A framework for caregiver education and support in Timor-Leste

AN ANALYSIS OF EXISTING PROGRAMS, CAREGIVER NEEDS AND SUGGESTIONS FOR WAYS FORWARD

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Abbreviations and Acronyms

BCC	Behavior Change Communication Strategy
ECCD	Early childhood care and development
FGD	Focus group discussions
GoTL	Government of Timor-Leste
IEC	Information, education and communication
INGO	International non-governmental organization
MoE	Ministry of Education
MoH	Ministry of Health
MSS	Ministry of Social Solidarity
M&E	Monitoring and evaluation
DNRS	National Directorate Social Reinsertion
PSF	Promotores Saude Familia (Health Promoters)
SECOMS	Secretary of State for Communications
UNICEF	United Nations Children's Fund
UNMIT	United Nations Integrated Mission in Timor-Leste

Executive Summary

Project Background

Although development outcomes for children in Timor-Leste have considerably improved over the last ten years, several challenges remain. Significant numbers of children remain undernourished, pre-school enrolment and survival rates to the end of basic education remain low, violence against children is widespread, and adolescents' future is put at risk by issues such as teenage pregnancy, child marriage, alcohol and substance abuse.

International research in developed and developing countries have provided strong evidence that early interventions in support of healthy physical, mental and social development have long-lasting positive effects on children's all-round development, on their performance in school, on their relationship with others, and on their productivity well into adult life. Not only are these early interventions long-lasting, they are much less costly than repairing problems that develop as a result of delayed or damaged development. Increasingly, such interventions work not only with children directly, but also their caregivers, to improve parenting skills and capacities, and ultimately improve outcomes for the children in these households.

UNICEF and the Ministry of Social Solidarity (MSS) have identified the development of community sessions for recipients of the MSS' *Bolsa da Mae* conditional cash transfer program as a potential entry point for the development of a holistic, integrated and nationally-delivered parent education program for Timor-Leste. Specific tasks as part of this consultancy related to the development of these sessions were to:

- Map and assess existing parenting programs/parenting initiatives in the country
- Conduct a needs assessment of caregivers who have not benefited from parenting programs/initiatives to date and identify key messages which might need to be promoted within the community sessions
- Conduct a partnership/stakeholder analysis to identify those who might serve a role in the implementation of the parenting program
- Create a draft framework for a parenting program in terms of key messages, forms of delivery, potential messengers *with a particular focus on developing community sessions for Bolsa da Mae beneficiaries*

This document reports on these activities and suggests some potential ways forward for the further development of the community sessions.

Summary of approach

UNICEF and MSS contracted Dr. Ritesh Shah, a consultant from the Faculty of Education, University of Auckland to carry out the above tasks between the period of February and May 2014. Tasks related to this consultancy were completed from his home base, and two in-country inputs in February and April. As part of the consultancy, current parenting support and education activities of three different Government ministries (Health, Education, Social Society), eight civil society actors and three faith-based organizations were reviewed. Additionally, consultations with approximately 130 caregivers occurred through focus group discussions in Dili, Liquica and Manatuto was undertaken. Focus points within each of the sectoral units of UNICEF were regularly consulted throughout this period, as well as the National Directorate Social Reinsertion (DNRS) from MSS. More detail on the methodology employed, as well as its limitations, is noted in Appendix 6.

Key findings from the needs analysis

Review of existing programs

- Key Ministries are engaged in caregiver support/education to varying extents. Amongst them, the Ministry of Health, through regular activities operating as part of SISCas, have the most established presence in this area.
- The majority of parenting initiatives at present are targeting caregivers of children in the first years of life (0-5), rather than caregivers with children in school/adolescents. Current programs of the Alola Foundation, PLAN, World Vision, Child Fund, and Pastoral de Crianças are examples of this.
- By in large, programs reviewed tended to fall under *parent support* rather than *parent education*.[1] One notable exception to this is CARE's Lafaek Community Media project, which has as its primary goals improved literacy and numeracy skills amongst low-literate adults, and improved knowledge and capacity to support their families' livelihood through specific content on microfinance/enterprise opportunities.
- There is variable coverage across the country of where such activities occur. There would appear to be particular districts—such as Ainaro, Manufahi, Ermera, Manatuto—that are not well served at the moment through existing activities, and others—such as Liquica, Aileu and Lautem—that are better served at present.
- Those supporting caregivers through their ECCD initiatives, such as World Vision, PLAN and Child Fund, as well as Pastoral de Crianças have a more comprehensive curriculum established to simultaneously explore various domains of parenting (caregiving, stimulation, responsiveness, and protection).
- PLAN's program employs what international literature suggests is best practice in the field, where they analyze the specific needs of caregivers at the start, and focus messaging on issues identified by the beneficiaries themselves. This helps to ensure relevance, buy-in and ongoing interest in the program itself.
- Amongst the programs surveyed, there is not an explicit focus on supporting or engaging groups other than the mother and father (such as older siblings, namely young adults, or grandparents) in parent education and support activities.
- It is difficult for most actors to engage fathers in their activities at the present time.
- Most programs use group-based sessions as their primary modality of delivering messages.
- Media remains a fairly underutilized vehicle for message delivery, despite its potential for broad reach, and the success it has shown in initiatives such as the Lafaek Community Media Project.
- Most programs use one primary modality for delivering key messages to caregivers, despite the fact that international literature suggests that such messages need to be delivered over more than one time period, and using more than one modality for behaviors to change.
- While many actors are promoting key health and education messages, less emphasis is being given to messages which emphasize the need for caregivers to protect children from violence, abuse, neglect and exploitation.
- Many partners do not coordinate well with the activities of the other actors, and in some cases duplicate/contradict efforts of others.

[1] The difference is that parent education programs are any training or learning activity that is provide to parents, while parent support programs are ones which specifically support parents' child-rearing practices (Evans, 2006).

- The evidence base in Timor-Leste on the efficacy of interventions to date remains weak. Systems of M&E, and particularly mechanisms for capturing changes in caregiver's knowledge, attitudes and behaviors as part of their interventions remain poorly developed and need significant strengthening.
- While volunteers were commonly used to run such activities, many organizations noted that volunteer attrition, the need for ongoing support/training, and the identification of the right individuals to deliver messages were significant challenges to using volunteers.

Beneficiary analysis

- Amongst caregivers interviewed, there appeared to be high levels of knowledge about the importance of seeking timely medical care for ones' child, supporting children's learning through regular attendance at school and by creating a time/space for learning at home. Caregivers also understood the benefits of pre-school education.
- Less knowledge appeared to exist on ways to discipline children without violence.
- Caregivers are often precluded from acting on existing knowledge by traditional customs/practices, the influences and beliefs of other family members (such as mother/father in-laws, grandparents), as well as practical matters such as distances from education/health services and economic hardship that precluded caregivers from acting on this knowledge.
- Caregivers of vulnerable children, such as those with special needs, children living and/or working on the streets and adolescents were also noted to face particular hardships and often lack knowledge of specific resources or ways of engaging with these groups of children proactively and productively.
- In general, the care of children is seen to be a matter dealt with internal to the family, largely out of issues of shame/embarrassment and the need to protect the family name.
- On particularly difficult and/or unresolvable issues community leaders such as the Chefe de Aldeia may be asked to arbitrate or intervene.
- It would appear, based on FGDs, that immediate and extended family exert the greatest influence on what parents do with their children. Specifically, older siblings of the children, uncles/aunts, and grandparents are all key resources and sources of support within the family.
- It does not appear at present that outside actors from civil society, government, or faith-based organizations are perceived to be a critical resource in the raising of a child in Timor-Leste. The exception to this is in regards to health matters, where doctors/nurses are seen as experts with specialized knowledge and treatments that they can use to heal children's ailments.

Recommendations moving forward

Government, media, civil society, community leaders and faith based organizations all have a critical role and contribution to make to supporting caregivers in the raising of their children through education and support activities. The potential roles of each are specified below.

Government

- Ministries should take a leadership role on deciding over the coming years what key ideas are most important to convey to caregivers and what the actual message should be. Annually, it is suggested that no more than four to five messages are promoted by

the various Ministries to allow them to be reinforced, repeated and supported over a period of several months.

- Aligned with this, the government and/or various Ministries should facilitate close coordination and awareness amongst all civil society actors of its overall strategy for engaging with caregivers, and the key message/s it is aiming to promote at any one time. This may require Ministries to play a stronger role in quality assuring the messages that are promoted by civil society and faith based organizations at present and into the future.
- Local staff/volunteers of various line Ministries involved in social service provision could take a stronger role in facilitating group-based parent education sessions and/or follow up home visits into the future.
- Existing and future government activities such as SISCa posts and the community sessions provide a way to reach families and deliver messages on a regular basis across the nation.

Media

- Through the recently established Secretary State for Communications (SECOMS) there is ample scope for media campaigns promoting messages developed by various Ministries to be promoted through government print, TV and radio channels (TVTL, Radio Timor-Leste, community radio, government billboards and newspaper advertisements).
- Scope also exists to broaden the reach and content of media publications supported by civil society, such as Lafaek ba Komunidade, to reinforce and support the range of parenting education/support initiatives occurring at present.

Civil Society

- A stocktake of existing IEC materials produced by civil society should occur as part of identifying which of these resources might be of utility and greatest effectiveness in promoting the messages identified by government on an annual basis.
- Given civil society's longstanding expertise and experience in providing parenting education/support activities, and training and supporting volunteers to support such work, they should act to support initial training and ongoing support of parent education facilitators/volunteers for government-led parenting initiatives into the future.
- Civil society can continue to complement and add depth to the caregiver education that is and will be promoted through community sessions, SISCas, and other government channels. In particular, their existing peer-to-peer support groups and home visitation programs will help to deepen the impact of the work done through existing/planned government activity.

Faith based organizations

- Future activity should leverage on the strength of existing home/apostolate visits, which provide ready access to vulnerable households across Timor-Leste, by supporting the expansion of such service to other locations and households.

Community Leaders

- Based on the model of CARE's School Drop Out and Prevention Program, community leaders (such as the Chefe de Suco and Chefe de Aldeia) can and should play a more active role in facilitating dialogue between service providers and the beneficiaries/recipients of such services. They have the potential to act as brokers of information and a conduit through which concerns of either party can be communicated to the other party.

A framework for community sessions

Within the partnership model described above, the community sessions proposed by MSS should work at three tiers—non-targeted, targeted, and intensive parenting support as shown below. This structure is predicated on international research suggesting that it is critical that messages are presented more than once to caregivers, and in more than one way. Such research has found that high-risk families—namely those most impacted by conditions of poverty or other structural disadvantage—need at a minimum 30 to 40 hours of contact time for positive and long-term impacts on their behaviors and practices.

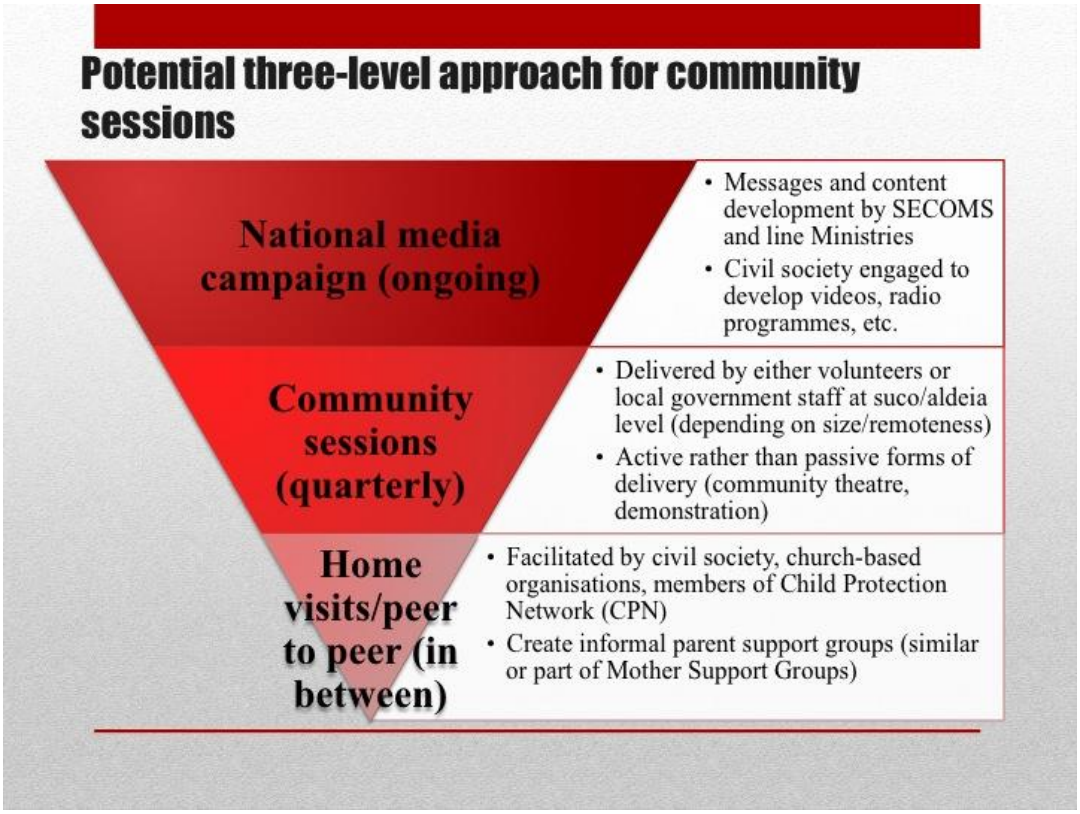

Figure 1: A model for delivering messages through the community sessions

It is suggested that the community sessions follow the general model noted below:

National media campaign: A national media campaign would be targeted at all caregivers in Timor-Leste and use television, radio and print outlets to communicate the quarterly key message(s) which would subsequently be promoted in the community sessions and through home visits/peer networks.

Community sessions: *Bolsa da Mae* recipients and other vulnerable households would participate in quarterly community sessions. The sessions themselves could be delivered by a number of different local government personnel (teachers, members of the Child Protection Network, PSFs, social animators, community health post volunteers), or by volunteers, depending on the topic to be discussed and the level of expertise required to discuss such matters. Regardless of the messenger, all facilitators should be carefully trained and supported prior to ensure that the modalities of delivery they use are engaging, involve the participants, and engender discussion. Specifically, active learning methodologies such as demonstration, role-play, and community theatre, as well as IEC materials (flip charts, posters, videos, brochures) would need to be effectively utilized for such sessions to be of interest and value to participants.

Follow up support: Dependent on the topic, home-visits and peer networks could be facilitated and supported through locally recruited volunteers, members of the clergy, or members of the Child Protection Network or health workers. Home visits would take place in households identified prior as the most vulnerable on the topic of the sessions themselves. The objective behind these regular home visitations is that they would provide caregivers with the necessary knowledge and confidence to begin to value and enact the desired behavior change. For families needing less intensive intervention, or to supplement home visitations, peer support groups could also be established to provide small groups living in close proximity to each other, or facing similar challenges (such as having children with disabilities) with a forum to meet in between the quarterly community sessions.

Appendix 3 provides an example of what this framework would look like in practice for specific issues of concern at present in Timor-Leste in terms of potential messages, modalities of delivery, and actors to be involved.

Other key considerations

Coordination mechanisms

For this approach to work, coordination and agreement amongst the various Ministries to work towards this common approach, and the wilful co-optation of civil society and faith based organizations into such efforts will be needed as a prerequisite. While the beginnings of such a process are in place, there is significant work to be done in this regard prior to the establishment and initiation of the sessions. To that end,

1. It is critical that "champions" who are sufficiently empowered within each Ministry to drive this component of the process continue to be identified and supported.

2. Thought will also need to be given to what form of coordination mechanism/agreement will be necessary between the various line Ministries for this project to work in practice.

3. Buy-in and agreement must come from the highest levels of the Ministries of Social Solidarity, Health and Education and a 'blessing' may also be needed from the Vice Prime Minister or Prime Minister's office for this intra-Ministerial coordination mechanism to have the necessary clout to do what is required.

Piloting the intervention

Additionally, it is recommended that at the outset this model be piloted in one or two districts, or even sub-districts of vulnerability within these districts, to assess how, whether and why this approach works, and what modifications may be needed to scale up the interventions. With a robust M&E framework sitting underneath this pilot, an evidence base can begin to be created to advocate for scale up. The pilot could also provide government with a sense of the cost of such an endeavour on a wider scale.

Section One: Review of existing activities and programs

A table appended to the back of this report provides a detailed summary of the parenting programs that were reviewed or analysed during the consultant's first field visit in February 2014 (Appendix One).

There are a range of parenting (caregiver)[2] education initiatives occurring at present. Some are explicitly acknowledged as such while other programs are classified under other titles such as health promotion, livelihoods education, socialisation programs, economic empowerment initiatives, etc. In one way or another, however, all of the initiatives noted in the table are working with caregivers of children 0-18 in one way or another. By in large, programs reviewed tended to fall under *parent support* rather than *parent education*.[3] One notable exception to this was CARE's Lafaek Community Media project (Lafaek ba Komunidade), which had as its primary goals improved literacy and numeracy skills amongst low-literate adults, and improved knowledge and capacity to support their families' livelihood through specific content on microfinance/enterprise opportunities.

Key conclusions that can be made from this initial review, is that: (1) despite the range of parent support and parent education programs occurring at present in country, they are occurring in a piecemeal fashion and do not provide comprehensive coverage of the range of issues faced by caregivers of children 0-18, (2) many programs are sectoral-focussed (health/nutrition, education, child protection), particularly when operating through government agencies, (3) many partners do not coordinate well with the activities of the other actors, and in some cases duplicate/contradict efforts of others; (4) a fairly narrow range of delivery mechanisms are employed to disseminate messages; and (5) many programs have weak or non-existent approaches to measuring changes in caregiver knowledge, attitudes and practice through their interventions.

Target populations, reach and coverage

The majority of parenting initiatives at present are targeting caregivers of children in the first years of life, rather than caregivers with children in school/adolescents. Current programs of the Alola Foundation, PLAN, World Vision, Child Fund, and Pastoral de Crianças are examples of this. In part this may be the product of a strong body of research which demonstrates the benefits of supporting caregivers on the various domains of caregiving in the first eight years of life; important for children's well-being during and beyond those initial years (Evans, 2006; Britto & Engle, 2013, unpublished). Additionally, given the high rates of maternal and under five mortality and the high rates of malnutrition and associated rates of stunting, and low levels of basic literacy skills that children have in the early years of schooling in Timor-Leste at present, this focus is addressing the most acute needs of the country situation at present. That stated, there is clear scope for support to caregivers of children who are older than eight, given that there are clear needs based on UNICEF's recent situational analysis to support pre-adolescent/adolescent children on matters of child protection, early pregnancy/marriage, and prevention of violence in the home.

[2] Given the wide range of duty bearers who are responsible for the care of children in Timor-Leste, ranging from older siblings to grandparents, the term caregiver may be a more appropriate term to encapsulate these individuals.

[3] The difference is that parent education programs are any training or learning activity that is provide to parents, while parent support programs are ones which specifically support parents' child-rearing practices (Evans, 2006).

An additional focus amongst many of the programs surveyed were caregivers living in districts/regions outside of the capital, with particularly attention given to those living in remote or rural sections of the nation. From a rights-based approach, explicit targeting of those most disadvantaged in terms of meeting basic entitlements, which data does generally illustrate are those living outside of Dili and in remote/rural sections, may be appropriate; however there are some issues, for example child malnutrition, which are universal across Timor-Leste and require national attention. Additionally, there are specific sub-populations of families, such as the urban poor/new migrants to Dili, whose needs may not be adequately met by a focus which to date, has largely been shaped by geography. On the whole, coverage of the various programs surveyed varied, and was often tied to where other existing activities of the organisation were occurring. There would appear to be particular districts—such as Ainaro, Manufahi, Ermera, Manatuto—that are not well served at the moment through existing activities, outside of activities with national reach (see Table 1). Additionally, it is important to note that even when districts are served by additional caregiver support and education activities, coverage is often limited to selected sub-districts and sucos, with most communities in the district not well served by such programming.

Programs utilising group-based delivery approaches noted that not all caregivers within a given community are reached through their activities, namely those living considerable distance from the health post, school or ECE centre where sessions were conducted. Conversely, home-based support programs often were able to reach all households within a community, but often with diminished overall coverage geographically.

	Oe-cuse	Dili	Baucau	Aileu	Liquica	Bobanaro	Manatuto	Manufahi	Viqueque	Covalima	Ermera	Lautem	Ainaro
Catholic Relief Services (MAHON Project)					X								
World Vision (Early Childhood Care and Development (ECCD) Project)			X	X		X							
PLAN (SISCa ECCD Pilot)				X									
PLAN (ECCD Parenting Education)				X								X	
Canossian Sisters (Family Apostolate program)		X				X						X	
Canossian Sisters (Parent education sessions)		X											
Red Cross (Cross-sectoral programs)	X	X	X	X	X	X	X	X	X	X	X	X	X
Alola Foundation (Mother Support Groups)	X	X	X	X	X		X	X	X		X	X	X
Alola Foundation (Community Discussion Forums)	X		X						X				
Child Fund (Community Health Promotion)					X	X						X	
Child Fund (Parent to parent sessions)						X						X	
CARE (Lafaek Community Media)					X	X				X	X		
CARE/USAID (School Drop Out and Prevention Program)					X	X	X		X		X		
Ba Futuru (Transforming Timorese Classrooms)		X											
Ba Futuru (Feto Fantastico)	X	X	X	X	X	X	X	X	X	X	X	X	X
Pastoral de Criancas (Home Visitation Program)		X	X	X				X			X		
MoH (Integrated Health Posts)	X	X	X	X	X	X	X	X	X	X	X	X	X
MoH (Cuidado Saude Primario Pilot)	X			X									
MoE (Eskola Foun)	X	X	X	X	X	X	X	X	X	X	X	X	X
MSS (Social Mobilisation Campaign)	X	X	X	X	X	X	X	X	X	X	X	X	X
Rede Feto (Prevention of violence in the home)			X		X								

Table 1: Coverage by districts of parenting support/education programs to date

There is also a trend amongst the programs, despite the footnote earlier, to focus education activities on parents (mothers more specifically) rather than others. While there is evidence to show that mothers are often key to changing household practices and behaviors, there is

also growing evidence that the engagement of fathers is important to changing practices that might be detrimental to the well-being of children, particularly when fathers have been found to be engaging with their children to a far lesser degree than mothers across many developing world contexts (McAllister, Burgess, Kato, & Barker, 2012). In many of the parenting programs surveyed, fathers were encouraged to attend, but many organisations found that engendering fathers' active participation was difficult for a number of reasons (time, value given to such activities, perceived opportunity costs). Other groups of caregivers, such as grandparents and older siblings were often not a target audience for the programs, barring CVTL's pre-parenting project. Outside of specific pre-parenting/life skills programs offered by Catholic Relief Services and Red Cross, there is not an explicit focus on supporting or engaging other groups of individuals (such as older siblings, namely young adults, or grandparents) in parent education and support activities. This is an issue that might need to be better considered, given the extensive role that these individuals play in the care and welfare of many Timorese children.

Key messages promoted

Across the surveyed programs, it would appear that the caregiving function of parenting was most heavily stressed in their formal or informal curriculum/messaging. As Britto and Engel (2013, unpublished) note, caregiving relates to practices, knowledge and attitudes about health, hygiene and nutrition-related issues of child rearing. This is common not only in Timor-Leste, but internationally as well, where a systemic review of parenting programs done by Lansford and Bornstein (2007) and Meija et. al (2012) noted similar trends in terms of focus. Specific health/hygiene and nutrition topics included across a number of programs were: antenatal care, appropriate breastfeeding practices, timely and complete vaccination of children, prevention of communicable diseases, awareness-raising of local health services/facilities, identification of danger signs of serious illness in children, and appropriate nutrition for children. The majority had sought permission and approval of MoH for the content of their curriculum.[4]

Where programs were based inside an early childhood centre, or delivered as part of a broader ECCD intervention (as was the case of PLAN, World Vision and Child Fund), the scope of messaging was broader, and their curriculum tended to promote caregiving, stimulation, support/responsiveness and some basic protection messages as part of its content. Child Fund's program, which extended to caregivers whose children were already in primary schools, also discussed specific types of support that can be offered to support children's literacy and numeracy learning in school. CARE's Lafaek Community Media program, embedded key messages on children's protection/rights within its magazine and wrap around activities to low-literate adults in four districts of the country. The more holistic approach to parent support programs taken by these actors may be a model to follow moving forward, given that international research strongly advocates for a comprehensive approach which incorporates all domains of parenting into its messaging (Evans, 2006; Al-Hassan, 2009; Llewelyn, 2012; Mejia et al., 2012; Britto & Engle, 2013, unpublished).

[4] In some instances the approval process was noted by outside INGOs to take considerable time, and the MoH itself noted that there were some instances where the approval process had taken longer than anticipated. In an interview, representatives from MoH noted that typically there was a fairly streamlined process for approval where they go through the Directorate of Health Promotion in first instance and then up the chain of command for final sign off by the Vice Minister/Minister.

It is important to note, that on the whole none of the current caregiver education and support programs have an explicit focus on ways to protect children from harm, abuse and neglect. While some have child protection messages built into their broader curriculum, it does not appear to be a strong area of emphasis or focus. Those working specifically in the protection sector, such as Rede Feto, tend to work closely with Ministry of Social Solidarity to raise awareness of legislation related to domestic violence. At present Rede Feto is developing two modules focussed on educating couples on the prevention and reporting of domestic violence (in partnership with MSS), but there remains an urgent need to promote messages directly focusing on the protection of children from violence, abuse, neglect and exploitation, including for example, raising awareness of forms of hidden child neglect that are common in Timor-Leste (such as prioritising cultural obligations over basic needs of child).

Often content within comprehensive parenting education programs were based on an externally developed model and curriculum from other country program offices, with the insertion of local images/examples to make content more relevant.[5] While this may be appropriate, careful consideration needs to be given to importing models that (1) may not have a strong evidence base behind them; (2) do not have an appropriate program theory for the context of intervention; and (3) present values, beliefs, and messages which may stand in strong contradiction or are seen as irrelevant to local practice (Llewelyn, 2012). In the case of World Vision and Plan International, they noted that they adapted programs based on those with a track record for success, but no evidence/evaluations of the success of these models was available at the time of the consultancy. It would also appear the range of topics that are covered in their curriculum is more extensive than can be suitably covered in the timeframe they have for operating such activities, and choices were regularly made on what messages to focus on within each programmatic cycle. Program managers noted that caregivers were given some voice over the issues they wanted to know about. Of these organisations, PLAN appeared to have the most "emergent" curriculum where at each site, a needs analysis was conducted in each community prior to commencement of the sessions and a tailored program of support created to best fit content to the needs of that group of caregivers. This approach is in line with what is generally seen as 'best practice' when it comes to adult education.

Finally, research suggests that messages must be targeted at the right audience. For example, messages about enrolling children in school at the right age are best directed at caregivers with children who are 4-5 years old, while messages about discussing reproductive health with children are best targeted at the caregivers of pre-adolescent/adolescent children (Ward & Wessels, 2013; World Health Organisation, 2013). It is unclear from the ways in which programs are currently delivered, whether such targeting is employed, and there would appear to be some indication that common messages are promoted irrespective of the audience, in many of activities occurring at present.

Coordination, cohesiveness and consistency of messaging

Outside of the BCC for Maternal Health developed by the Ministry of Health, there appeared to be little comprehensive guidance from government agencies on the types of messages that were important to promote with caregivers. The Ministry of Health is currently revising its BCC for Maternal Health to include Reproductive Health, and is also revisiting and revising the BCC for Child Health, which was developed in 2008-09 but never finalised. In the short to medium term this should provide an overarching framework for messaging, but on its own

[5] This was found to be the case with both World Vision and PLAN's curriculum.

will not ensure consistency of messaging as delivered. Nonetheless, of the Ministries spoken to, MoH appeared to be most active at present in seeking partnerships to promote caregiver education and support activities. As one individual within the Ministry noted, "*we cannot do it alone, so we rely on our partners.*" More than one organisation was working closely with MoH to link local level officials (such as PSFs and district/community health posts staff) with those who might demand their services, and to try to actively engage MoH staff in their educational activities with caregivers.

A key challenge for MoH, is how such messages from the BCC are selected and delivered at present. Currently, messages to be delivered through SISCa posts are selected at the sub-district level. In some cases, messages selected by district or community health posts are not aligned with the MoH's overall BCC strategy. The director of the Health Promotion Unit noted that this situation is less than ideal, particularly when there may be a desire to promote messages through more than one avenue, such as media campaigns, group discussions and home visits. According to the directors of the Health Promotion Unit, MCH, and Nutrition, MoH has agreed in principle to better coordinate the timing and delivery of its health promotion messaging, to ensure there is national consistency around key health campaigns initiated at the central level in the future.

The Ministry of Social Solidarity has in the past worked with UNICEF to raise awareness of children's rights to protection. Since 2009, social mobilisation campaigns have been conducted nationally on all aspects of children's rights to protection; stages of child development; potential harm to children that includes child abuse (physical, mental and sexual abuse), exploitation, and neglect along with examples of how to protect the children from such harms; and who to report to or seek help when such case happen. Much of this work has been done using a 20-page flip chart tool, developed by UNICEF, which covers these topics. At the moment MSS, however, does not have an explicit behavior change strategy[6], nor would it appear that the locus of its socialization work is on preventative mechanisms. A significant barrier for MSS taken a more active role in promoting key preventative messages to caregivers is human resourcing. The director of DNRS notes that social animators and CPOs are already stretched to follow up on their assigned caseloads of families/individuals. In the past, however, MSS has used its Child Protection Officers and broader Child Protection Network to disseminate the messages noted above. Ultimately, MSS will need to actively engage with civil society and other partners should they seek to play an active role in coordinating community mobilisation sessions.

At present, MSS is working with two civil society partners to support socialization and awareness-raising campaigns on matters of child protection and domestic violence. One partner is Ba Futuru's, who has recently completed a pilot in Dili district, working with secondary school teachers (and sometimes parents) to improve understanding of the importance of child protection issues, namely the elimination of violence in schools and at home. The other key partner is Rede Feto's who has assisted MSS in socializing the SOP on violence against women, and is currently developing a plan to educate couples about the prevention of domestic violence.

Direct consultation with the Director of Pre-School Education suggested that the Ministry of Education had very few messages that were communicated consistently to caregivers. With

[6] It should be noted that as part of the training module for DNRS Child Protection Officers and Child Protection Staff on Social Mobilisation and Advocacy, there is an implicit behavior change strategy

the current roll out of the National Pre-School Policy Framework, the director did suggest that the Ministry would be launching a socialisation campaign to raise community awareness of the importance of children enrolling in pre-school at age three, and of the Ministry's ambitions to support pre-school education.

As part of the *Eskola Foun* program supported by UNICEF, some modules have focussed on helping primary schools to engage parents more in their children's education. In the 121 schools that have been part of the program, parents have been encouraged to play an active role in the schools' PTA and read their child on a regular basis. UNICEF has also provided promotional materials to schools in the past to ensure that children are regularly attending school and enrolling children in primary school at the right age. That said, there does not appear to be a large-scale or systematic uptake of these messages in Ministry activity at present, nor does there appear to be an explicit strategy for MoE engaging with caregivers in the basic education setting.

It was noted by more than one organisation spoken to, and apparent in conversations with the Ministry of Education, that there is not great understanding or appreciation of the role of caregivers in supporting children's cognitive, psychosocial and emotional development, particularly before they enter formal education (in the form of either pre-school or primary school). That stated, there appeared to be some level of consistency between the various INGOs promoting ECCD messages in terms of key child stimulation, responsiveness and protection issues within their curriculum. Specifically, the programs stressed the fact that caregivers play a significant role in the early growth and development of their child, and that as part of that it was important to provide children with love, affection, attention, stimulation and exposure to language from birth. Those within the preschool directorate of the Ministry, however, were unaware of such activity occurring.

Two areas where actors are promoting differing messages, which were also at odds with government regulations/guidelines, are on the topic of reproductive health[7], and on the use of violence as a form of discipline.[8]

Delivery modalities and mechanisms

As Table Two notes, existing parenting support and education programs use a range of modalities to deliver their key messages.

[7] This was largely the product of whether an organization was closely aligned with the Catholic Church or not. One organization, with strong ties to the Catholic Church felt that any mention of "family planning" or contraception would raise ire with the leadership and as a result, they steered away from any discussion of the topic, instead promoting birth spacing through the rhythm method. This is despite the Ministry of Health's most recent BCC for RH stressing that for people to make informed decisions about RH issues they should be "made aware that there are other choices which can provide the best protection against HIV/AIDS and STIs" and that men should be made aware of contraceptive use (MoH, 2007).

[8] One organisation acknowledged that current caregiver to being asked to end any form of physical/emotional violence against their children led them to allow community volunteers to state that violence, when it did not end in 'visible' physical harm, was acceptable towards children. This is despite current government policy which stipulates that violence of any kind against children in unacceptable.

	Group Discussions	Home visits	Community theatre	TV/Radio Clips/Video	Printed material	Demonstrations
Catholic Relief Services (MAHON Project)		X	X			
World Vision (Early Childhood Care and Development (ECCD) Project)	X				X	
PLAN (SISCa ECCD Pilot)	X	X				
PLAN (ECCD Parenting Education)	X	X			X	X
Canossian Sisters (Family Apostolate program)		X		X		
Canossian Sisters (Parent education sessions)	X					
Red Cross (Cross-sectoral programs)	X					
Alola Foundation (Mother Support Groups)		X				
Alola Foundation (Community Discussion Forums)	X			X		
Child Fund (Community Health Promotion)	X	X	X	X	X	
Child Fund (Parent to parent sessions)	X					
CARE (Lafaek Community Media)			X	X	X	X
CARE/USAID (School Drop Out and Prevention Program)	X	X			X	
Ba Futuru (Transforming Timorese Classrooms)	X					
Ba Futuru (Feto Fantastico)	X		X			
Pastoral de Criancas		X				
MoH (Integrated Health Posts)	X			X		
MoH (Cuidado Saude Primario)		X				
MoE (Eskola Foun)	X				X	
Rede Feto (Prevention of violence in the home)	X					

Table 2: Modalities of delivery amongst parenting support/education programs

Amongst programs surveyed, there appeared to be two main approaches undertaken: home based visits and group-based support/education. Organisations supporting caregivers of children ages 0-5 tended to employ home visits to a much greater degree than those working with caregivers of children of school or adolescent ages. Home-visits were often conducted through a case-management approach, where individuals would visit the homes of identified vulnerable/at risk families, speak with caregivers in a more informal setting, observe activities in the home, and provide just-in-time support if necessary.[9] Home visits were often linked to supporting caregivers in their home environment on matters such as

[9] The notable exceptions to this was CARE's School Drop Out and Prevention Program (SDPP), which focuses on visiting homes of children in Grade 4-6 where there are 'warning' signs of children in these households dropping out of school, and of the Canossian Sisters where home visits were non-targeted and reached all households in the community four to five times annually.

care of the child in the post-natal period, support of exclusive breastfeeding, or the preparation of nutritious foods for children. At present, the Ministry of Health is trailing a home visitation program (*Cuidado Saude Primario)* where a team of doctors, nurses and midwives conduct home visits of vulnerable families as part of their management of community clinics, to ensure that appropriate medical assistance or preventative measures are taken in these households. Home visits were also used by PLAN International in its parenting education program to reinforce key messages promoted as part of its group-based discussions and hold caregivers to account for actions they had committed themselves.

Home visits are noted to be an extremely effective approach, particularly in key development periods, such as the ante/post-natal period, to support the early role that mothers and fathers play in caregiving, stimulation, responsiveness and protection within the first few months of a child's life. It also allows for a more tailored program of support to the individual circumstances of a household, and foster a situation where individuals are more receptive to express ideas/concerns and attempt new practices (Llewelyn, 2012). Significant challenges with home visiting, however, are the intensive resourcing of skilled individuals that required for effective delivery, and the reduced breadth of coverage that might be expected from such an approach. These challenges were noted by a number of the organisations employing such approaches. Often, home visitations relied on a large cadre of volunteers or support groups (in the case of Alola Foundation), who shared the case load between them.

Group-based approaches to caregiver education took place in a variety of forms and modalities throughout the programs surveyed. For ECCD interventions, parent meetings were often held on a regular basis (usually monthly but dependent on funding available to the organisation). Health promotion messages were also supported through group-based presentations. Often presentations were linked or associated with the conduct of SISCa posts that occur (theoretically) monthly in each suco.[10] According to MoH, one post at SISCa is dedicated to providing attendees with information using either PSFs or staff assigned to the community health posts. In addition, the night prior to the SISCa posts, a health promotion film is usually screened for the community, with a follow up discussion facilitated by a health worker from the community health posts.[11]

As discussed previously, group based approaches had varying degrees of pre-determined structure to them, but often focussed on a key theme or topic, and used visuals, videos, or demonstration approaches to engage caregivers in discussion. Unclear from conversations with program managers was the degree to which content was delivered in a didactic versus participatory/conversational fashion. Llewelyn (2012) suggests that critical to the efficacy of group-based parent support programs are methods that are parent and child-centred. Many of the programs attempted to do so through role-plays, scenario analysis, and/or hands-on activities such as producing simple toys from local resources, which individuals could then take home with them afterwards to use with their children. A challenge noted by one program manager, however, was that often the degree to which facilitators allowed for participatory engagement was reliant on the skill of the individual him/herself.

As a review of parenting programs from across the developing world suggests group-focussed delivery is the most frequent modality for a number of reasons, including

[10] An issue noted in interviews was the failure of SISCa Posts to operate as planned in 2013.
[11] Health promotion videos are usually sourced from various INGOs and other actors who have produced such materials in the past.

resourcing involved and potential coverage (Lansford & Bornstein, 2007). Benefits of group-based delivery is that it offers an opportunity for caregivers to identify and discuss issues of concern with their children collectively, learn from each other, establish formal or informal support networks, and influence each others' attitudes/behaviors through regular engagement. Pragmatically, group based delivery can reduce volunteer or staff time extensively. That stated, the significant disadvantage of group delivery is the level of intervention, particularly for high/at-risk families may not be sufficient to change attitudes, behaviors and practices in the home. Additionally, monitoring and assessment of changed practices becomes more difficult with this form of delivery.

Relatively few actors were noted to use media as a key modality of delivery. Two exceptions to this were CARE and Ba Futuru. CARE, through a magazine known as *Lafaek ba Komunidade* was communicating key messages related to livelihoods, health, education and environmental stewardship to approximately 20,000 households three times annually. Using a combination of photos, cartoon images and small segments of texts, content was presented in a user-friendly and accessible format to low-literate adults that are its primary readership. The key to the success of the project, however, were the reinforcing messages presented to the magazine's readers through community theatre, demonstrations and radio programs, according to the pilot project's final evaluation. Likewise, Ba Futuru's *Feto Fantastico* project was successful because of a well-developed character (a female superhero heroine) and imaginative and interesting storylines which 'hook' viewers into the messages on conflict mitigation that were part of the series' first episodes. The majority of the viewers of the series, in a small-scale evaluation conducted by the organization, noted that they could empathize with the situations presented in the short clips, and could readily understanding the key messages being promoted. Such examples suggests the power of media as a vehicle for communicating key messages, but also highlight the need for media messages to be engaging, relevant, accessible and interesting to viewers/listeners.

In some circumstances, program designs were built around providing support to caregivers using a number of different delivery modalities, and over an extended time period. In some instances this involved combining group-based delivery with follow up individual support or vice versa, or combining media campaigns with community theatre/dialogue/demonstrations. Some organisations found use of video or community theatre to be a more engaging approach to delivering key messages as either a follow on or initial activity, but also noted that it was important to support mass messaging with more intensive intervention, in the form of discussion/dialogue. Those organisations using more than one modality of delivery and promoting messaging over more than one time period, are following what international research suggests to be most effective approach to changing entrenched attitudes, behaviors and practices (Mejia et al., 2012). Specifically, without prolonged exposure to the parenting messages that are being promoted, and exposure that occurs in a variety of formats, it is unlikely that changes in attitudes and practice will be achieved. Research has found, for example, that interventions working with "high risk" families"—namely those most impacted by conditions of poverty or other structural disadvantage—need at a minimum 30 to 40 hours of contact time for positive and long term impact (Llewelyn, 2012).

Who is delivering the program?

Most programs, whether visiting caregivers in the home, or running group-based interventions, use volunteers. These volunteers are typically members of the community who were selected/nominated by the Chefe de Aldeia or Chefe de Suco, and were often young adults. In some instances, such as Alola's Mother Support Groups, or World Vision and Child Funds' ECCD interventions, facilitators were either teachers in school/ECE centre

or peers/colleagues of participants. In some instances, home visits were conducted by existing government volunteers (specifically the PSFs) but this was also an issue as the MoH acknowledged that these individuals often have multiple demands placed on them with very little incentives that go along with this additional work. Additionally, varying levels of motivation and skill were noted to exist amongst these volunteers, and volunteer attrition was a continual challenge to effective delivery for many organisations. While some organisations attempted to incentivise volunteers by providing t-shirts, mobile phone credits, or opportunities to attend trainings in Dili or overseas, the lack of financial incentives meant that some volunteers incurred high opportunity costs to remain involved in such activity, and chose to leave with other options arose. Some organisations noted that they lost up to 30% of their volunteers over the span of a two-year period, and were in need of replenishing and training new individuals.

As noted by the World Health Organisation (2013) the use of volunteers to support program activity is often cost-effective and allows for expansion. There is, however, a strong need in such settings to ensure that these individuals receive regular supervision and support. It is unclear at present time, if all actors using volunteers in either home-based or group-delivered programs provide such continual support, or have the capacity to do so. The MoH, for example, made it clear that until recently all training to PSFs has occurred at a district level, making it difficult for many to attend. Additionally, they acknowledged that outside of the two districts where *Cuidado Saude Primario* is currently operating, paid health workers (doctors, midwives, nurses) do not provide regular support or oversight of the work of PSFs in community-based education programming.

Additionally, those acting as facilitators need to be carefully recruited and selected to ensure that they have appropriate understanding of the need to be empathetic and to respect individual differences of participants. It is also important that they are respected individuals of the community. Yet in many programs, it is youth without families who either have interest and availability in taking up such work, and are often nominated to act as facilitators in such programs. Some program managers noted this created challenges in terms of engendering trust and respect from caregivers, as they lacked community credibility to promote messages on caregiving. In contrast, the strength of mother support groups, or the utilisation of parent educators, is the peer-to-peer base of support at the core of such activity, which may help.

In a minority of programs surveyed, support and education programs were using existing staff or local government workers to deliver key messages. PLAN International, for example, used local staff members to facilitate its parent education and SISCa-based discussions with caregivers. Likewise, Child Fund relies on its pre-school teachers to run some of the parent education sessions. MoH also use its district and community health posts workers to facilitate parent education sessions which operate alongside the SISCa posts.

Measuring effectiveness

A significant issue noted in the international research is the lack of a robust evidence base behind many of the parenting programs that are occurring at present in the developing world. This proved to be the case for many of the interventions reviewed as part of this scoping study in Timor-Leste. The majority of programs reviewed did not have clear, measureable targets or indicators related to behavior change, and tended to collect data largely at the output or activity level, if at all. There appeared to be no clear avenue for many of these programs to be assessing their overarching program theory. There were some exceptions to this.

Ba Futuru, for example, as part of its Transforming Timorese Classrooms and Feto Fantastico[12] programs, has conducted pre/post surveys which demonstrate clear shifts in participants' knowledge of ways to prevent violence and deal with students/children in non-aggressive ways. Similarly, CARE's Lafaek ba Komunidade has strong evidence demonstrating shifts in caregiver knowledge, and the application of knowledge to practice in several domains such as hand washing, utilisation of medicinal plants for home treatment, prevention of malaria, reading with children, and secure seed storage. World Vision's recent evaluation of its ECCD intervention, in Bobonaro, however, suggests that its program has had less effect in changing caregiver behaviors and attitudes. Data suggests that after the initiative presented messages within the key domains of parenting: (1) there was little difference in behaviors of caregivers on the feeding of leafy greens and proteins in addition to rice pre/post; (2) hygiene practices (specifically utilisation of a latrine and appropriate disposal of faeces) had improved; and (3) while caregivers were more likely to ensure their children attend school, they did not report reading with their children more, or playing or engaging with children in stimulation activities to a higher degree. There was also not a discernable difference between participating and control-group parents in terms of utilisation of positive rather than punitive discipline techniques.

What is evident from the review is the need to ensure that future activity is: (1) guided by an overarching program theory/logic of intervention; (2) develops indicators that assess progress against this logic of intervention, and robust measures of behavior change; and (3) ensure that there is an ability to demonstrate attribution/contribution of particular interventions to outcomes observed. This will require, as has been recommended in previous international studies, much greater investment from programatic teams in M&E activities than has been the case in caregiver education activities to date.

[12] A dilemma for an organization such as Ba Futuro who is using media (radio/TV) as a primary delivery mechanism is establishing how to measure the reach and impact of the messaging. Issues of attribution and contribution proved especially problematic for these programs.

Section Two: Beneficiary Analysis

Background

One objective of the consultancy was to conduct a needs assessment of primary caregivers, including *Bolsa da Mae* recipients, and those that had never benefited from participation in any formal parenting education initiatives, and to identify their needs. This including analysing both strengths and weaknesses of existing parenting practices and beliefs, and also specific gaps in knowledge, attitudes and skills that might be important to the well-being of children 0-18. This section synthesizes this information.

Existing knowledge, beliefs, attitudes

Addressing the illness of a child

Amongst the caregivers interviewed, there appeared to be high levels of awareness of danger symptoms for a young child's illness and a willingness to seek professional medical advice for such ailments, should health facilities be available to them. The majority of caregivers when asked how they would deal with a child who had been sick for two days with vomiting and/or diarrhoea responded that they would seek the advice of health professionals immediately. Depending on their locations, some would go to the local health clinic (if in a rural setting), or if in Dili or a regional centre, visit a doctor in the hospital. One of the groups of caregivers in Liquica also discussed how they would immediately prepare an Oralite solution of salt, sugar and water to ensure that their child did not become dehydrated, and several groups discussed using traditional herbs and remedies as a precursor or in conjunction with visiting skilled health professionals.

A minority of the focus groups raised the idea of first seeking assistance of traditional healers (*Matan-dook*) before seeking professional medical advice, particularly in the first days of an illness. When asked why, one parent in the focus group noted that, "*according to our belief, there must be a spiritual threats that we, as parents, should find out the root of the spiritual threats. Many times we believe that the child is sick because of the spirit/soul of parents and/or grandparents who feel angry with the family, and that is why the child is sick. Once we feel this spiritual threat then we have to prepare flowers, candle and go to the church to ask for a special Holy Mass and after that we bring the flowers and the candles to the cemetery to pray there*."

With scepticism, however, another group noted that, "*with the Matan-dook cannot see what exactly the illness because he or she just do guessing. And many times it failed*." Many felt that medical professionals, with the equipment, skills and medicines they had on hand, were more efficacious in addressing their child's illnesses. The teen parent focus group in particular recognised this issue, but noted that often they felt pressured to seek the advice of traditional healers first by their own parents or other close family members. In one instance, this had led to a negative outcome for one teen mother, whose child ended up in hospital for over a month, and suffered growth stunting as a result of severe malnutrition and dehydration. In retrospect, this mother noted that she wished she had not listened to the advice of her family and sought out attention promptly.

Additionally, many caregiver groups were able to identify important measures they could take to prevent such illness from occurring in the first place. Common responses were: ensuring their child was bathed every day, washing hands regularly, children not playing in

the dirt/dust, preparing fresh food for children at each mealtime, and making sure toys and play equipment were kept hygienic.

Academic underachievement

Caregivers appeared to have some knowledge of how to address a child's academic underachievement, but often their solutions involved punitive measures towards the child as the first response, and they had limited knowledge/capacity to support their child's learning in the home. Specifically, in most groups, they stated their initial reaction to such news would be to beat or speak to their child in a harsh way. For vulnerable families, in particular, there would be very high levels of disappointment if such news arrived at the house, largely because as one parent described, "*we have worked hard to send them to school.*" This would then be followed, with some of the parents, with increased support for the child academically in the home, by creating a schedule for completing homework, ensuring they had a structured workspace to complete schoolwork in, and the parent checking homework nightly for completion.

Caregivers were less likely to seek external advice or support for this matter, and often felt as if this was a family responsibility to address. A key source of support to caregivers were older siblings to the child, as many caregivers did not feel they had the adequate skills or knowledge to usefully help their child with school work (due to language or literacy/numeracy issues). Some caregivers would also seek assistance from a peer in their child's class or an extended family member (such as an uncle), particularly if there were no siblings who could help at home. A minority of caregivers noted they would go and speak to their child's teacher directly and seek advice from him/her, but more than one focus group discussed how they often felt uncomfortable or uneasy approaching the school for support. One parent, who had tried to do this noted, that, "*I tried one time go to school teacher, I presented him my problem, but he said that teachers' are only responsible for students during school hours (8-12)…After that it is your own responsibility, you have to solve it yourself, they are your children, you know how to make children, you should also know how educate them. This answer somehow, has discouraged me from seeking outside supports*."

Most parents felt that underachievement could be prevented by ensuring they constantly monitored their child's progress in school, by checking that he/she had completed homework, was attending school regularly, and reinforcing to their children the importance of doing well in school for future opportunities. The challenge for many, however, was one of time, and also of their own lack of skill and knowledge to adequately support their child's learning.

Disciplining a child

An area where caregivers appeared to struggle in regards to insufficient knowledge, but also harmful attitudes and practices towards the rights of children, was in how they deal with a child's perceived misbehavior. Most parents, when asked how they would discipline a child who was not listening, responded that beating him/her would be the first response. Often mothers would be the first to discipline the child in such a way, and if this failed, then they would ask the child's father to intervene. According to many of the groups, mothers would often 'lightly beat' their children by slapping them or pinching, but fathers were known to be more aggressive and would kick or punch a child if he/she continued to not listen. A few parents (the notable minority) noted they would try to speak nicely to their child first, but others in the group felt that such approaches were ineffective. According to one parent, "*Speaking nicely to children is hard to do every day. At some stage 'hard education' (physical violence) is needed to apply in order to discipline them.*" Amongst caregivers interviewed, there was some fear that if adolescent children were disciplined too harshly, they would

react adversely and either run away from home or threaten their families with suicide. In fear of such an outcome, the parents of adolescents often believed that the only way they could keep their children behaving was to buy them things. One parent of a teenager noted, "*My son asks for a mobile phone, motorcycle and money as well…to avoid [the] problem and for [him] to be able to listen to us, we just fulfil the requests.*" Even parents of younger children resorted to buying their children small toys to keep them happy and disciplined. One parent noted, "*My kids if they want something like toys on the street they would cry for that and we have to buy it, if we don't have money to buy it, would cause a problem, they will sleep on the floor and never stop crying.*"

As would be expected, this added to the financial strain faced by many of the caregivers spoken to. In general, it would appear that positive discipline techniques were not widely known about amongst the caregivers spoken to, and even with the minority of caregivers where such awareness existed, there remained great skepticism about whether such an approach would actually be effective.

Caregivers appeared to be reluctant to seek outside existence or support for their child's misbehavior, believing doing so would bring shame to the family and cause others in the community to speak badly about their parenting abilities. There was also a sense that a child's perceived misbehavior was a reflection of the 'poor morals' of the child, which by extension could then reflect on the family name. When caregivers faced continuous issues with their children's perceived misbehavior, they noted they would seek assistance from other family members, most often an uncle or aunt who was respected by the child. To prevent the situation from arising, the caregivers spoken to felt they had to set clear parameters and expectations for behavior with their children from a young age, and also ensure their children were raised with 'good morals'. Many caregivers noted that it was important to stress with children the need to protect the family name, and their behavior was a direct reflection of how that name would be perceived in the community-at-large. As children grew older, and reached adolescence, caregivers often felt that they struggled more to control their children's behavior, and felt that the influence of their peers became stronger. If the parents judged their peers to be exerting a negative influence on the behaviors and attitudes of their adolescent child, they would prevent their child from leaving home, or give him/her more household chores to make sure they did not have time to spend with such friends.

Addressing teenage relationship with the opposite sex

In general it would appear that parents of adolescent do not have sufficient knowledge of how to discuss the prevention of teenage pregnancy with their adolescent children, and often their existing attitudes and practices work counter to effective communication with their children on such a topic. Parents of adolescent children were those most often to raise concerns related to controlling and/or being aware of the activities of the children outside the home. For example, one parent noted how, "*My elder son now stud[ies] at secondary school, but everyday he goes out without any reason, he also always get phone call from his girlfriend at all the time. We don't know where he is go when he goes out*," and another parent was alarmed that, "*My teenage girl always talk on the phone, probably with her boyfriends, I am afraid…*" In general these parents were worried of a breakdown of communication with their children as they entered into adolescence, and of their children entering into relationships with children of the opposite sex before they finished their schooling. When asked how they might deal with news of their child being in such a relationship, however, a common initial response was to either beat them or speak to them sternly about the importance of finishing their studies before they entered into a relationship. Parents would counsel their children to abstain from being in any form of a

romantic relationship until their education was finished and they were economically self-sufficient. For caregivers of teenage girls, a common solution was to limit their forays outside the home to attending school. None of the caregivers appeared to be willing to discuss matters of sexual or reproductive health with their children, or ways to prevent pregnancy through the use of contraception. In one group they stood concerned that discussing contraceptive use would serve as an excuse for their child to engage in sexual activity to a greater degree. Another group of caregivers felt that they did not have sufficient knowledge about sexual and reproductive issue themselves, to then discuss such matters with their children. They also felt that their children learned about such topics in school, and that continuing such discussions at home was not important. Teenage parents in particular regretted such conversations not occurring in their family's home, as they felt that if their parents had been more open with them about the topic, they might have avoided falling pregnant and being married at such a young age.

When parents were asked what they would do if their child continued the relationship despite counselling and disciplining within the family, they noted that they would encourage marriage, particularly if the girl became pregnant. As a first step, they would meet with their child's partners' family to negotiate the dowry, and then work to formalize the union with the assistance of the Church. This would occur despite awareness amongst caregivers interviewed about the dangers of early pregnancy/marriage.

Caregivers appeared to be extremely reluctant to seek assistance from anyone outside immediate, extended family, and the family of the boyfriend/girlfriend in question when initial interventions failed to redress the situation. Issues of shame and fear of gossip arose prevalently as factors preventing them from seeking help. In certain circumstances, caregivers noted that they might ask an uncle/aunt or godfather/godmother to intervene. The Church was not identified as a source of assistance in such a circumstance, in part because there was a fear of being judged poorly for allowing such a relationship to have occurred in the first place.

Addressing the specific needs of a pre-schooler

Caregivers were also asked to describe how they care for toddlers in their home. Many of the caregivers agreed that special care and attention was necessary for three and four year old children, and listed several different forms of support they give to children of this age including: singing songs with them, making and/or buying toys for them to play with, providing them with fresh food including meats and vegetables, taking them to a health clinic when they are ill, providing them with love and support (including treating them well), protect them from hazards in the home and outside, and spending extra time with them in the home. Caregivers also acknowledged that while this was the ideal, they were often juggling a number of responsibilities in the home, and one mother made clear that as long as the child was not crying or needing attention, she would leave this child alone to his/her own devices. In general, caregivers were able to note important caregiving, responsiveness, and stimulation functions that are critical for the development of a toddler. None of the groups, however, mentioned reading with this child, and only one group discussed counting or pointing out the names of objects/reciting the alphabet with a child of this age. There was strong willingness amongst caregivers to send their child to pre-school but noted that often distance or cost (as most are private or church-operated ones at present) often precluded them from doing so. They acknowledged that preschool attendance was critical to preparing their child adequately for school, specifically in terms of literacy and numeracy development. What appeared to be lacking was knowledge about how as first and primary educators in the home, they could support this development as an alternative.

Given the fact that within most Timorese families, such children are one of many under the care of the adults in the home, responsibilities was often shared amongst several parties within the home. Mothers acknowledged that they took on much more responsibility for the care of toddlers, with fathers noted to spend very little time with their young children. In some cases, care for a toddler was relegated to older siblings, particularly if and when the mother/father were off at work or attending to other duties. Aunts or grandmothers would also provide assistance in the care of such a child.

Factors influencing caregiving practices

Through the FGDs, and separate conversations with community leaders and health workers, some clear enablers and barriers to positive parenting practices could be surmised.

For many caregivers, immediate and extended families remain key support structures for child rearing. This type of influence is both a key enabler and barrier to positive parenting practices—and examples of both were raised in the focus group discussions. Caregivers often relied on their family in situations where they felt that seeking outside support or assistance would bring shame or embarrassment on them, and were one of the few people they could trust in difficult situations such as teenage pregnancies. However, family advice and support could sometimes work to the detriment of the well being of the child. On more than one occasion, in the FGDs, parents noted they would seek the permission or advice of their parents, or extended family on coping with the illness of a child. In some circumstances, they were advised to not visit a health clinic until they had first satisfied traditional customs and practices such as *Matan-dook*. Doing so put the child's health at greater risk, and also added to financial burdens on the parents (due to sacrifice and ceremonial costs).

At present, there are some areas where surveyed caregivers exhibit high levels of knowledge and encouraging attitudes towards positive parenting practices. These include: the timely treatment of a child's illness in health facilities and/or with skilled health professionals, knowledge of ways to mitigate or prevent diarrhoea and other communicable diseases in young children, knowledge of the benefits of, and willingness to send their children to school/pre-school, and approaches to stimulating and caring for a young toddler in the home. In many circumstances, this knowledge was gained through SISCas, or public service messages on television or radio.

Additionally, when caregivers had knowledge and trust in the forms of support external parties might be able to provide (such as doctors and nurses helping in the diagnoses and treatment of a child's illness), they appeared to utilise such services to a larger degree, suggesting the importance of linking caregivers to high-quality service provision, and ultimately the knowledge, advice and support they might be able to offer. At the same time, service providers need to understand that an open and receptive attitude to caregivers seeking advice and/or assistance is necessary if behaviours and practices are to change. Specifically, the current situation which exist in the formal education setting—between educators who have told caregivers that their responsibilities end at the school gate, and caregivers who in response, or mistakenly, do not see schools as vital resources in the upbringing of their children—needs to change if greater partnerships are to be built between the home and school. A model with success in this regard, is that employed through SISCAs and the Ministry of Health's *Cuidado Saude Primario* project. These initiatives have brought professional government workers to the local community, and in some circumstance the home environment itself, and effectively served to break down barriers between service providers and caregivers. Parent teacher associations and

community-based schooling initiatives (particularly in the early childhood sector) may be important opportunities to begin to break down such barriers in this regard.

It should be noted that even when parents were aware and willing to send their children to preschool or visit a health post, a significant impediment to action was often the lack of easy accessibility to such resources in the community. When such facilities were in close proximity and offered services at little or no cost, conversely, caregivers were more than willing to take advantage of such opportunities. Additionally, sometimes caregivers were not aware of specific resources and opportunities that might be available to them or their children, and as a result did not readily take advantage of such support. For this reason, those providing ongoing support and assistance to families in need, including MSS Child Protection Officers & Social Animators/Child Protection Networks, Ministry of Health PSFs, and church based programs visiting the home have a key role to play in linking families in need of support with vital services. At the moment, this does not appear to be consistently occurring. A key example of this was parents of children with special needs. Most noted that they often spent years finding out who might help their children, and many service providers (including health professionals and members of the Church) lacked knowledge of where to direct them. Those that eventually found services often stumbled on them through word of mouth, rather than a clear referral pathway.

Issues of shame and embarrassment often preclude caregivers from seeking assistance outside the home in raising their children. Effective forms of parent support would be ones that would work to reduce the shame/embarrassment and isolation that many caregivers feel when they have troubles with their children. Doing so will require creating safe space for caregivers to seek advice and support (potentially anonymously on more sensitive issues), and share experiences in an environment of high trust where they begin to realise that they are not alone in their challenges. What this might look like is discussed in the next chapter.

Key influences on parenting practices

Figure Two below provides a visual representation of whom/what, in general, plays a significant influence on parenting practices in Timor-Leste at present. Moving from the top of the diagram down (most significant to less significant influences), it would appear, based on FGDs, that immediate and extended family exert the greatest influence on what parents do with their children. Less influential, are messages coming from 'outside' the immediate community.

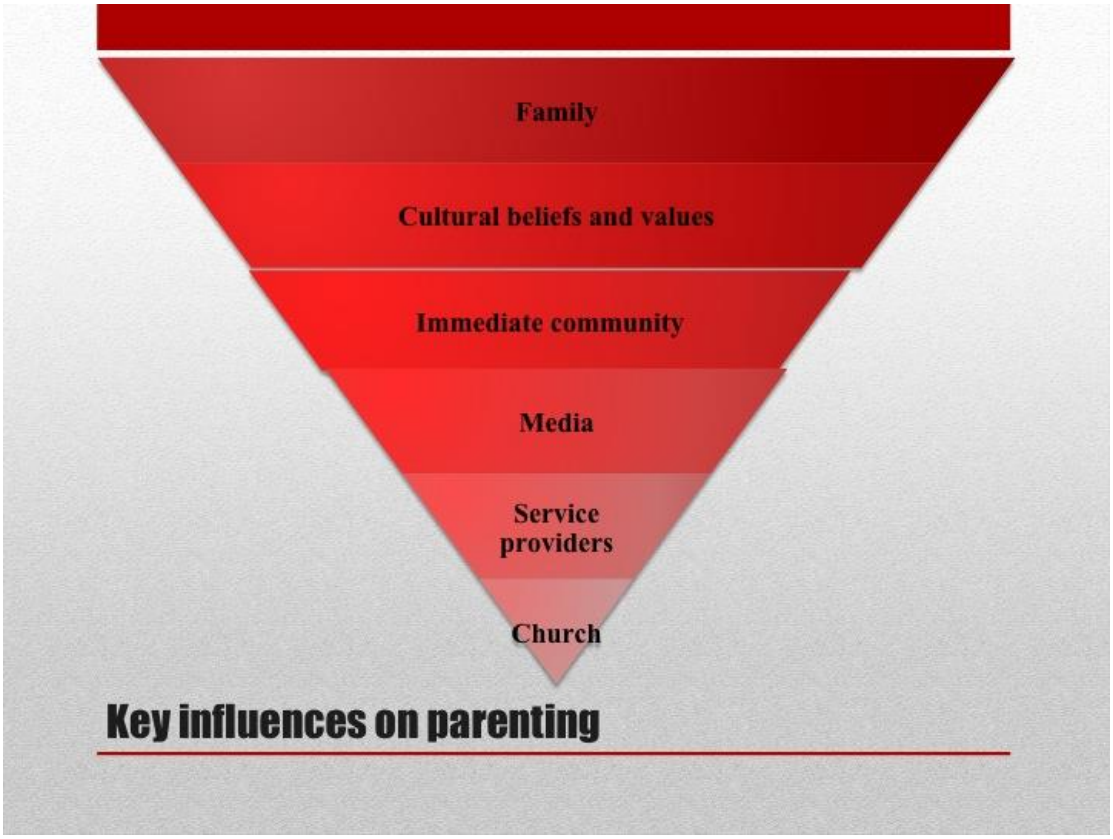

Figure 2: Key influences on parenting

It is important to note that influences do vary across the domains of parenting, and the age groups of children being raised. For example, when caregivers were asked where they had learned about preparing Oralite solution for their children, or ensuring that they washed their children's hands before eating food, they noted that SISCas and health promotion campaigns had a significant impact on improving their knowledge and changing existing practices. On the other hand, on more sensitive issues such as teenage pregnancies and child discipline tactics, it would appear that existing beliefs and values play a strong role in maintaining the status quo, despite the work of outside actors (including organizations like Marie Stopes, MSS and the Child Protection Networks) to better educate communities on these topics.

As discussed in previous sections, the immediate and extended family of parents of children 0-18 have a significant influence on what they do with their children. For this reason, effective parenting and support programs in the context of Timor-Leste may need to think more holistically about who the target population for particular interventions is, and extend reach to the broader caregiving network to include older siblings, grandparents, and aunts/uncles of a particular child. However, given the constraints between wide reach, and deep impact that plague many initiatives, a multi-pronged approach may be called for in which this extended network of caregivers to a particular child is reached through media campaigns that reach all households.

Another significant challenge/issue to consider moving forward is how traditional practices, beliefs, and customs around parenting—such as the need to beat a child, to rid the child's body of spirits first before seeking medical attention, or encourage the early marriage of a teenager in a romantic relationship rather than discuss contraception and family planning options—could be surmounted given the significant influence they continue to play in child-rearing in Timor-Leste. Rather than alienate or dichotomise traditional cultures and practice

as 'backwards' it may be important to identify examples from folklore and mythology which speak to the positive practices of parenting that are in need of greater support. Some programs have already begun to do this, such as Catholic Relief Service's MAHON Project, in which church doctrine, legal statue and cultural traditions are brought together to identify why domestic violence is unacceptable in all three contexts. This type of messaging may need to be considered across caregiving, responsiveness/support, protection and stimulation messages moving forward, particularly if the goal is to change deeply entrenched beliefs, values and practices.

Finally, while community leaders were not specifically mentioned as influencers on caregiving practice, other studies, such as UNMIT's (2011) *Communication and Media Study* suggest that they are still the most trusted source of information amongst the population. In the FGDs, caregivers also acknowledged that should they be unable to resolve a problem within the family, the Chefe de Aldeia or Chefe de Suco might act as their point of 'last resort'. The reason why, is that these community leaders are often those that caregivers fear will judge or shame them if their children are deemed to be 'abnormal' or causing problems. For that reason, the engagement of community leadership in proactive change is essential if changes to deeply entrenched values and beliefs are desired.

Areas of identified need

As part of the FGD's, caregivers were asked about the specific types of support they might require to raise their children more effectively. A key, and universal concern of caregivers regarded their family's economic security. Many noted that they were struggling to keep their children in school, feed them nutritious foods, and make sure they had all the basic necessities. For caregivers of older children, or those with children of pre-school aged, the desire and will to send their children to secondary or early childhood education was often tempered by economic constraints. For this reasons, a key area of need for economically vulnerable families is the need to improve livelihood (i.e. income generation) opportunities within their communities using existing resources at their disposal.

For example, in one rural community visited in Manatuto, livelihood opportunities were limited to producing sago flour from the palm trees, a time-consuming and laborious process with relatively low yields according to the group spoken to. Caregivers, particularly those living in areas outside of Dili, were eager to diversify crops and develop other small-scale industries that could then be used to supplement their largely subsistence lifestyle. Given that parenting education and support activities extend beyond skills directly related to child rearing practices (discussed in last chapter), there is ample scope to address this need within a National Parenting Education Framework. The work of CARE International through the Lafaek community media project is already operating in this space and a number of other actors in Timor-Leste are working on food security and livelihood projects. What is necessary now are ways to better integrate this activity more directly into parenting support and education programs.

The FGDs also revealed that particular types of parents require specific forms of support. For example, parents of adolescents acknowledged that they were struggling with the pressures of modernization in the raising of their children, specifically their children's utilization of technology (i.e. mobile phones/internet), the increased mobility of children out of rural communities to district/urban centers for study, and the rise of a wage-focused economy. These new factors and influences led many caregivers to feel that they were losing control over their children, and had no way to regulate or stay actively involved in their children's lives as they grew older. Caregivers expressed a desire to know more about

how they could cope with these new pressures effectively. Similarly, the parents of children with special needs acknowledged that they often lacked awareness or information of how to effectively interact and engage with their child in ways that would support their growth and development.

Section Three: A Framework for a National Parenting Program for Timor-Leste

The final section responds to two key tasks noted in the initial ToR: (1) to identify who within government, civil society, and church based organisations might usefully contribute to any potential parenting education/support program in Timor-Leste, and the potential roles they might play; and (2) begin to draft a framework for a parenting program for Timor-Leste, using the community sessions envisaged by MSS as an entry point for this.

Key stakeholders and their role in parenting support/education

Through the FGDs, interviews with representatives from various government agencies/directorates, meetings with community leaders and members of the Child Protection Network, and an assessment of the strengths of civil society actors (see Chapter One), this section describes a potential role for government, media, civil society and church-based organizations in establishing a model for parent education and support. The aim is to leverage on the strengths of each sector of society, to ensure that messages and activities aimed at supporting caregivers to raise their children are effective and efficiently deployed. A summary diagram of the role of each sector of society is provided below.

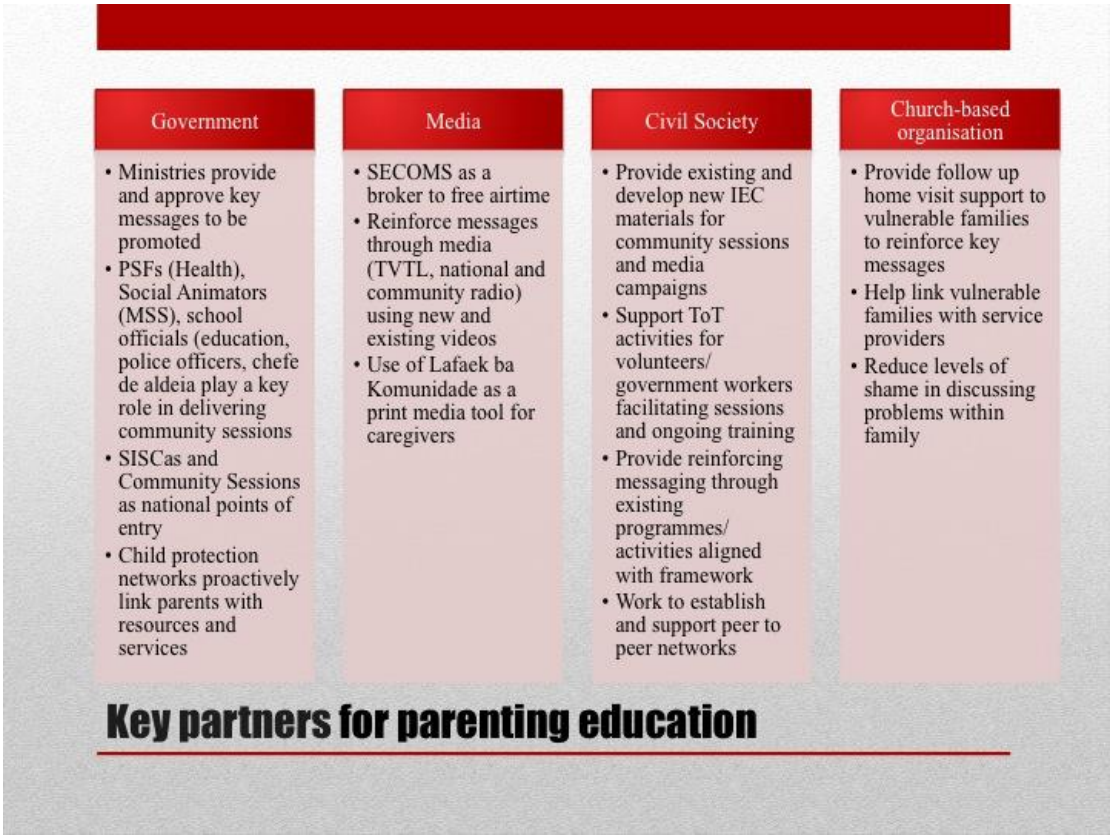

Figure 3: The key partners for parenting education

Government

At present various line Ministries, such as Social Solidarity, Health, Education and Justice play multiple roles and serve a variety of function in supporting caregivers in the raising of their children. In addition to the direct services they provide, they all are working to communicate key messages from their sectors, which are aimed at better engaging

caregivers and other adults with the services and support they offer, and to promoting key child welfare and protection messages which are part of the government's role in protecting and guaranteeing the rights of children. To date, it would appear that the link between the communications/community engagement and service provision arms remains weak. Additionally, while it is clear that each line Ministry has some key messages that it is aiming to promote with caregivers/community-at-large, most line Ministries lack a overarching behavior change/communication strategy, and have little direct and/or awareness of the range of messages that are being promoted by non-government actors. As an impetus for further discussion, a compilation of key messages promoted by various Ministries and civil society in Timor-Leste has been compiled in Appendix 2. These messages are broken down by the age of the children for which they are especially relevant

Moving forward, a clear and cohesive strategy for engaging caregivers should be developed within each Ministry's communication units. Such a strategy should specify the types of key messages and modalities of delivery through which they might be promoted. Examples of this already exist through the Ministry of Health's BCC, which is now moving through a period of refinement and consolidation. Important in deciding which of the myriad of message are most important at present time, would be an assessment of: (1) the most critical concerns facing children's welfare; (2) an analysis of which messages might be easily enacted on by caregivers with a minimal of external resource, in other words the 'low hanging fruit'; and (3) careful consideration of how messages are linked to key development outcomes which are aspired to in Ministry and national government strategic plans at present.

From this, the range of actors who might be involved in promoting various messages with caregivers would need to ensure that what they are communicating is aligned with these strategies, and government would need to play a role in quality assuring the messages that went out through these channels.

Moving forward, government also has opportunities to deliver such messages through staff and volunteers it already has mobilized at local levels. There are a number of key government representatives who already work at the local level, and have ongoing engagement with caregivers. These include: (1) school officials (teachers and principals) who have as part of their job description the responsibility of engaging with their community and the parents of children at their school on an ongoing basis; (2) MSS social animators who administer the Bolsa da Mae program; (3) Child Protection Officers who should function, in part, as social workers at the community level; (4) PSFs, or Ministry of Health volunteers who are instrumental in mobilizing the community for SISCas and supporting the Ministry of Health's promotional messages; and (5) local government officials who have some experience of being engaged in the parenting education/support programs of civil society actors such as SDPP.[13] While only a few representatives from each of these groups was interviewed as part of this consultancy, the PSFs, social animators, school officials and local government officials spoken to all indicated willingness and desire to better support caregivers through parenting education programs. While at present, these individuals do not figure largely in influencing the behaviors, attitudes and practices of caregivers, there remains ample opportunity for this to change over time, should they be given a role and

[13] The School Drop Out and Prevention Program is discussed in Chapter One, and involves community volunteers, including the Chefe de Aldeia, in conducting visits to households deemed at risk of their children dropping out of school due to frequent absenteeism or poor academic performance.

responsibility for supporting caregivers through educative activities—including running group sessions and conducting home visits. At the same time, encouraging these individuals to more closely engage with caregivers may also help to bridge the gap between service providers and those in need of and demanding such services. As these parties are trained and become more knowledgeable of the resources they can direct caregivers to, the hope would be that demand for services will also increase.[14]

Finally, existing and planned government activities provide a mechanism for reaching vulnerable families and caregivers across the country. With the regular resumption of SISCas, presumed to be occurring on a monthly basis within each suco of the country, [15] and the planned roll out of community mobilization sessions through MSS, a large proportion of the country's caregivers can be reached through one or both of these venues. These platforms are critical opportunities to capitalize on times that the community has already been mobilized together, and deliver key messages to those assembled in a group-based setting. At present, SISCas are already proving to be an effective mechanism for doing so, and acknowledging this, organizations like PLAN are working through SISCa to introduce other messages on early childhood stimulation, responsiveness and protection into the monthly education sessions.

Media

In 2011, UNMIT conducted a media survey which revealed that: (1) radio and television campaigns were effective mechanisms for disseminating vital information from government actors and other agencies, and (2) radio, television and mobile phone viewership/ownership had dramatically increased since 2006 and would continue to grow in coverage. Since that time, the country's electrification project would have expanded access to television to more households, and it might be expected that moving forward television and radio (along with mobile phones) will play a more significant role in communicating key messages to households across the country. In 2013, the government established the Secretary of State for Communication (SECOM), to broker such information more effectively across the various state-owned communication channels including TVTL and radio.

At present SECOM has taken over control of TVTL and national/community radio, and have allocated free airtime to each line Ministry, as well as ensured a dedicated slot for government communication on a daily basis through the Government Page television program.[16] This presents an important opportunity for various Ministries, particularly after they have developed their communications strategy, to use these media channels and disseminate their messages on a national level. As a first step, a stocktake should commence within each of these Ministries of the types of audio-visual materials that have been produced (either internally or through civil society partners). The stocktake should consider the quality and continued relevance of existing audio-visual materials, and an analysis of what new audio-visual material might be required to effectively communicate the key messages they have decided on. SECOM has indicated a willingness to co-produce new

[14] As an example of what might be possible, one PSF interviewed, noted that through her active involvement in Alola's Mother Support Groups, she was able to encourage expectant mothers to deliver their babies at the community health post, rather than at home. After two years, delivery at the health post for this particular community had quadrupled. According to the PSF, much of this is attributable to her having a more active and engaged support role in expectant mothers' well being.

[15] Based on communication with the director of the Health Promotion Unit, MoH

[16] At present, according to the Secretary of State, many Ministries are failing to use their allocated airtime.

material with various Ministries using its staff and facilities, and to provide technical expertise on reviewing draft scripts and content to ensure it is engaging and interesting to potential listeners/viewers. Additionally, there are a number of civil society actors, such as Ba Futuru and Bibi Bulak, who have developed previous media campaigns and could be called on to provide technical expertise or to write/produce new material for various Ministries.

Concurrent to a television/radio campaign, other forms of media can also be used to reinforce and support key messages from each respective Ministry. As noted in Chapter Two, the *Lafaek ba Komunidade* magazine, produced three times annually by CARE has proven to be an accessible, relevant and well-utilised print media resource that effectively reaches vulnerable households. In a country where, according to the UNMIT 2011 media survey, reading material in the home remains extremely limited, there is ample demand for the expansion of such a resource. At present CARE is negotiating to expand coverage of the publication nationally by distributing the magazine through early childhood centres and Grade One and Two students. In the past CARE has developed its messages internally or through a small advisory board, but there is ample scope for messages be derived from various Ministries' communication strategies. With CARE's team of skilled writers, illustrators and graphic design artists, and a proven track record of success in communicating with low-literate adults, such a resource could mutually reinforce radio/TV message and act as a reference tool in the home environment.

Civil Society

As noted in Chapter Two, civil society has played an active role in parenting education and support activities to date. They have managed to develop comprehensive and holistic programs of support addressing all domains of caregiving, and reaching vulnerable households and underserved communities in Timor-Leste. They have developed innovative models of delivery, which combined group sessions with follow up home-based support. They have also developed a significant body of IEC materials as part of their activities. The significant challenge to date has been one of a lack of coordination, inconsistency of messaging, and unfortunately a duplication of efforts in many regards.

If government were to take more of a leadership role in setting the parameters for parenting education and support initiatives in the country, civil society's existing strengths and assets could be leveraged in several ways. A strength to date of the activities of these actors has been their ability to mobilize and train a cadre of willing volunteers who are able to deliver their parent education curriculum and/or provide ongoing support. Through carefully developed ToT approaches, and clear systems of ongoing monitoring and support to the volunteers, some of these civil society actors have helped to ensure a level of consistency of message and service delivery around their programs of support. Given this expertise, civil society could act as a critical partner in helping to train volunteers or government workers on specific modules within the national parenting framework (based on their area of strength), and monitor and support these volunteers or local government workers as they carry out their tasks. At the same time, the plethora of IEC materials produced to date—such as curricula, flip charts, posters, and information booklets—may provide a useful starting point for delivering key messages identified by government ministries. Based on a brief review of the materials produced by civil society actors, it would appear that rather than developing new materials, a key initial task may be to review existing IEC materials produced to date, and work with civil society to modify/reproduce what they have already created in line with the newly developed communication strategies of each Ministry.

Finally, civil society should continue to play an important delivery role in parenting support and education activities. The limited resources of government ministries will mean that particular activities, such as home visits, or peer support networks, may not be able to be supported through their existing staff and/or cadres of volunteers. Given civil society's ability to identify and mobilize volunteers to date, they could be called on to provide follow on support to Ministry led initiatives, and help to reinforce particular messages through more intensive forms of intervention with the most vulnerable families. Additionally, where they already have existing programs in operation, there may be ways for civil society to work more closely through and with government mechanisms to support key messages. Examples of this already occur, such as Child Fund's work with PTA's, and PLAN International's work through SISCas.

Faith-based organizations

Similar to civil society, faith based organizations remain important partners moving forward in the delivery of parenting support and education initiatives led by government. As noted in the previous chapter, many caregivers remain reluctant to publically discuss challenges they are facing within the home, particularly with those that they do not trust. Faith based organizations have a key role in overcoming this barrier. At present, the Canossian Sisters and Pastoral de Crianças have systems of home-based visits/support established to counsel families on both practical and moral/religious matters. By their own claims, they are successful in identifying and visiting the most vulnerable households, and as members of the clergy, they act as respected figures in the community. While to date, faith-based organizations have not been identified as important figures in influencing the practices and attitudes of caregivers, the Catholic Church remains an important influence on cultural beliefs, values and norms in contemporary Timorese society. Members of the clergy remain a place of refuge for families and vulnerable children, particularly when other sources of assistance have failed. They are also addressing topics that are not addressed by other actors, such as drug and substance abuse in adolescents, and controlling pornography in the home environment. There is potential to leverage on these strengths. Through home visits to the most vulnerable families, these organizations may hold the key to initiating a more open and frank discussion on issues of violence or adolescent delinquency that families are loathe to discuss publically. Over time, there is potential for these organizations to help link these households to other peers and government service providers/resources who may be able to assist them, particularly as caregivers come to trust and rely on the support of those visiting homes on a regular basis. A key issue that will need to be addressed, however, in engaging the faith-based organizations in such work, will be ensuring their agreement to deliver a message that is consistent with that promoted by other actors and through other channels, and an assurance that they are able to provide some level of quality assurance and monitoring over such activity, as this appears to have been a weak aspect of their visits in the past.

An initial point of entry: Community Sessions

The Ministry of Social Solidarity has signalled interest in commencing a regular series of community sessions for *Bolsa da Mae* recipients. The intent behind this, according to the Director for DNRS is to promote and support a process of behavior change in the most vulnerable households across Timor-Leste and improve the situation for children within these households in particular. At the same time, there is hope that by increasing knowledge with these individuals about the benefits of seeking professional medical advice and enrolling and keeping children in school, for example, will increase demand for these government services and also public accountability for the quality of such services. Community sessions have become a common feature of many conditional cash transfer and

social protection schemes globally, for example in the Philippines through the *Patawid Palmilya* program, and in Latin America through *Bolsa Familia* (Brazil) and *Opportunidades* (Mexico).[17] Nonetheless, education sessions linked to CCTs remain an increasing important point of entry for caregiver support, given that messages promoted in such programs often support and enable achievement of other conditions.

General recommendations

The design for the community sessions is based on a growing body of literature, which have begun to identify the components of effective parenting programs. The research suggests that strong parenting programs: (1) begin with a solid program theory, which clearly articulates how the program should be delivered and designed to achieve its aims; (2) work with a clearly defined target population; (3) delivers message that are appropriately timed, and matches the needs and goals of the target population regarding their children; (4) provides an adequate 'dosage' or exposure to each message; (5) uses well trained and supported staff/volunteers; and (6) builds a robust monitoring and evaluation system to track progress against stated aims ((UNICEF, 2006; Lansford & Bornstein, 2007; Al-Hassan, 2009; Llewelyn, 2012; World Health Organisation, 2013). It is on this foundation that a framework and general recommendations for the community sessions are made. The framework, presented in Appendix 3 outlines expected outcomes, key messages, modes of delivery and the actors who might be involved in delivering these messages in each modality in more detail.

Program theory: It is clear that at present MSS has begun to articulate a clear theory of change/program theory about what the community sessions are envisaged to do, namely, support behavior change in caregivers receiving Bolsa da Mae by offering regular parenting education and support intervention to these households. The other component of the program theory is that incentivising participation by linking attendance to the payment will compel higher rates of attendance at the sessions. Given that this is the theory, the M&E systems need to be established to effectively assess whether such theories hold true over time.

Target population: The target population of the community sessions, according to the director of DNRS, are all vulnerable households who have children between the ages of 0-18, namely all households who are receiving Bolsa da Mae. A recent review by the World Bank (2013), suggests that at present, the scheme's targeting is not necessarily clear enough, and that many of those living in the bottom 40% of income in the country continue not to receive the scheme. In response, the MSS is dramatically increasing the reach of the scheme to reach over 70,000 households and approximately half of the nation's children in the coming period. As the identification and targeting of vulnerability of these households improves with the assistance of the World Bank, it is more likely that using Bolsa da Mae recipients as the target population of the community sessions will indeed reach the most vulnerable. For this reason it would appear sound long-term logic to focus on these recipients, but in the short-term the community sessions may need to also include other households who are not yet recipients of Bolsa da Mae but face particular hardships with their children. Additionally, there may be some benefit at the outset in targeting the community sessions in one or two districts of extreme vulnerability and/or specific subdistricts within a broader range of districts and then scaling up from there. This pilot phase, with a robust M&E system behind it could then also begin to assess whether Bolsa da

[17] In this consultancy, time was spent searching the literature to receive more specific information about the curriculum content themselves, and whether the sessions themselves had contributed to changes in behaviors. No firm evidence was found in this regard.

Mae recipients are the right audience for the messages, content and focus of the community sessions and vice versa.

At the same time, an issue that will need to be resolved moving forward will be who will or should be participants within specific households to these sessions and follow-up interventions. As the beneficiary analysis has shown, parenting duties extend to beyond just the mother and father and include the broader family unit. Importantly, fathers have significant influence, but are often not actively engaged in parenting education interventions. The community sessions will need to consider how it might effectively target fathers and other caregivers to be participants in all/some of the activities. As noted earlier, this might take the shape of smaller peer support groups that build a community of ongoing assistance focussed on the specific roles that individuals play within the family unit.

Messaging: As noted in the previous section, a number of messages, promoted by line Ministries, civil society and faith-based organizations have been shared with caregivers in Timor-Leste to date. Lacking, however, has been an overarching strategy for how and why these messages are promoted. As part of this consultancy, and based on a review of key findings to come out of UNICEF's recently completed situational analysis for Timor-Leste, four key areas of need, specific to the domains of caregiving, stimulation, responsiveness and protection were developed. From these areas of need, relevant messages promoted by government, along with through UNICEF's *Facts for Life* program, were aligned to each of these areas of need (See Appendix 2). To date, this work has been done largely internal to UNICEF and before further development of the community sessions, it is critical that each of the line Ministries carefully reviews both the needs and the messages to ensure they reflect current key priorities of their organization. Additional messages for some of the areas of need, such as positive discipline, will need to be formulated as part of finalizing the framework. This could occur by consulting with civil society organizations who have worked in this area, and a through a review of their existing IEC materials. In thinking about the messages that are promoted, it is critical to consider the fact that particular ones, such as children's attendance at pre-school, may not be feasible at present time due to the lack of availability, in most part of the country, of such facilities. Similarly if there is a desire to encourage parents reading with their children in the home, it must be ensured that there is some provision for such materials as part of the broader framework. Therefore messages promoted in the near term must be ones that are achievable for the majority of caregivers to whom they are delivered. Finally, a menu of messages might exist under each area of need. Those that eventually are promoted may need to be decided based on an analysis of need with each group of caregivers.

The appended framework also suggests how the messages might be communicated within the three-tiered approach proposed. Critical for the community sessions themselves, will be the utilization of multimodal and active forms of learning. This will help to increase the engagement and interest of caregivers. Specifically, visual/video demonstrations, visual flip charts, community theatre, role-play, and/or hands on activity in which the caregivers attending leave with a tangible product should all be part of the session content.

Dosage: As already discussed in other sections of the report, behavior change is a process that requires multiple points of entry and frequent intervention to introduce, repeat and sustain what has been promoted. For that reason, sessions themselves, if operating once quarterly will not be sufficient to achieving desired changes in key development indicators for children in Timor-Leste. What is proposed as part of the community sessions model, is a three-tiered approach of global media messaging, quarterly community session and more

individualized forms of support which will follow this activity. There will be no standard 'doseage' for each Bolsa da Mae beneficiary participating in the program. Instead it may vary depending on their need and the issue/topic of discussion. For that reason it is recommended that while an eventual condition may be tied to the attendance of the community sessions, there will be some need to also incentivize participation in the other forms of support that go along with this intervention.

Monitoring and evaluation: A clear issue to date has been a lack of quality M&E practices and systems to assess the contribution that parenting programs are making to changing caregivers' knowledge, attitudes and practices. For this reason, it is strongly suggested that the community sessions be designed and implemented around an M&E framework that reflects the project's theory of change and the expected outcomes for specific behaviors of concern. A clear results framework should link project activities to higher-level outcomes. A key component of ensuring that that whatever targets and indicators are set are valid ones, it will be vita to conduct a baseline study of expected participants which may need to include a quantitative survey (for behaviors and attitudes) and observation (for practices) (see (UNICEF, 2009). Through this data, and secondary information/data, from household surveys and MICS, realistic targets and indicators can be set for the program activity. The beginnings of an M&E framework are presented in Appendix 4.

A general design framework

It is proposed that a three-tiered approach of non-targeted, targeted, and intensive parenting support be established as part of the establishment of community sessions (see Figure Four below).

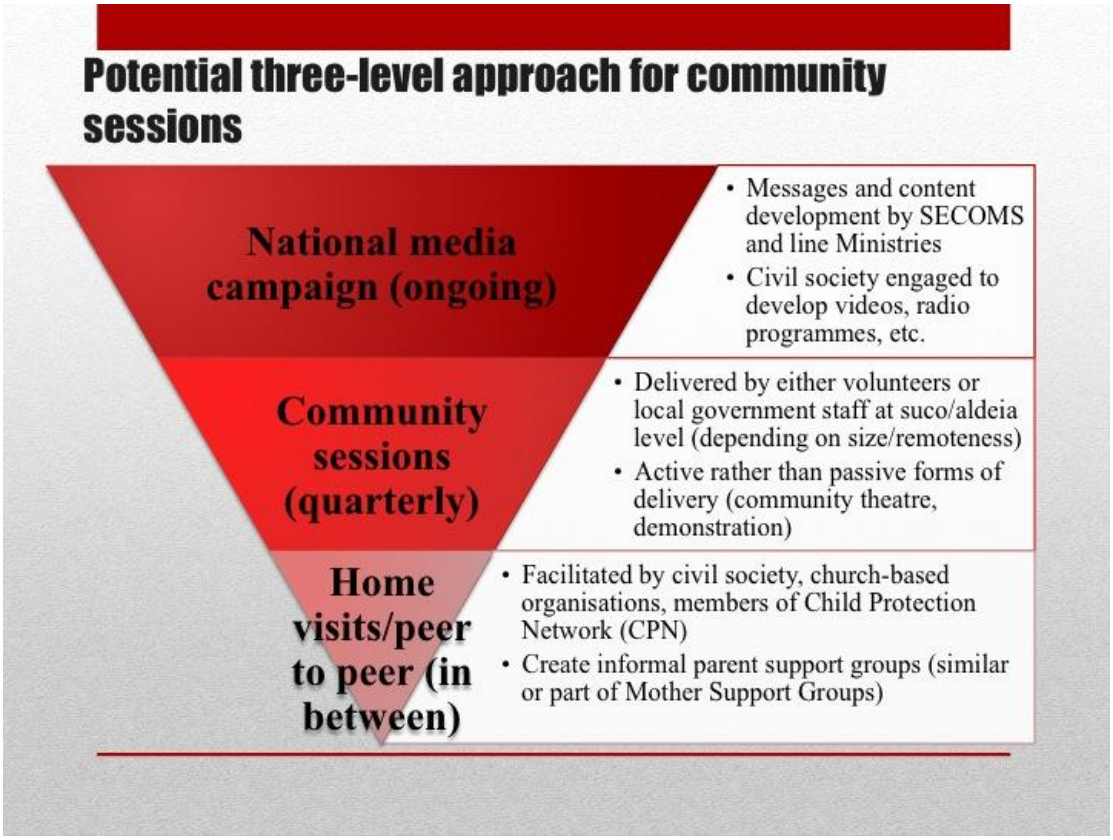

Figure 4: Framework for community session

Specifically, national media campaigns, focussed on disseminating the key behavior change messages developed by the various line Ministries would be broadcast through radio,

television and print media. The objective would be to prioritise a singular message for a set period (monthly, quarterly) with all other activity underneath this, harnessed on reinforcing this message. As part of this media campaign, existing and new video, radio and community theatre programs would be developed to be distributed/disseminated through SECOMS managed media outlets on government controlled airtime. Print media campaigns, utilising billboards, posters, advertisements in national newspapers, and publications such as Lafaek ba Komunidade would work to reinforce the concepts and ideas promoted on radio and television.

Following on this, a monthly or quarterly gathering could occur at the suco level[18], where the caregivers are mobilised as a group to attend a session discussing the message at greater length. If operating monthly, it could occur as part of SISCas, or if quarterly as part of the proposed MSS Community Sessions. These sessions could be delivered by paid or volunteer government affiliated staff (PSFs, Social Animators, teachers, police, Chefe Aldeia or Chefe Suco), or by other volunteers trained by civil society organizations. Important about these sessions is that that messages would need to be aligned with the national media campaign, and delivered consistently on a national basis. For this to happen, a clearly developed curriculum would need to be in place and a standard set of IEC materials utilized as part of the sessions. Important about the actual delivery of these sessions is that they would need to move away from didactic information sessions, and use activities such as role-play, demonstrations, or community theatre, to actively engage the caregivers in the topic at hand. As noted in outside research, programs that provide time for discussion, demonstration and practice, are much more effective at changing parenting practices, than those relying solely on lectures and discussions without modelling (Llewelyn, 2012). Given that many of those delivering such sessions may not have the prerequisite facilitation skills to naturally do this, it is critical that sufficient time is spent training the facilitators on the methods and approaches which these sessions will utilise. As suggested in the previous section, civil society could act as an important partner in managing and delivering such training.

Sitting underneath these group based sessions, are opportunities for those in attendance to reflect on, and discuss the topic of the sessions in more intimate settings—either in the home or in smaller peer networks which might operate at the aldeia level. Rather than operating geographically, these peer networks could also be organized to support caregivers facing particular challenges, such as raising a child with disability, being a first time parent, or supporting an adolescent child's transition to adulthood. Given the traditional challenge that parent education and support programs have faced in engaging fathers in group discussions, these peer networks could also be developed based on gender roles, and provide an opportunity for fathers to speak with other fathers about raising their children. Father to father groups have proven to be a successful approach in getting men to open up about their doubts and fears as caregivers, something which is found to not occur in many co-ed groups (Rosenberg, 2006). As noted previously, home visits may be required for the most vulnerable families, or for domains of behavior change that require intensive home-based support and/or modelling in the home environment (such as child discipline). This is something that could be facilitated through the existing activities such as Alola's Mother Support Groups and faith-based organizations' home visitations, but this alone may not

[18] In more remote regions of the country, to ensure adequate and equitable reach it may require offering such sessions at the aldeia level. This is suggested given the barriers noted by existing parenting education/support activities, particularly where distances for caregiver are large.

guarantee national coverage. This level of support and facilitation will necessitate the recruitment of additional community-based volunteers who will need to be trusted and respected members of the communities they serve, and who are able and willing to be trained to facilitate such activity. Organizations like CVTL may have a ready and willing pool of volunteers to assist, but whether they meet the above criterion would need to be further assessed.

Appendix One: Overview of existing programs/activities

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
Catholic Relief Services (The MAHON Project)	New couples to be married through the church, or couples that have been referred by either clergy or community members for participation	Five one on one sessions with trained volunteer facilitator and a couple. A three month follow up monitoring visit conducted by facilitator. A series of community theatre events also staged to support messaging of program within wider community.	Target of 240 couples in Dato Suco, Liquica. Broader reach of approx 1400 individuals through community theatre	Series of five modules, focussed on how church, traditional and legal frameworks all stress the importance of protecting the family through non-violent conflict resolution. Primary objective is to change participants' knowledge, attitudes and behaviours towards domestic violence.	Evaluation now being conducted. Evidence that participants have engaged in some behaviour change, but not clear if baseline or control group established as part of design. Some spill over effect of non-violent behaviour spreading to rest of family, but not primary focus of project	Support of clergy in communities (particularly nuns and parish priests, volunteers who are eager to be part of this, one on one delivery model	Small scale, resource intensive, some costs involved for volunteers ($15/month for transport and cell), engagement with clergy means steering away from particular messages (i.e. family planning, birth spacing)	Hoping to scale up program with AusAID support under Domestic Violence Prevention Scheme

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
World Vision (Early Childhood Care and Development (ECCD) Project)	Mothers and fathers of children 0-6	Group meetings held at regular occasions of caregivers focussed on discussion. Meetings facilitated by community nominated volunteer(s) who are also helping to manage either home or community-based ECCD centres. Training and ongoing monitoring of staff provided by WV Dili based support team. Frequency of meeting dependent on district and funding available for ECCD project. Sessions range in frequency from once per month, to once per quarter.	Selected aldeias in 3 districts of the country-- Bobanaro , Baucau and Aileu. Target population of 1,500 caregivers (70%) women in these selected aldeias.	Internationally adapted curriculum developed by WVI (originally Sri Lanka). Adapted by translating into Tetum, using photography from TL (based on feedback from parents). Would have liked to have included more on cultural beliefs/values but not possible within existing constraints. Issues covered in 72 lesson plans include health, nutrition, child protection, disability, stimulation and responsive parenting. Not all 72 lessons covered. Each group of parents identifies topics of greatest relevance to their interests/needs.	Interim evaluation results from Bobonaro (final report forthcoming in April) show mixed results in terms of behaviour change: appropriate nutrition to children (no diff between control/intervention), hygiene practice (no diff between control/intervention), early stimulation (some effect on intervention group particularly sending children to school), responsiveness (some effect on intervention group)	Linked to other ECCD initiatives supported by WV in the community, including mothers groups for pregnant/lactating women, home and centre-based education, programs focussed on early stimulation/hygiene, inclusion of PSF in sessions (many reflect learning as well from the sessions), high levels of interests and engagement from volunteers with little direct financial benefit (non-monetary incentives offered such as pulsa, trainings in Dili)	Lack of strong advocate within government (MoE not seen to really understand/appreciate value of parenting education/non-formal ECE), activity occurring outside of, rather than in partnership with MoE; inconsistent participation of parents in all sessions due to other commitments, unable to figure how to leverage PSF to follow up on messages thus no home-based follow up support to the content of the program specifically, fathers participation difficult (may need separate fathers' group), lack of inter-Ministerial coordination on ECCD	WV hoping to offer parents some incentive for completion of all modules-- parenting package to be given upon completion

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
PLAN (SISCa ECCD Pilot)	Parents of children 0-8 visiting monthly SISCa clinics	Group meetings held monthly since 2013, aligned with SISCa clinics. Held prior to start of clinic sessions. Meetings facilitated by one CF (PLAN Staff member) and PSF. Ideally PSF should be providing follow up home visits/monitoring (but not always occurring).	Started with three sucos in Aileu in 2013 (Tatilisame, Lerolisa, Fahiria), and recently added Fatisi)	Adaptation of international curriculum (from Bangladesh PLAN), on key health and nutrition messages— focussed on 0-5 age range issues (exclusive BF up to six months, importance of seeking medical assistance early, etc.). Set curriculum as agreed to with MoH. UNICEF ECD Specialist has copy of the curriculum (according to PLAN)	Evaluation of this pilot done in Sept 2013 (monitoring evaluation). Results were unavailable to consultant.	Attracts greater number of households than that which PLAN can attract through its centre-based parenting programs. Interest has grown over time in activity as parents value information as well as activities provided for children. Good interest/integration with PSF/SISCa. MoH appears to be an interested and willing partner to scale up	Hard to engage fathers in this, perhaps due to timing of SISCa visits. Challenge of relying on PSF for follow through.	

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
PLAN (ECCD Parenting Education)	Parents of children 3-6 attending PLAN community-based centres	Group meetings held monthly within PLAN ECE Centres (total of 29). All parents of children attending invited to participate (approx 25-30 per centre). Follow up monitoring home visits by CF to test if skills presented are practiced and followed up on. Unclear how systemic or regular home visits are. Group sessions facilitated by PLAN CF who has received training in Dili and Indonesia (visited Posyandu posts)	Has or is occurring in 29 communities (aldeias) in Lautem and Aileu reaching 464 caregivers in total (305 mothers, 159 fathers). Participation rates vary by centre (50-100% participation).	Adaptation of international curriculum from Sri Lanka. Focussed on the four domains of PLAN child well being index: health, child protection, child development (physical and mental development), language development. An emergent curriculum within these four domains based on pressing issues within these areas identified by parents themselves (real-time and based on individual learning plan)	No specific evaluation done specifically on impact of parenting education program	Face to face dialogue and participatory/interactive curriculum model. Involvement of parents in making teaching materials (i.e. simple toys) that they can take home and use with their children. Home visits help to hold families to account for what they say they are going to do. Ability to build some vesting in what is being learned by creation of individual learning plan--identifying needs within the family and then how such a program can help to work through these needs (empowerment approach)	Lack of engagement with fathers, not getting full community participation (mainly those who live within 1km of centre), project still seen as "NGO driven".	

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
Canossian Sisters (Family Apostolate program)	No specific target, but extra support provided to vulnerable families	Home-based visits by sisters. Goal is for each sister to visit the families at a minimum 4-5 times/yr.	Selected sucos in at least 3 districts in the country--Dili, Lautem, Bobonaro. Unclear if work extends to each of the orders in the other districts. Total no of households/beneficiaries not provided	No curriculum. Messaging delivered by sisters and based on self-accessed knowledge. No specific training providers. Sisters address areas of need identified in the home and work on building relationship first and then imparting messages that they see are important on issues such as health, nutrition, moral values, etc. Some of the messages are reinforced through Sister Guilhermina Marcal's weekly radio program	No form of evaluation conducted, all anecdotal evidence from sisters themselves	Built on strength of relationship between sisters and families, trust of Church, frequent home visits, respects peoples' positions on particular issues and tries to work with that	Not well integrated with other government services/or activities of other actors. No real consistency or quality assurance of messaging provided.	
Canossian Sisters (Parent education sessions)	Parents of secondary students attending Canossian High school in Dili	Parent education sessions held 3x/yr as evening meetings at the school, individual counselling sessions with parents on an as needed basis	Dili (only parents of caregivers in the school)	Informal discussions focussed on issues surrounding parenting of adolescents: drug/alcohol abuse as well as pornography	No form of evaluation conducted, all anecdotal evidence from sisters themselves	All parents attend these sessions as made compulsory by virtue of attendance at school	Not clear if there is a curriculum/guidelines that are followed	

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
CVTL (Cross-sectoral programs)	Varying audiences depending on need	Education sessions held with community resident using trained volunteers, including caregivers, youth (ages 12-25), beneficiaries of community WATSAN projects	Nationally	Discussion depends on identified needs of community. Promotion activities may include: hygiene promotion, conflict prevention, reproductive health, nutrition, HIV/AIDS, road safety, disaster preparedness/climate change adaptation. Also run pre-parenting programs for teenagers.	Use Most Significant Change methodology to measure changes. No quantitative indicators of change available.	Wide national reach due to extensive use of volunteers (ToT approach). Strong community involvement in program as most from the community they are serving.	Messaging promoted may not be consistent with that of other agencies (i.e. on child protection). Volunteer attrition an issue, but CVTL has ability to recruit new ones. Behaviour change on particular mgs difficult (i.e. discipline). People do not like to be challenged on what they do.	

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
Alola Foundation (Mother Support Groups)	Pregnant women	Home-based visits by members of a trained support group in each aldea.	120 Groups, spread around country except in Bobonaro and Covalima	Discussion focussed on key areas of: safe motherhood (antenatal care and delivery of child), newborn health/hygiene, breastfeeding support	Awaiting response from Alola regarding evaluation results from 2004, but many actors acknowledge success of MSGs in changing/improving breast feeding practices	Involvement of PSF in participation of mothers group. Work closely with community health posts to link demanders of services with suppliers. Groups used by PSF to help promote immunisation drive and information about SISCas. Build incentives into participation through contests (Health Baby Contests).	Still some gap between knowledge and attitudes (i.e. parents still do not understand risks of delivering at home). Attrition of MSG members over time, with no real ability to replenish them on a continuous basis. MCH workers are overstretched in terms of demands of time. MG activities not integrated into ECCD activities of Alola or others-- focus purely on maternal and infant health	

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
Alola Foundation (Community Discussion Forums)	Community-at-large	Group based discussions on key health and nutrition concerns/issue led by a Maternal and Child Health Specialists. Occur at least 4 times/yr at the suco level	Baucau (40 sucos covered), Oecusse (17 sucos), Viqueque (3 sucos)	Discussion usually focussed on Safe Motherhood Films produced by UNICEF. Screening of film followed by discussion. Some scope for community to identify issues of concern and to have these addressed by Maternal and Child Health Worker from Alola at next session	Unclear if evaluation done into effectiveness of intervention--need to follow up	Use of multi-modal presentation format. Film nights popular. Follow up with discussion. Scope for community to identify pressing health needs (i.e. malaria, dengue, diarrhoea) rather than following a set curriculum.	Funding dependent, so not consistently supported or universal in nature	

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
Child Fund (Community Health Promotion)	Families with children<5	Group based discussions on maternal and child health that are needs dependent. Focus on disease prevention. Children also learn songs in schools about health that are then shared around community.	Covalima (all sucos covered), Liquica (some sucos), Manatuto (some sucos), Bobonaro (some sucos), Lautem (some sucos). In total 54 sucos in 5 districts	Group based discussion on maternal and child health issues led by trained community volunteers (including PSF). Process involves showing film, followed by discussion about issues raised. Home visits often follow to reinforce messages, assess conditions in home environment, provide referrals to treatment if acute issues raised	No formal evaluation done as of yet, but anecdotal evidence suggest effectiveness of intervention (particularly with follow up home support	Use of film followed by group discussion. Incorporation of PSF into activities. Volunteers nominated by community. Purposeful attempts to connect service providers with home environment. Use materials provided by various Ministries (Health in particular) to promote messages	Use of volunteers leads to attrition of 'workforce' over time	

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
Child Fund (Parent to parent sessions)	Families with children in pre-school/primary schooling	Group based discussions on the role of parents in care of child-- focus on promoting what Child Fund identifies as two life stages. Life Stage One (ages 0-5) curriculum covers physical, cognitive, emotional dev. milestones. Life Stage Two (ages 6-13) covers support of children in terms of education, responsive parenting	Working in 22 pre-schools and 13 primary schools that have a functioning PTA. On average reaching about 50 parents/location. Sites located across five districts (Bobonaro, Lautem, other three districts to be confirmed)	Led by either pre-school teachers, or parent leaders	Some monitoring data that is anecdotal. Child Fund plans to establish a more robust M&E framework in 2015	Linking teachers with home environment by having them be messengers of promotional mgs. Views parents as partners through parent to parent education in primary setting	Child Fund faces challenges with engaging parents in their children's education because of belief that education is mandate of the school and not a responsibility of parents at home. Quality of trainers varies, many are resistant to embracing active learning modalities that parents respond better to. Also difficult to engage fathers in such activities. Difficult to develop content of program in a way that is not overwhelming. Often parent education curriculum packed with too many messages	

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
CARE (Lafaek Community Media)	Heads of households (particular focus on low literacy adults)	Distribution of community magazine and various extension activities (community theatre, demonstration sessions, radio messages)	Selected sucos and aldeias across Liquica, Bobonaro, Covalima, and Ermera. In total 20,000 households across these four districts were reached. Plan from 2014 onwards is to reach all households with children ages 3-7 nationally.	Magazine covers topics such as: health/hygiene messages (topics such as child nutrition, malaria prevention, hand washing), , economic development (availability of microfinance, development of small-scale businesses), and education (enrolling children at right age, providing space for children to study, reading with children) . Also supports development of basic literacy and numeracy skills in adults and early learners	Final evaluation conducted in 2013 found: (1) majority of households able to recall messages from the magazine (hand washing, medical use of local plants/herbs, secure seed storage, getting children immunised, ways of being involved in children's education) ; (2) strong evidence of application of particular messages into practice (planting medicinal plants, hand washing, playing games with children, secure seed storage)	Material covered in magazines well aligned with current development priorities of the country. Use of extension activities, particularly community theatre and demonstration session greatly assisted in providing supportive/reinforcing messaging leading to behaviour change. Inclusion of a supplement for children ages 4-7 helped to support learning/reading in the home and provided necessary reading material for this to happen	On its own, CARE unable to expand scope of magazine beyond current distribution. Relies on interests of other partners who would need to pay to reprint editions to expand coverage at current time. Radio ownership was not very high in communities served, thus messaging only reached a small percentage of households through that vehicle.	Project material overseen by an Editorial/Advisory Board comprising representatives from MoH/MoE/SEPI

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
CARE/USAID (School Drop Out and Prevention Program)	Children at risk of drop out at end of the primary and their caregivers	Use of community volunteers in each intervention school. Volunteers work within an Early Warning and Response framework to support students at risk of drop out by: serving to connect the school with the house through postcard communication, home visits, and hosting community-meetings	95 Intervention schools in 5 districts of the country (Bobonaro, Ermera, Liquica, Mantauto, Viqueque). Approximately 842 volunteers across these 95 schools (membership of 8-9/school). In six-month period (Oct '12-April '13), 257 home visits carried out, and 151 community meetings held.	The importance/benefits of keeping children in school and attending school regularly	Robust M&E framework set up as project geared as a research project aimed for advocacy within MoE. Final evaluation results to be done at end of program (Dec 2014). Monitoring data demonstrates 80% of community groups had at least half of their volunteers actively engaged, but 10% not active at all	Trained field workers support volunteers and monitor their activities. Strong links between school based individuals and community volunteers.	Some community volunteers not as engaged/active as they could be. Majority of fieldworkers men, a product of leaving nomination process to Chefe de Suco or school director. Ideally desire to use PTA as structure for promoting messages but PTA not active in all schools.	

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
Ba Futuru (Transforming Timorese Classrooms)	54 teachers in secondary schools with caregivers of children as a secondary audience	Training sessions at school sites	Three schools in Dili District	Understanding different forms of abuse, negative effects of violence on children, steps involved in disciplining children positively, referral pathways for children at risk, introducing teachers/caregivers to services of CPO's and Social Animators	Qualitative/quantitative data collected of small-scale pilot demonstrated shifts in teachers' strategies for disciplining children in non-violent fashion (9 to 69%), Changes in teachers beliefs(47% to 25%) about students learning best through physical punishment	Linking MSS services with demanders of service. Many eager to learn and change behaviours. Issue is not of resistance but more than adults do not understand negative consequence of their actions. Trained facilitators who are able to counter prevailing norms/beliefs and provide counter-arguments.	Targeting caregivers difficult, particularly when primary audience is teachers.	Parents a secondary target audience but have worked in a subcontracting arrangement with Child Fund to deliver modules within PTAs on these issues
Ba Futuru (Feto Fantastico)	General population	Short video clips produced. In some locations using road shows (film or theatre) followed by discussion to reinforce messaging	Nationally through TVTL in slots before, during or immediately after news ($20/min). Selected communities receiving road shows.	Messages about preventing conflict within the home and violence-prevention	Small scale studies done using pre/post testing: Results show increased knowledge of strategies to prevent violence and mitigate conflict. Self-reported increased capacity as well.	Work closely with MSS. Video/theatre highly effective at engaging and interesting audience according to formative evaluation conducted. Audience has strong association with characters (Feto)	Hard to get a sense of reach/coverage and impact of messages through media channels on their own.	Ba Futuru a willing partner in producing videos and theatre on a range of issues. Happy to be given guidance on content and produce from that.

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
Pastoral de Criancas	Households with children ages 0-6	Home-based visits by trained community volunteers (coordinators/leaders)	Programs have/are currently operating in the Baucau and Dili Dioecese. Dili Diocese covered up to 11 parishes, 40 communities at its peak serving 2,013 families in 2010. Current parishes covered include: Ermera (8 communities), Remexio (3 communities), Gulolo (3 communities), Turiscai (2 communities), Bedois (2 communities), Metinaro (1 community)	Focus on key health, nutrition and hygiene messages for caregiving of children. Curriculum content based on Brazilian curriculum, but translated and pictures/images changed for Timorese context	Only monitoring data collected on reach/coverage	One coordinator works with same families over an extended period of time and records progress in book. Also refers to external services of MoH. Structured home visit approach with clear guidelines, information, modelling.	Have not had their curriculum officially approved by MoH. High dependence on external funding for continuation of programming. Without small incentives available to facilitators (payment or bags of food) unlikely to maintain interest. Currently facing fragmentation of activity between the two dioceses.	Inviting PSF and Community Health Post staff from MoH to come along for home visits, particularly weighing sessions.

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
MoH (Health Promotion Unit)	Children under 5, as well as pregnant women (but through caregivers)	Integrated health service package using staff from community health posts to provide health promotion, preventative action, identification of health issues, and some treatment. Group based discussions embedded within SISCas. In 2013, Night Events were also conducted where health promotion films (i.e. UNICEF's Safe Motherhood) were shown, and a community discussion followed. This was facilitated by INGOs and MoH partners, as well as local staff and occurred at least once/suco.	Ideally national coverage, but varies depend on attendees of SISCas and their regular operation	Nutrition, Maternal Child Health Messages promoted based on BCC for Maternal Health (part of Reproductive Health under development) and Child Health (under review/development)	Unclear if any monitoring/evaluation data available	Potential for national reach/coverage. MoH has PSF and cadre of volunteers established in all communities throughout the country. Community health posts providing key messages to be promoted through SISCas based on BCC.	SISCas not operating consistently across the country. Quality/capacity of PSF volunteers for both community surveillance and health education using adult learning approaches limited. PSF volunteers have multiple demands placed on them with little incentives. At present coordination of messaging between various directorates, districts, as well as between INGOs not well coordinated. Until present, training to PSF only offered at district level making it difficult for some to come.	MoH acknowledges its limited ability to deliver messages and relies on active partnership with NGOs to develop promotional materials and deliver messages.

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
MoH (Cuidado Saude Primario) Pilot	Focus on households with children 0-55 months	Home based visits from district midwives, doctors, nurses with follow up support from PSFs	All sucos in districts of Oecusse and Aileu	Understand health danger signs, promote key health messages on Child and Maternal Health, build awareness on primary treatment options available in the home, provide referrals to Community Health Posts/District Hospitals	Unclear if any monitoring/evaluation data available	Has access to the resources of community health posts and District Hospitals. Home based visits and different levels of intervention providing holistic approach to health.	Unclear how much monitoring/support of activity occurring in reality. Difficult to scale up on a national level. PSFs overwhelmed by existing demands placed on them. Poor motivation of PSFs (in some instances) leads to failure to implement effectively	Currently a pilot program of MoH (completed at end of 2013 according to HPU)
MoE (Eskola Foun)	Caregivers of children in basic education	Opportunistic and ad hoc delivery of what exactly?, usually as part or events held at school. Use of posters/brochures in some circumstances	No data collected on such activity	Enrolling children in school at right age, ensuring children attend school regularly, parental participation in PTA, and reading to children at home.	BELUN did evaluation of Eskola Foun—awaiting report from UNICEF Education team on whether any assessment made of caregiver-focused messages	"Captive audience" particularly when caregivers at school already	Limited understanding of the purpose of parenting education in MoE--seen as more sharing of information/promotion rather than ensuring action leads to behaviour change. Engagement of parents not major focus of Eskola Foun.	Parent education as a concept still weakly understood in MoE.

Organisation and name of activity	Target Population	Delivery modality	Program Reach	Key messages	Assessment of success	Key enablers	Key barriers	Other info
MSS (Social Mobilisation Campaign)	Children, Child Protection Networks, caregivers, community-at-large	Use of flipchart and group-based discussions	In 2012, reached over 7,000 individuals across the country. Approximately 2-6 sub-districts visited in each district.	Information on all aspects of children's rights; stages of child development; potential harm to children that includes child abuse (physical, mental and sexual abuse), exploitation, and neglect along with examples and how to protect the children from such harms; and who to report to or seek help when such case happen.	No clear measure of behaviour change as part of intervention, focus instead on socialisation of key messages. As noted in 2012 report, "The impact of the social mobilization is difficult to measure as CPOs haven't conducted any evaluation, e.g. through pre- and post-assessment."	Wide reach and close partnership with MSS CPOs, Social Animators, CPNs to disseminate message.	Non-targeted intervention and may be difficult to change behaviours through such a format.	
Rede Feto (Violence Prevention Program)	Recipients of Bolsa da Mae (BdM)	Group-based discussions with couples, delivered through volunteers in each district)	In 2014, expected to reach BdM recipients in 5 sucos in Baucau, and 5 sucos in Liquica (sucos chosen based on high rates of identified violence in these communities)	Two modules: Prevention of violence in the home and sources of assistance when violence in the home is occuring	Monitoring data will be collected, but no efforts at present to look at impact of activity on behaviour (may not be feasible given limited scope)	Developed in close partnership and coordination with MSS. MSS taken lead in supporting work of Rede Feto to do this work.	Small budget provided by MSS limits potential reach of project at present. Unclear level of training/support/mentoring facilitators have in delivering activity due to ToT approach	

Appendix Two: Compilation of messages

Domains of parenting	Key Messages	Possible target group for each message			
		Ante-natal	0-5	6-12	13-18
Caregiving: Supporting children's health, hygiene and nutrition					
Ante-natal care	1. Child spacing gives couples time to prepare physically, emotionally, and financially for the next child if they choose to have one (MoH)	**X**			
	2. Both men and women have a role and responsibility to play in family planning and have a number of options available to them (MoH)	**X**			
	3. There are benefits to the health of a child and the mother of ensuring delivery by a SBA (MoH)	**X**			
	4. Women should receive antenatal care from a doctor, nurse or midwife at least 4x during pregnancy	**X**			
	5. Pregnant women need to eat a balanced and nutritious diet during pregnancy for the benefit of the foetus	**X**			
	6. Women need to be aware of danger signs during pregnancy and seek medical assistance quickly	**X**			
	7. Women should take appropriate supplements for the development of their foetus (folic acid, iron)	**X**			
	8. Exposure of pregnant women to second-hand smoke should be minimised	**X**			
Newborn and child health	9. The mother and newborn child should receive post-natal care within seven days of delivery, and again within six months of delivery by a doctor, nurse or trained midwife (MoH)		**X**		
	10. Every baby needs to be bought for immunization, five times before his/her first b-day. Unless your baby receives all the immunizations (s)he will not be properly protected from the diseases (MoH)		**X**		
	11. There are some signs which mean a newborn baby may be very sick and needs help from a midwife immediately (MoH)		**X**		
	12. If your child has high fever, or has had diarrhea for two days or more, and is not eating or drinking fluid, take your child to the clinic immediately (MoH)		**X**		
	13. Sometimes, coughs are signs of a serious problem. A child who is breathing rapidly or with difficulty might have pneumonia, an infection of the lungs. This is a life-threatening disease. The child needs immediate treatment from a trained health worker, who can also provide a referral to a health facility (UNICEF, FFL)		**X**	**X**	

Domains of parenting	Key Messages	Possible target group for each message			
		Ante-natal	0-5	6-12	13-18
	14. Ensure that children complete an entire course of medication for treatment (i.e. TB and antibiotic courses)		X		
Nutrition	15. Children should be fed exclusively breast milk until they are at least six months old to protect your baby and ensure they have a good start in life (MoH)		X		
	16. Colostrum should be given to babies immediately after birth because it is especially rich in vitamins and can protect the newborn from infections (MoH)		X		
	17. Breast milk should be complemented by other nutritious foods (a mixture of starches, leafy vegetables, fruits, and meats) from six months to two years old (MoH)		X		
	18. If your child has lost weight or you are worried they are too skinny, you should take him/her to be checked at the nearest SISCA or health posts for malnutrition. (MoH)		X		
	19. Children should be taken to the clinic or SISCAs every six months to get a dose of Vitamin A (MoH)		X		
	20. Use only iodized salt in the home (MoH)	X	X	X	X
	21. Children need to be fed well-balanced and hygienic meals		X	X	X
Sanitation, water and hygiene	22. To protect yourself and your family from germs and sickness make sure to wash your hands with soap, ashes or detergent—particularly after going to the bathroom, washing a baby's bottom, before handling food, before eating and before feeding your baby/child (MoH)	X	X	X	X
	23. Safely dispose of faeces of all family members (MoH)	X	X	X	X
	24. Treat all water to be used for drinking or cooking		X	X	X
	25. Formula milk needs to be hygienically prepared each time it is given to a child		X		
Sexual and reproductive health	26. Both fathers and mothers should proactively discuss with their children their changing body as they enter into adolescence.			X	
	27. There are risks and implications for early sexual activity of your child that you need to make your child aware of				X

Domains of parenting	Key Messages	Possible target group for each message			
		Ante-natal	0-5	6-12	13-18
	28. Unprotected sexual behaviour can put your child at risk of serious or life-threatening diseases				X
	29. Aside from abstinence and sexual intercourse, there are other options for protection available to mutually faithful couples that you need to make your child aware of				X
Communicable diseases	30. Serious diseases like malaria and dengue can be prevented in the home by ensuring that you keep your house clean, minimise pools of standing water, and sleep under treated mosquito nets		X	X	X
	31. Children's exposure to second-hand smoke should be minimised		X	X	
	32. Children should be made aware of hazards in the community (roads as well as natural features)		X	X	
Stimulation: Supporting children's cognitive development					
	33. Children can fully hear from six months in the womb and their later development is supported by singing and talking to them even before they are born	X			
	34. Parents should encourage their children's independent learning, problem solving and creative activities through games, songs/rhymes, stories and interactions		X		
	35. The early years, especially the first three years of life, are very important for building the baby's brain. Everything she or he sees, touches, tastes, smells or hears helps to shape the brain for thinking, feeling, moving and learning (UNICEF, FFL)		X		
	36. Encouraging children to play and explore helps them learn and develop socially, emotionally, physically and intellectually. This helps children get ready for school (UNICEF, FFL)		X		
	37. Parents/guardians should accept, appreciate and recognize the individual differences among children (pace of learning, developing different abilities, etc).		X	X	
	38. Children should attend some form of early childhood education by the age of three to prepare them for school		X		
	39. Parents play an active role in their children's learning at home by reading with them for at least 10 minutes/day, doing homework alongside them, and ensuring they have a time and space for study		X	X	
	40. It is imperative that children enrol in school at the right age and attend school regularly (MoE)			X	X
	41. Parents should get engaged in their schools' PTA (MoE)			X	X
	42. Parents have the right to send their children to school for free from Grades One to Eight (MoE)			X	X
	43. Technology should not be seen as a threat, but can usefully support your child's cognitive development when monitored and supported effectively			X	X
Responsiveness: Supporting children's emotional and social development through communication and appropriate parenting responses					

Domains of parenting	Key Messages	Possible target group for each message			
		Ante-natal	0-5	6-12	13-18
	44. Parents/guardians should encourage children to ask questions, express ideas and feelings, and participate in social activities.		X	X	X
	45. Emotional security, unconditional love, verbal and physical affection, respect for the child's development level, sensitivity for the child's needs and feelings should be provided by parents for their child's well-being (MSS)		X		
	46. There are ways of resolving conflict or redirecting misbehaviour using positive discipline approaches (MSS)		X	X	X
	47. Treating children violently can have significant consequences on a child's future emotional and social development (MSS)		X	X	
	48. To help your child grow in a happy and healthy way, it is important to try to keep them safe, but at the same time to respect their independence (MSS)			X	
	49. It is also important to help your child discover who they are as a person, what they believe and how they want to be (MSS).			X	X
	50. At this age, it is important to role model behaviours (such as resolving conflict without resorting to violence) for your child to learn to behave in appropriate ways (MSS)		X	X	X
	51. At this age, you must also monitor your child's activities to make sure they are safe, but this needs to be done in a respectful way – allow them freedom, but make sure you know what is going on in their life (MSS).				X
Protection: Ensuring children are protected from harm, abuse and neglect					
	52. Women should be protected from abuse during pregnancy for the well-being of the mother and child	X			
	53. Neglect of children is sometimes hidden, and caregivers have a responsibility to provide children with a minimal level of care (MSS)		X		
	54. Physically and mentally disabled children should also have an equal opportunity to all benefits afforded to other children.		X	X	
	55. Abuse takes many forms (physical, emotional, sexual) and there are ways that caregivers can protect their children from them (MSS)		X	X	X
	56. Register your child's birth with authorities within four weeks of delivery (MoJ)	X	X		
	57. Parents have primary responsibility for ensuring that their children are protected from exploitation (MSS)			X	X

Domains of parenting	Key Messages	Possible target group for each message			
		Ante-natal	0-5	6-12	13-18
	58. Risky behaviours and practices need to be openly discussed with your children in a supportive rather than punitive fashion				**X**

Appendix Three: Draft Community Session Framework

Issue	Behaviour Change Result Statement	Potential message(s) to be promoted	Delivery modalities	Who will deliver the message?
High rates of malnutrition in children under 5 in Timor-Leste	Minimum acceptable diet: 1. By the end of 2016, mothers and caregivers who attended the MSS pilot community sessions, feed the children aged 6-23 months who are in their care with food prepared in line with the standards of a minimum acceptable diet.	• Breast milk should be complemented by other nutritious foods (a mixture of starches, leafy vegetables, fruits, and meats) from six months to two years old (MoH). • Use only iodized salt in the home (MoH)	**Media campaign:** Short clips and drama segments on impacts of malnutrition on child health and ways to prevent this from happening. Supportive print media messages **Community sessions:** Discussion about effects of malnutrition on children, and cooking demonstration to show parents how to cook a nutritious meal for their young children using local ingredients. **SISCa Post:** Discussion about signs of malnutrition and importance of seeking assistance early. Weighing/measuring of children at SISCa of all children under five. **Home visits:** Visits to families where history of malnutrition exists, cooking demonstrations and	**Media**: MoH provides material to SECOM for broadcast on TVTL, national/community radio Message promoted in *Lafaek ba Komunidade* (CARE International) **Community Sessions:** Volunteers trained by CSOs involved in addressing malnutrition and educating parents on addressing this issue (World Vision, Child Fund, PLAN, CARE International, CVTL) **SISCAs**: PSFs alongside community health post workers (nurses, doctors) **Home visits:** PSFs, community volunteers,
	Hand-washing with soap: 2. By the end of 2016, mothers and care-givers who attended the MSS pilot community sessions wash their hands with soap or ash after going to the toilet, washing ~~a~~ baby's bottom, before eating and feeding their baby/child and before handling food.	• To protect yourself and your family from germs and sickness make sure to wash your hands with soap, ashes or detergent—particularly after going to the bathroom, washing a baby's bottom, before handling food, before eating and before feeding your baby/child (MoH)		
	Danger sign and care-seeking: 3. By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions seek advice or	• There are some signs which mean a newborn baby may be very sick and needs help from a midwife immediately (MoH)		

Issue	Behaviour Change Result Statement	Potential message(s) to be promoted	Delivery modalities	Who will deliver the message?
	treatment for the children under 5 in their care with diarrhea/fever in the last 2 weeks.	• If your child has high fever, or has had diarrhea for two days or more, and is not eating or drinking fluid, take your child to the clinic immediately (MoH) • A child's life is in danger if she or he has several watery stools within an hour or if there is blood in the stool. Immediate help from a trained health worker is needed (UNICEF Facts for Life) • Sometimes, coughs are signs of a serious problem. A child who is breathing rapidly or with difficulty might have pneumonia, an infection of the lungs. This is a life-threatening disease. The child needs immediate treatment from a trained health worker, who can also provide a referral to a health facility (UNICEF Facts for Life)	analysis of WASH issues conducted with solutions proposed.	members of mother support groups conduct home visits with training from CSOs with experience in the area (Alola Foundation, Pastoral de Criancas, CVTL). NOTE: Could also become part of MoH *Cuidado Saude Primario* activity.
High rates of grade repetition and drop	<u>Early stimulation:</u> 4. By the end of 2016, mothers and care-givers who were part of the MSS pilot community	• Parents should engage with and encourage their children's independent learning, problem solving and creative activities	**Media campaign:** Short video clips demonstrating how parents can work effectively with children to	**Media:** MoE and development partners provide material to SECOM for broadcast on

Issue	Behaviour Change Result Statement	Potential message(s) to be promoted	Delivery modalities	Who will deliver the message?
out, particularly in early years of schooling	sessions engage in four or more activities to promote learning and school readiness for the children in their care aged 0-35 months and 36-59 months.	through games, songs/rhymes, stories and reading from the time they are born until they enter into school • The early years, especially the first three years of life, are very important for building the baby's brain. Everything she or he sees, touches, tastes, smells or hears helps to shape the brain for thinking, feeling, moving and learning (UNICEF Facts for Life) • Encouraging children to play and explore helps them learn and develop socially, emotionally, physically and intellectually. This helps children get ready for school (UNICEF Facts for Life) • Where early childhood centres are available, children should attend these centres from the age of three to ensure they are well prepared for Grade One (MoE)	support learning, modeling of good practice Supportive print media messages **Community sessions:** Discussion about how children learn from an early age based on simple stimulation activities, workshops to practices games, songs, music and make simple toys; discussions about how to read alongside your child and support completion of homework at home. **PTA's and parent groups connected to ECE centres:** Discuss how parents can work together with teachers to support children's learning **Home visits:** Community trained volunteers visit households of children identified at risk by school (frequent absences, failure on exams) and support children to remain in school successfully	TVTL, national/community radio Message promoted in *Lafaek ba Komunidade* (CARE International). *Lafaek Ki'ik* distributed to all households with children in early childhood education, Grade One and Two, providing reading material at home. **Community Sessions:** School principals, primary/ECE teachers and community volunteers trained by MoE and CSOs on delivering message through community sessions **Peer groups:** CSOs work to facilitate discussion in PTAs and parent groups (UNICEF, World Vision, PLAN, Child Fund)

Issue	Behaviour Change Result Statement	Potential message(s) to be promoted	Delivery modalities	Who will deliver the message?
	<u>Support with homework:</u> 5. By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions support their child aged 6-12 with their learning at home.	• Parents play an active role in their children's learning at home by reading with them for at least 10 minutes/day, doing homework alongside them, and ensuring they have a time and space for study (MoE)		**Home visits:** MoE, based on SDPP model recruits and trains additional community volunteers (i.e. local leaders) to liase with ECE facilities/school and conduct home visits
High rates of child abuse and neglect, particularly amongst vulnerable families	<u>Neglect:</u> 6. By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions do not leave their child aged 0-5 years alone or in the care of another child younger than 10 years of age.	• Neglect of children is sometimes hidden, and caregivers have a responsibility to provide children with a minimal level of care (MSS) • Children under the age of five should not be left alone, or in the care of a sibling who is under 10 years old as there are many hazards and dangers that he/she could be exposed to • Healthy children have strong attachments to their parents (both father and mothers), and this is fostered by them spending sufficient time with them in the first years of life	**Media campaign:** Short clips/dramas demonstrating the hidden forms of neglect and abuse against children that exist in Timor-Leste and the impacts it has on children's emotional and physical well-being Supportive print media messages **Community sessions:** Discussion about forms of hidden abuse and neglect and ways to protect children from such neglect and abuse through protective parenting measures **Peer support groups:** Mothers and fathers' groups set up to discuss how they care and show love for their children. Positive role models	Media: MSS and development partners provide material to SECOM for broadcast on TVTL, national/community radio Message promoted in *Lafaek ba Komunidade* (CARE International) **Community Sessions**: Social animators and CPOs use MSS flip-chart with refresher training provided by UNICEF/MSS **Peer support groups**: Child Protection Network members and community
	<u>Birth registration:</u> 7. By the end of 2016, mothers and care-givers who were part	• Register your child's birth with authorities within four weeks of delivery (MoJ)		

Issue	Behaviour Change Result Statement	Potential message(s) to be promoted	Delivery modalities	Who will deliver the message?
	of the MSS pilot community sessions register their children at birth.	• Every child has a right to a name and nationality. Registering a child's birth helps to ensure a child's right to education, health care and legal and social services. Birth registration is a vital step towards protection from abuse and exploitation (UNICEF Facts for Life)	highlighted through these sessions, and discussions of how to find time to provide appropriate care for children discussed. **Home visits:** Child Protection Network members visit households where there large numbers of children living under one roof, and provide guidance on ways to ensure neglect and abuse prevented, including connecting households with relevant services.	leaders trained on facilitating dialogue and discussion within support groups on the topic **Home visits**: Child Protection Network members, church based organizations with training from UNICEF/MSS
Prevalence of physical and emotional violence against children by adults widespread	<u>Knowledge of alternative disciplining:</u> 8. By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions have knowledge about the consequences of discipline approaches which resort to violence against the child	• Treating children violently can have significant consequences on a child's emotional and social development (MSS) • Children learn how to behave (socially and emotionally) by imitating the behaviour of those closest to them (Facts for Life)	**Media campaign:** Short clips/dramas demonstrating ways that caregivers can interact with their children in ways that reward positive behaviours and are not punitive Supportive print media messages **Community sessions:** Discussion of positive discipline approaches to working with children with role plays/scenarios	**Media campaign:** MSS and development partners (Ba Futuru i.e. *Feto Fantastico*) provide material to SECOM for broadcast on TVTL, national/community radio Message promoted in *Lafaek ba Komunidade* (CARE International) **Community Sessions**: Volunteers trained by Ba Futuru based on its
	<u>Physical violence:</u> 9. By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions discipline their	• There are ways of resolving conflict or redirecting misbehaviour using positive discipline approaches, (MSS)		

Issue	Behaviour Change Result Statement	Potential message(s) to be promoted	Delivery modalities	Who will deliver the message?
	children in a non-violent manner.		**Peer to peer networks:** Groups facilitated to encourage parents to discuss challenges they are having with disciplining their children and to collectively brainstorm ways to address this situation in ways that do not resort to violence **Home visits:** Home visits conducted for parents of children with adolescents to privately discuss challenges families are facing with their child(ren) of this age, and suggestions and practical advice provided in privacy of home. When needed, referrals made to outside services.	positive discipline program with teachers **Peer to peer groups**: Groups facilitated by members of the CPN with training and supervision from Rede Feto/Ba Futuru **Home visits:** Members of CPN with training/supervision from Rede Feto and Ba Futuru

Appendix Four: Sample M&E Framework for Community Sessions

Issue	#	Behaviour Change Result Statement	Indicators	Baseline	Target
High rates of malnutrition in children under 5 in Timor-Leste	1	Minimum acceptable diet: By the end of 2016, mothers and care-givers who attended the MSS pilot community sessions, feed the children aged 6-23 months who are in their care with food prepared in line with the standards of a minimum acceptable diet.	• Number of breastfed children age 6–23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day • Number of non-breastfed children age 6–23 months who received at least 2 milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day	TBD TBD	Xx% increase Xx% increase
	2	Hand-washing with soap: By the end of 2016, mothers and care-givers who attended the MSS pilot community sessions wash their hands with soap or ash after going to the toilet, washing ~~a~~ baby's bottom, before eating and feeding their baby/child and before handling food.	• Number of people who wash their hands with soap or ash after going to the toilet, washing ~~a~~ baby's bottom, before eating and feeding ~~your~~ baby/child and before handling food.	TBD	Xx% increase

Issue	#	Behaviour Change Result Statement	Indicators	Baseline	Target
	3	<u>Danger sign and care-seeking:</u> By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions seek advice or treatment for the children under 5 in their care with diarrhea/fever in the last 2 weeks.	• Number of children under age 5 with diarrhoea/fever in the last 2 weeks for whom advice or treatment was sought from a health facility or provider.	TBD	Xx% increase
High rates of grade repetition and drop out, particularly in early years of schooling	4	<u>Early stimulation:</u> By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions engage if four or more activities to promote learning and school readiness for the children in their care aged 0-35 months and 36-59 months.	• Number of children age 0-35 months and 36-59 months with whom an adult has engaged in four or more activities to promote learning and school readiness in the last 3 days.	TBD	Xx% increase
	5	<u>Support with homework:</u> By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions support their child aged 6-12 with their learning at home.	• Number of children age 6-12 who received support with their learning for at least 30 minutes per day for the last 3 (school) days (response by adults/caregivers). • Number of children age 6-12 who received support with their learning for at least 30 minutes per day for the last 3	TBD TBD	Xx% increase Xx% increase

Issue	#	Behaviour Change Result Statement	Indicators	Baseline	Target
			(school) days (response by children).		
High rates of child abuse and neglect, particularly amongst vulnerable families	6	<u>Neglect:</u> By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions do not leave their child aged 0-5 years alone or in the care of another child younger than 10 years of age.	• Number of children under age 5 left alone or in the care of another child younger than 10 years of age for more than one hour at least once in the last week.	TBD	Xx% increase
	8	<u>Birth registration:</u> By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions register their children at birth.	• Number of children under age 5 whose births are reported registered.	TBD	Xx% increase
Prevalence of physical and emotional violence against children by adults widespread	9	<u>Knowledge of alternative disciplining:</u> By the end of 2016, mothers and care-givers who were part of the MSS pilot community sessions have knowledge about alternative disciplining.	• Number of care-givers who can name 3 non-violent ways in which they can discipline their child.	TBD	Xx% increase
	10	<u>Physical violence:</u> By the end of 2016, mothers and care-givers who were part of the MSS pilot	• Number of children age 1-14 years who experienced physical punishment during the last one month.	TBD	Xx% increase

Issue	#	Behaviour Change Result Statement	Indicators	Baseline	Target
		community sessions discipline their children in a non-violent manner.			

Appendix Five: Compilation of FGD with caregivers

FOCUS GROUP RESULTS FCJ GROUP ONE

1. Scenario 1.

#1. How would you normally address this situation?

- Bring the child to the hospital
- Solve via traditional ways(culture/beliefs)
- Give the child medicines
- Pray for the child's health
- Most of the participants said they will bring the child first to cure through traditional ways before the doctors. They strongly believe that fixing their wrong doings in traditional ways will help ease things when they go to see the doctors at the hospitals.

#2: At what point would go and seek outside help or assistance for this situation?

- When doctors at the hospitals did not help, we will bring our child to a traditional healers.
- We will have traditional rituals to heal our child

NB. Question 3 was not asked because of the similarity answers expected
#4. What might prevent you getting advice and assistance?

- No money for transportation to the hospitals
- Sometimes traditional healers could not help
- Sometimes we can solve it easily within our families

2. Scenario 2.

Answer to question
#1. How would you normally address this situation?

- We ask or force them to study
- My child fails because we do not have money to pay their school and this de-motivate child from learning and attending schools
- I will ban them from watching TV's
- I will beat them up and ask them to study
- I have two children that have finished their junior high schools but could not continue to higher level due to economic issue and this somehow has de-motivated my other children to study.

#2. : At what point would go and seek outside help or assistance for this situation?

- I sell vegetables to support my children's education/study
- I sometimes lend money from my other families(uncle, aunts, brothers)
- I do not seek outside supports, I try to solve it within my families through selling of vegetables, cakes, planting corns, etc.
- I got support (small amount of money from FCJ to buy vegetables and sell it in the market)

- The money I got from selling vegetables will use to pay my child's school.

#3. Whom would you go to ask advice and assistance?
- My older son(normally they listen to him)
- Aunts, uncles, Father
- We do not go to outsiders because usually we can solve it internally

NB: Question 4 was not asked because participants said that they did not seek support/advice from outsiders.

Scenario 3.

Answers to questions

#1. How would you normally address this situation?
- I normally beat them up but afterword, I give them good advice and encourage them to obey elderly people
- I will beat them when they do not listen
- I will slap him and at the same time advise him
- I will beat them and after that give them money to pay their school
- I will beat but no to injure or hurt them
- Give them good advice and moral

#2. At what point would go and seek outside help or assistance for this situation?
- What I normally do when my child is not listening is that I will ask my older brother to support and give some advice because my children usually listen to him
- I do not seek advice from outsiders (out of family), we try to solve it in our family
- When my child does not listen, I usually call up their uncles and aunties to give advice.
- One time I went to the teachers for advice, but most of them said "start from 9-12 o'clock your children are in our responsibilities but after that hour, it is your own responsibilities. This answer seems like de-motivated me for seeking their supports again in the future.

NB. Question 3 and 4 were not asked because answers are expected to be similar to question 2

3. Scenario 4.

Answers to questions

#1. How would you normally address this situation?
- I beat them up and tell them that it's not time yet for you to have boyfriend/girlfriend.
- Normally we call 2 families to solve the problem.
- I will call his/her parents/family to solve the problem
- Give advice

Follow up question: What if you child is pregnant?
- I will call both families to solve
- I will just accept it, what else can I do?
- I will call families and solve it through our traditional culture
- The boys families will pay money, buffalos, goats, etc
- We will arrange traditional ceremony for dowry things.

#2. At what point would go and seek outside help or assistance for this situation?

- We will seek outside supports when we could not solve in traditional ways or things get stuck at family level, we will go to chief of village or maybe police.
- Mostly we solve it within our families.

#3. Whom would you go to ask advice and assistance?

When things get stuck at family level, we will go to local leaders like chief of village and traditional leaders.

#4. What might prevent you getting advice and assistance?

- We rarely seek outside support because we have solved it within our families
- Because we already paid some amount of money, buffalos, etc between families therefore, we do not go for outside supports
- Both families have agreed to the solution, and we have accepted the solution
- We want to strengthen two families relationship in the future
- It's a shame when we let people know about our problem, embarrassing for our families

Final Scenario

Answers to question

#1. Who would normally take care this child in your household?

- Normally parents
- Elder siblings
- Extended families(aunts, uncles, cousins, nephew, etc)

#2. What types of special attention and care might be you give to a three years old?

- Not to make him/her sick
- Take a good care of them
- Good and clean clothes
- Do not let them fall
- Love them through giving full attention
- Show them role model
- Do not beat them
- Do not fight in front of them

#3. How would you normally interact with this child?

- I play with them
- I take care of them/look after them
- When I do not have time, I'll leave them with their elder siblings
- Sometimes I ask help from my sisters/brothers to take care
- I breastfeed them when they were young and a good care
- Do not beat them

#4. Would you send your three years old to pre-school or early learning centre?

- I would like to send my kids to a learning center because I wanted him/her to learn something like reading/spelling, writing, and talking
- I am doubt because worried of treatment people will give to my child (will it be the same like I did?)

- I would want it but they have to be accompanied by my other elder children
- I like it because they can train my child to write and read

FOCUS GROUP RESULTS FCJ GROUP TWO

- **Scenario 1. Child has been ill with fever and vomiting for two days**
  1. How would you normally address this situation?

  Answers:
  a. Bringing to hospital immediately
  b. Give him/her medicine
  c. Asking for help to some or nurses at neighbours

- **Scenario 2. Your child school report indicate that they are failing several subjects**
  1. How would you normally address this issues?

Answers:
  a. Ask older brother and sister for help to getting better the score and more focus on the subject that are failing
  b. Ask for support the colleagues who get better the score to learn together
  c. Give him/her an extra time for learning
  d. Parents should give a special attention and ask the child to be more focus on the subject that are failing
  e. Asked him/her in smooth manner to learn more

- **Scenario 3. Your child is not listening to you, and some time does things without your permission**
  1. How would you normally address this issues?

Answers:
  a. Not to blame at him/her but speak nicely for changing of the behaviours
  b. Parents should give more attention
  c. Never to hit the children as it would affected the mentality of the child and child will not going for school
  d. Bringing him/her to the teacher for an extra coaching and motivation
  e. Give him/her money for funs
- **Scenario 4. You find out that your fourteen years old child has a boyfriend/girlfriend**
  1. How would you normally address this issues?

Answers:
  a. Tell them to get married soon
  b. Give them chance but limited them to not often meet
  c. Allowed to courtship but must continue to prioritize learning

  2. At what point would go and seek outside help or assistance for this situation?

Answers:
  a. To solve the problems of child relationship no need to ask for outside's help because it would damage the image of the child

b. Tell them with nicely manner that at 14 fourteen years old is not the right time for them to falling love
c. Ask for others support or neighbours for information and controlling

3. Whom would you go to ask advice and assistance?

Answers:

a. Classmates or school friends as messenger or informant
b. Ask older brothers and sisters in the house hold telling their love story in the past
c. Ask for help at priest and nuns to teach about religious and moral education

4. What might prevent you getting advice and assistance?

Answers:

a. Do not want other to know the domestic problems because others will make small issues becomes a big problem.

Final Scenario

You have a three years old child in your household who is the youngest in your family. He or she is now at an age where they are walking and are talking and interacting with others. He/she is demanding more of attention and care.

1. Who would normally take care this child in your household?

Answers:

a. Basically the parents are the first line in taking care of the child
b. Secondly might be older brother and sisters

2. What types of special attention and care might be you give to a three years old?

Answers:

a. Telling of good story
b. Showing new thing for playing
c. Never talk and show bad things in front of them as at this age very easy to follow whatever they hear and see.

3. How would you normally interact with this child?

Answers:

a. Should get a special and routine attention because on this age cannot distinguish the good and the bad
b. Provide a quick help or attention particularly when he/she is doing something bad

4. Would you send your three years old to pre-school or early learning centre?

Answers:

a. Yes, although he/she cannot be admitted based on aged but, to simply know and familiarizing themselves with the school environment

b. No, It's depending on family economy, if sufficient yes, because most of kindergarten school in Dili are private and expensive. Otherwise, they have to wait and send to public primary school until the child reached the age of 7 years old.

FOCUS GROUP DISCUSSION WITH PARENTS OF TEENAGERS

Beginning questions:

What are the challenges you face as a parent? How do you deal with some of these challenges?

Five mothers form Comoro areas. Parents challenges:

- My elder son now study at secondary school, but everyday always go out without any reason, he also always get phone call from his girlfriend at all the time. We don't know where he is go when he is go out.
- My son (his 20 years old) had relationship with a girls and the girl got pregnant, we together with my son have to take responsibility, both side of family seat together to solve the problem, from our side have to give a bride price to girl family, until now we cannot afford to pay fully bride price, therefore they are not yet legalise their status as a legal couple.
- My kids give me a headache because they are not listen to me.
- They want to have a mobile phone, or want to have toys but we cannot afford to buy, because our economic condition.
- Sometimes they don't want to go to school and we have to talk to them how important to get formal education.
- My teenage girl always talk on the phone, probably with her boyfriends, I am afraid…..
- My boy wants me to agree in order to buy things that he wants such as mobile phone, motorcycle and ask for money as well, to avoid problem and for them to be able to listen to us, we just fulfil the requests.
- My kids if they want something like toys on the street they would cry for that and we have to buy it, if we don't have money to buy it, would cause a problem, they will sleep on the floor and never stop crying.

Scenario #1: *The chafe de suco visits your home and tells you that your son is constantly getting involved in fights in the street.*

1. How would you normally address this situation?
    - First of all we talk our son on why you involved in fights in the street? Tell him that is not good, you have to focus in their study, avoid to involve in this kind of activity.
    - Sometimes what they did not because of they want to do, but peer pressure from their peers or the influence of their friends, that's way as parents we have to find it out and try to minimize their participation in outside activity with friends.
    - Normally I as a mother will talk to him, but if he don't listen to me, will ask his father to talk to him (father use violence to teach his kids such as beaten and kick)
2. At what point would go and seek outside help for this situation and who would you seek help from?

- Actually this is internal problem in our family, but in case the problem getting worse and we need to ask help from outside such as local authority (chief of suco, chief of aldeia), family particularly uncle, neighbours.

3. What might prevent you from getting advice and assistance?
    - Shame, because when we ask for help, they might say that as a parents you have to educate your kids, not just to ask people to educate your kid
    - Some of people would become rude to us, for example, you as a teacher in school you educate people kids, why you don't be able to teach your own kids.
    - Embarrassing and scare to ask for help
4. How might you prevent this situation from arising in the first place?
    - Talk to them about moral in relation to attitude/behaviour
    - Fulfil their wants to make them listen to us
    - As a mother will handle the situation first, if come to worse will ask father to deal with the situation.

Scenario #2: *Your child's school report indicates that they are failing several subjects in school*

1. How would you normally address this situation?
    - Talk to them first why he/she failed in several subjects
    - Talk to the on the important of formal education for them, is good for their future and also they will support their parents in the future.
    - Some of the mothers said that they will go and talk to the teacher, why their son/daughter failed in several subjects in order to find it out the problems. According to them in the first and second assessment of they were had a god results, only in the final exam they failed several subjects, sometimes the teacher evaluate their students not best on the assessment or exam but on their attitude/behaviour, bad attitude can contribute to the failing subjects.
    - Some of the mothers said that they don't want to meet the teacher, they just support their kid to not be failed again in the future.
2. At what point would go and seek outside help for this situation and who would you seek help from?
    - The mothers said that their own problem to solve it, not need to ask outside help.
    -
3. What might prevent you from getting advice and assistance?
    - Scare to meet the teacher
    - According to the mothers, the teacher will be rude to them and also will lecturing them
    - They are not feel comfortable to talk to the teacher
4. How might you prevent this situation from arising in the first place?
    - Talk to their child
    - Set up the study schedule including in and out activity, in order to control by the parents
    - Support them on their homework from school

Scenario #3: *Your child is not listening to you, and sometimes challenges what you are asking them to do*

1. How would you normally address this situation?
    - According to some of the mothers, buy things that he/she wants in order for them to listen to us.
    - If they hardly ever not listen to use, normally we use violence (beaten and kick) to make them listen to us, because make us really headache.
    - Talk to them again and again
    - Talk to my child, teach him/her to listen to us, if they still not listen, we use violence (beaten and kick) if they against and want to beat us back we will call police.
    - One of the mother said that we need to see the traditional healer because a bad spirit in his inside body that way make them not listen to us.
2. At what point would go and seek outside help for this situation and who would you seek help from?
    - Most of the mothers said that they will ask help from their immediately family, specially their brothers, who the kids scare more
    - Seek help from their parents
    - Seek help from their godfather and godmother
3. What might prevent you from getting advice and assistance?
    - They are ashamed and they feel embarrassing
4. How might you prevent this situation from they are m arising in the first place?
    - Try to follow want that their children wants and fulfil their wants enable them to listen to them
    - According to one of the mothers said that if he/she don't listen to my advice not to be absent from school she/he won't be feed by the parents

Scenario #4: *You find out that your fourteen-year old child has a boyfriend/girlfriend*
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1. How would you normally address this situation?
    - Talk our child, to have girl or boy friend is normal but don't act or do things beyond that
    - Have to control their outside activity, for example, what time they have to be in school and what time they have to be at home
    - If the parents from both side know each other also the parents know the children is fine

2. At what point would go and seek outside help for this situation and who would you seek help from?
    - Ask immediately family (uncles)
    - Neighbours
3. What might prevent you from getting advice and assistance?
    - They are ashamed
4. How might you prevent this situation from arising in the first place?
    - Talk to them about moral, only girl or boy friend is fine, but not beyond that
    - Control their children on outside activity, keep their daughter at home, only when she go to school to prevent their daughter from risky behaviour

Scenario #5: *You find out that your daughter is pregnant or that your son has made a girl pregnant*

1. How would you normally address this situation?
    - Family from both side will meet to solve the problem, normally through culture or traditional approach
    - Most of the situation will be responsible by the parents, the couple will stayed with either girl or boy parents.
    - Solve the problem or situation using cultural or traditional ways with the boy family punishment such as give a girl family value materials (animals or money)
    - One of the mothers said that I am not going to agree receive the girl because I have to check about her status, her family background, is she has good attitude before, if the kid in her tummy is her son kid. The mother want to check before the two both side of the family will met and solve the problem.
2. At what point would go and seek outside help for this situation and who would you seek help from?
    - Sensitive issue, Only immediately family members
    - If the situation getting worse or the boy and his family doesn't want to take responsibility, than the parents and family will ask help from local authority
3. What might prevent you from getting advice and assistance?
    - Shine and embarrassing
    - Afraid about Gossip (all people will know the case), supposed to confidential
4. How might you prevent this situation from arising in the first place?
    - Most of the mothers said talk to them about moral
    - One of the mothers said that I will talk her daughter that you are still under age, we will have difficulty when you delivery the baby, will cause a lot of problems to you, and to her son, she will said that you don't have any job no money to support your family, you will have a lot of responsibilities to your family. It's not easy
    - Control their outside activities
    - One of the mothers said that, I will use an example that happen to my first child as a lesson learnt to my second son about his life today full of responsibility to his family.

FGD WITH TEEN PARENTS

What are the challenges you face as parents? How do you deal with some of these challenges?

- The challenge faced in early married is husband never at home even during childbirth husband out of home.
- Early married resulted in less good health particularly abdominal pain
- Do not feel comfortable and forced to work hard
- Most young couple has no experience to do work but they forced them self to do so

What types of information do you feel you need as teen parents?

- Feeling quite burdensome of responsibility, the couple start thinking about family planning

- Yes, we need information from other for early prevention (particularly family planning messages)
- Yes, because through communication channel can help in solving problems

Barriers to seeking assistance on parenting:
- Afraid to ask because parents would scold us
- Feel fear to ask others, because people would gossip about us.
- Feelings and shame too dominating so unwilling to ask

Who do you feel comfortable to ask?
- No fear asking to own parents as at present I still staying with my parents
- From both parents, more often we ask mother because she understand and full of compassion she would guide us

Scenario I: Your child has been ill with diarrhoea and vomiting to two days
1. How would you normally address this situation?
- Immediately bring to clinic
- Try with traditional medicine and if not cured immediately brought to clinic

2. At what point would you go and seek outside help for this situation and who would you seek for help from?
- Ask parents (mother and father) and husband for help specially bring kid to the hospital
- Not all types or kinds of disease need a help from others

3. What might prevent you from getting advice and assistance?
- Often they wait until three days before being taken to clinic/hospital (based on advice of parents/neighbours)
- Some couple more trust to traditional healers, and if doesn't cure then taken to Hospital
- There is no one to help the kid bring to clinic/hospital

4. How might you prevent this situation?
- Give him/her a bath regularly
- Cleaned the toys
- Dab of baby oil
- Give him/her an attention so that children are not playing in the dust

Scenario 2: Your baby was wakes up in the middle of the night, every night and you can't ever get enough sleep.
1. How would you normally address this situation?
- Providing food as early as possible so that once he/she wakes up feed him/her immediately
- The mother should eat enough food so that once the kids wakes up give him/her mother's milk
- Make sure the hot water is available before bed

2. Would you ssk for outside help or not?

- Occasionally ask for help to parents but sometimes the parents hitting their grandchildren so afraid to ask
- In the weekend ask for cousin to help
- Not so often ask mother or father to carrying the kids

3. What's make you afraid to ask for outsides help?
- Because others will never take care our child as we can (all participants raise the same reason)

Scenario 3. You have a three years old child in your household who is walking, talking and exploring the world around them. He/she demanding more of your attention and care, and sometimes they are starting to misbehave

1. How would you normally address this situation (specifically misbehaviour)?
- Tell him/her not to go out and not to make yourself dirty
- Hitting to making him/her scared
- Threaten him/her with a stern animals
- Threat him/her with a moustached or bearded person

2. What types of the attention should be given to them?
- Show them good example (Interacting to each and others in nicely manner, never talk bad things)in front of them
- Teach them singing

3. How you normally interact with this child?
- Give them milk if they are crying
- Carrying and dancing when they are crying
- Singing a song
- Play the movie doll
- Brought them out to beach for playing
- Kissing them with affection

4. Do you think it is important that this child attend school? Why/why not
- Yes, easily to adjust him/herself with the school environment
- Three years of age is ideal for pre-primary school
- Because at kindergarten school there are a lot of toys for children to play with.

FOCUS GROUP DISCUSSION WITH CAREGIVERS LIQUICA (MAUBARA GROUP ONE)

Scenario #1: *Your child has been ill with diarrhoea and vomiting to two days*

Response:

We bring our child to the health clinic. If the child gets diarrhoea at mid night, then tomorrow morning we have to bring the child to the health clinic for health treatment. We also do provide oralite (one tablespoon of sugar, little salt and ¾ glass of warm water) at

home to help the child at the first time before going to the health clinic. This is the first aid that we can do at home before we bring the child to the clinic. But first at our mind is to bring the child to the clinic. If after the treatment at the health clinic and the child still experience the diarrhoea, then we can also treat the child with the traditional medicines, like the leaf or the skin of trees. Of course we should go first to the clinic so that the doctor can use the medical equipment to test and know what exactly happens to the child. Through this medical examination we know the illness that suffered by the child. The traditional treatment is the second steps and also as additional to first step, which is health clinic treatment, if the first step still not working. We have many traditional healers here. In Tetum we call it "*matan-dook*" but the the *matan-dook* cannot see what exactly the illness because he or she just do guessing. And many times it failed.

If the child gets sick, diarrhoea for example, we cannot wait at home more than two days and then bring him/her to the health clinic. We should bring the child immediately to the health clinic. Because if we are late then the child can lose his/her energy and be more suffer and this can lead the dead. We believe the health doctor. We have one medical doctor here in Maubara and some nurses. They treat us well. We trust them because they are the ones who work in the area of health.

Sometimes we felt very hard to ask for help or assistance from others because according to our belief, there must be a spiritual threats that we, as parents, should find out the root of the spiritual threats. Many times we believe that the child is sick because of the spirit/soul of parents and/or grandparents who feel angry with the family, and that is why the child is sick. Once we feel this spiritual threat then we have to prepare flowers, candle and go to the church to ask for a special Holy Mass and after that we bring the flowers and the candles to the cemetery to pray there. Although we do three kinds of treatment (health clinic, traditional and spiritual), but always the health clinic is the first place we should go.

We knew that diarrhoea is bad for our child and for everyone. In order to prevent the diarrhoea, we as parents, should clean the child, wash the child's hands, the food should also clean and tell the children not to eat any food outside home. We got this kindly of information from the health workers at the health clinic and also at SISCa.

Scenario #2: *Your child's school report indicates that they are failing several subjects*

Response:

If we show the child's school report indicates some subjects are failed, then as parent we feel sad and frustrated. What we can do is to ask her/his teacher on the child's progress and why the child's school report indicates fail. After that, we then have to remind the child to study hard and spend less time for playing.

Usually one week after the school report collection, as parent, we should ask the teacher on the progress of the child when the child is in the school.

At home, we have to make sure that there is somebody accompany the child when the child is studying. If we know how to read and write, then we can also help the child to write his/her lessons and homework. But for the parents who do not know how to read and write, they usually ask help from the eldest to help. Also sometimes we ask the child from the neighbours and/or the child's uncle/auntie to help.

We also advise the child to form a group so that the child can also learn together and by that way each of them can learn from his/her peers.

But some parents do not aware about this issue. They just leave their children learn alone. They even never think on how to support the child. This is because the parents never go to school at their time when they were young and they never experience it.

Some parents do not ask support from the neighbours because they feel ashamed of their neighbours.

So, in order for the child to get great report at school, as parent, we should motivate the child to study hard when the child is at home. We, as parent, should also provide them enough time for the child to learn while she/he is at home, help photo copying the child's lesson, monitor the child not to hang around with his/her peers for things that is not important, and ask the child to make his/her learning schedule at home.

Scenario #3: *Your child is not listening to you, and sometimes does things without your permission*

Response:
We let the child to do whatever she/he wants. Because one day, the child will know that what he/she does is wrong.

But, if the child continue does not listen to the parents, then this make parent got angry and parent can beat the child. For some parents, beating the child for positive objective is normal because they were beaten by their parents in the past and that is why today they are still behave good. But, beating the child must be the last solution, if the child really does not listen and does not obey the parents for many times.

Sometimes, as parent, we ask for help from the child's aunty or uncle to help give morale for the child. Because here in Maubara, uncle and aunty is also a respectful person. The uncle and the aunty are fully respected by our children. And sometimes, this kind of problem can be solved through the intervention of uncle and aunty. Sometimes, we, as parent, also talk to the child's teacher to approach the child while in the school.

Sometimes we feel ashamed to ask help from other people (not relative to us even though the neighbours) because this is our own internal problem within the family and we do not want other people to know about it and intervene our problem. We can only ask help from the relative (uncle and/or aunty), if necessary.

In order to prevent this case happens, as parents, we should give morale to our children, talk to the children and advise them not to be naughty, go to school and focus on the school activities, do not just spend time to hang around with peers for not clear purposes and lastly to listen and obey the parents.

Scenario #4: *You find out that your fourteen-year old child has a boyfriend/girlfriend*

Response:

If the child is 14-yeard old and has a boy/girlfriend, then we let the child to do whatever she/he wants. Because having a girl/boyfriend is his/her decision. If something happen later then we start giving the advice or morale to the child.

Our objective of sending the child to the school is for study and to be a smart person in the future. But if the parent cannot afford to send their children to continue the school, then the child can drop out of school and get married.

Other parents said, if our child is 14 years old and have a boy/girlfriend, as parent, we feel so heartsick because we have spent a lot of money for him/her to school. This is unacceptable things. As 14-years old child should only go to school and not to have boy/girlfriend. "*My husband has passed away and I'm alone with my children. If this kind of thing happens to my child and I have no way to say, then I just beat my child. Because I feel nobody else can help me because I'm alone*", said a mother.

But some parents said they will talk to their 14-years old child not to have boy/girlfriend for this age because they still very young and convince the child that now is the time to study and not to have boy/girlfriend.

Sometimes, as parent, we ask for help from the child's aunty or uncle for help, but only one or two times and not always. Sometimes, the child's grandparent also can help address this issue.

If we know that our 14-years old child has a boy/girlfriend, then we should talk to our child immediately and not to wait until something bad happens to our child, like pregnant at young age. Because if our child is a girl and she got pregnant during the school age, 14-years old, then she cannot continue her school anymore and this is bad for her future.

What we should do as parent to prevent this problem happens to our children is to talk to our young children to continue their school and study hard for their future. As parents, we should always encourage our children to go to school because 14-years old is still at the pre-secondary school age and still very young. Parent should always motivate the children to go to school because this is good for their future. The children cannot just depends on the parents because one day parents will die and the children must have a good future to sustain their life and stand alone in the future. In the area of modern technology like today, parent should not give mobile phone for the children because otherwise the children could misuse the phone for communicating their boy/girlfriend and start having love relationship.

FOCUS GROUP DISCUSSION WITH CAREGIVERS LIQUICA (MAUBARA, GROUP TWO)

General questions:

What are some of the big challenges you face as a parent?

- Difficulty to pay our child school fee due to the economic reason, some of them are in public school, but some of them in private school.
- Because parent have many child, they face difficulty to fulfil their children needs
- Supply problem

- School distance

What types of information do you feel you need in your role as a parent?

- How to manage income (Income generating)

Scenario #1: *Your child has been ill with diarrhoeau and vomiting to two days*

How would you normally address this situation?

- Most of the parent said, normally they keep their child at home for two days when they are sick, and they will go first to traditional healer in order to give their child traditional medicine. If their child getting worse they will go to health clinic for treatment and cure.
- Some of the parent explained that they went first to traditional healer because the health clinic is far away from their suco (take 2 hours walking to get there), that's way they prefer go to traditional healer which close to their place as well as part of their belief.
- Two of the parent said, they will give assistance first to their child for example give the child water mix with salt and sugar to prevent the dehydration. They will observe for 2 days, if in case is getting worse and they will go to health clinic for health assistance

At what point would go and seek outside help for this situation and who would you seek help from?

- Most of the parents said that they will handle alone, because their kids are their own kids therefore they have to handle by them
- The rest of the parents said that if they don't have money, they will ask help from their family (brothers and sisters or uncles). They money for transport cost in order to send their child to health clinic.

What might prevent you from getting advice and assistance?

- Shine
- Embarrassing and scare to ask for help

How might you prevent this situation from arising in the first place?

- All of the parent said that, they have to take care of their children on what they eat, wash their hand before they eat, take a shower every day, don't play outside, sleep enough and play.

Scenario #2: *Your child's school report indicates that they are failing several subjects*

How would you normally address this situation?

- Most of the parents said, if they are in this situation they will be very angry, however they will call their child and talk to them. They talk about the important of education for their future. Ask their children why they are failed in several subjects? In the same time when they receive their report book actually they had an opportunity to discuss with their children teacher. Normally teacher will explain about their children attitude and why they have failed in several subjects? they discussed things that the teacher had said to them with their children to get their explanation, however we can't go back to the teacher to discuss more on the issues.
- Some of the parents said that they have worked hard to send them to school, in this sense the parent were angry and beat them up.

At what point would go and seek outside help for this situation and who would you seek help from?

- Most of the parents said, they will handle the problem alone. If the chid continue to fail in the second semester they will take seriously and ask for immediately family support like uncles.
- Some of the parents said that the problem is they don't know how to read and write, probably they will ask people (family or neighbours) who knows how to read and write to help their children
- One caregiver said, I am illiterate, I cannot support my brother (pre-secondary school), sister (primary school), sister (4 years old), I ask my uncle to help my brother, and I ask my brother to help my sister to do their school homework at home.

What might prevent you from getting advice and assistance?

- Shine because this issue consider as internal/family problem
- One of the parents said that I have my way to educate my child, if I say no is no, if I say yes is yes. Things can be discuss but they have to listen to me. If I have problem with my child I will solve it by myself. I cannot ask people help because I am afraid that people will be rude to me, and say that I am not a good parent. To send my chid to school I have to work hard, that's way my child have listen to me and study hard to become a good person in the future and get a job.

How might you prevent this situation from arising in the first place?

- Some of the parents said, we need set up the time table schedule activity both inside and outside activities, for example, time to eat, playing time, study time-do school homework, school activity, church activity, in this sense we are able to control in and outside home.
- Most of the parents agreed and said that to control the kids regular and support them when they do their school homework
- Some of the parents also said that to minimize the outside activities, stay more at home.
- One of the parents which really strict and said, if you want your children to listen to you, you have to teach and support them since they are child don't wait until they become teenager for example, if you plant a tree you have to give water for survive, and the branch of the tree is still soft you can be able to cut off or break it, however, if the tree getting bigger and bigger, you are face difficulty to break it or cut the tree. This example I refer to how to educate our child at home.

The parent realise that to maintain this kind of support, the parent need to apply to their children when they started to join the kindergarten or primary school not to wait when they get into pre-secondary and secondary school.

Scenario #3: *Your child is not listening to you, and sometimes does things without your permission*

How would you normally address this situation?

- Most of the parents said that normally we have to follow what they want and buy things that they want, this enable them to listen to us.
- Sometimes even we support and follow what they want they still don't listen to us, when they grow up they have many preferences, they want to many things, and normally they are more listen to their friends rather than

us, however, if the situation getting worse, we normally use violence, and stop them to not go out with their friends.

- The parents also said we always talk to them on this situation, if you want to go out, please let us know that where are you going and with who, if something happen to you we know where you are? Also if you in trouble or have accident than we know where to look for you, if you don't inform us where you are going, we don't know where you are.

At what point would go and seek outside help for this situation and who would you seek help from?

- One of the parent said that of course we need help from outside, if something happen to my child, and I don't know where to find he/she I would ask help from my immediately family, neighbours, local authority (chief of suco, aldaia) and the police
- Normally if the situation getting worse, my child not listen to me at all, I will ask help from my brothers, or people that he/she scare more in my family or from his/her father side.

What might prevent you from getting advice and assistance?

- Shine because this issue consider as internal/family problem
- Embarrassing

How might you prevent this situation from arising in the first place?

- Set up rules at home such as spend more time at home rather than outside

Scenario #4: *You find out that your fourteen-year old child has a boyfriend/girlfriend*

How would you normally address this situation?

- Most of the mother said that they feel so sad because our child have to thing to get more education or study not to have a boy or girl friend.
- Normally as a parent we call them and talked to them about the important of education, study first for your better future. If you have boyfriend or girlfriend in this stage will destroy your study, probably you won't focus in your study and will make you failed in the end of the day.
- Some parent said, it is normal to have a girlfriend or boyfriend, but do not act beyond that.
- Few of parent said, this is your life, if you want to have good future, please concentrate in your study, don't take seriously on your relationship with your boyfriend or girlfriend, otherwise you will destroy your future.

At what point would go and seek outside help for this situation and who would you seek help from?

- Most of the parent said that normally if we comes to know that our child has boyfriend or girlfriend from our neighbours and also our family. As parent we have limited time to control their attitude and activities outside. In this case, we always ask help from family and also neighbours, if they have notice or know anything about our child particularly in this situation.
-

What might prevent you from getting advice and assistance?

- Shine
- Sensitive issue and internal problem in our family

How might you prevent this situation from arising in the first place?

- Few parent said that we ask our child if they want to continue to secondary school, if they want to continue they have to take seriously and study hard to finish their high school, if they don't want to continue to high school they can get married or just help us at home. In this case our child have to be honest to us in order to not losing more things to our child.
- Most of the parent said that if possible always talk to our child good things in order to give them motivation and support to study and prevent them from bad things.

Scenario #5: *You have a three-year old child in your household who is the youngest in your family. He/she is now at an age where they are walking and are talking and interacting with others. He/she is demanding more of your attention and care.*

Who would normally take care of this child in your household?

- Most of the parent said, we are who the one take care of our child at home.
- Because of my parents pass away I (18 year old girl) who is the one take care of my one brother and two sister (one of the sisters is 4 years old) no one else.

What types of special attention and care might you give to a three year old?

- Most of the mothers said that we have to spend more time with our child such as play with them with toys, do not often go out to play, protect them from dangerous things, take care of their health, interact with them
- Take care of their health, don't let them fell down
- Give them good nutrition food
- Sleep enough
- Don't ask them to do a heavy work

How would you normally interact with this child?

- Most of the mothers said, we always interact with the kids when they eat, talk to them all the time, and sometimes sing a song together with them.
- Some of the mother said, sometimes our kids don't want to play with us, they prefer to play with their toys and spend all the time playing with friend, we only watch them play with their neighbour friends

1. Do you think it is important that this child attends school? Why/why not?
    - It is really important, because in kindergarten school they learn basic letter a, b, c and also numbers 1,2,3,….., singing, playing when they go to primary school it would be easy for the kids. The kids feel more comfortable because they use to it.
    - Some of the parents said, the kindergarten is transition for the 3 and 4 years old kids to enter primary school.

FOCUS GROUP DISCUSSION WITH CAREGIVERS LIQUICA (VILLA GROUP ONE)

Scenario #1: *Your child has been ill with diarrhoea and vomiting to two days*

Response:

We bring the child to the health clinic or hospital. The distance between our home and the hospital is only about 1 to 2 hours walking distance. Once the child got diarrhoea, we should bring the child to the hospital or health centre within two days and not too late. If our home

close to the hospital or health post, then we shall bring the child to the health post immediately. Sometimes we use the traditional medicine as the first step to treat our child when he/she is sick, if our home is far from the health post, and the next step we should go to the health post for further treatment.

Sometimes, we ask support from the neighbours, *aldeia or suku chiefs* to help calling the ambulance to transport our child to the hospital. Or if the ambulance is busy at that time, then we have to hire motorbike to transport us.

Sometimes difficult for us to ask for help from other people because we thought that the child is sick because it is caused by the spiritual influences (for example; the soul of the parents or grandparents got angry with the family). For this reason, we usually go to the cemetery and pray for the souls and ask the souls to bless the child so that the child can recover from sick.

What parent can do to prevent their children from getting diarrhoea is to always clean the child or help the child to take bath, wash the child's hand before eating because many times the children play with the dust, and not to let the child eat things out side of the home.

Scenario #2: *Your child's school report indicates that they are failing several subjects*

Response:
Parent should urge the child to study. Feel sad if the child's school report is indicating fail in some subjects. We saw them every day go to the school but at the end they got low score, then we feel so frustrated with that. At home, of course we can accompany them while they study, for example ask them about the lesson that they learnt during the day at the school. For things that we cannot help the child, especially on their study, we then ask support from the child of the neighbours. And sometimes, we also ask support from their teacher to really pay attention to the child when the child is in the classroom or sometimes we can ask support from the child's schoolmates. Literate parents can help their children but difficult for the illiterate parents. The illiterate parents just leave their children study alone and they do not know on how to seek help from others.

What we do as parent to prevent our child fail in the school is ask them to study when they are at home. Parent should not allow their children to spend more time to play compare to the time for studying. Parents also should not let the child watch the television for long time. But the most important thing is that parent should always motivate their children to study and not to leave them alone.

Scenario #3: *Your child is not listening to you, and sometimes does things without your permission*

Response:
Sometimes cause parents got angry if the child is not listen to the parents. If the anger level is high then we can beat the child. We are poor and we work hard for the child and that is why we want our child to behave well.

But instead of beating the child, some parents said, firstly we should talk to the children on how to behave well. We tell the children that they should listen to the parent so that in the future when they become parent, their children also can listen to them. If the child does not

believe us anymore as parent, then we can also ask support from the child's uncle or aunties. We can also ask support of the teacher because we know that the children are scared of their teacher to punish them and because of that they respect their teacher. So, we use the teacher as one of the supporters to help the children. Sometimes, we also ask the help from *aldea or suco chief* as the head of community. And if these ways do not work then finally we can go to the police office to solve it. We always seek help from other people to support our children behave well.

What we can do as parent to prevent children do not listen to parent is that from one side, we should educate children to listen to the parent. By educating or telling them to listen to parent means we educate them to respect their parent. Educating the children must start from the time when the child is young. And from the other side, parent should also behave well in front of the children. Parents should not be fighting each other in front of the children because parent is the model. If parent beats each other or say bad words one another in front of the children, means parent are the ones who teaches their children to behave negatively. Children learn as well from parent, so parent should be carefully when behave and talk in front of the children.

Scenario #4: *You find out that your fourteen-year old child has a boyfriend/girlfriend*

5. How would you normally address this situation?
6. At what point would go and seek outside help for this situation and who would you seek help from?
7. What might prevent you from getting advice and assistance?
8. How might you prevent this situation from arising in the first place?

Response:

We should educate the children that they should not have boy/girlfriend when still young. We can tell our children that they should not have love relationship with a boy or a girl because otherwise other people could put us down. Children should not be given the hand phone otherwise they will use it for communicating their boy/girlfriend. We should urge our children to go to school and to study. If the child continue having boy/girlfriend, then better stop him/her from school and let him/her get married.

But in some families, if the child have boy/girlfriend, that we can ask support from the uncle or aunties to help support with the moral for that child. Sometimes, we can also go to *aldeia or suco chief* to ask for help, if necessary. Otherwise, if we know the parent of the boy/girlfriend, we can also talk to them that, "*our children still young. And let them enjoy their time to go to school and study for their future. Because their age is not ready yet to become parent.*" In principle, parent should tell their children that they should go to school for their future, instead of focusing on having boy/girlfriend because that can hamper their future. We want our children to have better future compare to us as parent. That is our dream as parent.

General questions & answers:

1. What are some of the bi challenges you face as parent?
   Response:

- Economic difficulty in the family. We cannot afford to send our children to the university because it is very expensive. We can only afford them to complete secondary school.
- Said one mother, "*I'm disabled. And because I'm disabled person, it is really difficult for me to send my child to the university. The Bolsa de Mae fund that I got is not enough because it is only to cover 18 years old children abd below. But once my child is 19, then he did not get anymore the Bolsa da Mae's fund. This is my problem*."

2. When do you normaly get information from in terms of improving you knowledge and skills as a parent?
   Response: from our parents.

3. What type of information do you feel you need in your role as a parent?
   Response: It depends on the government what information they will be giving. If the government wants to give any information that good for us as parent, then we should accept it. We also need orientation/workshop from the government on the issues of family health and the prevention of the child labour.

FOCUS GROUP DISCUSSION WITH CAREGIVERS OTHER THAN BIOLOGICAL PARENTS

(Suco Mascrenhas, Dili)

Reason to take care of children other than their biological ones:

- Sister in laws husband pass away so she adopt her one child to reduce family burden
- The kids was stay with neighbour but they treated bad so she adopt him
- The kids parents was kill by Indonesia pro militia in 1999 in Suai
- Sister in law pass away
- The kids father was not responsible to the kids (foreign people)
- The kids father passed away
- Sister in law getting early pregnancy
- Unknown person give the child to her to adopt, economic reason
- The father of the kids getting married to other women

Scenario 1: We usually treated our kids at home with traditional medicine first (Guava leaves, Tea and Salt) as knowledge transfer from older generation and then wait for 2 days, if symptoms are severe, or if complications develop, then seek advice or help to hospital or clinic is needed. Nobody prevent us to seek medical advice.

To prevent this situation the parents said, they need to take good care to their children, make sure their child washes their hands regularly before eat, after going to the toilet, sterilized things before use, avoid provide kids with contamination food (always give fresh food). This knowledge the parents said they got from Clinic during immunization or SISCA day and some of them got from their formal education.

Scenario 2: When their children are failing several subjects, the parents said they will sit and talk with the children on what they need to do to improve the failed subject in the future and ask them to learn hard and they might going to check their child homework regularly specially the failed subject and putting more time into it.

They are hardly asking for outside help because they think people are busy with their own business and doesn't like to spend their time freely and other perception, they feel a shame if they should talk to other of their child failure. So they will teach their child as much as they can. But one participant said she will talk to the teacher to get a realistic view of her son because she need to know what specific problems her son faced before she can help him to make the needed improvement. Other participants said they might ask help from older siblings, neighbors or their children friends to help if really needed.

To prevent this situation happen the parents said, they will regularly monitor their children homework and encourage them to study hard at home.

Scenario 3: When children are not listen to their parents and do things without parents' permission, the parents will punish or beat their child to take them behave (after beating they will explain the reason why they beat their child) but if the children still repeat their attitude then they will seek help from an uncle or older siblings to talk with their children on the consequences that they may face when they continue to do the bad things.

To prevent this, they said they needed to speak nicely to their children, explaining that they represent the family name. They should understand that their actions can bring either praise or disgrace to their parents, siblings and extended family.

Scenario 4: When their fourteen-year old child has a boy/girlfriend, they will talk to the children to convey the cultural' value to their relationship, and remind their child that early pregnancy will bring disgrace to their parents, siblings and extended family and destroy their own future. One participant said if the child getting pregnancy then we need coordinate with family of the girl/boy to talk on the marriage process.

They seek help from an uncle, Godfather or Godmother to give their child advice.

To prevent this, the parents said they need to talk to their child that relationships should be based on the trust and mutual respect. One parent said I need to establish a basic rules and always checking up on where they're going, what they plan to do, and when they'll be home and other said we need to control our child behaviour. When asked about discussing reproductive health issues with their adolescent children, the parents said they did not have knowledge about the topic themselves, but their children were learning about it in school anyways.

Scenario 5: When they have three years old child in their household, people who normally take care is older siblings, mother, grandmother or father. Usually they will do normal things other parents do such as playing with the kids, telling them a history or fairy tale, teach them numeric, alphabetic, teach them how to wear clothes, take a bath, wash their hands.

They also feeding their 3 years child or grandchild or young sister/brother with nourish food such as porridge mixed with vegetable, egg, meat etc. Those experience they learned from brochure they found in the clinic, getting advice from service provider: SISCA.

It is important to bring our kids to preschools as foundation (where start form the kids mental, Kids start learning numeric and alphabetic, singing etc.) as preparation stage before they enrolled to the primary schools. The problem at the moment is that there is no free preschools around, so for the economic reason most our children just stay home wait until enough age to enroll in primary school.

General Questions:

1. **What children need:** We need to advise them to learned hard, behave in good manner so they can have a bright future and able to help their parents one day.
2. **Biggest challenges faced**: The challenges we face parents are: lack of livelihood to keep support up to high level schools, Time management how we could available all the time to support our kids.
3. **What types of knowledge are needed**: Type of Knowledge to raise our children: Education and Health
4. **Where we have learned about parenting**: our own parents, from our formal schools, health clinics, SISCA

FOCUS GROUP DISCUSSION WITH CAREGIVERS MANATUTO (GROUP ONE)

1. Scenario #1

Answers to question

1:

- Bring a child to a doctor/hospital
- I will bring my child to a clinic because it is near our place
- I will bring my child to see nurse/midwives immediately
- I always bring my child to a clinic

What if the clinic does not exist in your place?

- This clinic was just established in 2010, long before that we have always gone to clinics at sub-district (Laclo)

2:

- We always go to clinic/hospital
- In case we could not see a doctor, we will go for traditional medicine, we cook or boil it then give it to our child

3:

- We do not go to traditional healers because we don't have money to pay them.

- Traditional healers always ask for money and animals after treatment.
- We do not want to expose our family problems to others

4.

- We will take a good care to our families
- We want to solve everything within families

- Scenario #2

Answers to question

1:

- Force the child to study hard to get good grades
- Beat the child and ask him/her to study (we beat them but not hurt/injure them)
- We talk to them and give them good advice/moral

2:

- Only when our children do not listen, we ask support from their elder siblings
- I will normally call up their big sister because they only listen to her
- When they do not listen to me, I usually call their grandfather(my husband side)

3:

- We try our best to solve within our families because it is our problem
- I try one time go to school teacher, I presented him my problem, but he said that teachers only responsible for students during school hours (8-12) But after that it is your own responsibility, you have to solve it yourself, they are your children, you know how to make children, you should also know how educate them. This answer somehow, has discouraged me from seeking outside supports.

4:

- I always try to solve it in our family
- I give good advice to my kids
- I always ask my kids to study hard

3.Scenario #3

Answers to question

1:

- I try to educate and discipline them by not giving them food (during lunch time)
- I'll beat them up and slap them slightly in the face in order to listen to me
- I will give them moral advice

2:

- I sometimes call up my elder sister to advice my child when they don't listen to me
- We don't' go to seek outside supports because of family fame
- We don't want others to know our problem
- We want to solve it in our families

3:

- Because it is a shame to our family
- Because we know that people will think bad about us, they will think that we are not able to lead our child
- We wanted to solve it ourself

4:

- I will give my good advice to my children
- I will beat them up when they don't listen
- I will force them to obey

Scenario #4

Answers to question

1.

    - I will shout at him and ask him/her not to have boyfriend/girlfriend at the moment and be focus on study
    - Advise to continue their study
    - I will call both families to sit and talk for solution

2:

- I will call two families to sit and talk to get solution

- We try first to solve within families to avoid negative thinking from others
- We will go to local leaders, Church, Police only when necessary, meaning that we have failed to solve within families.
- We do not often go to other people to seek for solution because we do not want to reveal problems that can be a shame to our families.

3:

- Because we don't want to reveal problems in our family
- It will be a shame to our family
- Outsider may not always solve our problem
- It will be a shame to our children(both girls and boys)

4:

- I will give my kids moral and good advise
- I will say to my children that your parents have done much to support your education and therefore, you need to study hard
- I will beat them and force them to obey

Scenario #5

Answers to question

1:

- Take a good care of them and treat them well
- Feed them, bring them to hospitals when they are sick
- Give them love
- Not to make them sick

2:

- I have more than two children so I treat them equally like their elder siblings
- I'll give them love
- Look after them

3:

- Look after them

- Give them food
- When they are sick I take them to hospital

4:

- Yes, it is important because our children will have good future
- I have two children already graduated from senior high school and they are waiting for jobs
- Yes, it's really important

GENERAL QUESTIONS

1.

- Yes, I believe that my kids will grow up as good adults in the future because I always give them good moral
- If they attend good school, education, and moral they will become good person

2.

- Economic problem
- We don't have money to raise our children
- We don't have money get good education for our children
- My husband passed away and I am raising my children alone
- I need to work hard feed my children
- Sometimes we fight in the family and get divorce but our kids future is a priority

3.

- I need a good information from other people to raise my kids
- We need good information from teachers on our children's education

4.

- Xefe Suku
- School teachers

- Church
- Note: Our District Administrator has not visited us since 2010 how can we seek information from the government?

FOCUS GROUP DISCUSSION WITH CAREGIVERS MANATUTO (GROUP TWO)

Scenario 1: We have to run first to the nearby clinic (they have nearby clinic). Nobody prevent them to seek help in the clinic. If clinic is far away then they will use traditional medicine first.

To prevent this situation to happen in the first place, they said, good care for the children is the key, including knowing about what they eat and drink.

Scenario 2: When their children are failing several subjects they talked to them and asked them to study hard. They are hardly asking for outside help and all they do is asking the children to study harder. Two of the participants also mentioned that children also asked their friends for help.

To prevent this situation to happen in the first place, all they do is asking their children to be discipline and study at home. Sometime they also beat their children because of failing. But the children also threaten for suicide, therefore, the parent have to think twice before beating them.

Scenario 3: When children are not listen to their parent and do things without parent permission, parent will just follow what the children want. They respond to this when question is putting more specific to school related situation. But when their children is not listening to them for many times, they beat the child, but according to them, they beat their children to teach them not to kill them. When asking who is mostly do the beaten, father or mother? They laughingly said that father is the one that mostly beaten their children.

They also seek help from an uncle (from mother or father side) to talk to their children. This often they do because of family relationship and also sacred relation that exist in traditional culture. One of the parent mentioned that parent need to talk to their children in a more caring way but other parent said that talk nicely to their children is hard to do every day. To some stage hard education is needed to apply in order to discipline them.

Scenario 4: In general, the parent mentioned that they have told their children, first they have to complete their education, then getting a job, after that they can get married to a girl or a boy they want. But sometime if happened differently, the parent referred to a case where one of the children got pregnant early before completing her school. They have told their children that when they are away from their parent for study they need to think that parent is always think about them every day. When calling them, the parent always telling them to help with house work in the family that they live with, and to study hard. Having a

boyfriend and a girlfriend, according them is not a problem, but they have to think of their school first.

The parent is concern a lot about their daughter than their son. They also said that, whatever happen, the boy is always will be the man, but for the girl, the change for bad things is more, and it is also about family name. Its fine when the boy want to be responsible otherwise it will be bad for the girl's family. When a girl get pregnant, then it is all about 'rights' and we cannot forced her to continue her study. And we will call for family from the boy side to settle the issue through traditional mechanism.

For their teenage boy and girl that away for studying (in Manatuto, Metinaro and Dili) the family that they asked for advice and assistance is the family where they live with.

All the parent always telling their children that before living for studying other places, they need to think that they left their parents behind for studying not for other purposes. The parent did the same talk again and again whenever they visited them, call them or when their children coming back home during school break period. This is a gesture for prevention. But very often things happen differently. There was a case where a girl got pregnant and a boy was asking to be responsible. When family met to settle the issue, the girl was asked to leave her school because of being pregnant. However, boy's family wanted the boy to continue with his study. In this case, girl's family resisted by saying that if the boy going to school then who is going to look after the his wife. Then both family, from the boy's side also from the girl's side agreed to stop both, the boy and the girl, to continue their schooling.

The parent also think that their teenage children is listening more to their friends, particularly their girlfriend or boyfriend, than their parents. Mobile phones was blamed to be one of the causes of problematic relationships that the parent is having with their children at the moment.

Scenario 5: Mother is the one that mostly taking care of the three year old child. Other than mother is grandmothers or sisters. The special attention they have giving to their little child is more on bathing them, feed them and sleep them. Some of them said that they need to look after their little one because often the child are beating each other's or fall down when they are running around. But we only look after them when we hear crying voices, otherwise we will let them play by their own. Mother is the one that interacting with their little children, father's rarely done it. Only few of them mentioned that they are also teaching their little children at home.

They all think that education or attending school is the main thing for their children to get success in their future life.

General questions:

1. Most of them believed that education is the priority to become successful adult. One of the parent mention that parents are only preparing them, but success or not in their future is depend on them. Some parents also think that children also need to know how get a job done not just studying.

All parent are wanting their children to go to pre-school but there is no pre-school in the area. So the children have to wait until 6 years old to enter primary school.

2. One of the challenges is when children are not really listening to their parents. When parent talking too much to their children, the children said that their parent is mentally ill.

The biggest challenge is getting income to support their children. Both, mother and father bear the same responsibility for income generation. Most father's in this area are working in the farm and mother are taking care of other work nearby house such us raising chicken's, pigs or goats.

3. One of the parent said that hand washing is a new information to them. Because they used to not washing their hand after work, and directly eating their food.

4. So far their received information about children's health from clinic and from education staff. They all think that they have received good information

COMMUNITY LEADERS MANATUTO

1.
No money for schooling and food for children
Another challenge is that parents don't have time for their children because of their daily work(raised by xefe suku)
Many children don't go to school during rainy season
As teachers, we only have 6 hours working with children but families have more time to be their children
No electricity for children to study
Lack of attention from parents towards their children
Our children misused of telephones for negative things and this is out of our control because most of the time it happens at schools or out of home
2.
Take a good care and education of my children
Children can respect elderly people
Some families can manage their money to schooling
Students wear uniform at school

3.
In my observation I noticed that money is a problem for families to raise their children
Families don't have money to pay for their children's education at higher level(universities)
Now we have laws that ban us from beating our child even though we thought it is a matter of disciplianing our children
Our children have less time to study
When our children go to other places for sudy we kind of loose our control and not know what they are doing
Most of parents care much for their daughters compare to boys
Early marriage

4.
Support parents to talk with government on bolsa da mae(mother's purse)

In terms of communication, we talk with families to advice their children not to use telephone during school hours
We talk with families on school rules and regulation
School will write a letter to families on children's absence in school
Ask parents to support their children's education
As community leaders we can be a bridge for families and government
We wanted parents not to give work for their children during school hours so that they do better in school
We give advice to parents to not let their children involve in crimes, etc

5.
Knowledge on education
Stay away from crimes
Not to misused of telecommunication devices
Not to see pornographic things at schools, etc

6.
The Catholic Church
Local authorities
Teachers
Police
Parents
Traditional leaders

Scenario#1
A.
We need to seek for solution but let the boy and girl to decide their future
As Xefe Suku I will ask the mother to know what is happening and I will give advice to the children and I think together we can find the solution
I will help the family give some advice but let the children to decide because it is their rights
As Police officer, I will call and listen to all parties and come up with solution
Note: What if families feel shy to tell the story?
We will give both families and children motivation
I will advise children not to get marry at young age, they need to continue their study
I will see if children need some medical treatment or not
If the girl is not pregnant, I will advise them not to get marry soon But if she is pregnant already, we need to call two families to solve.
B.
As a community leader I have an obligation to provide supports to families when they come to me
Find traditional medicines
I will contact health people to provide treatment
I can direct them to a traditional healers if there is no doctors available
C.
Ask parents why did your child cry at night
Help families looking for solution
Give good moral and guidance
Seek for traditional healing

FGD NOTES FROM PARENTS OF CHILDREN WITH SPECIAL NEEDS (DILI)

- **Some parents believe that poverty are reason behind why their children are disabled**

  (**I** was believe that why my child being disabled is because I am poor and maybe I am the only one in the world but one day when there was an information that one of the priest (church) will conduct a worship to healed people who has disease and even disabled people, I saw many of parents with disabled children come with luxury cars and equipment then I am realized that I am not a lone and poverty not only reason behind of having disabled child and me and family believe that he is blessed son from God to be protected and love him as much as we can)

- **Access to information and resources has not been adequately provided to persons with disabilities and their parents regards to right to Education, Health, Justice etc...**
  - So far they only relay on Church Based Organization (Nuns) but sometimes only people living around Dili that able to access, The nuns often go to the community (door to door) and talk to the parents with disabilities children to send their disabled children to school otherwise their never send them to school specially in remotes area due to economic reason, where and how to go
  - Most of parent doesn't have any skills even resources (to attend their children with special needs, they do it by learning. Sad, Stress and patient are things that they could cope it in their daily life.
- **Persons with disabilities are sometimes victims of verbal and physical abuse within their communities**. Stigmatizing language (such as labarik alejadu, bulak etc...) is commonly used to refer to persons with disabilities.
- Limited Teachers in the country who **have specialized training** on teaching persons with disabilities
- Provide adequate **teaching materials, and resources** to ensure teachers have the necessary tools to promote an inclusive learning environment (Guidelines, sign language etc..).

- Establish a **national scholarship programme** for persons with disabilities (MSS and Ministry of Education)
- **Traditional believe system**. Some of parents believe that having disabled child as one of punishment by spirits because they have broken a cultural taboo. Parents often seeking for of traditional medicine to cure their disabled children rather than seek medical assistance to receiving proper diagnosis and treatment. Parents some time hesitate to seek assistance or help within their community because of feeling they may rejected, abused, economic reason and others.
- **To establish Inclusive education program for disabled children**. So far many of disabled children go to public schools and having equal treatments, Children with special needs sometimes having difficult to cope and adjust themselves with the situation same as normal child and sometimes they become victims of verbal and physical abuse within their friends.
- Relevant Ministries to **conduct additional research to determine the needs** of persons with disabilities and create and appropriate programme to address need of children with disabilities.
- Recommended to MSS to **implement the Community Session Programme**, many of NGOs or other institution in the past collected the data but never doing any programme to address of finding and recommendation where they collected.
- National Campaign or socialization to raise awareness of the right of children with disabilities
- Increase the number of **qualified medical personnel** and devote them to monitoring and implementing the highest standards of care for children with disabilities (Early detection, treatments, and etc..)

Appendix Six: Methodology

During the first field visit, the consultant focussed primarily on the tasks of mapping existing activity as well as beginning to map key messages and key actors who might be involved in a national parent education program. To do so, he met with a range of government Ministries (Health, Education and Social Solidarity) as well as civil society and faith-based organizations. UNICEF organized the meetings, and identified the organizations it wanted the consultant to

meet with prior to his arrival. For this reason, there may be particular actors, involved in parenting education/support activities who were not consulted, but efforts were made to meet with those noted to be 'key players' at present in terms of caregiver support and education. A full list of the organizations visited in that first visit is noted in the table below.

Organization	Individual(s)
Ministry of Health	Directors of Health Promotion, Maternal and Child Health, Nutrition
Ministry of Education	Director of Preschool Education Vice Minister for Preschool and Basic Education
Ministry of Social Solidarity	Director of Social Reinsertion
New Zealand Embassy	1st Secretary for Development, Program Assistant
Catholic Relief Services	Country Director
Red Cross Red Crescent Timor-Leste	Director Youth Programs
Alola Foundation	Program Coordinator and Manager, Maternal Health
Canossan Foundation	Head Sister Directors of Preschool and High School
Child Fund	Country Director Education Advisor
World Vision	ECCD Technical Specialist Operations Manager
PLAN International	ECCD Specialist ECCD Program Coordinator
CARE	Country Director Assistant Country Director, Programs
Pastoral de Criancas	Director, Dili Diocese Programs
Australian Aid Program	1st Secretary for Development
Ba Futuru	Country directors
World Bank	Social Protection and Education Consultant
Rede Feto	Director

Individual or small group interviews were conducted with those managing or implementing parent education initiatives within these organizations. The interviews were open-ended in nature and sough to elicit information on the types of activities they had conducted to date in regards to parent education and support, as well as the key challenges and successes they had encountered through such work. Follow up email correspondence helped to fill in gaps and allowed those interviewed to provide documentation to substantiate or illustrate claims on impact.

In the consultant's second visit, his focus was attuned to understanding the existing knowledge and attitudes of caregivers, and identify areas of need in terms of new knowledge or changed attitudes that would be necessary for desired improvements in child outcomes. In the weeks prior to the consultant's visit in April 2014, representatives from UNICEF worked closely with relevant government and civil society counterparts to organise a series of focus group discussions in several districts across the country. MSS, through its network of social animators played a key role in orchestrating and gathering parents together on specified days in specified locations. Additional FGDs were organized through civil society organizations in Dili, particularly with caregivers facing specific issues, such as children with disabilities, or teenage parents. Despite the specification that FGDs be kept relatively small, most had 20 or more in attendance. In such instances, caregivers were split

into two smaller FGDs. It is also important to note that across all the FGDs, more women than men attended each session. A summary of the FGDs is provided in the table below.

Focus Group	Location	Participants	Males	Females
FCJ (Parents of Street Children)	Dili	13	3	10
Comoro Youth Centre (Parents of Teens)	Dili	5	0	5
Comoro Youth Centre (Teen Parents)	Dili	5	2	3
Bolsa da Mae Recipients (Suco Maumeta)	Liquica	28	2	26
Bolsa da Mae Recipients (Suco Babequina)	Liquica	29	6	23
Parents of children with disabilities	Dili	1	0	1
Parents of children with disabilities	Dili	13	5	8
Bolsa da Mae Recipients (Suco Laclo)	Manatuto	17	4	13
Community Leaders (Suco Laclo)	Manatuto	10	7	3
Adoptive parents	Dili	11	9	2
TOTAL TO DATE		**121**	**38**	**94**

Table 3: Summary of FGDs conducted

In FGDs, caregivers were given a number of scenarios to common issues that are faced in Timor-Leste, such as the illness of a young child, the developmental needs of a pre-school child, a school-aged child struggling academically, a child who is not listening or perceived to be misbehaving in the home, and an adolescent child who has entered into a romantic relationship with a peer of the opposite sex. Each of these scenarios was developed in consultation with relevant sections within UNICEF to ensure that they addressed issues of acute concern in the country. For each of the scenarios, caregivers were asked what they would normally do in such a situation, when they would seek outside assistance, the barriers that might prevent them from accessing assistance, and the types of measures they might take to prevent the scenario from arising in the first place. Following or prior to the presentation of the scenarios, caregivers were also asked some general questions, such as:

- What are the most significant challenges you face at present in raising your children?
- What types of information and support do you feel you need to more effectively raise your child?
- Who do you trust or seek advice from when it comes to raising your child/children?

For specific sub-populations of vulnerable families spoken to—such as caregivers of children with disabilities and caregivers of adolescents—the scenarios or follow up questions were slightly modified in acknowledgement of the unique constraints or issues they might expect to be facing. The full set of FGD guides utilized is appended to this report.

Due to the nature of the focus group discussions, responses were not quantified. This was primary a product of the large sizes of many of the groups where it was almost impossible to obtain individual responses, or to ascertain whether agreement noted by others in the group was compelled by peer pressure. Instead, general responses were noted during the interview by either the FGD facilitator or a dedicated note taker (in either circumstance a member of UNICEF staff), and were later translated and thematically analysed by the consultant. A full copy of all FGD notes is appended to this report for further reference.

It is important to note that given the focus group format, and the fact that selected locations in each of the three districts were covered as part of this analysis, findings should not be assumed to be nationally or even regionally representative. While certain patterns and trends are evident across many of the groups, more in-depth investigation, in the form of

individually administered surveys to a nationally-representative sample of caregivers would need to be conducted prior to identifying the needs of caregivers, and to begin to draw comparison of differences by districts or urban/rural needs. It is also important to note, that despite the intention of the consultant to speak to vulnerable caregivers who are currently not recipients of Bolsa da Mae, the majority of participants in FGDs were recipients of the conditional cash transfer scheme. This was largely due to the involvement of MSS in organising the FGDs, and the group of individuals MSS' social animators were able to mobilize within the identified communities.

Appendix Seven: FGD guides

FOCUS GROUP DISCUSSION WITH CAREGIVERS

Scenario #1: *Your child has been ill with diarrhoea and vomiting to two days*

5. How would you normally address this situation?
6. At what point would go and seek outside help for this situation and who would you seek help from?
7. What might prevent you from getting advice and assistance?
8. How might you prevent this situation from arising in the first place?

Scenario #2: *Your child's school report indicates that they are failing several subjects*

5. How would you normally address this situation?
6. At what point would go and seek outside help for this situation and who would you seek help from?
7. What might prevent you from getting advice and assistance?
8. How might you prevent this situation from arising in the first place?

Scenario #3: *Your child is not listening to you, and sometimes does things without your permission*

5. How would you normally address this situation?
6. At what point would go and seek outside help for this situation and who would you seek help from?
7. What might prevent you from getting advice and assistance?
8. How might you prevent this situation from arising in the first place?

Scenario #4: *You find out that your fourteen-year old child has a boyfriend/girlfriend*

9. How would you normally address this situation?
10. At what point would go and seek outside help for this situation and who would you seek help from?
11. What might prevent you from getting advice and assistance?
12. How might you prevent this situation from arising in the first place?

Scenario #5: *You have a three-year old child in your household who is the youngest in your family. He/she is now at an age where they are walking and are talking and interacting with others. He/she is demanding more of your attention and care.*

2. Who would normally take care of this child in your household?
3. What types of special attention and care might you give to a three year old?
4. How would you normally interact with this child?
5. Do you think it is important that this child attends school? Why/why not?

General questions:

- What do you believe children need to grow up to be successful adults?
- What are challenges you face as parents in raising your children?

- What types of knowledge and information do you feel you need to better raise your children?
- From what sources do you currently get information and knowledge on how to raise your children?

FOCUS GROUP DISCUSSION GUIDE
COMMUNITY LEADERS

1. At the moment, what are some of the biggest problems and issues that are facing parents in your community right now?

2. From your observations and experience, in what ways are the parents of your community doing a good job in raising their children?

3. From your observations and experience, in what ways are parents struggling to raise their children?

4. In what ways do you personally work with parents (training, advice, support) to address some of these struggles at the moment?

5. What are the types of knowledge and information that you feel that caregivers in your community need more of?

6. Who do you think has the biggest influence on what parents do with their children in your community?

Scenarios:

A. Imagine a mother came to you saying she was worried about her 14 year-old daughter. Her daughter is not listening to her, and often the mother does not know where she is. She had heard from neighbours that she has a boyfriend from the next village and spends a lot of time with him after school. What advice might you give her?

B. Imagine a father came to you saying she was worried about her 2 year old son. The son has had not been eating well, and occasionally has diarrhoea or vomiting. What advice might you give?

C. Imagine a mother came to you saying she has a one-year old daughter who is often waking up at night, and crying for hours. She is getting increasingly frustrated with this child and is exhausted. What advice might you give her?

FOCUS GROUP DISCUSSION WITH TEEN PARENTS

Beginning questions:

What are the challenges you face as a parent? How do you deal with some of these challenges?

Scenario #1: *Your child has been ill with diarrhoea and vomiting to two days*

1. How would you normally address this situation?
2. At what point would go and seek outside help for this situation and who would you seek help from?
3. What might prevent you from getting advice and assistance?
4. How might you prevent this situation from arising in the first place?

Scenario #2: *Your baby wakes up in the middle of the night, every night, and you can't ever get enough sleep.*

1. How would you normally address this situation?
2. At what point would go and seek outside help for this situation and who would you seek help from?
3. What might prevent you from getting advice and assistance?

Scenario #3: *You have a three-year old child in your household who is walking, talking and exploring the world around them. He/she is demanding more of your attention and care, and sometimes they are starting to misbehave.*

1. Who would normally take care of this child in your household?
2. What types of special attention and care might you give to a three year old?
3. How would you normally interact with this child?
4. Do you think it is important that this child attends school? Why/why not?

FOCUS GROUP DISCUSSION WITH PARENTS OF TEENAGERS

Beginning questions:

What are the challenges you face as a parent? How do you deal with some of these challenges?

Scenario #1: *The chefe de suco visits your home and tells you that your son is constantly getting involved in fights in the street.*

1. How would you normally address this situation?
2. At what point would go and seek outside help for this situation and who would you seek help from?
3. What might prevent you from getting advice and assistance?
4. How might you prevent this situation from arising in the first place?

Scenario #2: *Your child's school report indicates that they are failing several subjects in school*

1. How would you normally address this situation?
2. At what point would go and seek outside help for this situation and who would you seek help from?
3. What might prevent you from getting advice and assistance?
4. How might you prevent this situation from arising in the first place?

Scenario #3: *Your child is not listening to you, and sometimes challenges what you are asking them to do*

1. How would you normally address this situation?
2. At what point would go and seek outside help for this situation and who would you seek help from?
1. What might prevent you from getting advice and assistance?
2. How might you prevent this situation from arising in the first place?

Scenario #4: *You find out that your fourteen-year old child has a boyfriend/girlfriend*

13. How would you normally address this situation?
14. At what point would go and seek outside help for this situation and who would you seek help from?
15. What might prevent you from getting advice and assistance?
1. How might you prevent this situation from arising in the first place?

Scenario #5: *You find out that your daughter is pregnant or that your son has made a girl pregnant*

1. How would you normally address this situation?
2. At what point would go and seek outside help for this situation and who would you seek help from?
3. What might prevent you from getting advice and assistance?
4. How might you prevent this situation from arising in the first place?

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