 30 KIIs were conducted with senior, middle and worker-level health staff and Community Leaders embedded in the village and sub-village levels to provide both spread of knowledge across the systems and interviews with people with an informed view point.

2. Findings

The findings have been organised under the DAC criteria, as well as criterion for gender and inclusion.

Effectiveness

The HAMORIS project has been found to be effective in delivering its primary objectives to:

- Increase access and utilization of quality SRMHS by women and men, and
- Improve gender relations at family and community levels.

The HANORIS project facilitated Mother and Father Support Groups to engage women and men, provide information and raise awareness on SRMHRs. Not all participants are married but the project targeted parents, as such, most participants are married. Twenty-five women joined the HAMORIS project via the MSGs in 2017, 12 in 2018 and seven in 2019. Three women joined in 2020 and 2021. Five respondents identified themselves as MSG leaders and community mobilisers. None are dissatisfied with participation in the MSGs. Twenty-one men joined the project FSGs in 2017, eight in 2018 and the remainder in 2019 (seven) and 2021 (one). Eight men were identified as community mobilisers. All responded that they are satisfied or very satisfied with the FSGs.

Over 80% of the men said their wife is a member of the MSG. If not, when asked, it is due to other commitments. This contrasts to the women's responses. Just under half the women respondents said yes when asked if their partner is a member of the support group. The reasons provided by respondents were that their husbands were working, had passed away or were divorced. During meetings, young children can attend with their parents, or stay at home to be cared for by other siblings or in-laws. Several respondents said their children are grown up and childcare was not required. When asked if MSG/FSG respondents share what they have learned with others outside of HAMORIS, 39 of 40 men and 44 of 49 women said yes. They share information with family, including their children, neighbours, and community which includes work colleagues.

Information men share is most commonly regarding antenatal and postnatal checks (ANC/PNC) and maternal health, followed by family planning, breast feeding and nutrition. Women shared information about ANC/PNC and family planning.

Three-quarters of married women believe that if their husband attends meetings, he is more supportive of her health needs during pregnancy, delivery and after delivery. Men support their wives by doing housework and childcare and accompanying them to the hospital for childbirth or health centre for check-ups. Men have greater awareness of preventative health care and nutrition.

Finding 1: Perceptions of Service Quality

The Health Workers, Administrators, Community Leaders and CITL staff agreed that health facilities are providing better care since the project started. Examples included:

- Better health services
- Increased number of doctors and nurses
- Improved availability of primary care medications such as Amoxicillin, Paracetamol and Ibuprofen
- Increased maternal knowledge
- Higher use of Skilled Birthing Assistant (SBA) services and health facilities when due dates are close
- Improved hygiene practices and resources
- Increase in health services provided to rural populations
- Increased sense of 'ownership' of HARMORIS project because of its collaborative nature with health professionals
- More husbands accompany their wives for consultations
- Improved breastfeeding information and support
- Improved infrastructure including clean water.

Health workers and administrators noted that there is still a need to improve:

- Continued rehabilitation of localized maternity homes
- Improved medical transportation services for emergencies and postnatal care for mothers and children
- Standardisation and certified training for midwives
- Coordination of health workers and focus on increased patient relations.

Of the 15 health workers, administrators and 10 community leaders, all said they had attended meetings at CHCs and concurred with the requests made by the community. The requests mirror issues from the baseline report period concerning infrastructure, access, and staffing:

- Infrastructure: roads, electricity, water
    - "The Community's concern was present at the … meeting. Transport because when we give birth, we contact the health service, but the ambulance sometimes transports other sick people. The road is difficult for us when there is rain." (KII Midwife)
    - Our community's concern is they want access to electricity, clean water, and roads. Now they can access electricity and clean water, but they do not have access to roads yet." (KII Chief of Village)
    - More health service provision
    - "Communities ask for use of implant contraception, but midwives do not yet have sufficient resources." (KII Doctor)
    - "Yes, we recommend CARE to continue developing our community through sharing health information related to childcare to pregnant women and lactating women who have babies 0-5 years old." (KII Chief of Village)
- More medical, nursing and midwifery staff

    "Communities lack midwives ... sometimes they did not want birth at the health centre because male doctors consult… women were ashamed." (KII CHC Chief)
- Regular village and sub-village visits of health personnel
- Ambulance services
- Mosquito nets

- Home visits of pregnant women
- COVID-19 information sharing

  “The Community’s wishes are healthier, electricity, ambulance, and roads.” (KII Program manager)

Finding 2: SRMHS Participant Satisfaction

To assess the extent to which key changes the program contributed to enable better quality health service outcomes, satisfaction with the SRMHS were surveyed. Respondents were asked if they were very satisfied, satisfied, neither satisfied or unsatisfied, unsatisfied or very unsatisfied (Indicator 1.9). The baseline did not record data against this indicator. This finding is comparable to the MTR Finding 4.1.6.

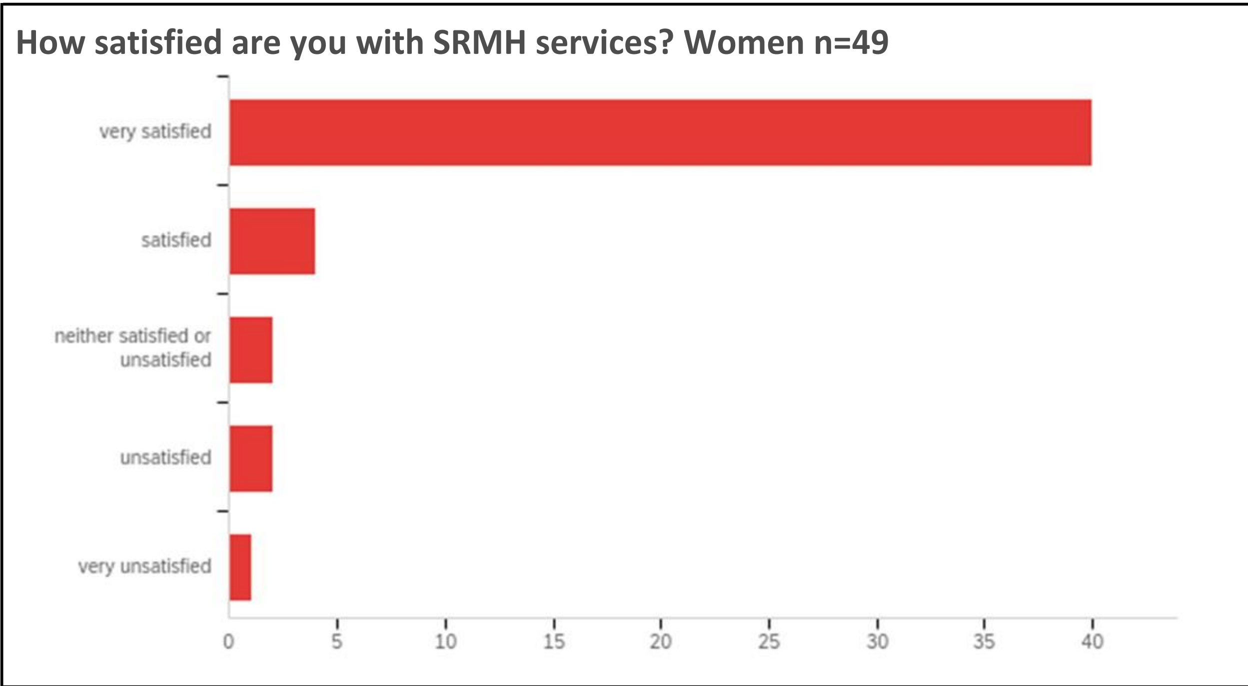


Figure 1:Women: How satisfied are you with SRMH services?

Very satisfied or satisfied accounted for 44 of 49 responses. The principal reasons provided included:

- Receiving timely and appropriate health care treatment and medications
- Information and resources
- Attention by health workers to women's needs before, during and after birthing
- Good health care for children
- Village visits and consultations
- Health staff are respectful, polite and helpful
- Ambulance came to the house when called.

One respondent stated that: “We feel that the health workers are like our family.” (FGD Participant). Causes of dissatisfaction related to the difficulty of receiving health care due to the distance travelled.

When men were asked about their satisfaction, they also reported high levels of satisfaction with SRMH services; 95% of 40 respondents.

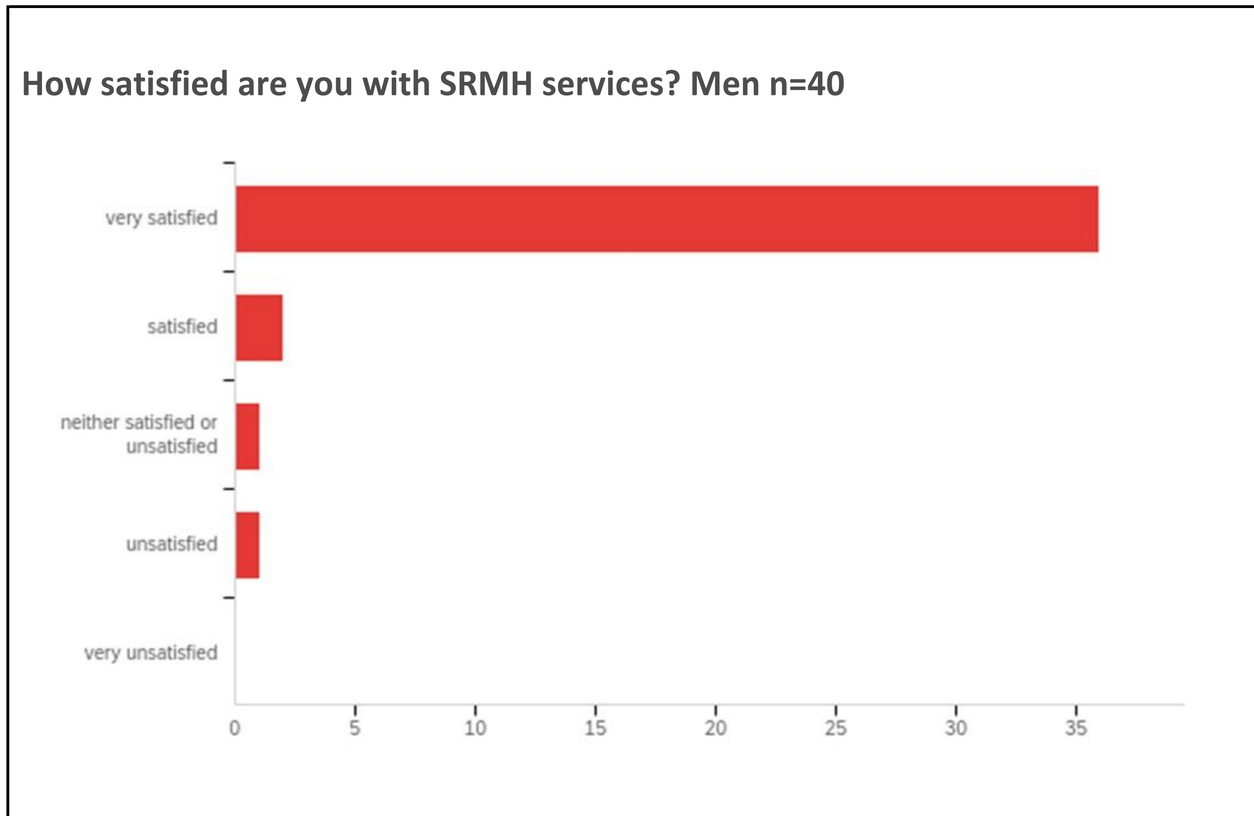


Figure 2: Men: How satisfied are you with SRMH services?

Reasons for men’s satisfaction in the services included:

- No longer fear for the health of mother and baby
- Health care treatment and medications
- Information and resources
- Attention by health workers to women's needs before, during and after birthing
- Normal and safe birth.

Dissatisfaction arose from the lack of service provision.

> “There is no health centre in the village so it’s very difficult for an emergency case.” (FGD Participant)

Finding 3: Community Score Card (CSC)

Outcome one: "What key changes has the program contributed to enable better quality health service outcomes?" is also addressed by reviewing the relationship of the community to health post and CHC service personnel, identifying changes or improvements over the length of the program. Participants of the survey and health workers and administrators were all asked a series of questions about the relationships between health providers and their communities, since the HAMORIS project began. This line of questioning included participation in CSC meetings and addresses Indicators 1.6 and 1.13.

The CSC program finalised action plans for each of the CHC and health post sites in the HAMORIS project from 2017. At baseline, the authors noted all sites had systemic issues and inadequate quality standards for health services. These included poor infrastructure, access and staffing. The MTR found the same persistent issues. "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" (p. 29).

As a part of enabling and providing better quality health service outcomes, community relations between health staff and the community is important. Health workers, administrators and community leaders unanimously agreed that the community has better relations with the health providers since the HAMORIS project started. They all agree that the community is able to meet with health personnel each time they need to and they agree that CHCs and health post staff communicate well with their communities. The results of the FGD with MSG/FSG groups validates this finding with all twenty focus groups strongly agreeing that the community has better relations with health providers since the HAMORIS project started.

In regard to meeting with health personnel on demand, like Finding 2 above, 90% of MSG and 85% FSG beneficiaries stated that they are able to meet with health personnel each time they need to. Distance to services is a barrier to receiving on-demand care as are road conditions which vary with seasonality.

All FSG/MSG respondents unanimously agreed that they feel listened to at a CHC or health post. More men than women had participated in Scorecard Meetings; 29 of 47 women and 35 of 40 men. Each said that health personnel were present, but male participants reported being able to inform health personnel about the community's needs during the Scorecard Meetings at a higher rate than women. Over 40% of women said they were not able to inform health personnel about the community's needs. Nearly 40% of women surveyed did not know what requests the community had made of the health services in their area.

Health workers and administrators agree that the CSC process is a good way to improve relations between services and the community. Their recommendations for improvement are:

- Information sessions on GBV for people with disability

- Continue beyond 2022 and target communities that experience high levels of poverty and malnutrition
- Continue health promotion for disease prevention for mothers
- Continue the program because behaviour change is not easy and requires more time.

Finding 4: CHCs Self-Report Meeting National Standards

The checklist from the MTR was given to CHC Chiefs to compare their reporting of staffing and infrastructure of services, and if, in their view, the CHC meets national standards. The results are presented in Table 4 below.

Across the three CHCs staffing has improved for all three, with Atsabe reporting higher changes in staffing since the MTR checklist was undertaken with notable changes in doctors, nurses and midwives. It is unclear why the number of observation beds reported declined, but ICU and maternity beds rose. Clean water is now reported in Atsabe, but access to clean water is a persistent health issue.

It is important to note that these results have not been validated by independent observers. However, they do show a trend of continuous improvement of the services in terms of their staffing, facilities and infrastructure. According to each Chief interviewed, all the CHCs of the HAMORIS's project area are meeting national standards for quality care.

Table 4 Community Health Centre Check list (MTR)

		MTR			Final		
#	Description	Fohorem	Fatumea	Atsabe	Fohorem	Fatumea	Atsabe
1	Doctor	1	1	2	4	1	5
2	Nurse	2	4	5	2	5	15
3	Midwife	1	1	2	1	1	6
4	Pharmacist	1	1	2	2	1	1
5	Nutrition Officer	1	1	1	1	1	1
6	Laboratory	1	1	1	1	1	2
7	Dentist	0	0	2	0	0	4
8	Malaria assistant	1	1	1	1	1	1
9	Medical record	2	1	1	1	0	0
10	Cleaner	1	1	3	2	1	10
11	Driver	0	0	1	1	1	1
12	Security	1	0	2	1	1	2
13	Toilet	7	10	3	7	n.a	2
14	Maternity Room	1	1	2	8	1	5
15	ICU bed	0	1	0	2	1	1
16	Observation bed	6	12	1	2	2	1
17	Delivery bed	2	0	2	n.a.	n.a	n.a
18	Drugs Availability	Sufficient	Sufficient	Sufficient	yes	yes	yes
19	Water Availability	Sufficient	No water	Insufficient	yes	yes	yes

Gender

Finding 5: Changing Social Norms and GBV

According to Outcome 2, the program will make improvements in gender relations at family and community level. The evaluation framework makes explicit the need to find evidence of changes in the broader community in attitude and/or behaviour regarding harmful traditional practices (Indicator 1.17). The following findings are cross-cutting themes across the HAMORIS project that demonstrate the project's effectiveness and impact at changing community attitudes towards women- both in their private and public lives.

Women surveyed report higher levels of tolerance of intimate partner violence (IPV) than men, and husbands are justified to physically abuse their wives under certain circumstances. Table 5

below provides the range of justifications women and men selected in the survey. The exception: a husband is never justified in hitting his wife, was selected by only 16% of women and 21% of men.

Table 5 Is it okay for a husband to physically hurt his wife if she (does/does not do) …?

	Disobeys her husband	Neglects household chores	Disrespects in-laws	Is unfaithful	Does not prepare food on time	Argues with husband	Husband is never justified
Women N=49	19 (14%) 21 (16%)	19 (14%)	17 (13%)	24 (18%)	15 (11%)	15 (11%)	
Men N=40	13 (15%) 18 (21%)	9 (10%)	9 (10%)	18 (21)	5 (6%)	9 (10%)	
Community Leaders N=10 men	1	0	0	0	0	0	6*

The MTR used a different question to examine the issue of GBV and the evaluators cannot determine if the program has shown any changes in people's attitudes and behaviours towards IPV and GBV since the program's commencement.

By contrast, in their response to the question: "Is it okay for a husband to physically hurt his wife?" health administrators and workers of the project's CHCs and health posts are nearly unanimous in their response that it is never justified. Some participants discussed attending to injured women, providing support counselling and counselling to young people about behavioural risks to prevent violence. Health workers are aware that domestic violence is a crime.

Health workers, administrators and Community Leaders were asked if they think the HAMORIS project activities could increase the risk of domestic violence. All respondents said no but made some suggestions to avoid any future risk. These are:

- Risk that men may suspect wives of drawing credit in the Savings and Loans group
- Ensure benefits continue to be for all the family
- Provide good information to communities to prevent violence
- Continue to provide training for health care workers and the community, with a focus on women living with a disability
- Continue to socialise the information related to domestic violence to increase their knowledge because the knowledge is not enough yet and CARE's program will end.
- Suggest disseminating CARE information at the sub village level.

> “[Married women cannot get contraceptives] when the husband disagrees, it can cause violence, then run back to the health sector, that is why, if a patient wants to get contraception, they must have permission from their partner.” (KII Midwife)

Nine out of ten Community Leaders reported that they had not heard of cases of domestic violence between husbands and wives or young couples planning to get married, in the past six months. Administrative data sets are not available as a system to collect administrative data on

VAWG, including DV/IPV, in line with international standards, across different sectors held with the National Statistical Office, is in development (European Union and the United Nations, 2020). One respondent commented that the dispute had been resolved and the couple was sent home.

Finding 6: Dowry Payment Continues to Limit SRMHR

A cultural practice that is found to undermine GE efforts is the custom of paying a bride price to secure marriages of young women and men, by their families. The practice of paying a dowry payment remains common but is contentious.

> "When a man and a woman have plans to get married, both families will talk together to talk about the cultural tradition of dowry to recognize a woman's family. We have a [belief] that when the man's family does not give dowry to the woman's family, they will get cursed and will be barren." (FGD Participant)

The practice is preventative of married women exercising their right to contraception to reduce and space children.

Disability Inclusion

Finding 7: HAMORIS Project Inclusion of PWD

An objective of the evaluation is to assess the inclusion of People with Disabilities (PWD) in the HAMORIS project. The surveys included questions on personal disability of which only three MSG/FSG respondents said they have a lot of difficulty with self-care, washing or dressing and five have a lot of difficulty seeing. Due to protocols around anonymity and de-identification of participants, it is not possible to report the three people's particular view on changes made in regard to access and social inclusion. However, the evaluators found enthusiasm and serious attention given to inclusion of PWD at CHCs and health posts and a line of questions were asked of KIIs.

Five health workers and administrators stated that they see PWD, that the service has conducted awareness raising and training on disability inclusion, and that PWD have been engaged in decision-making.

> "Yes! They have! They present arguments, analyse the consequences of a decision, give ideas, suggestions and ask something related." (KII Chief administrator)

Community Leaders responded that they did not personally have any disabilities, however all of them noted an increased engagement in decision-making and inclusion in their meetings for PWD such as:

- Modifications to buildings in four sub-villages
- Inclusion in the agriculture group to grow vegetables and kidney beans with the products being sold at market
- Encouragement to attend meetings
- Provision of time to hear from and share PWD's concerns at meetings

- Community awareness training and information to inform communities of disability inclusion strategies and antidiscrimination measures.

> "Before CARE implemented the program most of the community thought that it was not necessary or important to involve people with disability in the event or meeting." (FGD participant)

> "I think the program is really good because before CARE implemented the program, the community in this village did not respect people with disabilities… but when CARE asked people with disabilities to participate, they participated actively and were involved in the decision-making process. It means that people with disabilities have equal rights and this is good." (KII Chief of Village)

The primary reason why health service personnel said that they don't include PWD is due to not seeing them in their community. However, this comment from a nurse might provide insight into why this is the case.

> "Sorry we rarely attach the importance of [PWD] but we have recently received training… because our communities will lack knowledge of the participation of persons with disabilities in any decision." (KII Nurse)

Finding 8: Improvements for Women and PWD

Community Leaders recommended the following to continue to help women and PWDs be more active in decision making in the suco:

- Implement specific projects to enable and build capacity for PWD to have equal rights
- A specific program for women and girls with disabilities
- Involve PWD during implementation of the program to convey their ideas, suggestions and recommendations
- Project could facilitate PWD needs for increased participation, i.e. provide reading glasses and wheelchairs
- Continue to enable women to be leaders.

Coherence

Finding 9: Coherence with the National Strategic Development Plan 2011-2030

With a focus on maternal and child health the HAMORIS project is consistent with Timor-Leste health priorities to reduce the maternal mortality rate from 195 deaths per 100,000 live births (Demographic and Health Survey, 2016). The project aligns with the Timor-Leste National Strategic Development Plan 2011-2030 that contains a section on reproductive and maternal health. Priorities include:

- Reducing total fertility rate
- Increasing the prevalence of contraceptives
- Reducing adolescent fertility rates
- Increasing coverage of skilled care at birth, and
- Increasing coverage of neonatal/postpartum care.

The Government of Timor-Leste has also committed to a decentralisation plan and system of local government. The HAMORIS project has supported this decentralisation program by strengthening municipal level health service provision, including responsiveness to providing quality SRMH services which meet community needs.

> "Before it was too hard to attend to pregnant women in Nanu Health Post, but with the presence of CARE's help reporting our problem to the MoH, then finally we have a health post in Nanu. Meaning that CARE already solves problems for pregnant women and children compared with before, now is much better." (KII Chief CHC)

Relevance

Finding 10: Program is Relevant to the Program Participants and Stakeholders

Key informants from the health services and Post Administrators were unanimously grateful for the HAMORIS project since its commencement in 2017. They describe multiple benefits to the community including improved women's health, changing cultural norms, better access to services for PWD and more, in line with the project's goal, outcomes and outputs. The stakeholders and program participants welcome CARE International and acknowledge their culturally sensitive approach and adaptability, including during the COVID19 pandemic social lockdowns.

> **"**From the beginning when CARE entered in Atsabe, we worked together and worked very well, because it helped us in the SiSCa (Integrated Community Health Services), nutrition and breastfeeding programs. In the past, there were very few health workers, but with the presence of CARE, it helped us in sharing work plans to conduct cooking competitions – nutritious food, pregnant women and breastfeeding mothers at the rural level." (KII Midwife)

> "I appreciate the community and partner's on working together with leaders and partners who came together at the Fohorem Administration Post to work together for success. During the COVID-19 pandemic we worked hard. I am sad that CARE's program ends in my Administrative Post… It is necessary to look after the staff here because they have been working hard. (KII Chief Post Administrative)

Finding 11: Cultural Change

Evidence of changes in the broader community in attitude and/or behaviour regarding harmful traditional practices, are documented below. The evaluators find that the program has made an impact on community attitudes towards gender equality and a reduction in harmful cultural practices against women, in particular GBV and IPV (see Finding 5 above). Women's participation in decision-making and public life is improving (see Finding 24). However, while women and men say that there is greater sharing of household responsibilities and parenting in the home, the '24-hour clock' activity reveals that women perform between 30 – 45% of the daily household and child-caring roles. The activity also shows that fathers are participants in their children's care.

This activity was not undertaken at baseline or MTR stages so it is not possible to compare findings with earlier results.

Finding 12: Demand for MOdern Contraceptives

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. Participants of the evaluation agreed that married women who need contraceptives can get contraceptives. See more findings below, Findings 15, 16, 17.

Finding 13: Contraceptive Knowledge, Attitude and Practice

The MTR found that women's knowledge of at least one modern contraceptive increased from 37% to 86% from the baseline period. Of the 49 female participants of the final evaluation survey, 45 stated that they have knowledge of at least one modern contraceptive method (92%). It is important to note the variation in sample size however, this finding suggests that the project may have continued to develop women's knowledge of their reproductive choices.

As mentioned above in Finding 12, cultural barriers and limitations to extending contraceptive knowledge to unmarried and divorced women, prevail. Health workers and administrators were asked to describe their attitudes and practices around contraception and women outside of marriage. One stated that there are programs available for youth. However, many others reported that women cannot (and will not) be provided contraception if they are not married, and some health services will not give contraception to divorced women. (This is a sensitive topic and was not discussed in the FGDs.) The reasons provided are not always grounded in health science.

> "We did not attend to the problem requested by the youth. Actually, they cannot get contraception before marriage because it will cause infertility with large side effects." (KII Nurse)

> "We will not provide contraception if she is divorced." (KII Midwife)

Tensions between the teachings of the church and SRMHRs, challenge the decisions that health service workers can, or may want, to make.

> "In the past, if the church leader had not intervened, we would attend family planning for young people according to the orientation. However, it is now unauthorized for them." (KII Chief of CHC)

> "There are two parts of contraception: modern and natural contraception. They effectively use natural contraception like condom to prevent all disease regard sex relation. The health workers are opposed to the religion leader's opinion about

contraception. The church leader's mean that when a woman use contraception, she is a violation to God's creation and it violates human right to life. The health position means that contraception is one method to space children and good health for mothers to increase the domestic economy including family healthy life." (KII Nurse)

Efficiency

Finding 14: Project Efficiencies

In terms of the proportion of MSG members who received a minimum of four ANC visits; Finding 18: Access to SRMH Services (see below), provides participant data that suggests this target has been met.

Findings under the Effectiveness, Impact and Gender criterion all demonstrate high levels of regard for the project, improved service delivery through staffing, resources and infrastructure improvements and attitudinal shifts towards control and access for women and PWD. Project management coordinated stakeholders and implementing partners; staff received sufficient training to facilitate activities, and staff actively advocated and became champions for transformative change.

CITL has engaged project partners and maximised the efficiency of delivery of activities. For example, substantial changes to the community have been achieved regarding attitudes towards, and inclusion of, PWD as well as shifts in cultural norms towards GBV. This has been achieved with the strong collaboration between CITL and local disability partner Raes Hadomi Timor Oan (RHTO) who have provided technical support and support disability inclusion awareness raising around health, greater engagement of people with disabilities into activities, as well as referral services.

Impact

The impact of the HAMORIS project is found to be high with improved access and utilisation of services, engagement of men and women and consistent or improved participation in family planning, Ante-Natal Care (ANC), Post-Natal Care (PNC) and Safe Birthing.

Finding 15: Perceptions of MSG/FSG Members

The evaluation finds that the perception of MSG members to a series of questions concerning normative values and attitudes towards women's access to services, decision-making and violence, are improved in comparison to responses to these same questions in the MTR.

The MSG groups showed higher rates of agreement in 2022 concerning giving birth at a health facility and with a SBA. With regard to IPV, more women agree in 2022 that it is ok to tell other people if she has been assaulted by her husband and that others should intervene. More women

disagree with the proposition that a husband (or his mother) should be the one deciding when to have children.

Men from the FSG report a variation in response to the first question with higher numbers disagreeing that it is better for women to birth at a health centre in 2022 than 2020, and a slight shift regarding the use of SBAs. Regarding IPV, men agree that women should seek help by talking with others and more men disagree with the proposition that a husband (or his mother) should be the one deciding when to have children.

Table 6 Support Group members' perception on statements related to harmful practices – Comparison Between 2020 MTR and 2022 Final Evaluation (MSG Women N=49 / FSG Men N=40)

Item Description	Agree MSG 2020	Agree MSG 2022	Disagree MSG 2020	Disagree MSG 2022	Agree FSG 2020	Agree FSG 2022	Disagree FSG 2020	Disagree FSG 2022
It is better for a woman to give birth at home than in a health facility.	10%	19%	88%	81%	9%	3%	86%	97%
It is better for a woman to give birth with a traditional birth assistant than with a SBA.	7%	17%	93%	83%	2%	5%	89%	95%
If a married woman has been beaten up by her husband, it is okay for her to tell others.	58%	62%	39%	38%	41%	62%	37%	38%
If a husband beats up his wife, other people should intervene.	62%	67%	34%	33%	33%	73%	37%	27%
The husband (or his mother) should be the one deciding when to have children (spacing).	18%	10%	78%	90%	15%	10%	62%	90%

Finding 16: Contraceptive Use

The baseline report states that the available data on contraceptive use was 37% of MSG participants. Contraception includes implants (16), injection (82), tubal ligation (2) and the contraceptive pill (1). The mid-term notes that the proportion of members utilizing modern contraception methods increased from 37% to 57% among MSG members.

The survey conducted for the final evaluation found that 65.31% of MSG members, or 32 of the 49 respondents, have used contraceptives in the last 12 months. The participants of the FGDs agreed or strongly agreed with the statement: women in this community who need contraceptives can get contraceptives. Noting Finding 12 above regarding demand, this is likely to be available only to married women, not 'all' women. From the survey data available, this distinction is not able to drawn.

The most common contraception used in the last 12 months is an injection (18), followed by an implant (11). One woman stated she uses the natural method, and two women are on the pill. And yet, there are still prevailing barriers to accessing contraception based on cultural and religious norms.

"They [unmarried women] are unable to get the contraception because our chief and midwife are not authorized by the MoH." (KII Doctor)

"The Ministry of Health has a measure that when mothers want to get the contraception they must agree with her husband. Health personnel will confirm via phone when they [married women] get contraception." (KII Chief of CHC)

"I think that religion and culture are not barriers [to accessing contraception] but they are instruments to repair human life about morals and conscience. Culture and religion's intervention to educate our children because globalization affects their mindset to mistake using family planning for free sex." (KII Chief of CHC)

Finding 17: Family Spacing

As reported in Table 6 above, the evaluation's survey of FSG/MSG members shows that 90% of women disagree that family spacing (amount of time between children) is the husband (or his mother's) decision. However, in the FGDs there was division about the rights of mothers and the rights of families to make such decisions, by both men and women participants. If a dowry has been paid, husbands and their mothers have a right to dictate family size. Others suggest it is the married couple's responsibility as well as the mother's right. According to the health workers and administrators the primary reason for women's use and demand for contraception after childbirth is to space pregnancies. It is issued to women to aid them in their postpartum health and recovery.

Community Leaders all noted an increase in shared decision making about family planning (child spacing), as well as:

- Awareness that there is a need for post birth health care
- The impact to family economics without child spacing considerations
- Children are being born 5-6 years apart instead of annually
- Increase knowledge and access to natural and modern contraception
- Increased interest in CHC services.

Finding 18: Access to SRMH Services

"Before this project started, we felt very sad because so many mothers died, but after this project there were a lot of opinions and women's support groups were held along with health promotion. All of this makes me very grateful because human resources are not enough to promote health in rural areas and the CARE Project talks specifically about this and works for the mother and child. This is an emergency and priority job because our mothers can get check-ups and recover but they don't give birth. So, at every meeting I always remind the midwife that even though the pregnant woman is physically good, it is still a priority because previously we had only one midwife and we had one case when a mother died. This case occurred in Dato Tolu, the midwife from Fohorem before arriving,

the mother was already dead, but now we have a midwife at every health post." (KII
Program Manager of Municipal Health Service)

The baseline study used KIIs and FGDs to report that despite awareness of SRMH services and women's rights to access these, a high number of women chose not to access services. In terms of control, the authors reported that women felt a lack of empowerment and were not comfortable with decision-making, culturally the realm of husbands and mothers-in-law. This finding was closely linked to women's informed decision-making over sexual relations (Indicator
2.3). Women reported the freedom to access ANC and PNC but placed domestic responsibilities ahead of their visits. Health workers need to encourage women to attend.

The mid-term surveys found that only 56% of 61 women had access and control over quality SRMHS and the least accessed services were family planning and giving birth at a health facility. The midterm also noted that women who have been pregnant since the start of the project declared that they were able to access all basic SRMHS and the decision to access these services was taken together with their husband.

Women were asked in the evaluation's survey if they attended ANC visits now or in the past. 32 of the 44 (72.3%) who responded said yes. On average, women visit 5.5 times (Indicator 1.1
Number of MSG members who received a minimum of ANC4). Few reasons for not attending were provided but distance and weather conditions were reported. When asked: Who decided whether or not you should attend ANC visits? 68.7% of women said they decided with their husbands and 25% said they made the decision.

The final evaluation survey asked women where they had given birth. It is not known if these respondents had given birth since joining the program. Table 6 above shows a very high number of MSG/FSG members who agree that women should give birth at a health service despite this over half (54.3%) said they gave birth at a health facility with an SBA. 60% of women surveyed had given birth with an SBA. Nearly a third said they made this decision and just over two-thirds said they made it with their husband. One woman said the decision was made by her husband. The MTR stated that: "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." (MTR, p. 18). The final evaluation data does not suggest a decline in this trend.

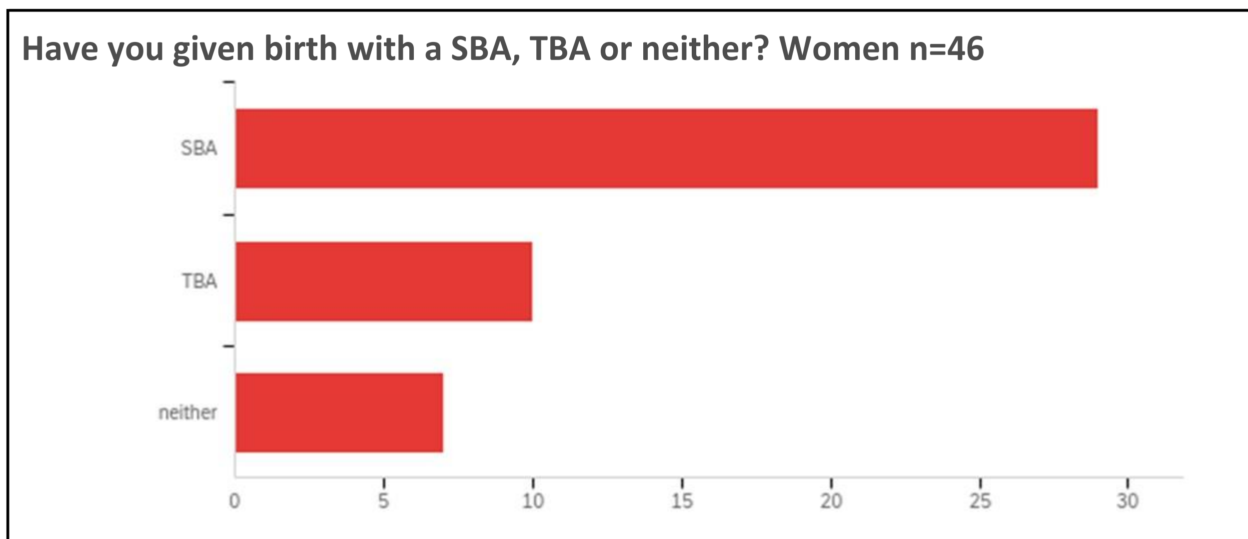


Figure 3: Have you given birth with a SBA, TBA or neither?

Like the midterm report, this decision was made by men and women together (63%). Women who did not give birth at a health facility reported overwhelmingly that this was because the hospital was too far from home or the roads were impassable at the time.

In terms of delivery preparation sessions, over 85% of women said they attended. Living too far from where the service was provided was the principal reason for not attending. Nearly 25% of women made the decision to attend, and 75% made it with their husband. All FGD participants disagreed or disagreed strongly with the proposition that it is better to give birth at home than at a health facility.

> "Want to give birth at the hospital because after giving birth the baby can get immunization, can get medicine for eyes. That is why we want to give birth at the hospital because we also get good attendance." (FGD Participant)

> "Because births at home are very dangerous for mothers; risk of death." (KII Health worker)

In regard to PNC, a very high number of respondents said they attended PNC visits, but it is unclear if women respondents answered in regard to any pregnancy or during the period of their involvement in the program. The average number of visits of the 39 women who said they attend PNC visits is 4.6, which may indicate exceeding the target of two set by indicator 1.2. One woman said support comes to her and another cited difficulty accessing health facilities. Decision-making is lower with only 8 women (17%) stating that they decided whether or not to attend PNC visits. Nearly 80% of the respondents said they decided with their husbands.

According to one doctor interviewed, more women are choosing ANC, PNC and deliveries at health facilities with SBAs because of the work done by CARE International and partners to promote quality and safe SRMH services.

> "There used to be many [at home], now they know which delivery is good through health promotion such as family planning, SiSCa, health in the family… and they know where to give birth." (KII, Doctor)

Although some changes may be shifting with intergenerational cultural change.

> "Changed because the traditional birth assistant is almost gone, the grandmothers who became a traditional birth assistant are all dead… giving birth at home still happens sometimes but always call health personnel to attend. Traditional birth is now just like 5% only." (KII, Ex. Chief of CHC)

The FGDs also reinforce the view that it is better to be assisted by a TBA.

> "I don't agree a woman to giving with TBA, because he don't have medicine and not understand the good and the bad and she doesn't have skill to giving birth. But in the days of our ancestors, we needed a TBA to help give birth, but now it's not because we have doctors and hospitals and complete medical equipment and get information about health from nurses and doctors." (FGD Participant)

Nine out of ten Community Leaders noted that there has been a positive change in the community's practice of giving birth at home instead of a health facility due to the project. One noted that some women prefer home births with an attendant because midwives at health facilities are not always available resulting in receiving treatment by a doctor (who is perceived to be mostly male) and the women are too 'shy'. Other reasons for giving birth at home are the poor road conditions and the travel distance to a health facility.

Additionally, all of the Community Leaders stated that the practice of using traditional birth assistants has decreased dramatically now that communities have a better understanding about the risk of delivering without support from health staff.

Finding 19: Men Sharing Information

The proportion of men who have shared information on breastfeeding with family and others, is an indicator of the utilisation and quality of the SRMHS. Over 97% of men surveyed said that they have shared breastfeeding information with their wife and extended family. Nearly 95% of the men stated that their wife has breastfed since joining the FSG. Men self-report that they support their wives while breastfeeding. When asked how, most men said by providing her with nutritious food, with several saying they cook, clean and support her with housework.

Finding 20: Men's Participation

Eight out of ten Community Leaders noted that although some men attended health education meetings, they also noted that women were more frequently attending more than men on a regular basis. The leader's interview gave a range of reasons why fewer men attended including, gender norms about women needing to be more informed than men about maternal and child health topics and the men taking on childcare so that women can attend.

Despite strong levels of support by the FSG members for women to access services rather than see TBAs, fewer men participated in the MSG/FSG meetings and activities. Across the 20 FGD sessions, it was mostly agreed or strongly agreed that there are usually less men coming to the meetings than women and that it is important to have men join the group meetings because of what they learn and the families' capacity for informed joint decision-making. They cite time factors and farming responsibilities as reasons for not attending.

> "Because this program talking about family planning means that the wife and husband can decide, that's why it is very important to us." (FGD Participant)
>
> "Want men and women to be equal because they can improve and increase knowledge about education, credit and fish ponds." (FGD Participant)
>
> "The change is women avoid TBAs because sometimes it can cause mortality because birthing practice is not safe, so the community have birth preparedness plans." (KII Chief of Village)

Data collection undertaken in September 2018 reported that out of the 92 FSG members surveyed 48 (or 52%) of group members reported that they (and/or their family members) were involved in developing the birth plan. While it is clear that the change to SBA and health facilities is encouraged and noted for their safety by all evaluation participants, it is unclear how many fathers are involved in developing the birth preparedness plan (Indicator 1.11).

Finding 21: Savings and Loans activity

While the MTR states that the saving and loans activity was initiated to attract men to join the FSG meetings, several Community Leaders commented that women have benefitted from using the savings and loans and its resources. One Post Administrative Chief commended the savings and loans activity stating it had generated $5,000 in his community (KII Post Administrative Chief).

Sustainability

Finding 22: Lasting Net Benefits

The HAMORIS project is likely to leave a lasting impact on the communities, but the net and long-term benefits are unable to be assessed, as the program only concluded in June 2022, at the time

of the preparation of this report. However, as this comment attests, the staff of the HAMORIS project note several changes in the community.

> "In my opinion, sustainable changes are:
> 1. Public awareness of the importance of maternal and child health and self-consultation at hospitals and health posts.
> 2. Regional leaders will drain KVK information about regional infrastructure development with parliamentary leaders about the progress of their respective regions.
> 3. The father's support group and the mother's support group work together to continue cooperative activities." (CITL HAMORIS project officer)

Training and capacity development of health staff has been raised by the health sector participants of the project. They want and need ongoing support to train more midwives as well as employ more nurses, doctors and health staff to fully equip their SRMHS. Similarly, the evaluation shows that community attitudes to gender equality, including women's rights and GBV, needs ongoing preventive campaigns and community awareness to achieve a transformative change.

> "More resources such as midwives need to be recommended, maybe also provide training to midwives because currently midwives touch science but there is no certificate in practice." (KII Doctor)

> "The CARE Intervention in our village allowed for good cooperation and annually we can convey our problems on a national level. CITL is a bridge between the community and the government." (KII Chief of Village)

Suggested improvements by these same community leaders and Post Administrators include adding doctors to Lactos Village (with four sub villages) to reduce the need to travel.

> "People now come with their spouse for a consultation as they already have a good knowledge of the health promoted by CARE. What is being promoted is the need to support the mother when she is sick and go to the health post and the father has to take the medicine because the mother's illness can be contagious. From CHC side, there are also cleaner services with hand sanitizer and hand soaps." (KII Midwife)

> "Currently [accessing] health services for those that are ill are also low because they understand what diarrhea is and how to take care of themselves at home if health facilities are far away. This is part of the promotion we have done to increase their awareness and knowledge." (KII Nurse)

Finding 23: Integrated Community Health Services (SiSCa) Activities

Health workers and administrator KII respondents all agreed that over the previous 2 years, SiSCa activities had continued to increase and remained more active than when the program commenced. This is attributable to the presence of CITL and the HAMORIS project. Regarding the responsiveness of the government to reducing barriers to SRMHS, community members overwhelmingly request the government to do more to meet local needs. Small gestures such as the one quoted below, are important supportive measures.

> "Increase also local leader consent to send their kids to the school in health sector then can help their communities in one day, because happen many times, health workers who come from other municipality not stay to long and back to their Municipality." (Health worker)

Finding 24: Community Roles and Leadership

According to the MSG/FSG participant surveys, there were slightly higher numbers of men reporting having positions in sucos and Councils than women, however both genders were equally involved at the community level (Indicator 2.8). Women reported higher participation levels of their partners having roles in the community vs men. Seemingly, men have been involved in community positions since the early 2000s and women's involvement has been more recent suggesting a positive increase in suco, municipal and community positions since the launch of the HAMORIS project in 2017.

According to the Community Leaders interviewed, they all have seen a greater involvement of women in decision-making in formal and informal spaces.

> "After the program was implemented, there were significant changes from women, who dare to speak in public spaces. I think this program has changed women's traditions. In the past women just in home, cooking and have no opportunity to speak but this program came and there are changes such as high participation of women in meetings, they make decision by themself and dare to speak in public however in first time so many people laugh at them but at the and there are changes." (KII Chief of Village)

> "The program made changes through creating meetings and socializing information and also changed women and men's mindset to involving women in events at sub village and village level and when women convey their ideas, men have to accept." (KII Chief of Village)

> "...currently they (women) have had significant changes, but not in all areas." (KII Chief of Village)

> "I also observe that in meetings women always involve themselves in there and they also talk about their rights and issues that they face." (KII Nurse)

Table 7 below summarises the reported roles of women and men in public roles and positions. The MTR found that 32% of men hold positions within the community and that the proportion of women in positions outside the home was 'significantly lower'. This indicates continued improvement in the status of women in their communities and is endorsed by health administrators interviewed as the following comment attests.

> "I think around 30% of women have positions in sub villages, villages and post administrative. We have to give them an opportunity. As we know, we targeted them 50% and now we achieve 20%-30%. We can see their participation in event activities in sub-village or village level and some of them have critical thinking. I follow their progress and I see their potential and now we are waiting for time to give them opportunity but sometimes because of patriarchal culture and male dominated marriage system (men give dowry to women's family). This is the problem, but now women got good education and they also need to be involved in decision-making. In Ermera municipality, for 7 years there are 2-3 women who hold positions as chief of the village. It means that there are changes like giving opportunity." (KII Ex. Director of Municipality Health Service)

Table 7 MSG/FSG Members Holding Roles in Councils/Municipal/Community (Xefe aldeia/suco/other)

MSG/FSG Members	#/% Postings at Suco Council	#/% Positions at Municipal Council	#/% Other Positions in Community	Partner (wife or husband) a member of the suco council	Partner (wife or husband) holding any other position in the community	Members reported having roles in the municipal government.
Women	8 (17%) sub village chief, youth chief representative,delegate	2 (4%) delegate	20 (42%) delegate, community mobilizer, family health promoter, secretary; youth chief representative, pre-school facilitator, group leader	9 (19%): sub- village leder, vice sub-village leader, cultural leader, youth chief, delegate	9 (19%) sub village leader, teacher, delegate, chief overseer for Uma Kbit Lek" since when held the position: since Care came to village, 2004, 2005 2017, 2020	0
Men	10 (27%) sub village leader, cultural leader,vice Sub Village Leader,Xefe Aldeia Asio, Chief Aldeia, chief of sub village	4 (11%) delegate, sub-village leader, Xefe Aldeia Asio	20 (51%) Sub Village Leader, Community Mobilizer, delegate, cultural leader, vice sub village leader, health family promoter, Xefe Aldeia Asio, organizer, Accountability & Planning Committee's President, Volunteer Teacher and Religion Teacher, Chelf Sub Village Coordinator	1 delegate	10 (26%) delegate,since Care came to village, 2017, 2018, 2019	0

Finding 25: Project Innovations to Improve Efficiency, Effectiveness or Sustainability of the Project Identified and Implemented

Project documents including AD Plans for DFAT demonstrate project adjustments, the inclusion of new activities and responses to the COVID-19 pandemic. CITL supported government efforts

to reduce the spread of the virus, public health promotion and promote vaccination. The COVID-19 pandemic response created a barrier for women attending SRMHS.

> "In the COVID19 pandemic situation no change because mothers are scared to come to the hospital because they are always getting swab tests in the health centre but after this, we reshared information and counselling with the mothers if they need to give birth and need to come to the health centre. That information is not just for mothers but also for fathers and now they come back again." (KII Health worker)

The evaluators also note efforts made to hand over the project to the local municipalities for its continuation under the direction of government other than CITL.

> "As in the handover process, during project closing, we handing over all the MSG and FSG group to our local government to take over the responsibility to monitoring and working closely to maintain all the groups to support community in terms sharing health information, mobilize community to participate in the SISCA program, and health family visit in their living areas, when Care ending the project." (CITL HAMORIS project officer)

3. Conclusions

Since 2017, CITL has operated the HAMORIS project to create lasting reductions in maternal mortality and morbidity by promoting appropriate and quality SRMHS. Explicit in the project outcomes is the objective to increase access and utilization of quality SRMHS by women and men and people with a disability, and improved gender relations at family and community levels.

The conclusions presented in Section 4 cut across the DAC and gender and inclusion criteria used in Section 3 to locate and organise the findings of the evaluation study. The conclusions below provide a synthesis of the findings and evaluators' overall assessment of the HAMORIS project. There are four sets of conclusions drawn from the findings:

- There is increased access and utilization of improved quality SRMHS by women and men in the targeted communities of the HAMORIS project
- Normative changes towards acceptance of Gender Equality and less tolerance for GBV, have been produced as a consequence of the project
- There are unintended consequences for marginalised voices, including PWD
- Many of the recommendations of the MTR were followed but further time, resources needed to implement them all.

Conclusion #1 - Increased Access and Utilization of Quality SRMH Services by Women and Men

Findings 1, 2, 3, 4, 9, 10, 13-17

> "I have felt the progress of my community in the Fohorem sub-district regarding pregnant women, giving birth to their children in health facilities and some mothers who always check up at the hospital. This all happened because the CARE Team had formed a men's group and a women's group that used to distribute tasks with his wife or his household family. With that, I once again convey to CARE that over the past 5 years there has been a lot of great progress and development through the health information shared by the HAMORIS project with its team of staff." Fohorem Post Administrator

The final project evaluation for CITL's HAMORIS project has found evidence of achieving steady progress since its 2020 MTR. Strong evidence was found that health facilities are providing better care since the project's inception, increased women and men's knowledge of SRMHR, and that health workers, administrators and community leaders have better relations with the health providers since the HAMORIS project was launched. Program participants are very satisfied with their ability to access and meet with health personnel when they need to, indicating an increase in staffing since the MTR, and they concur that CHCs and staff communicate well with their communities. There is a higher understanding by women and men of the importance of using modern birthing practices, medications, services, and health facilities.

The establishment of FSGs has shown positive improvement and could be sustainable with ongoing support with topics and scheduling meetings at appropriate times of the day, as these

activities are important for men as well as women to keep their families healthier. Many of the activities that can be attributed to the HAMORIS project and its partners, align well with Timor-Leste's work to decentralise its government resources by strengthening municipal health services to be more accessible to rural populations.

The evaluation authors commend CARE and its partners for the strong advocacy work done to increase collaboration and coordination of SRMH services as well as the noticeable efforts to engage and educate women and men resulting in increased awareness of safer birthing and nutritional options. The evidence indicates that the riskier 'traditional' birthing practices are used less frequently, and often only in case of emergencies or difficulty in accessing services due to transportation or road conditions. Additionally, program participants noted they felt more informed from the increased engagement with and reporting to the communities at the suco, aldeias, and administrative post levels on maternal health and modern contraception.

Conclusion #2 – Normative changes towards acceptance of Gender Equality and Gender Based Violence

Findings 5, 6, 7, 8, 11, 12, 18-20, 24

> "I have two barriers to contraception use:
> 1. No authorization from husband to their wife.
> 2. Cultural influences because according to my observation, women who already complete their dowry, the man's family will never authorize the use of modern contraception. They said that "we already paid the dowry, if you use contraception, you will be barren". If women are barren, they will suggest to their brother or son to divorce them immediately." (KII Midwife)

A primary goal for HAMORIS was the 'improved gender relations at family and community levels' which suggests demonstrating progress in the ways in which a culture or society defines rights, responsibilities, and the identities of men and women in relation to one another. Gender equality and women's empowerment, central to balanced gender relations, are a human right as well as an essential goal (SDG 5) of the United Nations Sustainable Development Agenda and Goals for 2015-2030[1]. Gender equality can prevent violence against women and girls, is essential for economic prosperity in any country and studies show that societies that value women and men as equal are safer and healthier. Yet, to date, no country has achieved gender equality.

Community roles and leadership show that MSG/FSG saw a slightly higher number of men reporting having positions of leadership and responsibility in sucos and councils than women, however both genders were equally involved at the community level.

Although this evaluation was able to document changing cultural norms and knowledge of SRMHR and SRMHS in the communities where HAMORIS was implemented, the evaluation also

[1] https://www.un.org/sustainabledevelopment/gender-equality/

illustrates mixed results in regard to GE. The community attitudes to gender equality, including women's rights to family planning, and prevention of GBV need ongoing campaigns and community awareness to achieve a transformative change. The evaluation does indicate that some men attended the education meetings where most of the SRMHR information was disseminated, however women are still the most predominant and consistent attendees.

Women surveyed indicated higher levels of tolerance of partner violence than men, and husbands are justified to physically abuse their wives under certain circumstances. Husband's perspectives have seemed to improve about their rights to perpetuate violence against their wives, yet the women seem to be less confident about their own rights. By contrast, community leaders (except for one) and health care workers reported that it is never appropriate for husbands to use violence against their wives. IPV and GBV in Timor-Leste is among the highest in Asia[2] and gender equality awareness and behaviour change programs are prevention measures to eradicate IPV and GBV.

The lack of women's empowerment was evidenced by the fact that women did not always feel comfortable with decision-making, which culturally is relegated to the realm of husbands and mothers-in-laws. Women felt they had freedom to attend pre- and post-natal care, but at times felt compelled to prioritise their domestic responsibilities over their health. Attitudinal work with health care providers on GBV response, GE, and contraceptive availability, is an ongoing requirement. Access to contraception is more tolerated when administered with a husband's formal permission, for married women.

Even with the documented progress of SRMHR, there are areas that still would benefit from additional efforts. At times, there may be conflict in families regarding who should be involved with family spacing decisions. In surveys, women overwhelmingly disagree that the decision should remain with the husband (or his mother's), as is currently the cultural practice. Women and men in the FGDs were divided about the rights of mothers and the rights of families to make such decisions. This power dynamic tension is influenced by the practice of paying dowries for a bride, which in essence transfers some decision-making powers from the mothers to husbands (and their mothers). The dowry system as noted by international agencies, dehumanizes women by treating them as goods that can be exchanged.

Conclusion #3 – Unintended Consequences for Marginalised Voices found

Findings 7, 8, 12, 21-23, 25

> "I agree because it [access to contraception for unmarried women] is related to a human's privacy but the church leader disagrees. We have one protocol named SARMANELA to attend to young people's problems with contraception but it failed… Because based on culture and morals, we just follow what the Church asks, that family planning is just for families who get married at Church. If there is some family who didn't get married yet

[2] https://evaw-global-database.unwomen.org/fr/countries/asia/timor-leste

> needs contraception for their health issue, then we will attend to them." (KII Director of Municipality Health Service)
>
> "No discrimination in project implementation, they involve men, women and people with disability to participate in implementation of project activities." (KII-Health Worker, Administrator)

To achieve authentic inclusion of PWD communities need to be educated about PWD strengths and capabilities. CITL and its partners are to be commended on their successful efforts to educate communities about the needs and benefits of increased inclusion of PWDs. Their empowerment, increased accessibility to some buildings, increased engagement with decision-making, and overall advocacy noted in the evaluation findings indicate a positive trend. Other support noted for PWD included:

- Inclusion in the agriculture group to grow vegetables and kidney beans to be sold at market
- Encouragement to attend meetings with attention to their voices heard
- Provision of time to hear from and share PWD's concerns at meetings, and
- Community awareness training and information to inform communities of disability inclusion strategies and antidiscrimination measures.

Without appropriate anti-discriminatory community education and awareness, PWD are at risk of being singled out for different treatment. The attitudinal sentiment of health workers and MSG/FSG participants did not present any evidence of differential treatment, and resource allocation towards physical accessibility aids, i.e. ramps, were accepted as needed reforms. As mentioned, there were too few PWD identified in the study to represent their views. More work regarding their perceptions of these changes is required.

As with most interventions that seek to shift cultural norms, there are always some positive and negative unintended consequences. Although no one under the age of 18 was interviewed, the need to target young people with SRMHS and information was noted by midwives, nurses, and local leaders. Although married women have increased access to contraception, and some are enacting their agency around family planning, contraception was often denied to unmarried or divorced women with information and services were denied to youth (male and female). Healthcare workers noted that new mothers often seek contraception after childbirth to space pregnancies, but these decisions are hampered by cultural norms which dictate a husband's need for approval for contraception use.

An ongoing, negative, yet influential contextual tension is the gender inequality guidance being advocated for by faith-based organizations and leaders which often contradicts the scientific recommendations and international standards for sexual and reproductive health. The rights to access SRMHS influence health and wellbeing for women and men with gender norms, roles and relations, and gender inequality and inequity, affecting people's health. Harmful gender norms – including those related to rigid notions of masculinity – affect the health and well-being of boys and men and can contribute them perpetrating violence against women and girls. The need for

a collaborative advocacy campaign for the sexual and reproductive rights for all members of a community, regardless of gender or marital status is essential.

A positive unintended outcome was the usage of the savings and loans schemes, originally targeting FSGs, but also used by MSGs. Community leaders also noted the additional revenue being generated for the community because of the financial schemes.

CITL's HAMORIS project's goal was '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.' Although this evaluation did not capture mortality and morbidity reductions from Timor-Leste government administrative sets, studies show that pregnant women and newborns need a continuum of quality health care to reduce preventable mortality and to improve maternal and newborn health.[3,4] This evaluation can conclude therefore, that the HAMORIS project contributed to this effort.

Conclusion #4: Many of the recommendations of the MTR were followed but further time, resources needed to implement them all

The final evaluation TOR asks the evaluators to comment on the progress made of the recommendations from the MTR. The following table provides this analysis. The original table is taken from the summary of recommendations in the MTR. The evaluators have considered the evidence found and noted change against each recommendation provided in terms of 'Yes' evidence is found, 'Some' evidence is found or 'No' evidence was found. The number in parenthesis corresponds to the numbered recommendations in column 1.

Table 1 2022 End Report Summary of Achievements based on 2020 Mid Term Report

	1. Improved access to quality SRMH services	Evidence Found		
		Yes	Some	No Evidence
(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.		(1) ✓ (2) ✓ (3) ✓	
(c)	Expand awareness raising on SRMHS outside Support Groups through: (1) role models by leading MSG members; (2) training the PSF working in remote areas on SRMHS activities; and (3) working with local radio channels to broadcast information on SRMH, interviews of Beneficiaries, success stories, etc.		(1) ✓ (2) ✓	(3) ✓
(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.			

[3] Bhutta ZA, Das JK, Bahl R, et al. Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? Lancet 2014; 384: 347–70.

[4] Miller S, Abalos E, Chamillard M, et al. Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. Lancet 2016; 388: 2176–92.

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. ✓

) 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 ✓

(b 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. ✓

) Targeting young men and women: (1) specific education sessions aimed to reduce adolescent birthing; (2) short interventions on contraception in high schools. ✓

(c)

(d
)

3 Effectiveness of the CSC approach

Advocate to MoH for prioritizing the action points in suco action plans which (1) ✓ (3)✓

(a
) 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. (2) ✓

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. (1) ✓ (2) ✓

(b Increasing women participation in CSC meetings at suco level: (1) use locations closer to communities; (2) provide children food incentives; (3) use official invitations. (1) ✓ (2) ✓ (3) ✓

) 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. ✓

(c)

(d

)

4 Effectiveness of the Social Analysis and Action process and promoting gender balance

Increase socializing of Gender-Based Violence law: (1) work with the (1) ✓

(a) community police; (2) organize night events/short movies; (3) work with traditional/religious leaders (2) ✓ (3) ✓

(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 ✓

(d)

s h o w s , or small movies) where the results of the 2018 GPA study could be socialized

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)**			
	Pursue project efforts to identify PLWDs in HAMORIS target areas.		✓	
(a)	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**			(1) ✓
	Systematically involve health authorities into project activities so as to			
(a)	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			(2) ✓ (3) ✓

	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 <u>local leaders</u>: 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 activities 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.			✓

4. Recommendations

> "My recommendation is, if the project will continue to implement cooking demonstrations for pregnant and lactating women and youth, and if we can choose, involve communities that have minimum knowledge. The program for them is related to preparing complete food for babies 0-6 months, foods for pregnant and lactating women because our community in Atsabe, they focus more on business. Ermera Municipality also has a high number of malnutrition." - (Midwife - Atsabe)
>
> "If possible, continue the program because based on my observation some communities lack knowledge, especially youth." (Chief of Village /PAAS - Parami)

Recommendation 1: Continue to provide key components of the HAMORIS project, advocating for government support to strengthen SRMHS

Program participants overwhelmingly request that the HAMORIS project be continued. Noticeable change in behaviours towards using modern day health care maternal and child health suggests that the work conducted by CITL and its partners has started to culturally shift cultural norms, and should be continued. CITL should consider:

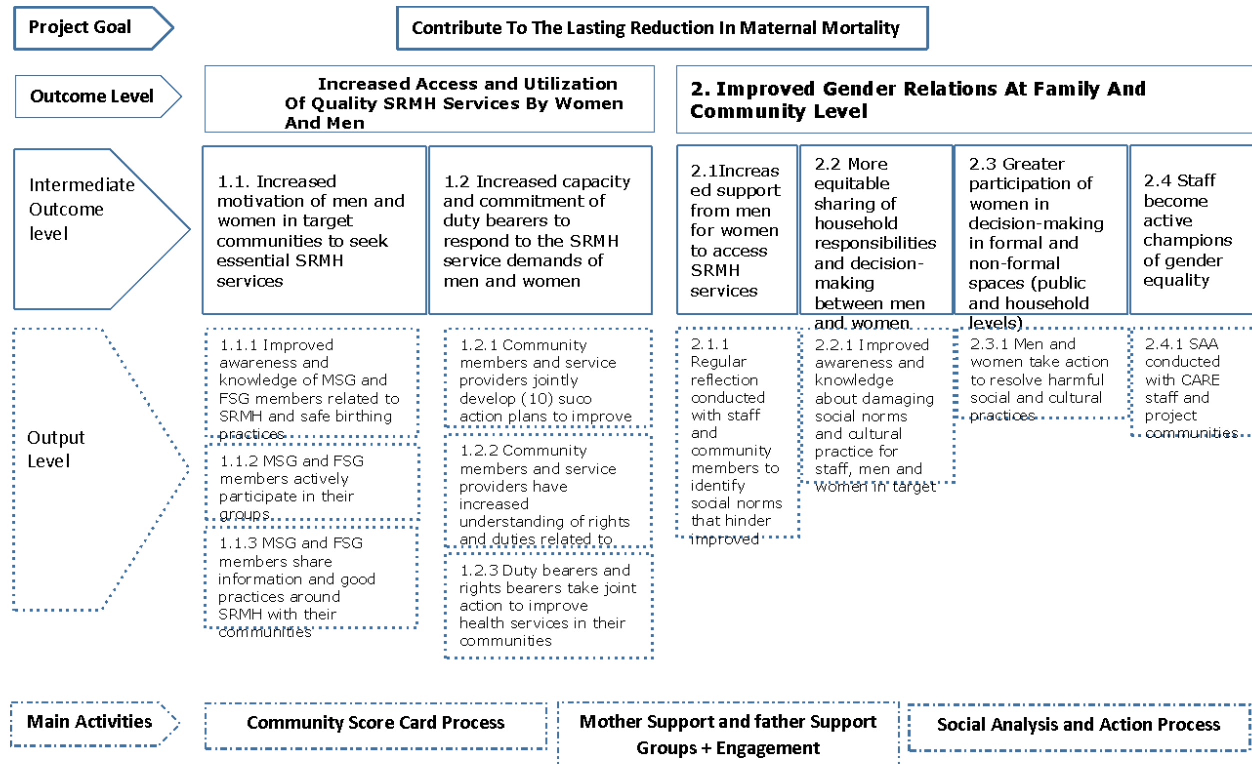
- Ensuring the project management team have a mix of men and women as it is noted that at the time of this evaluation, all staff were male
- Continuing the program, even if in some reduced manner by finding donors and funding support
- Supporting the training of midwives and other SHMHS personnel
- Continuing to assist infrastructure improvements at health services including access clean water and target areas that have the most difficulty accessing SRMHS
- Advocating with government to continue the provision of services, as well as reducing the barriers to access of services, particularly in rural and remote areas
- Supporting nutrition and immunisation projects to continue to reduce childhood malnutrition and improve the health of pregnant and lactating mothers
- Continuing working with men and boys, to improve their knowledge, awareness of gender norms, GBV and continue to nudge behaviour change
- Supporting and expanding CITLs involvement in women's leadership and participation including savings and loans groups.

Recommendation 2: Community Leaders recommended the following to continue to help women and PWDs be more active in decision making in the suco and aldeia levels

- Implement specific projects to enable and build capacity for PWD to have equal rights
- A specific program for women and girls with disabilities to encourage their full participation and appreciation of their SRHMR
- Continue to advocate for the facilitation of PWD needs at SRMHRS.

5. Appendices

Appendix 1: Logic frame and Theory of Change



Appendix 2: Research Method Instruments

Final Evaluation Survey for MSG/FSG Participants

HAMORIS
Questionnaire for MSG and FSG members

[Instrument no. Q MFSG V1]

INTRODUCTION AND CONSENT [CARE TO PROVIDE CONSENT AND PROJECT INFORMATION]				
Respondent agreed to be interviewed				
Yes				
No				
Name and signature of interview (optional)				
SECTION 1 - GENERAL				
RESPONDENT DATA				
Name:				
Age:				
Gender [Select one] [1] Male [2] Female [3] Other				
Highest level of education completed [Select one] [1] Primary School [2] Secondary School [3] Technical/trade certificate [4] Diploma or degree [5] Never attended school				
Household annual income in USD [Select one] [1] Under $500 [2] $501 - $1000 [3] Over $1000				
Program area location (village/subvillage):				
Time interview commence:				
Time interview end:				
Date:				
The next questions ask about difficulties you may have doing certain activities because of a health problem.				

1.	**Do you have difficulty seeing, even when wearing glasses?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all				
2.	**Do you have difficulty hearing, even if using a hearing aid?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all				
3.	**Do you have difficulty walking or climbing steps?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all				
4.	**Do you have difficulty remembering or concentrating?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all				
5.	**Do you have difficulty (with self-care such as) washing all over or dressing?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all				
6.	**Using your language, do you have difficulty communicating, for example understanding or being understood?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all				
7.	Are you the head of the household? [1] Yes [2] No If not you, who is?				

8.	Are you a member of the suco council (Xefe aldeia/suco/other)? [1] Yes Specify the position: [2] No				
9.	Are you a member of municipal government? [1] Yes Specify the position: [2] No				
10.	Are you holding any other specific position in the community? [1] Yes Specify the position: [2] No				
11.	Is your partner (wife or husband) a member of the suco council (Xefe aldeia/suco/other)? [1] Yes Specify the position: [2] No				
12.	Is your partner (wife or husband) a member of municipal government? [1] Yes Specify the position: [2] No				
13.	Is your partner (wife or husband) holding any other specific position in the community? [1] Yes Specify the position: [2] No				
14.	Since when has your partner (wife or husband) held this role/position? [Open answer]				
SECTION 2 - BEING A MEMBER OF THE MSG/FSG					
Please answer the following questions about your membership with the MSG or FSG.					
15.	When did you become a member of the MSG/FSG? [Open answer]				
16.	What is your position in the MSG/FSG? [Open answer]				
17.	How often do you join the group meetings?				

	[1] weekly [2] monthly [3] quarterly [4] 6 monthly [5] other				
18.	How satisfied are you being a member of this group? [choose one response] [1] very satisfied [2] satisfied [3] neither satisfied or unsatisfied [4] unsatisfied [5] very unsatisfied				
19.	Is your partner (wife or husband) a member of the MSG? [1] Yes [2] No				
20.	If No, why not?				
21.	If you both go to meetings at the same time, and you have children, who takes care of the children? [Open answer]				
22.	Do you share things you learnt at the education sessions with people outside the group? [1] Yes [2] No				
23.	If Yes, with whom?				
24.	If Yes, what topics are they interested in?				
For women only:					
25.	If your husband attends meetings, do you think he is more supportive of your health needs during pregnancy, delivery and after delivery because he is a member of the FSG? [1] Yes [2] No	Gender			
26.	If Yes, what does your husband do to support you? [Open answer]				
For men only:					
27.	Have you shared the breastfeeding information with your wife and extended family?				

	[1] Yes [2] No				
28.	Have you shared the breastfeeding information with your extended family? [1] Yes [2] No				
29.	Has your wife been breastfeeding since you joined the FSG? [1] Yes [2] No				
30.	How have you supported your wife during the breastfeeding stages? [Open answer]				
SECTION 3 - SRMHR SERVICES					
Please answer the following questions about SRMHR Services you are familiar with.					
For women only:					
31.	Do you know any modern contraceptive method? [1] Yes [2] No				
32.	Which modern contraceptives do you know about? [Open answer]				
33.	Have you used contraceptives in the last 12 months? [1] Yes [2] No				
34.	Which contraceptives do you use? [Open answer]				
35.	Did you use contraceptives before the program started? [1] Yes [2] No				
36.	If you do not use, why not contraceptives? [Open answer]				
37.	Who decided whether or not you should use contraceptives? [1] I decided [2] My husband decided [3] We decided together [4] Other [please name]				
38.	Do you think all the women in this community who need contraceptives are able to get contraceptives?				
39.	What barriers prevent women from getting access to contraceptives? [Open answer]				

40.	Have you been pregnant in the last 12 months? [1] Yes [2] No [3] I am pregnant				
41.	Have you been pregnant before the program started? [1] Yes [2] No				
42.	If Yes, did you or do you now, attend ANC visits? [1] Yes [2] No				
43.	If No, why not?				
44.	Who decided whether or not you should attend ANC visits? [1] I decided [2] My husband decided [3] We decided together [4] Other [please name]				
45.	Did you attend delivery preparation sessions? [1] Yes [2] No				
46.	If No, why not?				
47.	Who decided whether or not you should attend delivery preparation sessions? [1] I decided [2] My husband decided [3] We decided together [4] Other [please name]				
48.	Where have you given birth? [Open answer] [1] home [2] health facility				
49.	If home, why did you not deliver in a health facility? [Open answer]				
50.	Who decided whether or not you should deliver in a health facility? [1] I decided [2] My husband decided [3] We decided together [4] Other [please name]				
51.	Have you given birth with a: [1] SBA [2] TBA [3] neither				

52.	If TBA or none, why did you not get assistance from an SBA? [Open answer]				
53.	Who decided whether or not you should get assistance from an SBA? [1] I decided [2] My husband decided [3] We decided together [4] Other [please name]				
54.	Did you attend PNC visits? [1] Yes [2] No	IF YES TO Q50			
55.	If No, why not?				
56.	Who decided whether or not you should attend PNC visits? [1] I decided [2] My husband decided [3] We decided together [4] Other [please name]				
57.	How satisfied are you with SRMHR services? [choose one response] [1] very satisfied [2] satisfied [3] neither satisfied or unsatisfied [4] unsatisfied [5] very unsatisfied				
58.	If satisfied or very satisfied, why? [Open answer]				
59.	If unsatisfied or very unsatisfied, why? [Open answer]				
For men only:					
60.	Do you think all the women in this community who need contraceptives are able to get contraceptives? [Open answer]				
61.	If your wife is pregnant, do you:				
62.	agree that she completes all ANC check-ups? [1] Yes [2] No				
63.	agree that she completes all PNC check-ups? [1] Yes [2] No				

64.	accompany her to complete these check-ups at the health facility? [1] Yes [2] No				
65.	agree that she joins delivery preparation sessions? [1] Yes [2] No				
66.	accompany her to delivery preparation sessions? [1] Yes [2] No				
67.	agree that she gives birth in a health facility instead of giving birth at home? [1] Yes [2] No				
68.	accompany her to give birth in a health facility? [1] Yes [2] No				
69.	agree that she gives birth with a SBA instead of a TBA? [1] Yes [2] No				
70.	How satisfied are you with SRMHR services? [choose one response] [1] very satisfied [2] satisfied [3] neither satisfied or unsatisfied [4] unsatisfied [5] very unsatisfied				
71.	If satisfied or very satisfied, why? [Open answer]				
72.	If unsatisfied or very unsatisfied, why? [Open answer]				
SECTION 4 - RELATION WITH HEALTH PERSONNEL AND CSC PROCESS					
The following questions are about communication and your relationship with health services					
73.	Do you think the community has better relations with the health providers since the HAMORIS project started? [1] Yes [2] No				
74.	Are you able to meet with health personnel each time they need to? [1] Yes [2] No				
75.	If No, why not? [Open answer]				
76.	Do you feel that they listen to you when you go to the CHC or health post?				

	[1] Yes [2] No				
77.	If No, why not? [Open answer]				
78.	Have you participated in CSC/Community Score Card Meetings? [1] Yes [2] No				
79.	Were health personnel also present in the CSC meetings? [1] Yes [2] No				
80.	Were you able to inform health personnel about the community's needs during the CSC meetings? [1] Yes [2] No				
81.	Do you know what requests your community made of the health services in their area? [1] Yes [2] No				
82.	If Yes, what are their requests? [Open answer]				
83.	Do you have any recommendations to improve the CSC process? [Open answer]				
84.	**SECTION 5 - DECISION-MAKING**				
The following questions are about who makes decisions in households.					
85.	In your family, who usually makes decisions about				
86.	Big expenses [1] Wife decides [2] Husband decides [3] We decide together				
87.	To sell big animals [1] Wife decides [2] Husband decides [3] We decide together				
88.	To sell small animals [1] Wife decides [2] Husband decides [3] We decide together				
89.	To spend money for traditional ceremonies [1] Wife decides [2] Husband decides [3] We decide together				

90.	The number of children to have [1] Wife decides [2] Husband decides [3] We decide together				
The following questions are of a sensitive nature. Please answer questions about your personal relations with your husband or wife. You do not have to answer questions if you do not want to.					
91.	Is it usually you alone, your husband or wife alone or you AND your husband or wife together who:				
92.	Decide to initiate sex [1] Wife decides [2] Husband decides [3] We decide together	WOMEN ONLY RESPONSES	Outcome 2. Has the program made improvements in gender relation at family and community level?	2.3: Proportion of women aged 15-49 who make their own informed decision regarding sexual relation, contraceptive use and reproductive health care. (Indicator 9, CI)	
93.	Decide to use or not to use contraceptive [1] Wife decides [2] Husband decides [3] We decide together				
94.	Decide to use or not to use health reproductive services [1] Wife decides [2] Husband decides [3] We decide together				
SECTION 6 - SOCIAL NORMS					
The following questions are about social norms including violence in the home.					
95.	What are the cultures or traditions that prevent women from accessing SRMH services? [Open answer]				
96.	Do you agree with any of the following statements? **Is it okay for a husband to physically hurt his wife if she** [Tick all that apply] [1] Disobeys her husband [2] Neglects household chores [3] Disrespects in-laws [4] Is unfaithful [5] Does not prepare food on time [6] Argues with husband [7] Other [Please specify]				

	[8] A husband is never justified in hitting his wife.				
97.	If a married woman has been beaten up by her husband, it is okay for her to tell others. [1] Yes [2] No [3] Don’t know				
98.	If a husband beats up his wife, other people should intervene. [1] Yes [2] No [3] Don’t know				
99.	It is better for a woman to give birth at home than in a health facility. [1] Yes [2] No [3] Don’t know				
100.	**What services do you know about that can help women when they are hurt?** [Open answer]				
101.	**Do services help woman confidentially?** [Select one] [1] Yes [2] No **[3] Don’t know**				
102.	It is better for a woman to give birth with a traditional birth assistant than with a SBA. [1] Yes [2] No [3] Don’t know				
103.	The husband (or his mother) should be the one deciding when to have children (spacing). [1] Yes [2] No [3] Don’t know				
104.	Are people in your family complaining that you are a member of the GSI/GSA? [1] Yes [2] No [3] Don’t know				
END OF INTERVIEW: THANK YOU!					

HAMORIS
Health workers and administrators Key Informant Interview Questionnaire
[Instrument no. KKI HEALTH V1]

INTRODUCTION AND CONSENT [CARE TO PROVIDE CONSENT AND PROJECT INFORMATION]	
	Respondent agreed to be interviewed
1.	Yes
2.	No
3.	Name and signature of interview (optional)
SECTION 1 - GENERAL	
RESPONDENT DATA	
4.	Name:
5.	Age:
6.	**Gender** [Select one] [1] Male [2] Female [3] Other
7.	**Highest level of education completed** [Select one] [1] Primary School [2] Secondary School [3] Technical/trade certificate [4] Diploma or degree [5] Never attended school
8.	**Household annual income in USD** [Select one] [1] Under $500 [2] $501 - $1000 [3] Over $1000
9.	Program area location (village/subvillage):
10.	Time interview commence:
11.	Time interview end:
12.	Date:
The next questions ask about difficulties you may have doing certain activities because of a health problem.	
13.	**Do you have difficulty seeing, even when wearing glasses?** [Select one]

	[1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all
14.	**Do you have difficulty hearing, even if using a hearing aid?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all
15.	**Do you have difficulty walking or climbing steps?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all
16.	**Do you have difficulty remembering or concentrating?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all
17.	**Do you have difficulty (with self-care such as) washing all over or dressing?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all
18.	**Using your language, do you have difficulty communicating, for example understanding or being understood?** [Select one] [1] No – no difficulty [2] Yes – some difficulty [3] Yes – a lot of difficulty [4] Yes – cannot do at all
SECTION 2 - RESPONSIVENESS OF HEALTH SERVICES	
I am now going to ask you questions about the health services in which you are familiar	
19.	Are there more health personnel since the project started? [1] Yes [2] No
20.	Are there more SISCA activities about SRMHR since the project started? [1] Yes [2] No
21.	Are there more medicines for SRMHR since the project started? [1] Yes [2] No

22.	Do you agree that health facilities are providing better SRMHR services since the project started? [1] Yes [2] No
23.	If Yes, what has improved for example? [Open answer]
24.	If No, why do you not see any improvement? [Open answer]
25.	Please explain what needs to improve in order to provide better SRMHR services? [Open answer]
26.	Do you think all the women in this community who need contraceptives were able to get contraceptives? [1] Yes [2] No
27.	What contraceptives do women use in this community? [Open answer]
28.	Are women who are not married able to get contraceptives? [1] Yes [2] No
29.	If No, why not? [Open answer]
30.	What barriers prevent women from getting access to contraceptives? [Open answer]
31.	Can married women get contraceptives without their husband's consent? [1] Yes [2] No
32.	If No, explain what happens if a married woman who does not have her husband's consent, requests contraception? [Open answer]
SECTION 4 - CHC checklist	
NUMBER OF PERSONNEL IN THE CHC	
33.	Number of doctors [provide one response]
34.	Number of nurses [provide one response]
35.	Number of midwives [provide one response]
36.	Number of pharmacists [provide one response]
37.	Number of nutrition officers [provide one response]
38.	Number of laboratory personnel [provide one response]
39.	Number of dentists [provide one response]

40.	Number of malaria assistant [provide one response]
41.	Number of medical record personnel [provide one response]
42.	Number of cleaners [provide one response]
43.	Number of drivers [provide one response]
44.	Number of security persons [provide one response]
NUMBER OF FACILITIES IN THE CHC	
45.	Number of toilets [provide one response]
46.	Number of maternity rooms [provide one response]
47.	Number of patient beds in ICU rooms [provide one response]
48.	Number of patient beds [provide one response]
49.	Number of patient beds [provide one response]
50.	Do you have adequate supplies of drugs on site? [1] Yes [2] No
51.	Do you have a permanent and adequate supply of clean water? [1] Yes [2] No
52.	Is the CHC meeting national standards for quality care? [1] Yes [2] No
53.	Are the CHCs of HAMORIS's area meeting national standards for quality care? [1] Yes [2] No
54.	What are the main problems faced by this CHC? [Open answer]
SECTION 5 - RELATION BETWEEN HEALTH SERVICE PROVIDERS AND COMMUNITY	
I am now going to ask you questions about the relationships between the community and the health services in which you work.	
55.	Do you think the community has better relations with the health providers since the HAMORIS project started? [1] Yes [2] No
56.	Do you think the community is able to meet with health personnel each time they need to? [1] Yes [2] No
57.	If No, why not? [Open answer]

58.	Does the community have good communication with the health personnel when they come to a CHC or health post? [1] Yes [2] No
59.	If No, why not? [Open answer]
60.	Did you participate in CSC meetings? [1] Yes [2] No
61.	Do you know if the community shared information about their health needs during these meetings? [1] Yes [2] No
62.	Do you know what requests communities have made of the health services in their area? [1] Yes [2] No
63.	If Yes, what are their requests? [Open answer]
64.	Do you think the CSC process is a good way to improve relations between health personnel and the community? [1] Yes [2] No
65.	If No, what do you not like about the CSC?
66.	Do you have any recommendations to improve the CSC process? [Open answer]
SECTION 7 - SOCIAL NORMS	
I am now going to ask you questions about changes in the community that may or may not be a result of the program. *Since the program started…*	

67.	Have you seen people with disability in your community participate in decision making? [1] Yes [2] No
68. in	If Yes, please explain how the program changed people's participation decision-making [Open answer]
69.	If No, why has there been no change? [Open answer]
70.	Do you have any recommendations for the project to help women and PWDs be more active in decision making in the suco? [Open answer]
71.	**Is it okay for a husband to physically hurt his wife if she** [Tick all that apply] [1] Disobeys her husband [2] Neglects household chores [3] Disrespects in-laws [4] Is unfaithful [5] Does not prepare food on time [6] Argues with husband [7] Other [Please specify]
72.	[8] A husband is never justified in hitting his wife. Have you heard of cases of domestic violence between husbands and wives or young couples planning to get married, in the past [six months]? [1] Yes
73.	[2] No If YES, how did you respond? [Tick all that apply] [1] Let the family resolve [2] Resolve and send home [3] Refer to police [4] Refer to other service [5] Talk to victim/Listen to victim [6] Recommend traditional mediation [7] Other [Please specify]
74.	Do you think there is a risk that project activities could increase domestic violence? [1] Yes [2] No

75.	If Yes, why? [Open answer]
76.	Do you have recommendations for the project to avoid such risks? [Open answer]
77.	Has there been a change regarding the community's practice of giving birth at home instead of a health facility? [1] Yes [2] No
78.	If Yes, what has changed? [Open answer]
79.	If No, why has there been no change? [Open answer]
80.	Has there been a change regarding women's choice to give birth with a skilled birth assistant (SBA)? [1] Yes [2] No
81.	If Yes, what has changed? [Open answer]
82.	If No, why has there been no change? [Open answer]
83.	Has there been a change regarding who usually decides about children spacing? [1] Yes [2] No
84.	If Yes, what has changed? [Open answer]
85.	If No, why has there been no change? [Open answer]
86.	Do you have any recommendations for the project to be able to improve its impact for the better in your community? [Open answer]

Daily Clock Activity

7.6 Livelihood Analysis Tool 3: Daily Activity Clocks

7.6.1 Purpose

Daily Activity Clocks illustrate all the different kinds of activities carried out in one day. They are particularly useful for looking at relative work-loads between different groups of people in the community, e.g. women, men, rich, poor, young and old. Comparisons between Daily Activity Clocks show who works the longest hours, who concentrates on a small number of activities and who must divide their time for a multitude of activities, and who has the most leisure time and sleep. They can also illustrate seasonal variations.

7.6.2 Process

Organise separate focus groups of women and men. Be sure that each group includes people from the different socio-economic groups. Explain that you would like to learn about what they do in a typical day. Ask the groups of women and men each to produce their own clocks. They should first focus on the activities of the previous day, building up a picture of all the activities carried out at different times of day and how long they took. Plot each activity on a circular pie chart (to look like a clock).

Activities that are carried out simultaneously, such as child care and gardening, can be noted within the same spaces. When the clocks are completed ask questions about the activities shown. Ask whether or not yesterday was typical for the time of year. Note the present season, e.g. wet, and then ask the same participants to produce new clocks to represent a typical day in the other season, e.g. dry. Compare.

7.6.3 Materials

Flip chart paper, coloured markers and a ruler.

7.6.4 Notes to the RA team

One of the best (and often entertaining) ways to introduce the Daily Activity Clock tool is to start by showing what your own day looks like. Draw a big circle on paper and indicate what time you wake up, what time you go to work, when you care for your children, and so forth. (No need to go into great detail, but it is important to illustrate that all kinds of activities are included such as agriculture work, wage labour, child care, cooking, sleep, etc.)

7.6.5 Example

Livelihood Analysis Tool 3 shows Daily Activity Clocks for women and men in Ozinavene, Chivi District, Zimbabwe in the dry and wet seasons. They show that both women and men work long hours in the fields during the wet season, but during the dry season men enjoy a great deal of leisure time while women carry out a multitude of activities, including gardening.

Livelihood Analysis Tool 3: Daily Activity Clocks
Some SEAGA Questions to Ask While Facilitating

_ For each person, how is their time divided? how much time is devoted to productive

activities? domestic activities? community activities? leisure? sleep? How do they vary by season?
_ For each person, is time fragmented among several different kinds of activities, or concentrated on a few ?
_ How do the women's and men's clocks compare?
_ How do the clocks from the different socio-economic groups compare?
_ Of all the clocks, whose is the busiest?

Livelihood Analysis Tool 3
Daily Activity Clocks
Example: Seasonal Daily activities of women and men in Dzinavene, Chivi District, Zimbabwe

HAMORIS Review
FIELD GUIDE for Focus Group Discussion with MSG and FSG
Gia Base ba Fokus Grupu Diskusaun ho MSG no FSG

HOW TO USE THE TOOL?

Oinsa Atu Uza Tool Ne'e?

Follow the steps outlined below and take notes from the discussion in the recording sheet and tablet.

Tuir Etapa dezeino iha okos no foti notas husi diskusaun iha nia pagina gravasaun no Tabela.

Materials needed:

Material sira ne'ebe presiza:

- Coloured cards
- Markers
- Recording sheet and tablet
- Recording device
- *Karta koloridu*
- *Markadores/Simbolus*
- *Pagina gravasaun no tabela*
- *gravasaun Materia*

WHO SHOULD BE INVOLVED?

Se mak atu Involve?

The focus group should involve a minimum of 4 and maximum of 15 participants and should be conducted separatly for FSG/Father Support Group and MSG/Mother Support group members.

Ba focus grupo sei involve minimu partisipantes ba ema nain 4 no maximu ba ema nain 15 no sei konduta haketak ba membru GSI/Grupu Suporta Inan no GSA/Grupu Suporta Aman.

Focus group discussions should be held with women and men separately to ensure that they feel comfortable to speak freely. The focus group discussion should take 2 hours.

Fokus Grupo Diskusaun sei halao ho feto no mane haketak atu garantia katak sira sente konfortabel atu koalia livre. Ba focus grupo diskusaun sei presiza tempo oras 2.

Focus group discussion roles:

Regulamentu Fokus Grupo Diskusaun:

- The facilitator makes sure everyone has a chance to speak and that the discussion stays focused
- *Ba fasilitador konfia katak ema hotu iha oportunidade atu koalia no iha diskusaun ne'e focus nafatin.*
- The note-taker writes notes, sets the voice recorder, records number of votes in the tablet and takes photographs of the group (with the group's permission).

- *Ba ema ne'ebe foti notas hakerek notas, conjuntus gravasaun lian, numeru gravasaun ba votus iha tabela no foti fotografia ba grupo (ho grupo nia lisensa)*

INTRODUCTION – PURPOSE OF THE FGD

- After talking to each of you individually, there are some topics we wouldlike to discuss in group.
- *Depois koalia ho kada ema ida ba ita individual, sira ne'e topiku balun ita sei hakarak atu diskusaun iha grupo.*
- Please do not be shy – there are no right or wrong answers and your opinions are very important!
- *Favor labele moe-resposta sira ne'e laiha loos ou sala no ita nia hanoin importante tebes!*
- This discussion will take less than 1 hour. Is this ok with you?
- *Iha diskusaun ne'e sei foti la too oras 1. Ida ne'e diak ba ita?*
- **Ask participants if they have any questions.**
- ***Husu partisipantes karik sira iha Perguntas.***

ACTIVITY 1: VOTE WITH YOUR FEET - RELATION BETWEEN COMMUNITY AND HEALTH PROVIDERS
Atividade 1: Vota ho ita nia ain – Relasaun Entre Komunidade no fornesedor Saude

- **Introduction:**
- ***Introdusaun:***

The project tried to improve the relations between the community and health service providers. We would like to know what is your opinion about this.

Projetu koko atu hasae ba relasaun entre komunidade no servidor saude. Ami hakarak hatene oinsa ita nia hanoin kona ba ne'e.

- Facilitator places all 5 cards (cards far away from each other so enough space for everyone to see and walk around the different cards):
- *Fasilitador fo fatin/hatuur ba kartaun 5 (hadook kartaun oinsa husi ita sira ne'e depois fatin natoon ba ema hotu atu hare no lao tuir diferensia kartaun sira ne'e):*

STRONGLY AGREE
Konkorda Liu
AGREE

Konkorda

NEUTRAL *Netral* DISAGREE *La konkorda* STRONGLY DISAGREE *La konkorda liu*

Statement 1:

Deklarasaun 1:

- Facilitator reads and shows the statement card (big enough for everyone to read):
- *Fasilitador le'e no hatudo karta deklarasaun (boot natoon ba ema hotu atu le'e):*

The community has better relations with the health providers since the HAMORIS project started. ***Komunidade iha relasaun diak ho pesoal saude durante projetu HAMORIS hahu.***

- Facilitator asks participants to walk to the card they chose to answer to the statement.

Count votes and record on tab.

Fasilitador husu partisipantes atu lao tuir kartaun nebe sira hatudu atu responde ba deklarasaun ne'e.

Konta votus no gravasaun ba tab.

- **DISCUSSION:**
- ***DISKUSAUN***

1. Ask everyone to stay around the voting cards and asks participants of each card:

   Husu ema hotu atu kontinua ho kartaun votus no husu partisipantes ba kada kartaun:
   - Explain why you chose strongly agree / agree / neutral / disagree / strongly disagree.
   - *Esplika tamba sa ita hili konkorda liu/konkorda/netral/la konkorda/la konkorda liu.*
   - Provide clear examples of what has improved, what has worsen?
   - *Fornese ezemplu klean ba saida mak atinji ona, saida mak ladiak?*
2. Ask eveyone to return to their sits and continue discussion

   Husu ba ema hotu atu fila ba sira nia tur fatin no kontinua halo diskusaun
   - Who has already participated in CSC/Community Score Card Meetings? (ask to raise hands)

   Count how many and record on tab.

   Se mak partisipa ona in enkontru KVK/Kartaun Valor Komunidade? (husu sira hiit liman) konta nain hira no recorda iha tab.

   - Were health personnel also present in the CSC meetings?
   - *Oinsa pesoal saude hola parte hotu iha enkontru KVK?*

- Were you able to inform health personnel about the community's needs during the CSC meetings?
- *Oinsa ita bele informa pesoal saude kona ba komunidade nia presiza durante enkontru KVK?*
- Has there been any improvements on these issues since the CSC process has started?
- If yes, what has improved?
- *Karik iha ona atinjimentu seluk ba problema ne'e durante prosesu KVK hahu?*
- *Karik los, saida mak atinji ona?*
- Do you have any recommendations to improve the CSC process?
- *Ita iha rekomendasaun seluk atu dezenvolve prosesu KVK?*

Statement 2 (FOR MSG ONLY):
Deklarasaun 2 (BA DEIT GSI)

- Facilitator reads and shows the statement card (big enough for everyone to read):
- *Fasilitador le no hatudu karta deklarasaun (boot natoon ba ema hotu atu le):*

All the women in this community who needed contraceptives were able to get contraceptives. ***Feto hotu-hotu iha komunidade ne'ebe presiza kontrasepsaun sira bele assessu ba kontrasepsaun.***

- Facilitator asks participants to walk to the card they chose to answer to the statement.

Count votes and record on tab.

Fasilitador husu partisipantes atu lao tuir kartaun sira hili atu responde ba deklarasaun. Konta votus no record iha tab

- **DISCUSSION:**
- **DISKUSAUN:**

Ask everyone to stay around the voting cards and asks participants of each card:
Husu ema hotu-hotu kontinua nafatin iha kartaun votus no husu partisipants ba kada kartaun:

- Agree/Strongly agree: What are the most commonly requested contraceptives? Are women always satisfied with the contraceptives they are given?
- *Konkorda/konkorda liu: saida deit komun liu husu kontrasepsaun? Ba feto bai-bain satisfas ho kontrasepsaun nebe fo?*
- Disagree/Strongly disagree: What problems did women encounter? Why not all women can get contraceptives (no medicine, leave to far from health centre, etc)?
- *La konkorda/la konkorda liu: problema saida feto sira koalia/enkontru? Tamba sa feto hotu la bele hetan kontrasepsaun (la iha aimoruk, hela dook husi centru saude, etc)?*

ACTIVITY 2: VOTE WITH YOUR FEET - PARTICIPATION OF MEN IN FSG
ATIVIDADE 2: VOTA HO ITA NIA AIN – PARTISIPASAUN BA MANE IHA FSG

- **Introduction:**
- ***Introdusaun:***

The project tried to involve both women and men in the groups. We would like to know what is your opinion about this

Projetu koko atu involve parte rua feto ho mane iha grupu. Ami hakarak hatene saida mak ita nia hanoin kona ba ne'e

- Facilitator places all 5 cards (cards far away from each other so enough space for everyone to see and walk around the different cards):
- *Fasilitador fo fatin/hatuur ba kartaun 5 (hadook kartaun oinsa husi ita sira ne'e depois fatin natoon ba ema hotu atu hare no lao tuir de diferente kartaun sira ne'e):*

STRONGLY AGREE ***Konkorda Liu*** **AGREE** ***Konkorda*** **NEUTRAL** ***Netral*** **DISAGREE** ***La konkorda*** **STRONGLY DISAGREE** ***La konkorda liu***

Statement 1:

Deklarasaun 1:

- Facilitator reads and shows first statement card (big enough for everyone to read):
- *Fasilitador le no hatudu kartaun deklarasaun primeiru (boot natoon ba ema hotu atu le):*

There are usually less men coming to the group meetings than women. ***Hirak ne'e bai-bain mane mai menus ba iha enkontru grupu duke feto.***

- Facilitator asks participants to walk to the card they chose to answer to the statement.

Count votes and record on tab.

Fasilitador husu partisipantes atu lao tuir kartaun sira hili atu responde ba deklarasaun. Konta votus no record iha tab

- **DISCUSSION:**
- **DISKUSAUN:**

Ask everyone to stay around the voting cards and asks participants of each card:
Husu ema hotu-hotu atu kontinua nafatin iha kartaun votus no husu partisipants ba kada kartaun:

- Agree/Strongly agree: Why do less men usually join group meetings?
- *Konkorda/konkorda liu: tamba sa mane bai-bain menus partisipasaun iha enkontru grupu?*
- Disagree/Strongly disagree: You think there are as many men and women joining meetings?
- *La konkorda/la konkorda liu: ita hanoin katak ne'e mane barak no feto partisipa enkontru?*

Statement 2:
Deklarasaun 2:

- Facilitator reads and shows second statement card (big enough for everyone to read):
- *Fasilitador le no hatudu kartaun deklarasaun segundu (boot natoon ba ema hotu atu le):*
-

It is important to have more men join the group meetings
Ne'e importante atu mane sira partisipa barak iha enkontru grupo

- Facilitator asks participants to walk to the card they chose to answer to the statement.

Count votes and record on tab.

Fasilitador husu partisipantes atu lao tuir kartaun sira hili atu responde ba deklarasaun. Konta votus no record iha tab

- **DISCUSSION:**
- **DISKUSAUN:**

Ask everyone to stay around the voting cards and asks participants of each card:

Husu ema hotu-hotu atu kontinua nafatin iha kartaun votus no husu partisipants ba kada kartaun:

- Agree/Strongly agree:
- *Konkorda/konkorda liu:*
- Why is it important to have more men join the meetings?
- *Tamba sa ne'e importante atu involve mane sira partisipa barak iha enkontru?*
- What change do you think will happen if more men join the meetings?
- *Tuir ita bo'ot nia hanoin mudansa saida maka sei akontese wainhira Mane partisipa barak iha enkontru?*
- What could the project do to have more men join the meetings?
- *Saida mak projetu bele halo atu hetan mane barak partisipa iha enkontru?*
- Disagree/Strongly disagree:
- *La konkorda/la konkorda liu:*
- Why do you think it is not important to have more men join the meetings?
- *Oinsa ita nia hanoin katak ne'e la importante atu involve mane barak partisipa enkontru?*
- Do you observe negative effects of men joining meetings?
- *Ita observa efetu negativu ba mane partisipa enkontru?*

ACTIVITY 3: VOTE WITH YOUR FEET - SOCIAL NORMS
ATIVIDADE 3: VOTA HO ITA NIA AIN – NORMA SOSIAL

- **Introduction:**
- ***Introdusaun:***

We would like to know your opinion about the following statements regarding what is accepatble and

Ami hakarak hatene ita nia hanoin kona ba deklarasaun tuir mai relasaun saida mak acetabel no

- Facilitator places all 5 cards (cards far away from each other so enough space for everyone to see and walk around the different cards):
- *Fasilitador fo fatin/hatuur ba kartaun 5 (hadook kartaun oinsa husi ita sira ne'e depois fatin natoon ba ema hotu atu hare no lao tuir de diferente kartaun sira ne'e):*
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STRONGLY AGREE
Konkorda Liu
AGREE
Konkorda
NEUTRAL

Netral
DISAGREE
La Konkorda
STRONGLY DISAGREE
La konkorda liu

- Facilitator reads and shows each statement card.
- *Fasilitador le no hatudo kada karta deklarasaun*

For each statement: (1) Ask participant to walk to the card they chose. (2) Count and record number of votes on tab. (3) Discuss answers of each group: Why agree? Why disagree?

Kada deklarasaun: (1) husu partisipantes atu lao tuir karta nebe sira hili. (2) konta no recorda umero votus iha tab. (3) diskusaun respostas ba kada grupo: tamba sa konkorda? Tamba sa la konkorda?

It is better for a woman to give birth at home than in a health facility.
Diak liu ba feto atu partus iha uma duke iha fasilidade saude.

It is better for a woman to give birth with a traditional birth assistant than with a Support birth attendence/SBA
Diak liu ba feto atu partus ho asistente partus tradisional/liman badain duke ho SBA.

It is normal for a man to pay a dowry (bileki) to the woman's family when getting married.
Ne'e normal katak mane selu barlake ba feto nia familia bainhira kaben.

The husband (or his mother) should be the one deciding how many children to have.
Laen (ou nia inan) entre ida maka sei deside atu hetan oan nain hira.

The husband (or his mother) should be the one deciding when to have children (spacing).
Laen (ou nia inan) entre ida mak sei deside bainhira mak iha oan (espasu)

It is OK for a girl to marry before the age of 18 years old.
Ne'e katak diak ba feto foinsae kaben antes idade 18

It is OK for a wife to have a baby before the age of 18 years old.
Ne'e katak diak ba feen atu hetan oan antes idade 18

ENDING THE SESSION
SEKSAUN IKUS

- Give a brief summary of what has been said in case anyone has something to add
- *Fo resume sumario ba buat ne'ebe hatete katak ema hotu iha buat ruma atu hatoo.*
- Remind participants of the purpose of the discussion (see if progress has been achieved since start of the project).
- *Fohanoin partisipantes ba objetivu husi diskusaun (hare progresu nebe atinji durante projetu hahu)*
- Check if participants have any questions
- *Verifika karik partisipantes iha perguntas*
- Thank participants for their time
- *Hatoo obrigado ba partisipantes nia tempo*
- Check the written record has captured the main points and reflected the level of participants' involvement in the discussion.
- *Verifika recorda notas ne'ebe captura ba pontus importantes no reflet aba level no partisipante nia involvementu iha diskusaun.*
- Collect up materials
- *Kolekta material hotu*