USAID
FROM THE AMERICAN PEOPLE

USAID/Philippines Collaborating, Learning, and Adapting for Improved Development (CLAimDev):

Assessment of Select USAID Office of Health Project Activities (Family Planning, Adolescent Reproductive Health, Tuberculosis, and Community-based Drug Rehabilitation) and their Contribution to Gender Equality and Women's Empowerment

Final Report

May 31, **2023**

This document was produced for review by the United States Agency for International Development. It was prepared by Panagora Group for the USAID/Philippines Collaborating, Learning, and Adapting for Improved Development (CLAimDev) Activity, Contract No. 72049220D00004/72049222F00003 as a Technical Deliverable per Task Order Section F.5 and therefore uses USAID Branding.

Recommended citation: USAID/Philippines Collaborating, Learning, and Adapting for Improved Development (CLAimDev) Assessment of Select USAID Office of Health Project Activities (Family Planning, Adolescent Reproductive Health, Tuberculosis, and Community-based Drug Rehabilitation) and their Contribution to Gender Equality and Women's Empowerment Preliminary Report 2023 (January – May 2023). Silver Spring, Maryland: Panagora Group, Inc. May 31, 2023.

Panagora Group Contact:
Susan Minushkin
Senior Program Director—Monitoring, Evaluation, Research, Learning, and Adaptation (MERLA)
Lee Plaza
8601 Georgia Avenue, 8th floor
Silver Spring, MD 20910 USA

ACKNOWLEDGMENTS

The Collaborating, Learning, and Adapting for Improved Development (CLAimDev) activity gratefully acknowledges the expert work of Fatima Verzosa, a short-term gender consultant, who conducted this assessment on behalf of CLAimDev under the Panagora Group with funding support from the U.S. Agency for International Development/Philippines. Jose Paolo Ungson, CLAimDev's health data management and analysis specialist, drafted the Data Validation component of this report.

We also gratefully acknowledge the participation and contributions of the research team, composed of Danella Bianca Bona, junior consultant for the Gender Equality and Women's Empowerment (GEWE) component; Carlo Lorenzo, junior consultant for the Data Validation component; and our research assistants, Mark Auditor, Mikhela Baliola, Cheryl Basinillo, Jayvielyn Co, Margaret Golpe, Nikki Natan, and Jill Sason and Dominique Aluquin, who all participated in the data collection, processing, and data analysis.

We thank the key informants and focus group discussion participants from the four project sites in Sindangan Rural Health Unit in Zamboanga del Norte for the Family Planning program, Laguna Medical Center for the Adolescent Reproductive Health program, Taguig City's North Daang Hari Health Center for the TB program, and the Oro Wellness Development Center in Cagayan de Oro City for the Community-based Drug Rehabilitation Program.

We also wish to extend our gratitude to the CLAimDev team who supervised this study — Rowena Cañete, health program manager, and Roxanne Belen, senior research and learning specialist for health, for their leadership, technical direction, and guidance; David Callihan, chief of party of CLAimDev, for his continuing support for this study; Grace Olaybar and the finance team for the logistical support; and Dr. Mary Ann Lansang for her technical review of the full report.

This highly collaborative research project could not have been done without the full support of USAID's implementing partners, ReachHealth, TB Platforms, and RenewHealth.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

4Ps	*Pantawid Pamilyang Pilipino* Program
4Rs	recognizing, reporting, recording, and referring
ACF	active case finding
AJA	Adolescent Job Aid (DOH)
AMEL	activity monitoring, evaluation, and learning
ARH	adolescent reproductive health
BARMMHealth	Health Capacity Building in BARMM (program)
BHS	barangay health station
BHW	barangay health worker
BTL	bilateral tubal ligation
CADAC	Cagayan de Oro's Anti-drug Abuse Council
CBDR	community-based drug rehabilitation
CHO	city health office
CHW	community health worker
CLAimDev	Collaborating, Learning and Adapting for Improved Development Activity
CSO	civil society organization
DepEd	Department of Education
DOH	Department of Health
DQA	data quality assessment
DSWD	Department of Social Welfare and Development
DV	data validation
FGD	focus group discussion
FP	family planning
FPCBT	Family Planning Competency-Based Training
FY	fiscal year
GBV	gender-based violence
GEWE	gender equality and women empowerment
GINHAWA	General Intervention Health and Well-being Awareness (program)
GNDR	gender (indicator)
HEADSS	Home Education/Employment, Activities, Drugs, Sexuality/Suicide Risk (DOH)
IEC	information, education, and communication
IP	implementing partner
IRS	indicator reference sheet
IUD	intrauterine device
KII	key informant interview
KKDK	*Katatagan Kalusugan at Damayan sa Komunidad* (program)
LGBTQI	lesbian, gay, bisexual, transgender, queer, intersex
LGU	local government unit
LMC	Laguna Medical Center
M&E	monitoring and evaluation
NGO	non-governmental organization
OWC	Oro Wellness and Development Center

PhilHealth	Philippine Health Insurance Corporation
PHREB	Philippine Health Ethics Research Board
PIRS	performance indicator reference sheet
PITT	performance indicator tracking table
PWUD	people who use drugs
RBE	Reach–Benefit–Empowerment (framework)
ReachHealth	FP/Maternal and Neonatal Health (MNH) Health Innovations and Capacity-Building Platforms
RenewHealth	Expanding Access to Community-based Drug Rehabilitation Program in the Philippines
RH	reproductive health
RHU	rural health unit
SBCC	social and behavior change communication
SOGIESC	sex orientation, gender identity and expression and sexual characteristics
SRH	sexual and reproductive health
TB	tuberculosis
TB IHSS	TB Innovations and Health Systems Strengthening (project)
TB Platforms	TB Platforms for Sustainable Detection, Care, and Treatment (project)
USG	U.S. government

ABSTRACT

Gender equality and women's empowerment (GEWE) are cross-cutting themes in all activities that USAID/Philippines supports. The recent mid-term evaluation of the Mission's Health Project identified the need to demonstrate how the health activities of implementing partners are contributing to GEWE outcomes, and how the changes in social norms that advance GEWE lead to increased or better outcomes for women and adolescents who benefit from these programs. This assessment aimed to determine how the interventions from selected Health Project activities resulted in GEWE outcomes and how the involvement of women, men, and adolescents as beneficiaries of USAID activities increased women's agency (defined as the ability to act independently and make life choices). The selected USAID Health Project activities included family planning, adolescent reproductive health, tuberculosis, and community-based drug rehabilitation in four project sites, and this assessment focused only on women and adolescents who are direct beneficiaries of these programs in their journey towards women's empowerment. The assessment also included a data validation component to ensure compliance with the USAID data quality standards in the use of gender indicators.

The GEWE assessment used the Reach–Benefit–Empower framework to assess how the participation and services obtained by the women interviewees resulted in benefits, such as improved overall well-being, that contributed to the empowerment of women and adolescents. Measures of empowerment included: changes in perceptions before and after program interventions in the ability of women and adolescents to make decisions; changes in perceptions of prevailing social norms on gender equality; and changes in perceptions of women's voice and choice. The data from the in-depth interviews were analyzed using a comparison of Likert mean scores, frequency and percentage distributions, and content or thematic analysis from qualitative data from focus group discussions and key informant interviews.

The key findings showed that the benefits derived from program interventions have visible links to increased abilities that contributed to women's empowerment. The differences in mean scores, however, were generally marginal. In addition to the technical assistance provided by the USAID implementing partners, other enabling factors included the good quality service provided by well-trained and patient-centered health workers, and full support of the local government units in the project sites. These findings have implications on the design of program interventions in ensuring that GEWE is an explicit objective with well-defined metrics and data collection systems for measuring gender outcomes and gender-transformative results.

EXECUTIVE SUMMARY

This study, entitled "Assessment of Select USAID Office of Health Project activities (Family Planning, Adolescent Reproductive Health, Tuberculosis and Community-based Drug Rehabilitation) and their Contribution to Gender Equality and Women's Empowerment," sought to determine how the assistance from select USAID implementing partners (IPs) resulted in benefits from these health programs, and how the benefits contributed to the empowerment of women and girls. The gender equality and women's empowerment (GEWE) assessment is a response to the USAID Health Project mid-term evaluation finding on the need to demonstrate how the IPs' health activities are contributing to gender outcomes and gender transformative results, and how the changes in social norms that advance GEWE lead to improved outcomes for women and adolescents who benefit from these programs.

To support the objectives of the GEWE assessment, we adopted the Reach–Benefit–Empowerment (RBE) framework, supplemented by the project-level Women's Empowerment Index. The RBE is an approach for the study of women's empowerment and helps clarify strategies that *reach* women as participants, *benefit* women, and *empower* women by strengthening their ability to decide and carry out strategic life choices. The Women's Empowerment Index covered the dimensions of women's empowerment (decision making, access to resources, division of labor and gender roles, time use, and leadership or women's voice and choice). We selected four sites for the rapid assessment: Sindangan Rural Health Unit in Zamboanga del Norte for family planning (FP), Laguna Medical Center (LMC) for adolescent reproductive health (ARH), Taguig City's North Daang Hari Health Center for tuberculosis (TB), and the Oro Wellness and Development Center (OWC) in Cagayan de Oro City for community-based drug rehabilitation (CBDR). In measuring women's empowerment, we compared the changes in perceptions and abilities of the women respondents before and after their participation and use of the health interventions in FP, ARH, TB and CBDR, using a 5-point Likert scale. We conducted content and thematic analyses of qualitative data from the focus group discussions and key informant interviews. Alongside the in-depth interviews for the GEWE analyses, we conducted a data validation activity of standard USAID gender indicators and the indicators/data associated with the GEWE initiatives of selected IPs.

Highlights of Findings

1. The differences in the Likert mean scores are generally marginal, with small changes in perceptions before and after the interventions in FP, ARH, TB, and CBDR. While the changes may be small, the qualitative data showed visible changes in perceptions and increased ability of the women respondents in making decisions, which is one of the critical dimensions of women's empowerment.
2. The document reviews showed that women's empowerment was not a targeted objective of USAID in the design of the selected projects. Therefore, the IPs' gender-related indicators mainly measure participation (*reach*), such as number of persons trained, number of people reached by interventions, or number of persons who accessed services. There were no explicit metrics to measure benefits and women's empowerment.

3. The technical assistance and services that IPs provided to the health facilities led to concrete benefits, such as improved state of health and overall well-being, which were critical enabling factors contributing to women's empowerment. Other enabling factors included strong local government unit (LGU) support, such as those found in Sindangan (FP), Taguig (TB) and Cagayan de Oro (CBDR), and presence of well-trained, highly dedicated, and committed health facility staff who ensured protection from the risk of unintended pregnancies, complete treatment and recovery, and rehabilitation of their patients.

4. Findings on FP Interventions
    - Under *reach* and *benefit*, women respondents had a positive experience overall with using FP methods and services and high levels of satisfaction from health facility services and benefits received. However, while FP use increased their overall well-being and risk protection from unintended pregnancy, it also reduced their ability to refuse their husbands for sex.
    - Under *empower*, after FP use, the FP respondents showed increased ability to make independent FP-related decisions—i.e., when to have children; FP methods to use to limit and postpone pregnancy; increased ability to express their opinions on FP; and a high level of confidence to share FP use with others. There was a visible link between benefits derived and perceptions of women's empowerment among FP users.

5. Findings on ARH Interventions
    - Under *reach* and *benefit*, the adolescent respondents had a high level of satisfaction with LMC's good quality services, including FP counseling, prenatal, postnatal, and zero-balance billing, despite the bed-to-patient ratio in the obstetrics ward of one bed shared by three mothers and three newborn babies. The FP in Hospitals program has successfully prevented repeat pregnancies for adolescent mothers. Moreover, as acknowledged by LMC, the good FP practices developed with USAID IP assistance significantly contributed to their award for exemplary FP program and service delivery from the Department of Health Center for Health Development IV-A. Under *benefit*, the adolescent respondents stated that after FP use, their overall well-being increased; and their knowledge on FP use and FP methods for pregnancy prevention increased after FP counseling. Additionally, as mentioned in the focus group discussion with LMC, the use of the reproductive life planning tool during counseling helped the teen mothers to "dream again."
6. Under *empower*, after FP use, adolescent respondents had an increased ability to make their own independent decisions on modern FP methods to use; limit the number of children or postpone subsequent pregnancies; refuse to have sex without protection; and ask their husbands or partners to use condoms. Although differences in adolescent respondents' perceptions before and after the FP interventions were marginal, emerging positive shifts were visible in their increased ability to make empowering decisions.Findings on TB Interventions
    - Under *reach* and *benefit*, the recovered women TB respondents were highly satisfied, giving the Taguig health center a rating of 10/10 (the highest among the four sites) for the high quality of TB treatment, counseling, and services of the staff (barangay health workers [BHWs] and lab

aides) who were trained under the Come Alive[1] intervention. The TB respondents mentioned the consistent and constant follow-up by the health center staff and house visits by the TB Task Force in the barangay to ensure their adherence to the TB treatment protocol. The health center recognized that the assistance from USAID's IP directly contributed to its top LGU award for achieving a high treatment success rate of 90 percent among 17 cities in the National Capital Region. TB respondents cited improvements in their state of health and well-being; increased peace of mind from having recovered from TB; increased self-confidence and self-esteem; and increased knowledge on the cascade of TB screening, treatment, cure, and prevention.

- Under *empower*, there is a clear and visible link between *benefit* and *empower* in TB recovery. The TB respondents demonstrated strong ability in making independent decisions on TB screening, completing treatment and in encouraging their husbands and family members to be screened for TB; and in bringing those who screened positive for TB to the health center for treatment. These decisions showed the improved capacity of the respondents who recovered from TB to better take control and care of themselves and their families. The TB respondents expressed willingness and high level of confidence to share their positive experience in their barangay to raise awareness about TB; be an example to encourage and inspire other women and men to be treated for TB; and to share the message that TB can be treated, and it is not a cause of shame, especially for women.

7. Findings on CBDR Interventions
   - Under *reach* and *benefit*, the people who use drugs (PWUD) female respondents had a high level of satisfaction with the CBDR treatment and rehabilitation services of OWC and the barangay CBDR managers. Their experience with CBDR was highly positive in terms of overall improvement in their physical and mental state as well as family and social relationships. They developed a more positive outlook in life compared to their chaotic lives before CBDR. The female PWUD benefited most from the CBDR program through the removal of their names from the watch list, enabling them to return to their normal lives prior to CBDR. After completing the CBDR program, the female PWUD regained the trust of their family and friends and have become more capable in caring for their children.

   - Under *empower*, there is a clear and visible link between *benefit* and *empower* from CBDR. The female PWUD decided independently to remain drug-free and undergo treatment and rehabilitation to clear their names from the drug list due to fear of jail time and to improve their own well-being for the sake of their family and children. The female PWUD have high confidence in sharing with others their journey of rehabilitation from the time they started drug use to their rehabilitation. The enablers included the effectiveness of the CBDR services in stopping them from using drugs, and the accommodating and helpful staff who helped them change their perspective about drug abuse. For the latter, the shift of mindset from drug use as

[1] Come Alive is a communications training program developed by TB Platforms designed for Barangay Health Workers to Ask, Listen, Inform, Verify, Encourage (ALIVE) to assist TB patients in their treatment journey.

a crime to drug use as a health issue further empowered the female PWUD and enabled them to recognize that recovery and change are possible. The CBDR program helped to reduce discrimination experienced by women/LGBTQI PWUD from their families, particularly their children, who recognized their efforts in completing the program.

8. Findings from Data Validation
   - On USAID Indicator GNDR-6: the USAID Mission's ability to analyze the number and types of people who were reached by services is significantly limited by the considerable number of beneficiaries whose sex is recorded and reported. This constrains the analysis of programmatic gaps with respect to GEWE.
   - On GNDR-8: the IPs appeared to adhere to the guidance from USAID/Washington on GNDR-8 but said guidance should be clearly reflected in the performance indicator reference sheet (PIRS).
   - On GNDR-8: We found discrepancies in the TBHISS data beyond the 10 percent threshold pegged for performance deviation because the data reported contained duplicate names and individuals with no recorded affiliations.
   - On the number of PWUD who completed treatment reported, encoding backlogs and the lack of disaggregated data limit the validity and precision of the data reported. There are also limitations on data integrity and security due to transmission of data through an online app that is not password-protected.

9. Conclusions
   - Even if GEWE is not a stated or explicit objective of the USAID IP activities, the assessment found that the IP assistance directly contributed to the benefits that helped empower women.
   - All respondents in FP, ARH, TB and CBDR expressed high levels of satisfaction with the services and benefits obtained in the health facilities, direct and strong evidence of improvements in their overall well-being.
   - While the direct link between *benefit* and *empower* following the RBE framework may not be conclusive because of the marginal differences in perceptions on empowerment, there are small empowering changes in perceptions that are visible after receiving benefits from the IP interventions.
   - The USAID IPs have made a significant client impact in terms of high satisfaction ratings that they received from the women beneficiaries across FP, ARH, TB and CBDR. Other enabling factors to the empowering experiences were the presence of committed, well-trained, and dedicated health facility staff and strong support of LGUs for health interventions as one of their priority programs.
   - Comparing the four sites, respondents from TB and CBDR interventions had higher perceptions of empowerment compared to the respondents from FP and ARH. Between the FP and ARH respondents, there is a higher perception of empowerment in decision making among the FP users than among the adolescent mothers in LMC, mainly because parents rather than teen mothers make decisions on RH services. The difference may also be due to the big age difference between FP and RH respondents.
   - The women respondents have strong perceptions that reflect prevailing social norms about women's obligation to take care of their family and their children. This normative belief

reinforces the reproductive and productive divide that perpetuates gender inequality and disempowerment of women and girls.

- While the use of social media is heavily associated with younger population groups as a communication and social relations tool, social media (online) did not appear to be a significant source of information for FP, ARH, TB and CBDR clients in this assessment. Rather, information received from BHWs, and tarpaulins posted in health centers appeared to be the more important information sources.
- Counseling across the health programs assessed is a highly effective empowerment intervention that increases women's agency. Providing women access to knowledge about interventions, services, treatment protocols, methods, and side effects empowers them to make independent decisions, reduce feelings of stigma, and change mindsets on negative social norms and traditional beliefs.
- The findings are based on a limited sample of study sites and respondents for FP, ARH, TB and CBDR, and the conclusions may not be comparable with studies with bigger samples. However, most of the findings of the gender assessment resonated with the research findings from the review of literature relating to other countries' experiences in empowering women after their involvement in FP/ARH, TB, and CBDR programs. These findings included the same enabling factors that directly contributed to women's empowerment –(1) benefits from services by trained health workers; (2) access to FP and the opportunities to women that resulted after FP use; and (3) quality ARH services in adolescent-friendly centers and the role of family, parents, and school as influencers in educating and guiding their children in healthy sexuality.

10. **Recommendations**

General:

- As USAID develops its projects, there is a need to ensure that GEWE is integrated starting from conceptualization and design, with clear and explicit transformative objectives and performance measurements embedded in the IPs' monitoring and evaluation databases.
- Because online social media as a tool for advocacy and demand generation has not been identified as a source of information, there is a need for research and evidence-based approaches in developing targeted social and behavior change communications (SBCC) strategies for GEWE.
- For future health activities, use the RBE framework to build empowerment dimensions into the design of technical assistance activities. Ensure that proposed activities go beyond the *benefit* dimension of the framework and develop metrics to measure women's empowerment.

FP

- GEWE topics should be included in FP counseling sessions, including joint responsibility for FP, sharing of workload for childcare and household domestic work, and increased ability of women clients to make decisions about their body autonomy.
- Provide gender sensitivity training to health workers to help break gender social norms that reinforce gender inequality and disempower women.
- Health workers cited community theater as an effective demand generation activity even though none of the FP respondents experienced the community theater. We recommend that

the IP continues to support the resumption of the community theater post-pandemic as an advocacy tool for increasing FP use; for preventing teen pregnancy; for reducing gender-based violence (GBV) in its many forms (physical, psychological, emotional, economic, or non-support); for greater male involvement in FP/RH; for reducing women's workload at home; and for transforming social norms that reinforce gender inequality and the disempowerment of women.

ARH:

- Considering the continuing rise of unplanned teen pregnancies, develop practical and actionable strategies for pregnancy prevention that could be implemented and scaled up in local health facilities. This may include building and strengthening partnerships with 1) the Department of Education in implementing its Comprehensive Sexuality Education program; 2) local health facility staff to serve as resource persons to deliver sex and age-appropriate information on sexual and reproductive health in schools; and 3) parent-teacher associations to educate parents and teachers on adolescent sexuality.
- Specific to providing continuing assistance to local partners, there are important interventions that could contribute to sustainable results such helping in the accreditation of health facilities, e.g. LMC as an FP Training Center, and replicating their good practices in other similar health facilities; and assisting in the supply chain management of FP commodities to avoid stockouts and ensure the timely delivery of FP commodities to health facilities.
- In five years, conduct an evaluation on the impact of reproductive life planning and FP counseling with adolescent clients to provide a larger body of evidence on its effectiveness and transformative outcomes.
- Segment SBCC sexuality messages according to the parents' generation, e.g., baby boomers, Gen X, and Gen Y, to effectively advocate action to promote FP and ARH. Consider the parental factors that contribute to adolescent pregnancy, such as the need for attention and guidance from parents.
- Work with Adolescent Friendly Facilities to broaden the reach of teen-friendly services (dental, career counseling services, others) to encourage use of the facilities for both sexually and non-sexually active female and male adolescents.
- Use the findings of the GEWE assessment to develop gender transformative SBCC messages, particularly in changing negative social norms that promote gender inequality and disempower women and adolescents. Recognize and reinforce their increased abilities after FP use to make independent FP-related decisions.
- Scale-up *Konektado Tayo* for parents to help reduce pregnancy, in collaboration with parents-school associations and with the Family Development sessions under the 4Ps (Pantawid Pamilyang Pilipino Program).

TB:

- Conduct a case study of Taguig as a model health center for replication and scaling up in other high-burden TB communities, following its unique and pioneering good practices such as the creation of lab aides and TB Task Force at the barangay, and full LGU support in actively finding, treating, and curing marginalized groups of men and women, and their good practices in counseling and tracking TB cases.

- Consider replicating the Come Alive/Be Alive training program as a high-impact TB intervention in line with the IP's TB Roadmap framework. Enhance the program with the inclusion of gender-responsive and culture-sensitive content (e.g., removing perceptions of stigma that disempower women, addressing the low health-seeking behavior of men, who have a higher risk for TB than women).
- Include women's empowerment in TB counseling, including joint responsibility in TB treatment, sharing of household work to reduce women's workload, and misperceptions that limit women's opportunities, e.g., women should not work when they have TB.
- Mobilize women who recover from TB to play the role of effective partners in the treatment process of other women patients, and as companions in overcoming difficulties during the treatment journey, as it can empower others to follow their lead.
- Provide women who recover from TB the empowering opportunity to take part in advocacy and social mobilization activities.

<u>CBDR</u>:

- Counseling or motivational interviewing in CBDR needs to include the ability to deal with GBV among female PWUD. Develop partnerships with referral networks that provide GBV services.
- Identify and capacitate empowered and recovered female PWUD as champions to educate and advocate against illegal drug use.
- Embark on communications research to design and adopt gender-sensitive and data-informed SBCC approaches to destigmatize PWUD, especially women, who experience greater stigma and discrimination.
- As part of the IP support for the PWUD livelihood programs, assist partner LGUs to develop sustainable marketing strategies to support women PWUDs' livelihood activities, such as the monthly *Tabo* (fair) supported by LGUs.

<u>Data Quality for Gender Indicators:</u>

- For USAID OH
  - As USAID develops gender-responsive projects, there is a need to ensure that GEWE is integrated starting from conceptualization and design, with clear and explicit transformative objectives and performance measurements that are embedded in the IP's M&E databases.
  - As online social media as an advocacy and demand generation was not identified as a source of information in the interventions assessed here, there is a need for research and evidence-based approaches in developing targeted SBCC strategies for GEWE.
- For USAID IPs
  - USAID IPs need to exercise due diligence in complying with USAID DQA requirements for sex and gender disaggregation of all people-level indicators in progress reports and the PITT, as mandated by USAID gender policies. IPs should also comply with the USAID gender guidance in the PIRS on data collection and reporting of gender data for GNDR 6 and GNDR 8.
  - Reflect details from the GNDR-8 IRS from USAID Washington as well as the actual data sources in the PIRS.

- Work in collaboration with DOH, on how to capture data of people with diverse sexual orientation, gender identity and expression and sexual characteristics (SOGIESC) from data source forms, such as attendance sheets (by creating a data item for gender identity) and WPCU reports in health facilities.
- Include data management diagrams for each indicator in the Activity Monitoring, Evaluation, and Learning plans.
- Regularly report sex disaggregation in the progress reports and PITT to meet the USAID gender guidance in the PIRS on data collection and reporting of gender data for GNDR 6 and GNDR 8.
- Ensure that the data are validated for duplicates and incomplete information before they are reported in the progress reports.
- Work with LGUs and other government agencies in developing information systems with relevant fields to capture disaggregation specified in the PIRS.
- Explore other data sharing systems and develop password-protected templates.

1. INTRODUCTION

1.1. Background

In FY 2021, the USAID Office of Health conducted a multi-year whole-of-project evaluation of the Health Project for 2018–2021, which included health care programs in family planning (FP), adolescent reproductive health (ARH), tuberculosis (TB), and community-based drug rehabilitation (CBDR), as well as two cross-cutting themes—health systems strengthening (HSS) and gender equality and women's empowerment (GEWE). The whole-of-project evaluation findings showed that the Health Project implementing partners (IPs) had adopted and implemented innovative health interventions in all the assisted health programs, increasing men's and women's access to health services. A recurring finding, however, among most of the IPs is that they aspired to deliver gender-transformative outcomes, but they have yet to show concrete transformative results from their activities. More specifically, the IPs wanted to demonstrate how health activities contribute to GEWE outcomes and how changes in social norms that advance GEWE lead to increased or better health outcomes for women, men, and adolescents in project sites.

Toward this end, USAID tasked the Collaborating, Learning, and Adapting for Improved Development activity (CLAimDev) to conduct an evidence-based assessment on how the Health Project's interventions from selected activities resulted in GEWE outcomes and how the involvement of women, men, and adolescents as beneficiaries of USAID programs increased women's agency (defined as the ability to act independently and make life choices). This may be seen through women and girls having greater accountability for the outcomes of their actions and increased control of their lives.

For this assessment, CLAimDev examined how the following IPs and their respective interventions and activities contributed to or resulted in GEWE outcomes that focus on women's empowerment over the past year (FY 2021–2022 from October 1, 2021–September 30, 2022).

1. ReachHealth and its family planning/adolescent reproductive health (FP/ARH) activities
2. RenewHealth and its CBDR activities
3. TB Platforms and its TB activities

In addition to the gender assessment of these selected activities, the USAID Philippines Office of Health tasked CLAimDev to conduct data validation of the following gender indicators and other indicators associated with the selected GEWE initiatives of USAID activities in FY 2021–2022, using available data from these IPs.

1. GNDR 6 (Number of people reached by a U.S. government (USG)-funded intervention providing services against gender-based violence (GBV) (e.g., health, legal, psychosocial counseling, shelters, hotlines, among others)
2. GNDR 8 (Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations)
3. Number of new FP acceptors
4. Number of adolescent girls who accessed ARH services
5. Number of community health workers (CHWs) trained under the Come Alive/Be Alive Program

6. Number of people who use drugs (PWUD) who participated and completed CBDR services.

1.2. Gender Issues in FP/ARH, TB, and CBDR

1.2.1. FP/ARH

- The Responsible Parenthood and Reproductive Health (RPRH) Act poses challenges to ARH in denying adolescents access to FP without parental consent. Sex is a taboo topic in traditional households, and parents do not discuss sex with their children for two key reasons: their children are too young, and such discussions are "too vulgar and embarrassing." [2] As RPRH Law has closed access to FP among adolescents, assistance to them comes late because they access the adolescent-friendly facilities when already pregnant or about to give birth.
- The high maternal mortality ratio has been a persistent problem among women of reproductive age. Maternal deaths in the country are most prevalent among poor Filipino women with low educational attainment. Moreover, adolescent pregnancies contribute to maternal deaths. In 2019, the Philippines registered 177 maternal deaths in the 10 to 19 years old age group.[3]
- There is a high prevalence of adolescent pregnancy and high adolescent birth rate at 54.8 percent among those ages 15-19.[4] Early childbearing is higher among girls with lower educational attainment (elementary education at about 32 percent) and who come from lower income households (lowest quintile at approximately 15 percent).[5] Teen mothers are less likely to complete high school, are more likely to live in poverty, and have children who frequently experience health and developmental problems.[6]
- Three important delays prevent women and adolescent girls from accessing health care. Poor maternal health outcomes are not only due to economic and human-resource concerns, but also to socioeconomic and other interwoven factors, including gender issues. The three delays are in 1) deciding to seek care (lower status of women compared to men, fear of being ill-treated in the health facility); 2) identifying and reaching the health facility (cost, distance); and 3) receiving adequate and appropriate treatment (disrespectful care and abuse).[7]
- The lack of information about reproductive health and contraceptives increases the risk of unintended pregnancy for adolescents and young women.[8] While many factors contribute

[2] Kiesel, R. and E. Rottach. *The Fade-Away Effect: Findings from a Gender Assessment of Health Policies and Programs in the Philippines*. Washington, DC: Futures Group, Health Policy Project, 2014.
https://www.healthpolicyproject.com/pubs/345_FORMATTEDPhilippinesGPMReport.pdf

[3] Department of Health, RPRH Annual Report 2021.

[4] Save the Children, *Global Childhood Report 2021: The Toughest Places to be a Child*.
https://www.savethechildren.org/content/dam/usa/reports/advocacy/2021-global-childhood-report.pdf

[5] Philippine Statistics Authority (PSA) and ICF, *Philippines National Demographic and Health Survey 2017*. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF. 2018.
https://psa.gov.ph/sites/default/files/PHILIPPINE%20NATIONAL%20DEMOGRAPHIC%20AND%20HEALTH%20SURVEY%202017_new.pdf

[6] Department of Health, *RPRH Annual Report 2021*.
https://doh.gov.ph/sites/default/files/publications/2021%20RPRH%20Annual%20Report.pdf

[7] Kiesel, R. and E. Rottach. *The Fade-Away Effect: Findings from a Gender Assessment of Health Policies and Programs in the Philippines*. Washington, DC: Futures Group, Health Policy Project, 2014.

[8] Ibid.

to teen pregnancies, the role of parents is an important social determinant to prevent them. Parents' education is key to reducing teen pregnancy.

1.2.2. TB

- TB cases were found to be twice as common among males as females (65 percent vs. 35 percent.)
- Men, especially daily wage earners, have difficulty accessing TB services; most facilities' operating hours overlap with working hours.[9]
- Men and women have different exposures to TB due to type of employment and risk factors
- Men and women may experience TB stigma differently and may have differing levels of knowledge on treatment options. Gender norms push men to be "macho" and strong. Men fear the stigma and loss of work that would come with a positive TB diagnosis. Both often lead to delays among men in seeking care.
- TB patients with special health needs from marginalized groups (e.g., LGBTQI and people with disabilities) may experience poor patient care, inadequate and inefficient health services, stigma, and discrimination in health facilities.

1.2.3. CBDR

- Women who use drugs experience greater stigma and shame than men who use drugs. These women receive less social support, and are more vulnerable to violence and abuse that can lead to drug use. They tend to have a partner who plays a role in their drug use initiation, continuation, and relapse. They are also more likely to have mental health issues and have a greater likelihood of comorbidity.[10]
- Childcare becomes a barrier to the treatment of female PWUD when they do not have access to childcare support. The effects of drug use become more complicated for pregnant women, especially when they are incarcerated.[11]
- Family factors play a role in the use of drugs by female PWUDs, such as having a male partner who is also a PWUD.[12]

[9] Health Project Appraisal Document, USAID/Philippines, 2017.
[10] Health Project Mid-Term Whole of Project Evaluation, USAID, 2022.
[11] Ibid.
[12] Ibid.

2. PURPOSE OF THE STUDY

The objectives of this assessment are divided into two parts:

Part 1 is an in-depth gender assessment that seeks to:

- Identify the significant constraints and gender equality issues confronting women and adolescents in obtaining FP, ARH, TB, and CBDR services from local health facilities and the actions to address the issues and constraints.
- Assess the enabling factors and critical interventions that contributed to the dimensions of empowerment[13] of women and adolescents who obtained FP, ARH, CBDR, or TB services from selected local government unit (LGU) health facilities that received technical support from ReachHealth, RenewHealth, and TB Platforms.
- Identify opportunities in the household and community to initiate gender transformative approaches to change social norms and institutional practices that contribute to gender inequality and disempowerment of women and adolescents.

Part 2 is a data validation activity that focuses on the following objectives:

- Validate gender-related activities associated with the selected GEWE initiatives that ReachHealth, BARMMHealth, TB IHSS, TB Platforms, and RenewHealth report for FP, ARH, TB, and CBDR, following USAID's data quality standards, and document compliance with these standards.
- Identify and document the challenges and enabling factors in data collection, monitoring, reporting, and verification and develop recommendations to address data collection challenges.

To support the above objectives, we conducted separate site assessments of USAID-funded activities in FP, ARH, TB and CBDR, focusing on women and adolescents who are direct beneficiaries of these programs. Specifically, this report presents our findings by project sites in Sindangan, Zamboanga del Norte for FP; Sta. Cruz Laguna for ARH; Taguig City for TB; and Cagayan de Oro for CBDR.

The assessment study was conducted from August 2022–April 2023.

[13] Women's empowerment dimensions include decision making, access, and control over resources, division of labor, time use, and leadership.

3. ANALYTICAL FRAMEWORK

For the Part I (gender assessment) objectives, the study adopted two analytical frameworks: the Reach–Benefit–Empowerment (RBE) framework and the Project-level Women's Empowerment Index.[14] The International Food Policy Research Institute developed the RBE framework and the Project-level Women's Empowerment Index.

The RBE framework is a tool that helps clarify project objectives and strategies that "*reach* women as participants, such as by including them in program activities; those that *benefit* women by improving their circumstances in some way; and those that *empower* women, by strengthening their ability to decide and carry out strategic life choices."[15] RBE is an approach for the study of women's empowerment which is not only an important development objective in itself but also has been shown to have strong connections to women's health and nutritional status and that of their children. The RBE operates from the assumption that simply reaching women does not ensure they will benefit from a project. Even if women benefit (e.g., from increased income or better nutrition), that does not ensure that they will be empowered (e.g., having control over that income or making choices or decisions for their households) or that gender transformative changes are achieved.

Figure 1 presents the RBE framework with examples of project objectives and implementing strategies for each component. The *reach* component of the framework is premised on a general gender awareness/sensitivity that considers gender issues and barriers to participation, but with no expected action to address the issues. Under the *benefit* component, the approaches are assumed to be gender-responsive because activities directly address gender issues and benefit women, men, and adolescents. Under the *empower* component, the approaches are ideally gender transformative and target changes that support or result in greater GEWE. An innovative approach that our gender assessment added to the RBE framework is the use of a reference point (before and after obtaining services and deriving benefits for FP/ARH, TB and CBDR services), and comparing changes in women's and adolescents' abilities, perceptions, and practices.

As a supplement to the RBE framework, the research adopted the women's empowerment dimensions in the Project-Level Women Empowerment in Agriculture Index (Pro-WEAI) tool, as applied to the health sector, to analyze gender issues related to empowerment. The Pro-WEAI measures women's empowerment in various projects, mostly in agriculture, health, and nutrition. For health projects, the empowerment dimensions include decision making in FP, ARH, TB care, and CBDR, access to and control over resources such as FP commodities, health facilities and services, division of labor into productive and reproductive roles, time use and workload, and leadership (having a voice in group meetings and community activities), and how these dimensions are reflected in the RBE components.

[14] Malapit, et al. (2019). Development of the project-level Women's Empowerment in Agriculture Index (Pro-WEAI). World Development.

[15] Reach-Benefit-Empower-Transform (RBET) Framework. CGIAR Gender Platform. (n.d.).

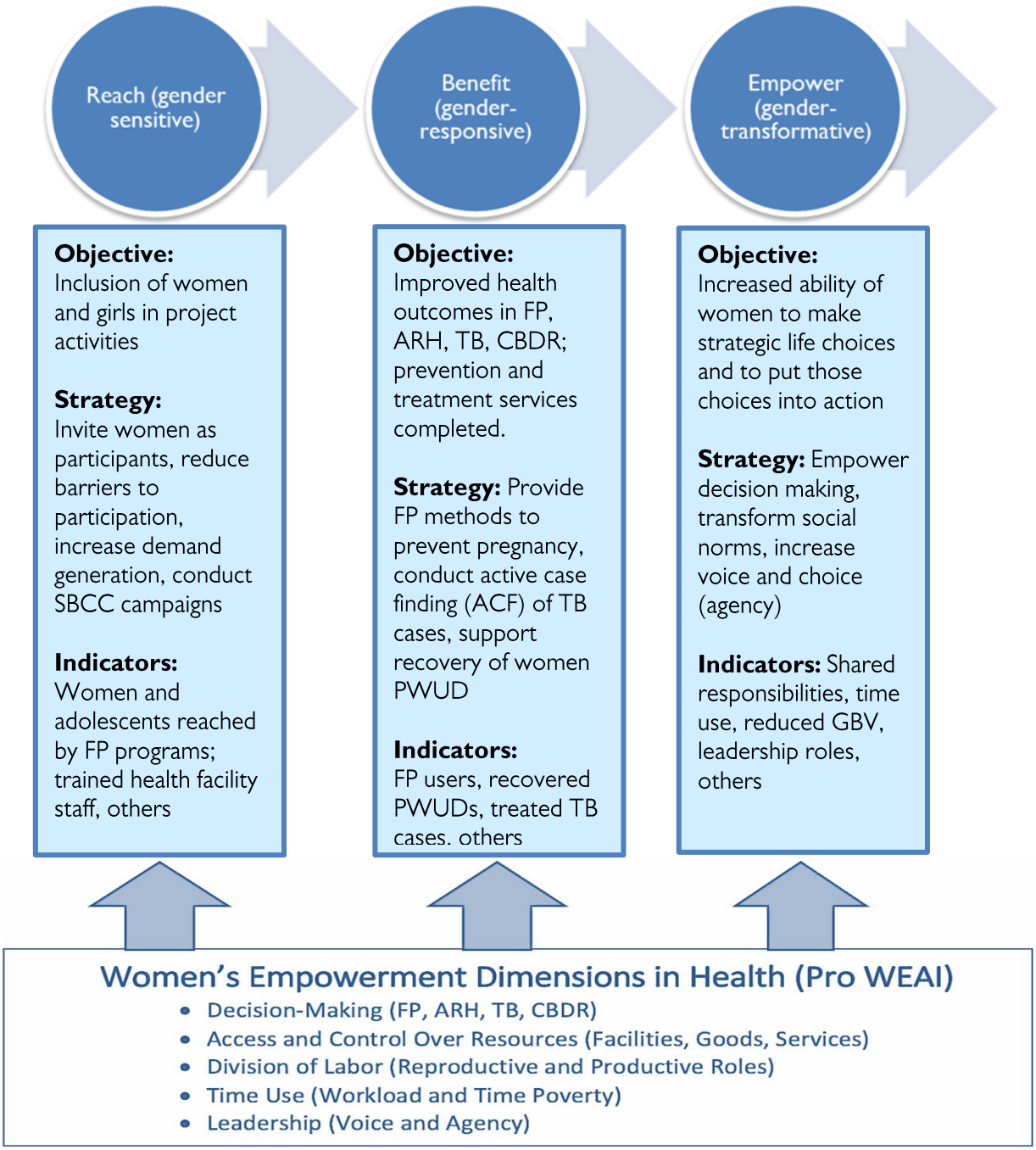


Figure 1. Nexus of Reach–Benefit–Empower Framework and Women's Empowerment

4. METHODS AND LIMITATIONS

4.1. Part 1 Gender Assessment

4.1.1. Data Collection

The data collection methodology used qualitative and quantitative research methods, using primary sources to validate the data gathered, which included: 1) in-depth face-to-face interviews with the women patients/clients; 2) focus group discussions (FGDs) and key informant interview (KIIs) with health facility staff; and 3) KIIs with local IP staff in the project sites. The study also conducted desk reviews of secondary data, including gender analyses by the selected IPs, gender action plans and annual reports, USAID annual performance reports, Health Project performance evaluation reports, and review of related literature and studies that focus on the empowerment of women and girls in FP, ARH, TB, and CBDR.

4.1.2. Sampling and Inclusion Criteria

Under Part 1 primary data collection, we used specific inclusion criteria in the purposive sampling of women respondents who obtained FP, ARH, CBDR, and TB services in selected health facilities in the USG sites. Local health facilities helped identify and contact the women in coordination with the local IP staff of ReachHealth, RenewHealth, and TB Platforms, as well as local partners. During the KIIs, the research team also validated with the interviewees whether they actually received the health services in the local health centers/facilities that the IPs partnered with. We conducted the interviews mostly in the health facility, with some interviews done in the communities, such as the interviews related to CBDR. In some interviews, such as with the adolescent respondents, the research assistants in tandem take turns in taking care of the babies so that the interviewees can focus on the research questions. The research team aimed to interview a maximum of 15 women and girls who were 18-45 years old for each of the programs (FP, ARH, TB, and CBDR), for a maximum of 60 interviewees.

4.1.3. Site selection criteria

We selected sites based on the following:

1) Sindangan Municipality in Zamboanga del Norte has a rural health unit (RHU) that has been conducting a community theater on FP for each of the 52 barangays for the past three years as a demand-generation strategy. The play depicts real-life experiences regarding FP. After the play, a community *usapan* or discussion follows, with an FP Caravan providing FP counseling and FP services/commodities for new and old FP users. The uptake of modern FP methods has reportedly risen in this municipality.
2) Laguna Medical Center is one of the best functioning health facilities in Laguna Province that has provided FP in hospital[16] services for postpartum women of reproductive age and ARH, including services to teenage mothers for the past five years.

[16] Family Planning in Hospitals, Good Practices and Promising Interventions Series, Panagora Group. May 2020

3) Oro Citizen's Wellness & Development Center of Cagayan de Oro implements the Anti-Drug Abuse Council (CADAC)'s programs and coordinates CBDR services for PWUD in several city barangays. According to the CADAC head, the CBDR has female clients who have completed CBDR services and actively participate in community activities.
4) For TB, the research team, in collaboration with TB Platforms, selected communities that implemented the Come Alive/Be Alive program (i.e., training of barangay health workers [BHWs], called lab aides) and active case finding (ACF) activities. For Taguig City, the TB program ranks first in the National Capital Region in terms of its accomplishments.

4.1.4. Interview Guide Questions

The study developed three interview guides per site: one for in-depth interviews with female respondents for FP, ARH, TB and CBDR; one for FGDs with the health facility staff; and one for KIIs with the local staff of the IPs. The three interview guides enabled the research team to triangulate the data obtained from these sources.

- ***Questions for Women Interviewees***

The RBE framework guided the formulation of the in-depth interview questions. **Table 1** shows the different topics covered under each component. **Annex E** presents the formatted interview guide questions in English and language of the project sites (Tagalog and Bisaya).

Table 1. Interview Topics

Demographic Profile of Interviewees: name (optional), sex, age, address, marital status, education, occupation, religion, number of living children, spouse's/partner's age, occupation, and education.
Reach: Participation in the FP, ARH, TB, or CBDR activities of IPs and LGUs:

- Why, when, and where FP, ARH, TB, and CBDR services were obtained (e.g., health status before accessing services)
- How they received the information about the health services (channels of communication, e.g., social and behavior change communications materials, social media)
- What information was provided for women of reproductive age, for adolescents (FP methods to prevent pregnancy, during pregnancy, and post-partum, if RH commodities are provided free), for TB patients, and for PWUDs
- Activities participated and specific services accessed in the past years for FP, ARH, TB, and CBDR. If interviewees were adolescents, whether they availed of the services of Adolescent Friendly Facilities and services provided.
- Challenges, issues, and problems faced by interviewees related to participation and accessing services for FP, ARH, TB, and CBDR, including post-abortion care, GBV services.
- Who decided and who accompanied the interviewees to obtain health services, who provided the health service in the health facility
- If the interviewees were CHWs, services they provided and where they provided the services

Table 1. Interview Topics

(e.g., at home, barangay health station), including specific services provided to adolescents to prevent pregnancy
- For TB and CBDR, if treatment/rehabilitation was completed, and who the other members of the families were who also availed of the screening/rehabilitation (e.g., children, husbands)
- Satisfaction rating of the services obtained (using a scale of 1-10) and reason(s)

Benefit: Effects of the FP, ARH, CBDR, and TB interventions:
- Observed changes and health outcomes after participating and obtaining FP, ARH, TB, and CBDR services
- Increased well-being of the interviewee (self-perception of wellness)
- Challenges and how these were addressed
- Reduction of stigma and discrimination (especially for TB, CBDR, ARH, and LGBTQI clients)
- GBV and services obtained from the community (e.g., police station women's desk, hospital women and child protection unit, Department of Social Welfare and Development, NGO, helpline, etc.)
- Strategies used to address other challenges

Empower (defined in Filipino as *kakayahang gawin at sundin ang sariling desisyon*), compared the actions and perceptions of the women interviewees before and after obtaining services in FP/ARH, TB and CBDR, in three areas:
- ability to make decisions and act on the decision
- changes in perceptions of social norms, beliefs, and practices
- changes in perceptions of women's voice and choice, using a Likert scale of 1–5 (Strongly Disagree to Strongly Agree). Some of the Empowerment questions were adapted from the "Practical Guide to Measuring Women's and Girls' Empowerment in Impact Evaluations."[17]

The assessment considered the following:
- Ability to make strategic life choices and act on them: deciding when to have children, what FP methods to use, going to the health center on their own, remaining drug-free, to go for TB screening and treatment, engaging in livelihood, among others.
- Improved communication and relationship with the spouse or partner in household management of family; shared responsibilities, resources, care, and discipline of children.
- Overcoming difficulties in implementing choices/plans (e.g., returning to school, finding a livelihood, limiting the number of children and subsequent pregnancies; for CBDR interviews, discontinuing use of prohibited drugs/staying clean from substance abuse).
- Making own decisions and overcoming areas of disempowerment: Other persons/people (spouse/partner/relatives) controlling and making decisions for the interviewees in FP and RH choices, using financial and other resources, and GBV experienced by the interviewees.

[17] J-PAL. A Practical Guide to Measuring Women's and Girls' Empowerment in Impact Evaluations, Appendix 1. Examples of Survey Questions Related to Women's Empowerment.

- ***Questions for the Health Facility Staff and Local IP Staff***

Before the interviews with the key informants, the research team interviewed the local project staff of the IPs to gather information about the programs and activities where the women and adolescents were involved, and the assistance provided by the IPs to the health facilities. To triangulate the information, the research team also interviewed the local facility staff at the RHUs, barangay health station, and CBDR facility on the assistance that the IP provided to them (e.g., technical assistance, training of healthcare providers and facility staff).

4.1.5. Research Team Training and Pre-Testing

We conducted a data collection and processing workshop for the research team prior to data collection. The research team is composed of the senior consultant/team leader; two junior consultants for the GEWE and data validation components, respectively; and six research associates to cover the four sites. Because of the nature of the research study on the empowerment of women and girls, the senior consultant/team leader, who is a gender and development specialist, also conducted gender training prior to data collection to ensure that the research team members were gender aware/sensitive to women's empowerment issues and constraints. During the workshop, the research team conducted pretesting of the interview guide questions for the gender assessment, which resulted in the redesign of the questions to better capture empowerment experiences and perceptions before and after the project interventions.

4.1.6. Ethics Review Approval

Because of the sensitive nature of the questions about women's experiences with the health programs, especially with perceived stigma attached to ARH, TB, and CBDR, the study sought approval from the St. Cabrini Medical Center–Asian Eye Institute Ethics Review Committee prior to the start of field data collection. The committee also reviewed and approved the informed consent form, which was in English and local languages (Tagalog and Bisaya).

4.1.7. Data Analysis

Guided by the RBE framework, the study used a combination of analysis of frequency distribution, percentage analysis, comparison of Likert mean scores, and content or thematic analysis of all the data sources, including in-depth interviews, FGDs, and KIIs. We applied this approach to the data analysis of FP, ARH, TB, and CBDR.

Specific to the empowerment questions, we analyzed the mean scores in the Likert scale using a reference point by comparing the changes in perceptions before and after obtaining services for FP/ARH, TB and CBDR. To support the mean score analysis, we analyzed the percent change in responses of women interviewees ~~key informants~~ across the Likert scale using the same reference point. We used the findings of the thematic analysis, and comments and quotes from the women interviewees

to further explain the findings. The research team conducted a week-long data analysis write shop to capture on-site observations and brainstorm on findings from the field interviews. To ensure that the identities and other pertinent personal information of the participants were safeguarded at all times, the names of the interviewees were anonymized.

On the empowerment questions, the standard deviations in both before and after reference points are below two points, which means that the responses are closer to the mean scores and are therefore more precise. The majority of the women interviewees or respondents gravitated toward the end points of the 5-point Likert scale where number 1 represents strongly disagree and 5 is strongly agree; therefore, we conducted a percentage analysis of those who strongly agreed and those who strongly disagreed. Because of the small sample size per site, we also showed the actual number out of the total number of respondents, together with the percentages in the comparative analysis to show a clear picture of the findings.

Following the RBE framework, we examined the evidence and manifestations of women's empowerment in three parts. For FP and ARH, we used the same scale to measure the changes before FP use and after FP use.

- *Part 1 measured the changes in perceptions on decision making and women's ability to decide on:*
  1) FP use—when to have children, when and what FP methods to use, continuing use of modern FP, limiting the number of children, or postponing subsequent pregnancies.
  2) Sex practices—asking their husband/partner to use protection whenever they have sex, refusing to have sex if the husband or partner does not want to use a condom.
  3) Going to the health center—asking the husband/partner to go with her for medical check-ups or prenatal/postnatal care; going on her own without the husband's permission.
  4) Access to resources—use of family income for her needs (transportation to clinic, medicines) and use of her own income for her own needs without telling her husband.

- *Part 2 measured the changes in perceptions of prevailing social norms, beliefs, and practices using statements relating to:*
  1) Reproductive roles and responsibilities—having the sole responsibility to avoid pregnancy; obligation to have sex even if the wife does not want to; taking a passive role by asking her husband for permission to use birth control devices; and dedicated focus of a wife to take care of their children and not work outside the home.
  2) Keeping the family together—forgiving a cheating husband to keep the family intact; women reconciling with their husbands first after a fight or argument about FP to maintain peace in the household.
  3) Use of FP outside of marriage—opinion on use of FP by non-married women; access to free RH services; stricter control over daughters than sons.

- *Part 3 measured changes in perceptions of women's voice (ability to speak out), and choice (ability to select options in given situations) using statement relating to:*

1) Right to express her opinion—having the final say on disagreements about FP because she bears the child; expressing disagreement with what her husband is saying about FP; contradicting her husband in public when he presents incorrect information about FP.
2) Sharing responsibilities at home—asking husband/partner to share responsibilities and workload at home; men's participation in child rearing; men's willingness to sacrifice their own well-being for financial provisions.
3) Violence against women—whether it is justifiable for a drunk husband to hit his wife.

For TB and CBDR, we adopted a slightly different approach to measure the women's ability to make their own independent decisions to be screened and treated. Part 1 examined the recovered TB and CBDR respondents' ability to make decisions around screening, visits to the health center, getting and completing treatment, encouraging and bringing their families to be screened for TB or CBDR, sharing household responsibilities while on treatment, how they spend their free time, and joining organizations. Unlike Part 2 and 3 that measured changes in perceptions before and after TB treatment or CBDR rehabilitation, Part 1 is a retrospective analysis of their actual abilities and experience in the whole regimen of TB treatment.

4.2. Part 2 Data Validation of Selected Gender Indicators

Alongside the in-depth interviews for the GEWE analyses, the Junior Consultant for data validation and CLAimDev's health data management and analysis specialist conducted a data validation (DV) activity of standard gender indicators and the indicators/data associated with the GEWE initiatives of selected IPs covering Q1–Q3 FY 2022. **Table** 2 shows the indicators covered by the data validation activity and the IPs that report on them.

Table 2. Gender Indicators and Other Indicators Associated with GEWE Interventions, by Implementing Partner

Health Project Activity/IP	Indicators
ReachHealth	GNDR-6: Number of people reached by a USG-funded intervention providing GBV services (e.g., health, legal, psychosocial counseling, shelters, hotlines, other) GNDR-8: Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations Number of new FP acceptors Number of adolescent girls who accessed ARH
BARMMHealth	GNDR-6: Number of people reached by a USG-funded intervention providing GBV services (e.g., health, legal, psychosocial counseling, shelters, hotlines, other) GNDR-8: Number of persons trained with USG assistance to advance

Table 2. Gender Indicators and Other Indicators Associated with GEWE Interventions, by Implementing Partner	
Health Project Activity/IP	**Indicators**
	outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations
TB Platforms	GNDR-8: Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations Number of CHWs trained under the Come Alive/Be Alive Program[18]
TB Innovations	GNDR-8: Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations
RenewHealth	Number of PWUD who participated and completed CBDR services.

To understand previously documented data quality challenges and develop appropriate data collection tools, the DV team reviewed the quarterly progress reports of IPs for Q1–Q3 FY 2022, Activity Monitoring, Evaluation, and Learning (AMEL) plans, performance indicator reference sheets (PIRS), and performance indicator tracking tables (PITT). Based on the results of the desk review and using USAID data quality assessment (DQA) checklist questions as a guide, the DV team developed guide questions to validate gender-related data according to the five data quality standards of validity, integrity, precision, reliability, and timeliness. From December 2 to 13, 2022, the DV team conducted online KIIs with the identified IPs (see **Table 1**) to clarify/validate insights from our desk review and requested the source documents/means of verification for the above GNDR indicators. The KIIs focused on the data management and reporting systems of the IPs and their compliance with USAID's data quality standards. Because IPs report information that their partners submit, the DV team also conducted online field interviews[19] with the following IP local partners:

- ReachHealth partners: Sindangan RHU in Zamboanga del Norte (December 19, 2022) and Laguna Medical Center in Santa Cruz, Laguna (January 12, 2023).
- BARMMHealth partners: Basilan Integrated Provincial Health Office (December 20, 2022) and Lamitan City Health Office (CHO) (December 16, 2022).
- TB Platforms partner: Taguig CHO (January 12, 2023)
- RenewHealth partner: Oro Wellness and Development Center (OWC), Cagayan de Oro City (December 16, 2022)

[18] According to TB Platforms, the number of CHWs trained under the Come Alive/Be Alive program is not part of their AMEL plan indicators.

[19] We conducted field visits in the following areas to validate initial findings of the interviews: Laguna Medical Center, Taguig CHO, and Oro Citizens Wellness and Development Center.

After conducting the interviews, the DV team compared the selected indicators data from various sources such as IP progress reports, PITTs, source documents as well as internal IP databases (e.g., validated database of trained health workers). This verification process checked for data consistency across reporting platforms and databases and data consistency across time (i.e., from Q1–Q3 FY 2022). Using the updated USAID DQA checklist, the DV team triangulated the findings from the desk review and KIIs with the review of the means of verification. Based on the review of the information gathered using tools from the updated DQA checklist, the DV team ascertained the concurrence of the data management systems and indicator data of IPs with USAID's data quality standards. We also proposed actions to address identified data challenges. The DV team will conduct an after-action review of the gender data validation findings and recommendations in tandem with the dissemination session of the findings of the GEWE assessment.

4.3. Profiles of the Implementing Partners

- ReachHealth (2018–2024) is the implementing partner for the FP program of Sindangan RHU to help achieve its objectives of reducing unmet need for family planning services and decreasing teen pregnancy and newborn morbidity and mortality. ReachHealth strategies include: 1) improving individual, household, and community knowledge and behaviors of FP and maternal and neonatal health; 2) increasing access to comprehensive quality care, including lifesaving maternal and newborn services; 3) increasing the capacity of providers to deliver quality care; and 4) strengthening functionality of health systems across governance, finance, human resources, commodity availability, and data.

- RenewHealth (2019–2024) is the implementing partner for the CBDR program of OWC to help achieve its objectives of expanding access to quality community-based drug rehabilitation and encouraging voluntary drug demand reduction in the Philippines. The strategies for implementation include: 1) helping PWUD and their families access informal care, self-help, or community-based treatment and recovery support without fear or prejudice; 2) enhancing capacity of communities to deliver, sustain, and scale up CBDR services; and 3) supporting the creation of evidence-informed and culturally appropriate social and behavior change communications (SBCC) and CBDR interventions.

- TB Platforms (2018–2023) is the implementing partner of Taguig LGU to help achieve its objective of improving the health behaviors of individuals and communities to prevent, detect, and treat TB; improving TB service delivery in Region III, IV-A, and National Capital Region; and strengthening the capacity to manage TB programs at LGUs and within service delivery points. TB Platforms' strategies, based on USAID's TB Roadmap Framework, are the following: 1) Reach: expand TB case finding activities; 2) Cure: support facility-level patient-centered care; 3) Prevention: strengthen infection, prevention, and control practices through Come Alive/Be Alive; and 4) Self-reliance: capacitate health workers and LGUs to scale up implementation of TB interventions.

4.4. Limitations of the Assessment

General Limitations:

1. A review of the IP documents showed that women's empowerment was not a targeted objective in the design of the selected projects. Consequently, the adopted gender-related indicators mainly measure participation (the *reach* component of RBE), such as number of persons trained or number of persons who accessed services. There were no explicit metrics to measure women's empowerment. This posed a challenge and limitation in linking or attributing women's empowering experiences—such as the increased ability of women to make their own decisions, and the small but visible transformative changes in women's perceptions relating to gender equality—to the assistance IPs provided to the health facilities.
2. The findings from this in-depth study cannot be generalized to other women beneficiaries in similar health programs, given the small sample sizes (9–17 women interviewees per site). Nonetheless the qualitative content analysis of the women's experiences provides useful insights for designing future women's empowerment activities.
3. Other enabling factors contribute to women's empowering experiences, posing a challenge in teasing out the extent of correlation between women's increased empowerment and the technical assistance and services provided by the IPs. Other enabling factors include strong LGU support, as was found in Sindangan (FP), Taguig (TB) and Cagayan de Oro (CBDR), and presence of highly dedicated and committed health facility staff who ensure the complete treatment and recovery of their patients.
4. For the DV component, we did not conduct client-level data validation because of data privacy concerns pertaining to the women interviewees in the gender assessment component. Instead, the DV team reviewed source documents and compared them with IP reports and internal databases. Additionally, we did not validate data on the participants trained; rather, the DV team relied on attendance sheets.

Specific Limitations

1. With respect to the specific project sites, the assumptions for site selection did not hold for all sites. For example, for FP in Sindangan, the community theater has not yet resumed since the COVID-19 pandemic; therefore, the study findings linking women's empowerment experiences may not be attributable to the community theater's contribution primarily but may be more directly linked to the overall ReachHealth assistance to the RHU.
2. For ARH, unlike in other sites, we did not pre-select interviewees because the local ReachHealth staff had left the project, and the research team had to rely on available hospital staff to select qualified interviewees based on their availability. Hence, out of 15 teen mothers interviewed, three were dropped because they did not meet the inclusion criteria.
3. Another limitation is the physical discomfort of the adolescent respondents who had just delivered their babies. We addressed this by ensuring the interviewees lay down on the bed with their newborn babies with them. Most of the time, the research team took care of the babies to enable the teen mothers to focus on the interview questions. Because of the long questionnaire, which took about one hour to complete, some of the teen mothers experienced interview fatigue.

4. For TB, the research team changed the inclusion criteria of at least one year of complete treatment and recovery to six months (or less than six months for three interviewees). The time duration after recovery was not found to be a significant factor in the empowerment of recovered TB patients.
5. For CBDR, only nine female PWUDs were interviewed because of the limited number of qualified women interviewees with at least one year of rehabilitation. Most of the interviewees had been in the CBDR programs for less than six months, so the study reduced the duration of rehabilitation in the inclusion criteria. In addition, the majority of the respondents were not familiar with OWC and thought that the research team was from the Philippine Drug Enforcement Authority, resulting in low trust of interviewers and reluctance of interviewees to share information initially, though this improved as the interview progressed. Another factor was that RenewHealth's assistance was at the facility level (OWC), and not at the barangay level. Finally, we belatedly found that more respondents could have been reached had we coordinated directly with the barangay CBDR managers who were trained by RenewHealth, and who were the implementers of CBDR.
6. Two out of the nine female PWUDs were not actual drug users but were mistakenly included in the Philippine National Police/Philippine Drug Enforcement Authority watch list, and they were required to join the CBDR to clear their names. They were not deleted from the set of interviewees because their experience with CBDR turned out to be helpful and positive.
7. The CBDR team had to re-translate the formal Bisaya version of the in-depth interview questions into more conversational Bisaya to help interviewees understand the questions. This entailed more time, effort, and interview fatigue on the part of the research team and the interviewees.

5. REVIEW OF RELATED LITERATURE

There are few studies on women's empowerment that link access to services and benefits to empowerment. We found four studies that provided strong evidence that a number of enabling factors directly contributed to women's empowerment, including (1) benefits from services by trained health workers; (2) access to FP and the opportunities to women that resulted after FP use; and (3) quality ARH services in adolescent-friendly centers and the role of family, parents, and school as influencers in educating and guiding their children in healthy sexuality (not taking risks, or reducing risks). One of these studies also showed that the lack of access to resources affected women's ability to recover from substance abuse. Most of the findings of this GEWE assessment resonated with the research findings from other countries' experiences in empowering women after their involvement in the FP/ARH, TB and CBDR programs.

5.1. Family Planning

According to a study by Countdown 2015 Europe, about 222 million women in developing countries are not using modern contraception, despite wanting to avoid pregnancy, because of the unavailability and lack of accessibility of family planning commodities and services. It posited that with the ability of FP to empower women and girls in various spheres such as the household, community, school, and labor force, FP is perceived to be a tool for social change.[20] This finding is reinforced in a study conducted by Sangar, who found that because of FP, women are able to arrive at informed decisions on whether and when to have children and reduce unintended pregnancies. Moreover, the result of using FP methods paved the way for women to have better educational and economic opportunities. Finally, as women get exposed to using FP commodities, they tend to make empowered choices on childbearing, which result in investing more on their children's education and aid in poverty alleviation.[21]

5.2. Adolescent Reproductive Health

A qualitative study conducted by Alimoradi et al. with eight KIIs looked into the empowerment of adolescent girls in sexual and reproductive health (SRH) care. The study hypothesized that the reinforcement of sexual and reproductive knowledge, life skills, spirituality, and ethics, as well ass responding to adolescents' concerns, will achieve the desirable reproductive and sexual self-care of adolescent girls. The study found that adolescents receiving SRH services, especially in adolescent-friendly centers by trained providers, contribute highly to the empowerment of adolescents in terms of sexual self-care.

[20] Countdown 2015 Europe. Fact sheet 2012: Family planning saves lives and improves health. Retrieved from https://www.countdown2030europe.org/storage/app/media/IPPF_FactSheet-4_Health.pdf

[21] Sangar, S. (2018). Bringing a women's perspective to family planning. *Current Science*, 115(4), 633–637. https://www.jstor.org/stable/10.2307/26978270

The study also presented the importance of the family and schools as the main institutions responsible for educating adolescents on sexuality. Mothers in particular play a crucial role in providing education on SRH issues to their children. The participants in the study also believed that families have a great influence in the formation of sexual and reproductive behaviors of adolescents, and that parents can best help their adolescent children reduce the possibility of taking risks by improving their parental control. Schools have the capacity to design and provide educational content on SRH and train teachers to deliver this.[22]

5.3. Tuberculosis

The World Health Organization and the Stop TB Partnership released a report in 2007 on empowering TB patients. This is the only study that we found on this topic. Data were not disaggregated by sex, so the findings apply to both males and females. According to the report, the first factor that heavily contributes to the empowerment of TB patients is helping them improve their capacity to better take control and care of their lives – for example, by helping them understand and be aware of the diagnostic process and proper treatment, educating them to choose a health facility and provider who will assist them deal with problems resulting from the illness. Support from peers, who serve as allies, also empowers other TB patients. Patients and those who recover from TB can be effective partners in the treatment process of other patients as well as companions in overcoming difficulties during the treatment journey. Finally, giving TB patients the opportunity to take part in advocacy and social mobilization activities empowers them as well by providing a means to present a positive image for persons affected by TB and how TB care and treatment are being organized.[23] In the Philippines, the *LusogBaga* (healthy lungs) group, which is an organization of TB patients and cured patients, provides peer support for treatment and actively partakes in national fora like the Country Coordinating Mechanism (for the Global Fund project) and the Philippine Coalition against TB.[24]

5.4. Community-based Drug Rehabilitation

A study looked into the factors that influenced the empowerment of women in terms of recovery from substance abuse.[25] The study included a total of 296 women who lived in recovery homes in the United States. The research questions focused on measuring women gendered and cultural empowerment, knowledge of resources in the community, participation in community activities and helping behavior, and on assessing their leadership behavior. Among these measures, the study found that the lack of access to and unavailability of knowledge resources affect women's ability to recover from substance abuse. This finding is supported by what the empowerment theory suggests that when women have access to resources, they are more likely to have a more critical understanding of their environment and

[22] Alimoradi, Z., Kariman, N., Simbar, M., & Ahmadi, F. (2017). Empowerment of Adolescent Girls for Sexual and Reproductive Health Care. *African Journal of Reproductive Health / La Revue Africaine De La Sante Reproductive*, 21(4), 80–92. https://ajrh.info/index.php/ajrh/article/view/1286

[23] Macq, J. (2007). *Empowerment and involvement of tuberculosis patients in tuberculosis control: Documented experiences and interventions* (pp. 1–36).

[24] Ibid.

[25] Hunter, et. al. (2012). Factors of Empowerment for Women in Recovery from Substance Use. *American Journal of Community Psychology*, 51(1-2), 91–102. https://doi.org/10.1007/s10464-012-9499-5.

situation. On the other hand, skills building and understanding of causal agents are also important in women's recovery and eventually contribute to their empowerment. For women recovering from substance abuse, this study underscores the importance of their knowledge of available resources to their overall empowerment, and how access to these resources results in a domino effect in their empowerment as members of the community. [26]

6. FINDINGS FROM THE GENDER EQUALITY AND WOMEN'S EMPOWERMENT ASSESSMENT

While the research team aimed to interview a maximum total of 60 interviewees for all the programs (FP, ARH, TB, and CBDR), the actual number of interviewees reached was 53, as shown in **Table 3**.

Table 3. Location Sites for Primary Data Collection

USAID Activities	Programs/Inclusion Criteria	Number of Interviewees	Location
ReachHealth	FP: Women of reproductive age who accepted and are still using long- or short-acting FP methods for at least one year from a health facility supported by ReachHealth.	17	Sindangan Rural Health Unit, Sindangan, Zamboanga del Norte
	ARH: Female adolescents (aged 18-19) who have obtained FP and ARH services (e.g., teenage pregnancy counseling, hospital delivery, postpartum care) for at least one year, from an LGU health facility supported by ReachHealth.	12	Laguna Medical Center, Sta.Cruz, Laguna
TB Platforms	TB: Female patients who received TB counseling in the past 12 months from the CHWs trained by the Come Alive/Be Alive program supported by TB Platforms. At a minimum, the female patient must have availed of TB screening, tested positive for TB, and completed treatment.	15	North Daang Hari Health Center, Taguig City

[26] Ibid.

Table 3. Location Sites for Primary Data Collection			
USAID Activities	**Programs/Inclusion Criteria**	**Number of Interviewees**	**Location**
RenewHealth	CBDR: Female PWUD who have participated in and completed CBDR services (e.g., barangay counseling, after-care support, others) for at least one year and are not currently enrolled in drug rehabilitation programs.	9	Oro Wellness and Development Center, Cagayan de Oro City
	Total Interviewees	53	

During data processing, we found that the differences in the Likert mean scores were generally marginal, with small changes in perceptions before and after the interventions in FP, ARH, TB, and CBDR. While the changes may be small, the data showed visible changes in perceptions and increased abilities of the women respondents in decision making. We hypothesized that the project interventions are critical enabling factors toward women's empowerment.

We present the findings from the GEWE assessment by project sites and programs, following the RBE framework.

6.1. Family Planning

HIGHLIGHTS:

Reach:

- Prior to their pregnancy, the majority of the FP users had no exposure to FP for pregnancy prevention.
- Overall, women had a positive experience using FP methods and services, and level of satisfaction with services was high.
- The perceived good services of the RHU increased demand generation for FP more effectively than the community theater for FP.

Benefit:

- Benefits were mixed: women had increased overall well-being and risk protection from unintended pregnancy; but FP access had the unintended consequence of reducing their ability to refuse their husbands for sex
- Knowledge gained in FP increased their agency as a woman.
- The overall client satisfaction of benefits was high.

Empower:

- After FP use, the FP respondents increased their ability to make independent FP-related

decisions—i.e., when to have children, FP methods to use, limit and postpone pregnancy.
- The FP respondents increased their confidence to express their opinions on FP and a high level of confidence to share FP use with others.
- There is a visible link between benefits derived and perceptions of women's empowerment among FP users.

6.1.1. Background

Profile of Sindangan RHU

Sindangan is a first-class coastal municipality in Zamboanga del Norte with a population of 104,156 in 52 barangays. The RHU has two doctors, eight nurses, and 16 midwives; 343 BHWs in 50 barangay health stations; three birthing clinics; and one infirmary that is open 24/7. Services include pre- and postnatal care, provision of FP methods (pills, Depo-Provera shots, implants) including after-birth services, immunization (including COVID-19 vaccines), and medico-legal services for cases of violence against women.

Sindangan is the second highest in the province in the number of teen pregnancies for the 15–19-year-old girls in Grades 11–12. As an Adolescent Friendly Facility, the RHU provides counseling to prevent teen pregnancy, serves as teachers in the Department of Education's (DepEd) Comprehensive Sexuality Education, and Sex and Drug Education for Grades 7–12, and assists teens to access to FP commodities (condoms, pills) through school clinics, with no parental consent required. Parents, however, usually provide consent to prevent a second pregnancy.

Many RHU patients are women in their early 20s, with age typically ranging from 17-44 years; have high school-level education and an average of four children. Most are members of 4Ps (Pantawid Pamilyang Pilipino Program), a national conditional cash transfer program. The majority of the RHU clients are self-employed as fish and food vendors, with incomes ranging from P250-300 per day. With respect to health care, major problems that patients cited include lack of transportation to go to the RHU (among women from remote areas, who are only reached by BHWs on foot); their reliance on unqualified doctors for treatment and traditional birth attendants (*hilot*) for deliveries; and stockouts of long acting FP commodities, resulting in women buying their own supply, such as pills and condoms, adding to their financial burden.

The Sindangan Community Theater started from FP *Usapan* sessions[27] three years before the onset of the COVID-19 pandemic but was stopped and has not resumed. The community theater depicted real-life experiences in a play on FP in all 52 barangays, with full support by the LGU and its mayor. The mayor, who has made FP one of the LGU's priority programs, helped develop the script based on his personal experience with his mother who died at childbirth because she could not be brought to the hospital from her remote residence. After the presentation of the play, a community *Usapan* session followed, together with an FP Caravan where all FP methods were presented, explained, and offered to new and current FP users. The RHU reported that the uptake of modern FP methods increased after

[27] USAID/Philippines, Introduction to the *Usapan* series, Facilitator's Guide, September 2014.

each community theater, reaching more than 600 FP users, with implants (Implanon) being the most popular method.

ReachHealth provided the following technical assistance to the Sindangan RHU:

- Together with the LGU, supported the community theater to increase demand for FP.
- Developed RHU capacity by training health care providers, including training of trainers (two organic staff per RHU with return demonstration of what they learned to other health providers); training of nurses (including insertion and removal of implants); and training of health facility staff on the 4Rs (recognizing, reporting, recording, and referring) of women and children who are victims of abuse.

Other ReachHealth assistance included enhancing *Usapan* after the community theater; providing COVID-19 support; reporting of data for the field health service information system; assistance with licensing of birthing facilities for Philippine Health Insurance Corporation (PhilHealth) accreditation; installing continuing quality improvement for RHU (use of Smiley rating scales to assess services); delivering commodities to avoid stockouts; and providing information, education, and communication (IEC) materials, such as tarps, FP wall chart, among others.

6.1.2. Socio-demographic Profile of FP Users in Sindangan

- The gender assessment included in-depth interviews with 17 women who are FP users and served by the Sindangan RHU and its barangay health stations. All the women are regular FP users of the RHU's reproductive services, with the majority accessing prenatal services every three months prior to delivery. The FP respondents were on average 32 years old, with more than half (9 of 17; 53 percent) in the 19-30 age group, and the rest in the 31-50 age group (8 of 17, 47 percent). The youngest was 19 years old and the oldest was 50. The majority (7 of 17; 41 percent) have elementary education; 5 of 17 who have high school level-education, and 5 of 17 have a college-level education. About three-fourths (13 of 17, 76 percent) were married, and the average number of children was 2.53, with 11 of 17 having one to two children.
- Most respondents (11 of 17; 65 percent) are housewives with no occupation; 6 of 17 are employed/self-employed, as food and fish vendors, mostly below the minimum of P350 per day. In terms of religious affiliation, the majority are Catholics (10 of 17; 59 percent) and 41 percent are born-again Christians.
- Among the husbands/partners, 15 of 17 (88 percent) are employed or self-employed, but the majority earn below the minimum level of P350 per day. Women with unemployed husbands/partners said that they were forced to work to support their families.

6.1.3. GEWE Findings on *Reach* of FP Interventions

- Most of the patient respondents had prenatal care at the barangay health stations, with four to six visits (35 percent), and seven to nine visits (47 percent), and went to the health centers by themselves. Others said they were accompanied by their husbands or mothers. Midwives tended to

most of the women at the health centers. Only a few women, however, go for postnatal visits that are timed with the immunization of their infants.

- Current FP methods used are pills, Depo-Provera, and implants at 29 percent each across users. Only 11 percent of the women used an intrauterine device (IUD). Most of the FP users (82 percent) obtained their information about FP from the RHU staff and barangay health station as part of their counseling, and some from their neighbors. None mentioned participation in the community theater as their source of information, possibly because this event has not been resumed since the COVID-19 pandemic. The women in the study also did not cite social media as a source of FP information.
- Prior to their pregnancy, most women interviewed had no exposure to FP for pregnancy prevention. Among those who heard about FP, 5 of 17 (29 percent) heard about FP from marriage counseling seminars that are required for marriage, and from 4Ps seminars.
- The main reasons women cited for using FP include their desire not to get pregnant, not to have many children, and the convenience in using long-term reversible methods (Depo-Provera-Provera, implants, and IUD). Others mentioned that the use of FP will enable them to access opportunities for employment and schooling. One woman stated that she already has enough children, and her use of FP is an entitlement. The majority of the women mentioned that they did not have any health issues during their pregnancy because of their frequent prenatal clinic visits, but for those who had issues, some experienced mainly symptoms of nausea and dizziness. One woman mentioned emotional stress because of her abusive and alcoholic husband who beat her up even when she was pregnant.
- Their main challenges in FP use included stockouts of FP commodities and added expense to buy their own FP supplies. Another challenge is the distant location of the RHU and cost of transportation which is exacerbated when they find that the doctor is not available for consultation.

6.1.4. GEWE Findings on *Benefits* from FP Interventions

- With reference to the benefits that the women received after using FP, the majority said that their overall well-being improved, such as having a better appetite and gaining weight (positive result), no menstruation (an issue for most women), and peace of mind knowing that they have protection from FP use.
- The women appreciated their learnings about FP that related to preventing pregnancy; obtaining good FP services from the RHU with available and helpful staff who provide them with counseling on FP and using FP methods; and accessing free FP commodities and services.

6.1.5. Level of Satisfaction with FP Interventions

- The study measured the level of satisfaction with the FP services and benefits that the women received from the RHU. On a scale of 1–10 (10 being the highest), the respondents gave the Sindangan RHU a high overall rating of 9.24 (with a range of ratings from 6–10) under the REACH component and another equally high rating of 9.29 under the *benefit* component (with a range of rating from 5–10, with the majority—12/17—rating the RHU at 10).

- The enabling factors that contributed to these ratings are the services of the RHU staff, who were cited for their "efficient, good and helpful service," the effectiveness of the FP methods with no side effects, support by their husbands/partners, and the post-partum house visits of BHWs, or house visits after a miscarriage. The only issue stated by the women was the stock-outs of FP commodities (Depo-Provera-Provera was not available for almost two years), and their added personal expense for contraceptives to avoid unintended pregnancies.

6.1.6. GEWE Findings on *Empowerment* from FP Interventions

Below are the highlights of the findings on women's empowerment in FP, based on the comparison of Likert mean scores before and after FP use, frequency distribution and percentage analysis of responses across the Likert scale, and supplementary content analysis from all the data sources, including the in-depth interviews, FGDs, and KIIs. The differences in the Likert mean scores were generally marginal, with small changes before and after the use of interventions in FP, ARH, TB and CBDR. While the changes may be small, the data show visible changes in perceptions and mindsets on the empowerment statements. We hypothesized that the project interventions are critical enabling factors toward women's empowerment.

Part 1. Changes in perceptions on decision making and women's ability or agency

The findings under Part 1 showed changes in perceptions and in the ability of women to make FP decisions before and after FP use, based on statements that depict women's empowerment in **Figure 2**. The highlights are presented below:

- On FP use
  - More women (14 of 17; 80 percent) strongly agreed that they have the increased ability to make their own decisions on family planning after use of an FP method—when to have children, when and what FP methods to use and continue to use, and to some extent, the ability to limit the number of children or postpone pregnancy, compared to women before FP use (12 of 17; 70 percent). One respondent explained her empowering experience—that initially, her husband used to be the one who decided for her to obtain FP services. After using FP, she is now able to decide on her own when to use FP methods and which one. The mean scores in **Figure 2**, even if the differences are small before and after FP use, are consistent with these findings.
  - Most respondents felt that family planning had a positive impact on themselves and their lives, as shown by the FP users' overall level of satisfaction of benefits rated at a high 9.29 out of 10 points. This finding showed a direct empowerment link with the benefits they received from the RHU and barangay health stations (BHSs).
- Sex practices
  - More women after FP use (13 of 17; 76 percent) perceived that they have the ability to ask their husband/partner to use protection whenever they have sex, compared to before FP use (11 of 17; 64 percent), showing positive changes in perception after FP use.
  - Whether before or after FP use, there was a strong agreement among the women on their perceived ability to refuse to have sex if the husband or partner does not want to use a condom. However, there was a slight change in their perception after FP use (10 of 17; 59

percent), compared to before FP use (11 of 17; 65 percent), with the women citing that the use of FP methods gave them protection, resulting in their reduced ability to refuse their husbands.

- Visiting the health center
    - Before FP use, more women (15 of 17; 88 percent) perceived that they have the ability to ask their husband/partner to go with them for medical check-ups, prenatal and postnatal. Interestingly, after FP use, the number of women asking their husbands to go with them decreased to 76 percent, because the women decided to go to the RHU and BHS by themselves.
    - Another finding is that 12 of 17 (70 percent) of the women strongly agreed that they can decide to go to the health center without asking permission from anyone before and after FP use. More women after FP use however, ask permission from the RHU before deciding to get their FP supplies (due to stockouts) or ask someone to look after their children while they are gone.
- Access to resources
    - More women after FP use (53 percent) are able to decide on the use of their own income for their own needs without telling their husbands, compared to before FP use (47 percent). Increased access to resources is an important dimension of women's economic empowerment.
    - There are no comparative changes in perceptions on their ability to use the family income for women's needs (transportation to clinic, medicines) before or after FP use, because most of the women have no sources of income.

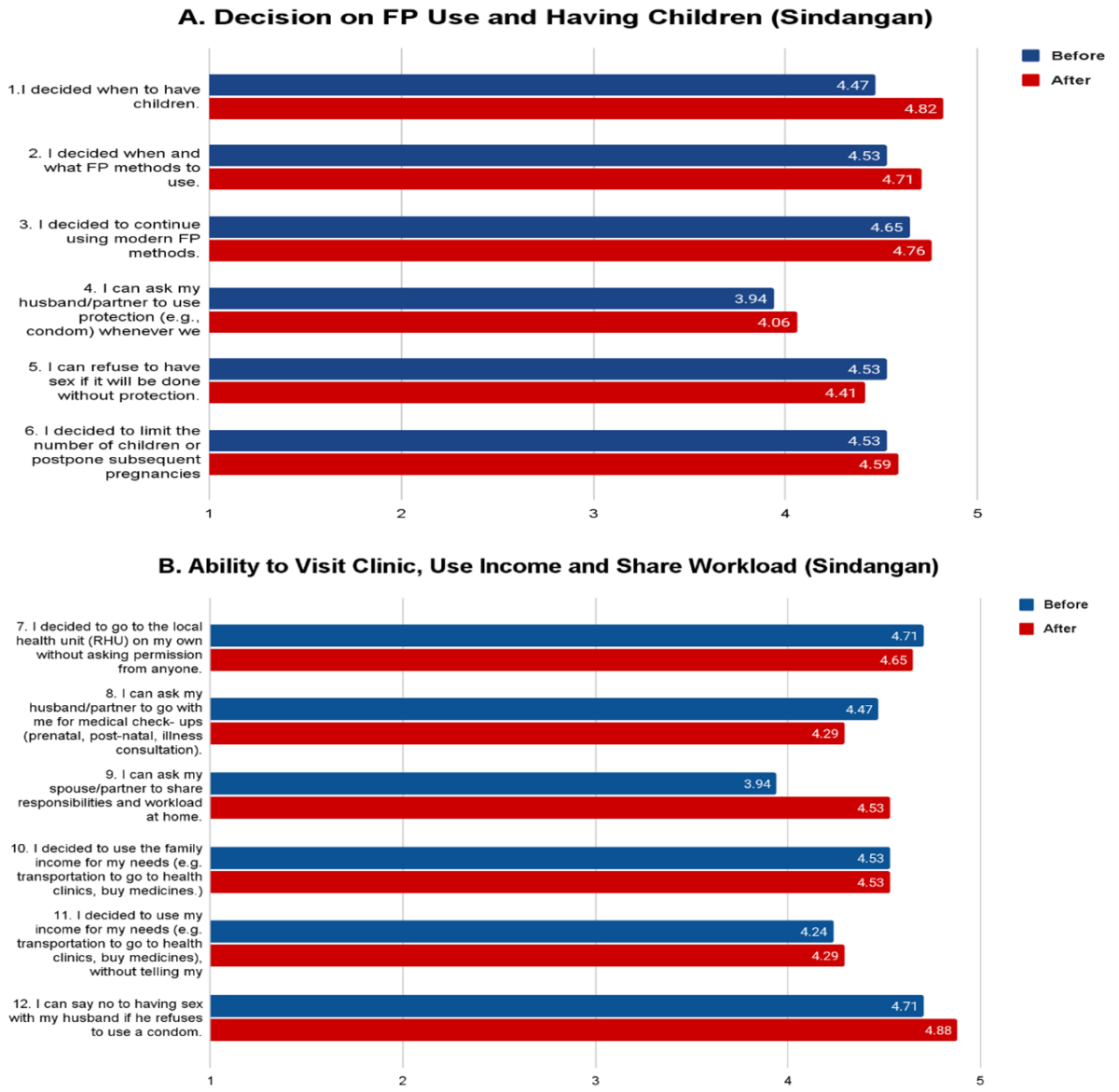


Figure 2. Part 1: Changes in Perceptions on Decision-making and Women's Ability (FP) Likert Mean Scores (n = 17)

Part 2. Changes in perceptions of social norms, beliefs, and practices

The findings under Part 2 show changes in perceptions in relation to normative beliefs and practices that are related to FP (**Figure 3**).

- Reproductive roles and responsibilities
  - Before FP use, 12 out of 17 FP users (70 percent) agreed that only women should be responsible for avoiding pregnancy. After FP use, more women (15 out of 17; 88 percent) agreed with this statement. When asked for the reason for the changed perception, the FP users said that this belief is reinforced by the FP services that mainly target women as the main

beneficiaries. This suggests that the normative approach of FP delivery as a "woman's issue" could backfire against women and discourage joint responsibility of women and men in pregnancy prevention.

- Similarly, 10 out of 17 women (59 percent) agreed after FP use that it is the wife's obligation to have sex with the husband even if she does not want to, as compared to before FP use (8 out of 17; 47 percent). They reasoned that because of FP use, they are protected and have less risk of pregnancy due to FP use.
- In terms of a woman's reproductive role in the family, 13 out of 17 women (76 percent) after FP use agreed with the statement that she should focus on taking care of her children, instead of working at home, as compared to before FP use (9 out of 17; 53 percent). The reason cited for the changed perception is that the husband is expected to support the family and the wife should stay at home and take care of the children. This reflects the prevailing social norm and the productive and reproductive divide between men and women.
- Before FP use, 15 out of 17 women (88 percent) perceived that they do not need to ask for their husbands' permission to get birth control devices. After FP use, however, only 65 percent agreed with the statement on not asking permission. This was because when there are FP commodity stockouts (e.g., Depo-Provera was not available for two years), they would need to get permission to buy pills using the income of their husbands/partners.

- Socially prescribed behaviors
  - There are entrenched perceptions of social norms and beliefs among FP users expecting women to keep the family to stay together. More women (11 out of 17, or 65 percent) strongly agreed after FP use, in contrast to before FP use (9 out of 17; 53 percent), with the statement that the wife should forgive a cheating husband to keep the family together. However, before FP use, 11 of 17 women (65 percent) believed that they should be the ones to reconcile with their husbands first after an argument, for the sake of peace in the family. This perception changed after FP use, with fewer women (7 out of 17; 41 percent) agreeing to the statement. While these issues may not be directly related to FP use, these findings reflect the continuing challenges that women face to conform with and transform harmful socially prescribed behaviors.
- FP use outside marriage
  - Another example of entrenched social norms relates to the use of FP outside marriage and the challenging access of adolescents to FP services. We found a positive shift in attitudes on this front: after FP use, 11 out of 17 women (65 percent) disagreed with the statement that it is wrong to use contraceptives if a woman is not married, compared to those who disagreed before FP use (7/17; 41 percent). FP counseling that FP users receive from the RHU may have contributed to a shift in attitude.
  - The FGD of Sindangan RHU also revealed that adolescents do get access to pills and condoms in school clinics even without parental consent after the RHU teaching sessions in DepEd's Comprehensive Sexuality Education. All the women in the FGDs also strongly agreed that if RH services are not free, they must be accessible and affordable.
  - Before FP use, 13 out of 17 women (76 percent) agreed with the statement that parents should maintain stricter control over their daughters than their sons. After FP use, there was a slight decrease (12/17; 71 percent) in this perception, possibly because of the FP users' exposure to counseling. Some women explained that they were generally stricter about

daughters to avoid teen pregnancy. One enabling factor cited in the FGD with the RHU staff is that the RHU partners with NGO parents' groups, such as the Zamboanga del Norte Federation of Parents Association, in their community outreach and health programs.

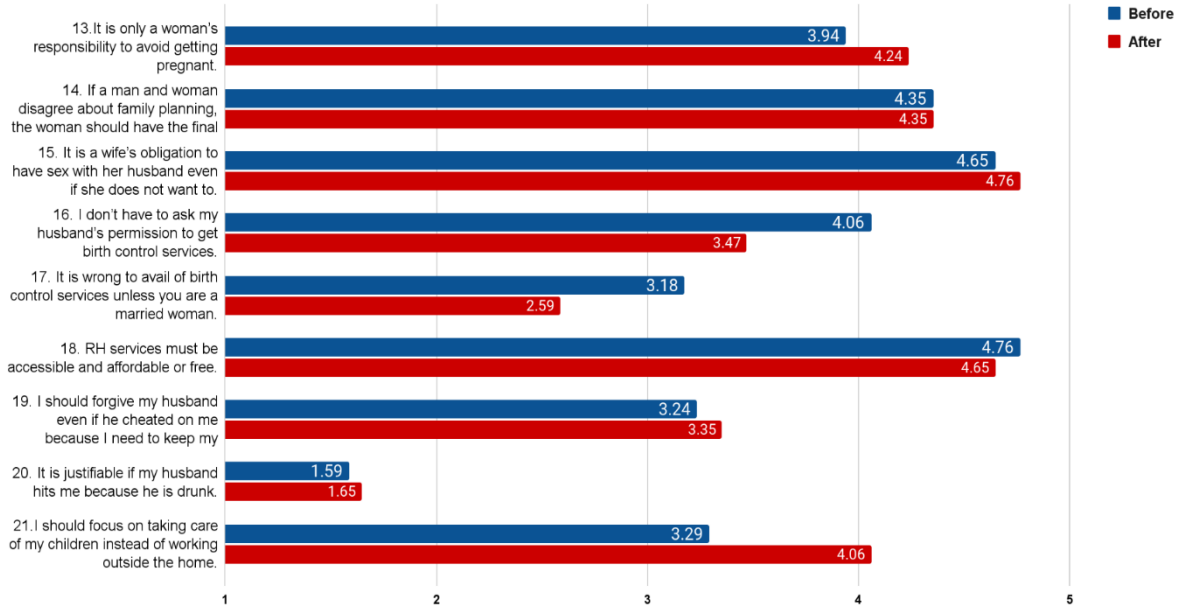


Figure 3. Part 2: Changes in Perceptions of Social Norms, Beliefs and Practices (FP) Mean Likert Scores (n=17)

Part 3. Changes in perceptions of women's voice and choice

We measured the changes in the perception of women on their ability to speak up, voice their opinions, and open choices to improve the domestic situation of women, using the reference point of before and after FP use (**Figure 4**). The highlights of our findings are presented below.

- Right to express opinion
  - Slightly more women after FP use than before FP use (13/17; 76 percent vs. 12/17; 70 percent) agreed that they have a right to express their opinion when they disagree with their partners about family planning. The knowledge they gained after FP use could have contributed to this finding.
  - Seventy-one percent (12 out of 17) of women agreed that a wife can contradict her husband in public about FP if he is saying incorrect information, but five women (29 percent) expressed that they would rather discuss their disagreements in private.
  - Slightly more women after FP use compared with women before FP use (15/17; 88 percent vs. 14/17; 82 percent), strongly disagreed that the woman should have the final say in disagreements between men and women about family planning simply because she bears the child.
- Sharing responsibilities at home

- More women after FP use, compared to women before FP use (15/17; 88 percent vs. 11/17; 65 percent) strongly agreed that they can ask their spouse/partner to share responsibilities and workload at home to help reduce their domestic work in the household. Sharing workload is one of the dimensions of women's empowerment that reduces women's time poverty.
- Before FP use, 16 out of 17 women (94 percent) strongly agreed that men should participate in child rearing and household chores rather than leaving all the domestic work to the women; after FP use, all women (100 percent) agreed with the statement. However, the respondents also said that they would rather take on the load because they are responsible for household work. More women (13/17; 76 percent) after FP use compared to before FP use (11/17; 65 percent) also strongly agreed that men should be willing to sacrifice their own well-being to provide financially for their families.

- Violence against women
  - The majority of the respondents disagreed that it is justifiable for their husbands, when drunk, to hit them. There were, however, slight changes in perceptions—15 of 17 (88 percent) women before FP use disagreed with the statement, compared to 14 of 17 (82 percent) after FP use. This finding may not be related to FP use, but for a few women who had a changed perception, this could reflect the norms on socially prescribed behaviors to keep peace in the family. One interviewee mentioned that "it is okay with her to sacrifice than to have a broken family." For the past 19 years, she had been beaten and maltreated by her husband when he was drunk. She had reported this violent behavior to the Department of Social Welfare and Development (DSWD) and the police, but she said that she could not pursue the case because of her children, and she is still hoping that her husband will change.
- Sharing knowledge on FP with others

  Another dimension of women's empowerment is leadership and membership in community organizations. We measured the ability of the women to share their knowledge on FP with other members in the community as well as their participation in organizations. Questions included whether the women's opinions were sought on important matters, such as access to FP services and commodities; level of participation in community activities; and their willingness to share their experience with FP use. Below are the findings:
  - After FP use, 8 of 17 women (47 percent) said that their opinions were sought by their female neighbors and schoolmates who asked about their experience with FP, including FP services in the RHU/BHS, use of FP methods and contraceptives (including Depo-Provera, pills, and implants), and their experience with sides effects.
  - Sixty-five percent (11 of 17) of women actively participate in community organizations and activities, including membership in church, joining religious activities such as Bible sharing in church, and attending meetings of women's association and savings associations. Most of the women are involved in planning and informing others about these meetings. One of these meetings with the BHW and the women's association was on the benefits of FP.
  - Just over three-quarters (13 of 17, 76.5 percent) of women expressed willingness to share their positive experience with FP in their barangay. Their reasons included raising awareness about FP, encouraging other women to use FP methods, and for others to experience the benefits she derived from FP use, such as having a better life and "not suffer from too much poverty."

- When asked to rate their level of confidence in sharing their experience, the weighted mean score was 9.71 on a 10-point scale.

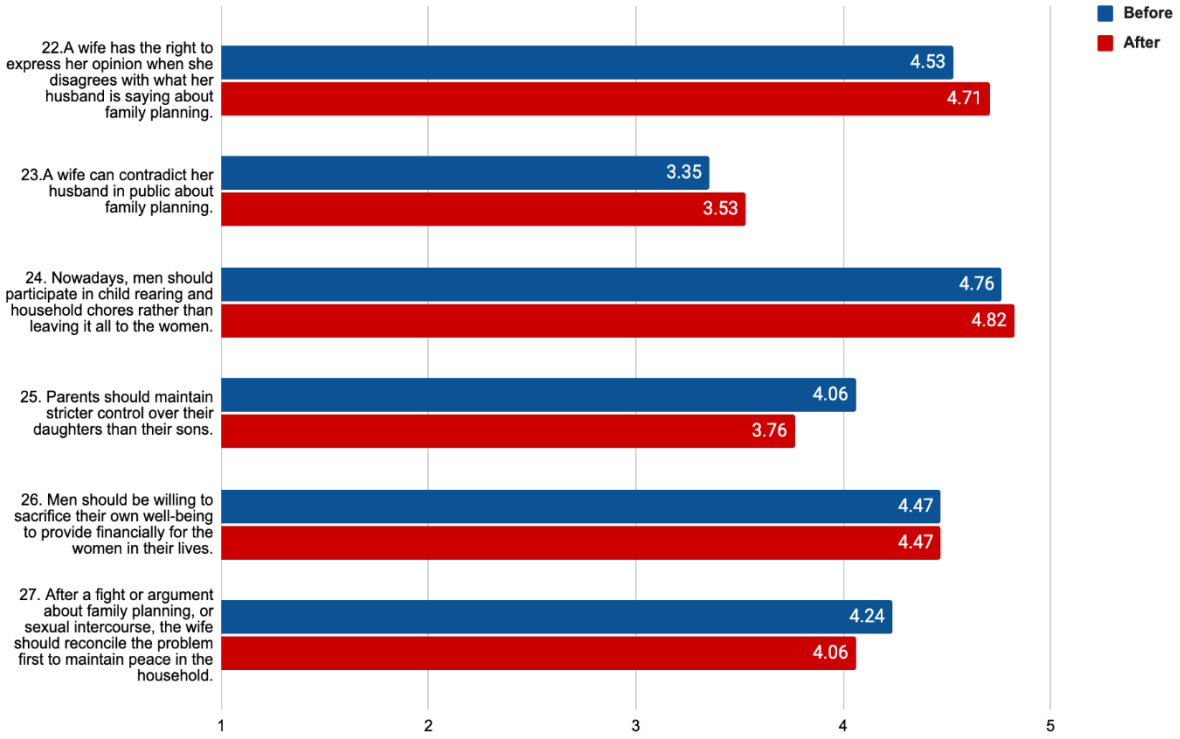


Figure 4. Part 3: Changes in Perceptions of Women's Voice and Choice (FP) Likert Mean Scores (N=17)

6.2. Adolescent Reproductive Health

HIGHLIGHTS

Reach:

- High level of satisfaction of the adolescent mothers with Laguna Medical Center's (LMC's) good quality service
- FP in Hospitals programs has been successful in preventing repeat pregnancies for teens
- Good FP practices with ReachHealth assistance resulted in a regional award for LMC for exemplary FP program and service delivery

Benefit:

- Increased well-being of teen mothers from FP counseling
- Increased knowledge on FP use and pregnancy prevention
- Increased agency to do reproductive life planning, allowing the teen mothers to "dream again"

Empower:

- Emerging positive shifts in perceptions of ability of teen mothers to make their own decisions to prevent pregnancy after benefiting from FP use
- Increased ability to decide on their own on FP methods to use
- Increased empowerment to refuse sex without protection. Even with low and marginal differences in the perceptions of adolescent respondents, emerging positive shifts were visible after FP use in their increased ability to make empowering decisions.
- On the part of LMC, empowerment means the achievement of their vision to be a Level 3 hospital and FP training center for Laguna.

6.2.1. Background

Profile of Laguna Medical Center

Laguna Medical Center (LMC) is a Level 2 provincial health facility with 150-bed capacity. It is considered an Adolescent-Friendly Facility that offers pre- and post-natal, dental, and nutrition counseling services, among others. It implements the FP in Hospitals program of the Department of Health (DOH), which includes postpartum use of long-acting reversible and permanent contraceptive methods (implants, IUDs, bilateral tubal ligation [BTL]). Prior to the implementation of the FP in Hospitals program in 2017, it only offered post-cesarean section and BTL services, and declined FP referrals due to the absence of FP-trained providers and had no purposive FP demand-generation activities. Two USAID activities—Luzon Health (2013–2018) and ReachHealth (2018–present)—helped strengthen the FP in Hospitals Program and Teen Parents' Clinic of LMC.

LMC received the following technical assistance from ReachHealth:

1. Competency training in FP methods (long-acting reversible and permanent contraceptive permanent methods, including implants, IUDs, and BTL);
2. Assistance in obtaining PhilHealth reimbursements for FP services (implants, IUDs, and BTL), which has generated P11 million for these services (from 2019 onwards);
3. Provision of IEC materials;
4. FP training on recording and reporting;

5. Training on 4Rs for GBV, and assistance in setting up the Star Room for cases of violence against women and children, and rape, and associated staff training; and
6. Assistance in working toward the accreditation of LMC as a FP Training Center.

In early 2023, DOH Region IV-A awarded LMC for Exemplary Family Planning Service Delivery and Programming for the entire Region IV-A, or CaLaBaRZon (Cavite, Laguna, Rizal, Batangas and Quezon), the second most densely populated region in the Philippines after the National Capital Region. This was made possible by LMC's good FP practices (described below), including its organized and structured reporting system that ReachHealth introduced which resulted in more effective and efficient validation of data and reports. The reporting system also uses a back-to-back joint digital and manual system of recording and reporting (as the system transitions toward computerization).

Among its good practices, LMC, with ReachHealth assistance, trained encoders to prepare Claim Form 4, which PhilHealth uses to evaluate and review applications for case rate claims. This contributed to faster filing of applications, freeing up the time of the doctors in preparing these forms (which used to be a bottleneck in the filing of claims), and resulted in speedy PhilHealth reimbursements. Additionally, participation in collaborating, learning, and adapting seminars on good practices in other hospitals enabled LMC to gain new knowledge that they applied to hospital operations.

LMC conducted continuous health education sessions for its patients using the television sets in the lobby and waiting areas with messages on good health-seeking behavior covering FP, ARH, sexuality, nutrition, sanitation, childcare, and other health topics.

Capacity building of staff also contributed to the continuous improvement of LMC's capacity to provide quality services. LMC acknowledged ReachHealth's efforts in advising them on useful and available training programs, reserving available slots for training, and checking on the number of trained staff to ensure continuous staff training.

Another good practice of LMC is the use of the Reproductive Life Plan (**Figure 5**) as an empowerment tool for adolescent counseling and demand generation. The tool is used for counseling pregnant teens in intake interviews and those who are not yet in active labor. By using this tool, which was developed by ReachHealth, the FP coordinators help teens to define their life goals (e.g., complete schooling, find work, have a career, earn decent income, and support their families) in relation to where they are at the present time as the reference point. The FP coordinators advise teen mothers on spacing childbirths in relation to their life goals. Through reproductive life planning, teen mothers recognize the need for long-acting contraceptives and are empowered to make decisions on their own.

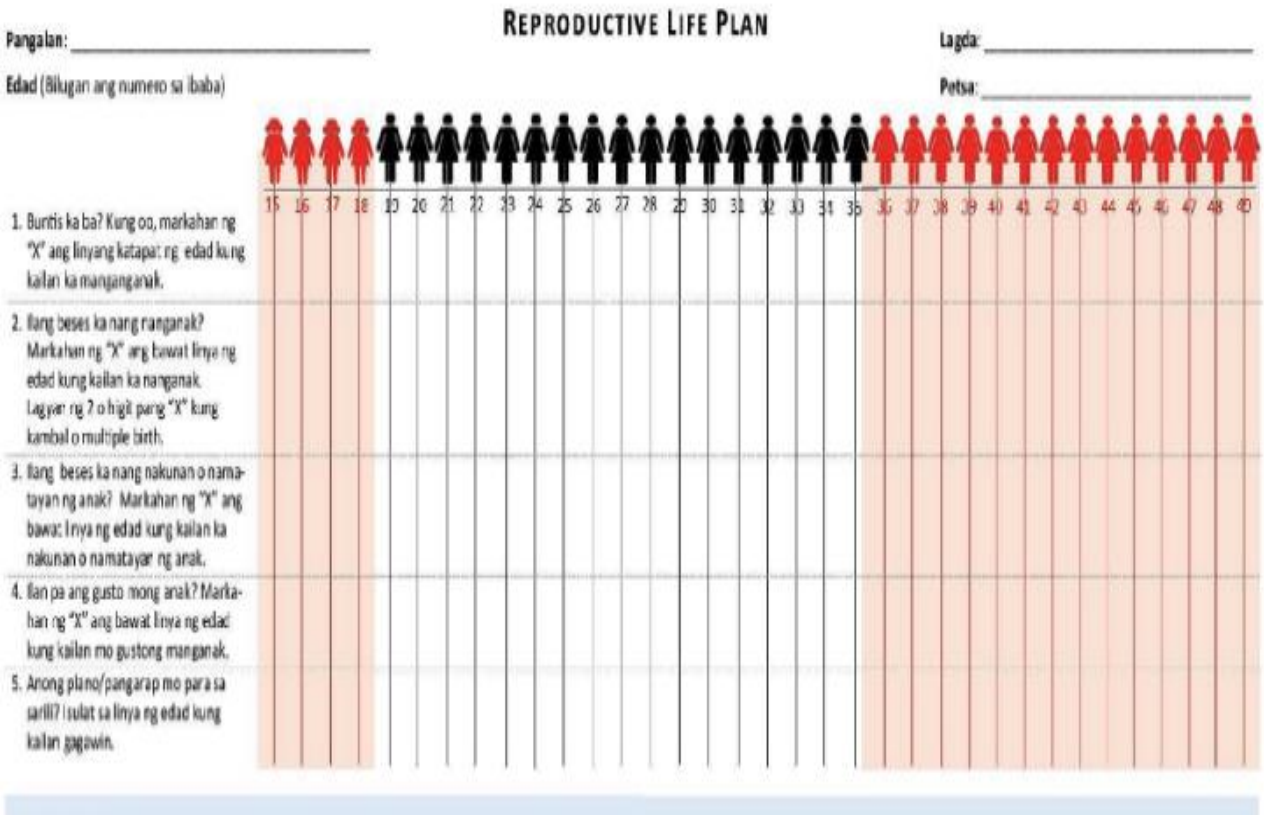


Figure 5. Reproductive Life Plan[28]

Despite its many good practices and enabling strategies that contributed to the success of LMC's health and ARH services, the hospital faced challenges with the change in hospital leadership in 2021, which was not as supportive as the previous administration. There were complaints from pro-life groups that LMC forced postpartum patients to accept FP methods, and not discharge them if they refused. Hence, the new leadership wanted to eliminate the FP in Hospitals program in LMC. ReachHealth assisted LMC by recommending the use of a logbook as documentary evidence to show the names of patients who accepted or did not accept the use of modern contraceptives. In addition, the new leaders were presented with a record of huge reimbursements from PhilHealth for its FP in Hospitals program, which amounted to P11 million (from 2019–2021). These actions enabled the FP program to continue in LMC.

Another challenge is that some parents did not support modern FP use, preferring the use of natural methods. After the postpartum FP methods (such as implants and IUDs) were inserted, these parents would bring their daughters (teen mothers) to other health facilities to have them removed. To address this problem, LMC asks the teen mothers to get their parents to accompany them for hospital visits and explain to them the benefits of more effective modern FP for the adolescent respondents.

A major public health issue faced by LMC is the increasing prevalence of teen pregnancies in Laguna province, with more pregnancies in younger age groups (16 years old and below). The youngest they

[28] Annex 5, Guide in Establishing Teen Parents' Clinic and Adolescent Friendly Services in Hospitals, USAID-RTI

have admitted was a 10-year-old girl who had menarche at 9 and was impregnated by a 15-year-old boy. In 2020, hospital admissions for adolescent delivery were at 14 percent; 19 percent in 2021; and 22 percent in 2022. During the fourth quarter of 2022, 9 percent of admissions were repeat pregnancies of teens, probably exacerbated by stockouts of long- acting FP commodities. The LMC policy mandates the acceptance of all birth deliveries, which, with rising adolescent birth rates, has led to a ratio of three mothers and their babies to one bed in the obstetrics ward (see **Figure 6**).[29]

Figure 6. Photo of Adolescent Mothers in Laguna Medical Center's Obstetrics Ward
(Photo credits: Taken by Fatima Verzosa with photo consent)

The FGD with the hospital staff of LMC identified areas of assistance to help strengthen their ability to provide adolescent-friendly services, including the following:

1. Continue providing technical assistance for the accreditation of LMC as an FP Training Center, and to be a Level 3 DOH hospital, working with both the LGU (*Sangguniang Panlalawigan*) and the DOH.
2. Access PhilHealth reimbursements—once LMC becomes an FP Training Center, it can be reimbursed by PhilHealth for FP services. This will enable them to have buffer stocks of FP commodities and increase benefits to FP counselors, the same way that the HIV Hub gets PhilHealth reimbursements that fund increased benefits to HIV counselors.

[29] Photo sharing was approved by LMC.

3. Obtain logistical support for more dedicated television sets in the obstetrics ward for health education to support messaging on family planning, especially on infant care for first-time mothers.
4. Explore possible support for additional staff (through a job order) for the obstetrics ward, where the current nurse-to-patient ratio is 1:40, resulting in a very heavy workload for the ward staff.

ReachHealth provided the following assistance to LMC, based on the KII with ReachHealth's local Provincial Technical Officer:

1. Common visioning for LMC as the provincial training center for modern FP
2. Training of hospital staff in: FP Basic Competency 1 (for doctors, nurses, midwives); counseling training; gender sensitivity training (three days); 4Rs (recognizing, reporting, recording and referring of women and child abuse); competency training for postpartum FP in Hospitals Program (long and short-acting reversible and permanent FP methods); and rollout of DOH Adolescent Job Aid (AJA) Manual, Adolescent Health Education and Practical Training, Healthy Young Ones and HEADSS (Home, Education/Employment, Activities, Drugs, Sexuality/Suicide Risk) for screening and counseling of teens.
3. Teen Parents' Clinic for adolescents
4. Informed voluntary consent for FP methods
5. Assistance in PhilHealth claims
6. Data quality—recording and reporting of data, design of forms such as Reproductive Life Planning Logbook system (manual database)
7. IEC materials for FP; and pick-up and delivery of FP commodities from DOH regional and provincial offices to LMC.

6.2.2. Socio-demographic Profile of the Adolescent Respondents in Laguna Medical Center

The inclusion criteria for ARH required adolescents who are 18–19 years old and had used FP services, including FP methods and FP counseling. Because of the challenges we faced in finding samples within this age group, we decided to include women in their early 20s who became mothers when they were 18–19 and have used FP services from LMC, including childbirth. We selected 12 adolescent mothers out of 20 that we sampled. Their average age was 20 years. Ages ranged from 18–23 years, with 5 in the 18–19 age group, and 7 in the 20–24 age group. The average number of children was 1.92 (range: 1–4). Most of the respondents had repeat pregnancies, which means that they started childbearing when they were much younger. Ten of 12 have high school education, are living with their partners, and have no occupation. Only 2 of 12 are employed/self-employed, working as a food vendor, earning a minimum of P350 per day; and as a car wash cashier, earning below minimum at P2,000 per month. In terms of religious affiliation, 8 of 12 (67 percent) are Catholics and 4 of 12 (25 percent) are born-again Christians. All the husbands or live-in partners of the key informants are employed/self-employed, with the majority (7 of 12) earning an income at the minimum level and the rest earning below P350 per day.

6.2.3. GEWE Findings on *Reach* with ARH Interventions

- Seven of the 12 (58 percent) adolescent respondents had not heard of FP before they got pregnant. The other five heard about FP only after pregnancy. Nine of the 12 (75 percent) learned about FP

through the RHUs/BHS staff. Other sources of FP information were peers, family members, relatives, and IEC materials such as leaflets/pamphlets. None mentioned social media as a source of FP information. The adolescent respondents said that the information they received from the sources covered the different FP methods and how to use them, the purpose of FP (mainly to prevent pregnancy), benefits of FP (such as spacing/limiting pregnancy, having peace of mind, better quality of life for them and their children, and improvement in one's well- being), and side effects of FP methods.

- Almost all the 12 adolescent respondents (92 percent) received childbirth and FP/counseling services from LMC; 7 of 12 (58 percent) received prenatal services; and only 3 of 12 (25 percent) availed of postnatal services. Other RHUs/BHS also provided the adolescents with prenatal and postnatal services.
- Some of the challenges faced by adolescent respondents included pregnancy-related issues, financial problems, strained/conflict in relationships with partners and other family members, emotional stress, loss of working and educational opportunities, and feeling of shame because of getting pregnant at an early age.

6.2.4. GEWE Findings on *Benefits* of ARH Interventions

- Eight of the 12 (67 percent) adolescent respondents observed changes in their health condition after participating in and obtaining FP services. Changes observed by six (50 percent) were possible side effects of FP, such as weight gain, fatigue, being hot-tempered, and irregular menstruation. On the other hand, two of 12 (17 percent) teen mothers identified peace of mind after obtaining FP services because they do not have to constantly worry about getting pregnant.
- Five of 12 (42 percent) adolescent respondents identified the unavailability of FP commodities as a problem when availing FP services. One respondent shared that the stockouts of implants and delay in replacement/insertion of implants resulted in her unintended pregnancy.
- We asked adolescent respondents about the support they received from LMC. They cited financial support through DSWD's *Malasakit* program, zero balance billing at discharge from the facility, FP counseling, FP assistance (including check-ups and FP commodity replacement), and prenatal, delivery, and postnatal services.
- Data from the FGD with LMC showed that the FP counseling during the intake interviews with pregnant teens increased the knowledge and ability of the adolescent respondents to make independent decisions on FP use, especially after the presentation of various FP methods in preventing repeat pregnancies. The FP counseling also included reproductive life planning to guide the teens in charting and spacing pregnancies in the context of their goals in life. Counselling however, is done with the female pregnant adolescents, and not with the adolescent male partners.

6.2.5. Level of Satisfaction with ARH services

The study measured the level of satisfaction with the ARH services and benefits that the women received from LMC. On a scale of 1–10 (with 10 being the highest), adolescent respondents gave LMC an overall weighted mean rating of 8.8 (range: 5–10) under the REACH component for delivery services; 9 (range: 6–10) for prenatal services; 9.5 (range: 8–10) for postnatal services; and 9.63 (range: 7–10) for the *benefit* component (see **Figure 7**). The enabling factors that contributed to these ratings were: good

facilities and services provided by LMC, attentive and accommodating staff, effectiveness of FP methods, and LMC's welcoming environment for pregnant women. However, respondents also cited challenges, including stockouts of FP commodities, long waiting lines, and some unfriendly hospital staff (*masungit*).

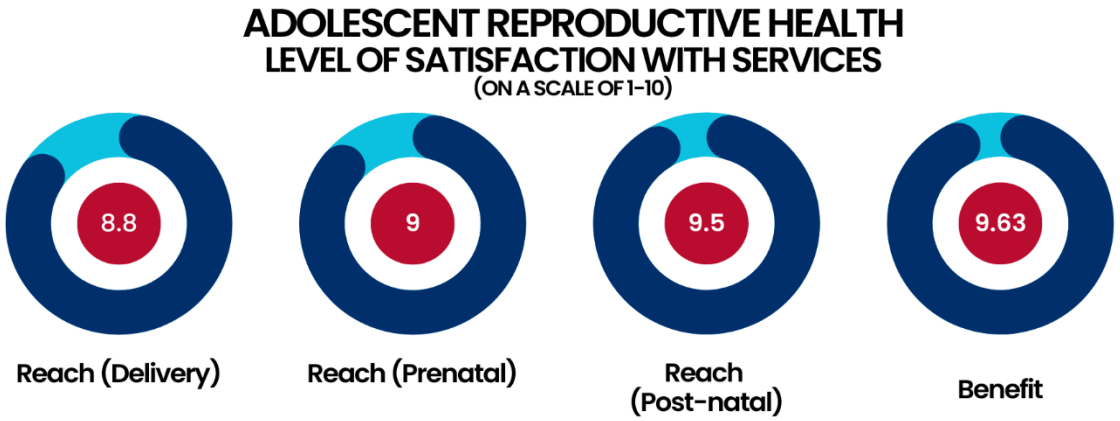


Figure 7. Level of Satisfaction with ARH Services

6.2.6. GEWE Findings on *Empowerment* from ARH Interventions

Using the RBE framework, we examined the evidence and manifestations of women's empowerment in ARH in three parts, similar to the approach and methodology that we adopted in FP (Sindangan). In LMC, we compared the perceptions of adolescent respondents on statements that measure women's empowerment. **Figure 8** shows the comparative Likert mean scores before and after their use of FP. To supplement the mean scores, we also analyzed the frequency and percentage distribution of responses that showed strong agreement or disagreement with the responses.

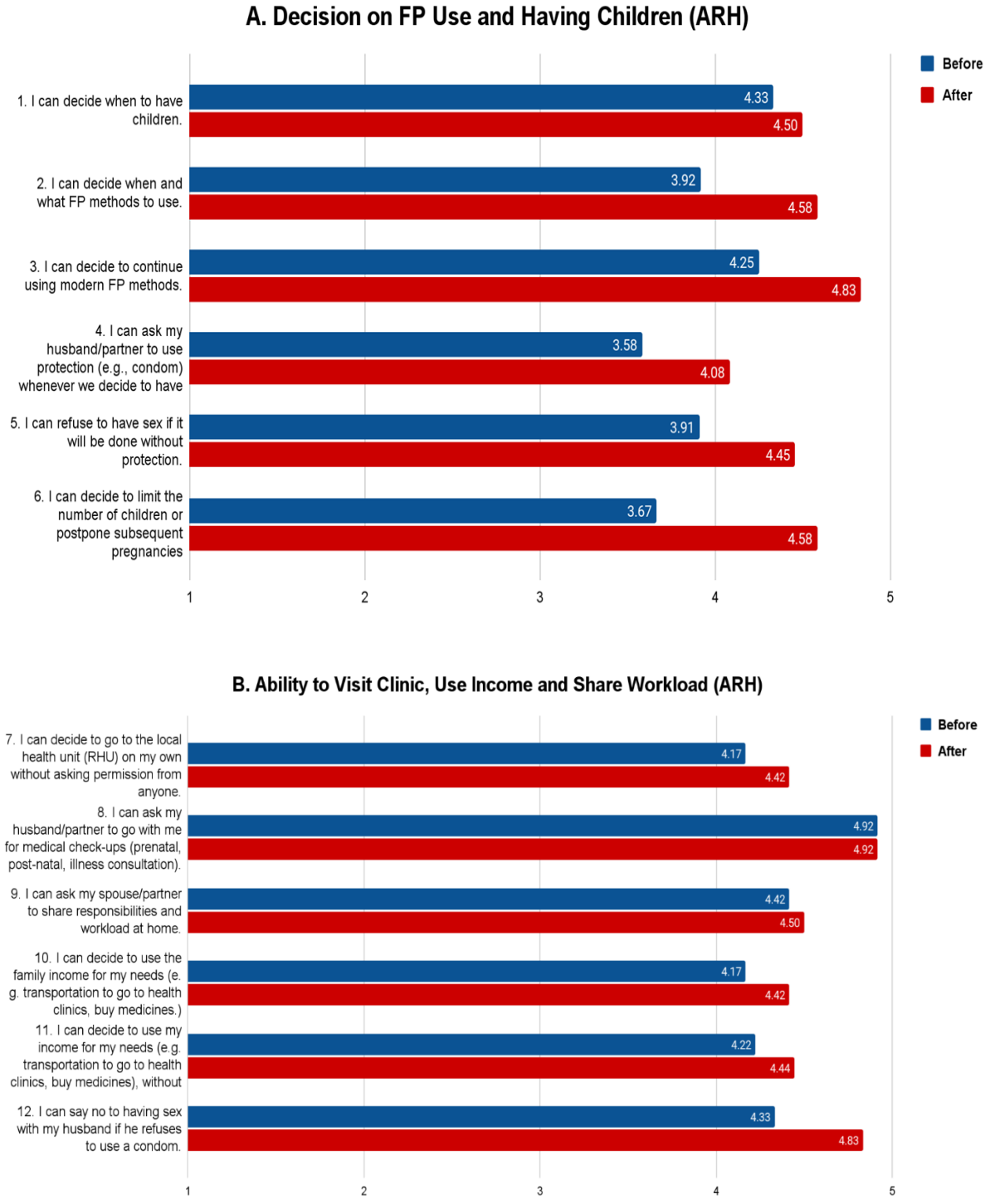


Figure 8. Part 1: Changes in Perceptions on Decision-making and Women's Ability (ARH)
Likert Mean Scores (N=12)

Part 1. Changes in perceptions on decision making and women's ability or agency

- On FP use
    - There were emerging positive shifts in perceptions of the adolescent respondents on decision making after FP use. More adolescent respondents after FP use (vs. before FP use) strongly agreed that they have the ability to decide: 1) when to have children (8 of 12; 67 percent vs. 7 of 12; 58 percent); 2) when and what FP method to use (9 of 12; 75 percent vs. 6 of 12; 50 percent); 3) to continue to use modern FP methods (11 of 12; 92 percent vs. 9 of 12; 75 percent); and 4) to limit the number of children or postpone subsequent pregnancy (9 of 12; 75 percent vs. 4 of 12; 33 percent). One adolescent mother explained her empowering experience—that initially, her husband decided for her to obtain FP services, but after using FP she is now able to decide on her own when to use FP methods and which ones to use. The FP counseling that adolescent respondents received from the RHU could have contributed to the change in perceptions.
    - Eight of the 12 (67 percent) felt that FP had a positive impact on themselves and their lives, as shown by the overall high level of satisfaction of benefits, rated at 9.63 on a scale of 10. This finding showed a direct empowerment link with the benefits they received from the RHU and BHSs.
- Sex practices
    - Slightly more adolescent respondents after FP use, compared to before FP use (9 of 12; 75 percent vs. 8 of 12; 67 percent, respectively) perceived that they have the ability to ask their husband/partner to use protection whenever they have sex, showing some positive changes after FP use.
    - Similarly, more adolescent respondents after FP use, compared to before FP use (9 of 12; 75 percent vs. 7 of 12; 58 percent) agreed that they can refuse to have sex if without protection.
- Visits to the health center

  There was only a slight difference before and after FP use (50 percent vs. 58 percent) in the perceived ability of adolescent respondents to go to the health center on their own without asking permission from anyone. This is because the LMC requires the adolescent respondents to be accompanied by their parents, husband/partner, or other family members or relatives when accessing ARH services. Hence, the adolescent respondents believe that they must ask their husbands/partners/parents to go with them for medical check-ups. LMC also requires parents or family members—rather than the adolescent respondents—to be the signatory in the request for hospital services.
- Access to resources
    - More adolescent respondents after FP use (10 of 12; 83 percent) believe that they can decide to use the family income for their needs, such as transportation to the clinics or to buy medicines, compared to before FP use (8 of 12; 67 percent). Those who said they could make decisions reasoned that their husbands/partners are highly supportive of their pregnancy and their young children and are the ones budgeting their family income.

Part 2. Changes in perceptions of prevailing social norms, beliefs, and practices

The findings under Part 2 show changes in perceptions in relation to normative beliefs and practices that are related to FP, as presented in Error! Reference source not found..

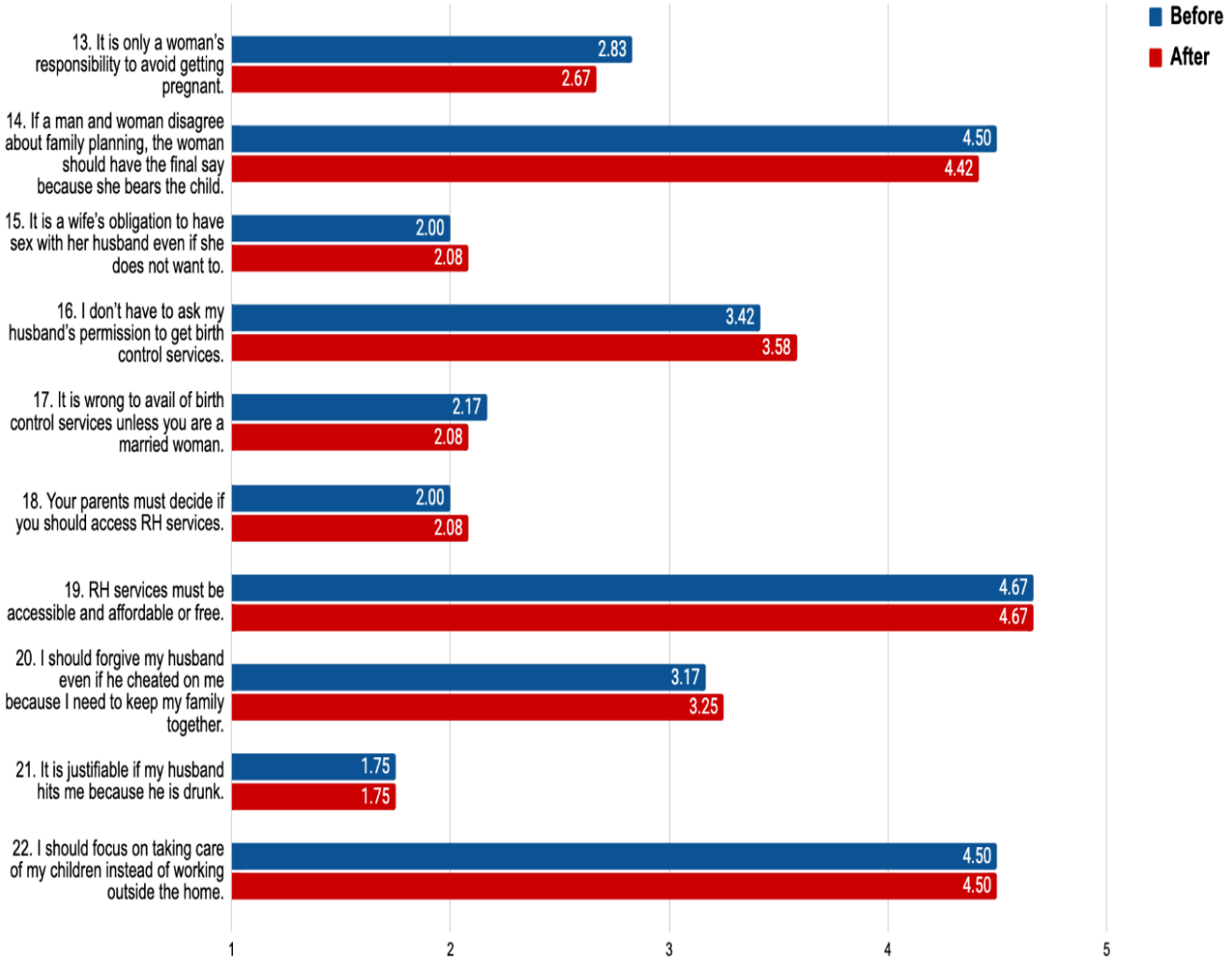


Figure 9. Part 2: Changes in Perceptions of Social Norms, Beliefs and Practices (ARH)

- Reproductive roles and responsibilities
  - There were only marginal differences in the mean scores and percentage analysis of adolescent respondents in their perceptions of social norms and beliefs before and after FP use (**Annex A**). The adolescent respondents had mixed responses. Half (both at 50 percent) equally agreed or disagreed with the statement that only women should be responsible for avoiding pregnancy. During the interview, which asked the respondents' reasons for their opinions on this statement, most of them stated that "they have not thought about this yet."
  - Whether before or after use, most of the adolescent respondents have set opinions about some statements. For example, 75 percent (9 of 12) disagreed that their parents should decide if they (adolescent respondents) should have access to RH services, and 58 percent (7 of 12)

strongly disagreed that it is wrong to avail of birth control services unless you are a married woman. All the adolescent respondents agreed that RH services must be accessible and affordable or free.

- There was a slight change in the perception of the adolescent respondents in the statement that it is the wife's obligation to have sex with her husband even if she does not want to. Nine of 12 (75 percent) adolescent respondents before FP use disagreed with the statement. After FP use, the response went down to 67 percent, with one respondent changing her view, explaining that because of her FP protection, her husband could have sex with her anytime as part of her obligation.
- In terms of a woman's reproductive role in the family, there was no difference in the perception before and after FP use among the adolescent respondents (both at 83 percent, or 10 of 12) who strongly agreed with the statement that she should focus on taking care of her children instead of working outside the home. They believe that the husband is expected to support the family and the wife should stay at home and take care of the children. This belief reflects the normative expectation of the productive and reproductive roles of women and men.
- There were slight changes in the perception of the adolescent respondents regarding asking permission for birth control services. Slightly more adolescent respondents after FP use, compared to before FP use (8 of 12; 67 percent vs. 7 of 12; 58 percent) agreed with the statement that they do not have to ask permission from their husbands to get birth control devices. This may be because most of the pregnancies of the adolescent respondents are unintended or repeated pregnancies, as shown by the average number of their children of 1.92 for this group of young mothers. Four out of 12 or 33 percent disagreed with the statement about not asking permission from their husbands/partners because they used their husbands/partners' incomes to buy contraceptives during stockouts of long-acting FP supplies in LMC and RHUs.

- Socially prescribed behaviors.
  Whether before or after FP use, there were mixed perceptions among the adolescent informants about the expectation that women should maintain peace and keep the family together. The majority (7 of 12; 58 percent) agreed that the wife should forgive a cheating husband to keep the family together. Five out of 12 (42 percent), however, disagreed about forgiving a cheating husband. This may be a good gender entry point to include counseling of adolescent husbands and partners about their joint responsibility in keeping the family together.

Part 3. Changes in perceptions of women's voice (ability to speak out) and choice (ability to select options in given situations)

- Right to express women's opinion
  There are marginal differences in the mean scores of adolescent respondents in their perceptions of social norms before and after FP use. Nonetheless, respondents did demonstrate a fairly strong sense of agency even before FP use, and any visible changes in perception in the following statements could be a good beginning for adolescent respondents to further build on this and possibly help transform prevailing cultural beliefs that contribute to the disempowerment of women and adolescent girls. Error! Reference source not found. shows that both before and after FP use, a dolescent respondents agreed that 1) a wife has the right to express her opinion when she

disagrees with what her husband says about FP (10 of 12; 83 percent); 2) a wife can contradict her husband in public about FP if he provides incorrect information (8 of 12; 67 percent); and 3) If there is a disagreement about FP, the woman should have the final say because she bears the child (10 of 12; 83 percent).

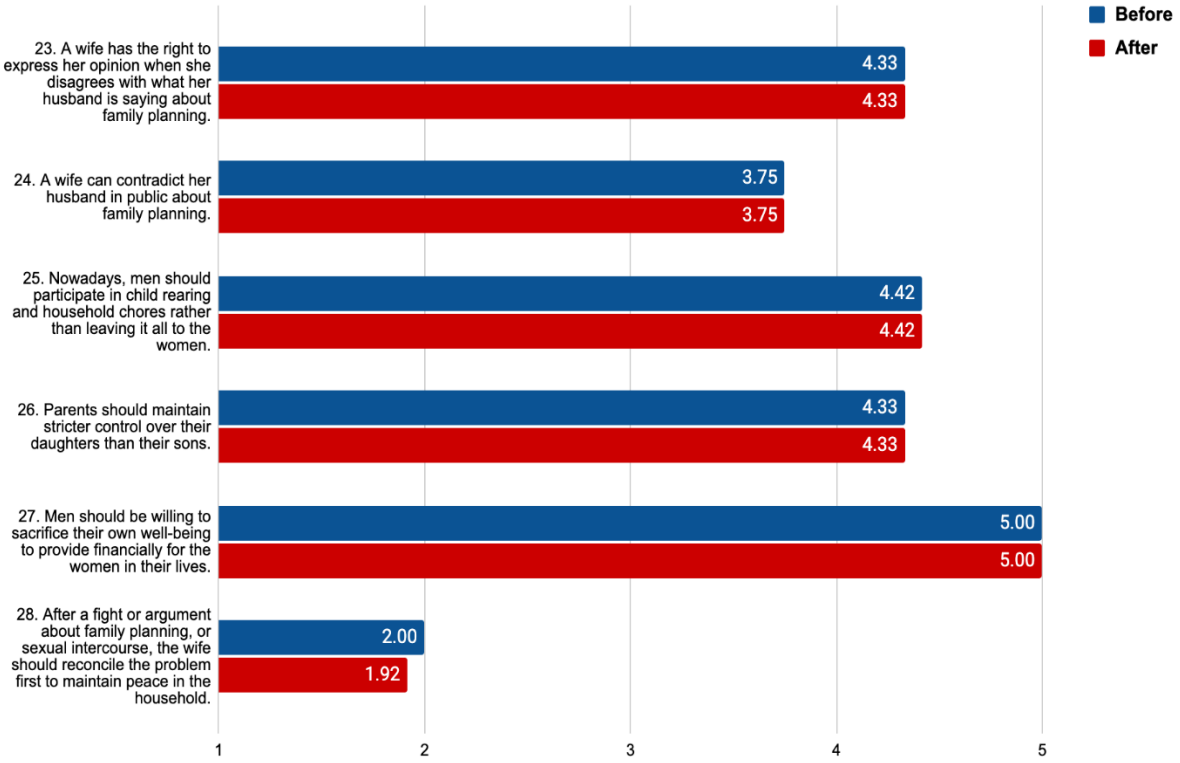


Figure 10. Part 3: Changes in Perceptions of Women's Voice and Choice (ARH)
Likert Mean Score (N=12)

- Sharing responsibilities at home
  - Whether before or after FP use, adolescent respondents perceived that men should participate in child rearing and household chores, rather than leaving them all to women (both with 4.42 mean scores).
  - Adolescent respondents strongly agree before or after FP use in their perceptions that men should be willing to sacrifice their own well-being to provide financially for their women and their families (12 of 12; mean score of 5.0).
  - Whether before and after FP use, the adolescent respondents also equally believed (10 of 12; 75 percent) that parents should maintain stricter control over their daughters than their sons, because they would not wish the same fate for their daughters to suffer from early pregnancy.
- Violence against women
  - There were no changes in the mean scores of the adolescent respondents before and after FP use in the statement that it is justifiable if their husbands hit them because they are drunk. All

the respondents disagreed, with a mean score of 1.75 (see **Error! Reference source not found.**).

6.2.7. Findings from Content Analysis: ARH

We conducted a thematic analysis of the qualitative findings from our in-depth interviews with the adolescent respondents, FGDs, KIIs with the health facilities and with the local IP staff, and findings from the desk review. Below are some themes from the content analysis.

- Improvement in adolescent's agency: ability to decide and act on the decision
  - Pregnancy prevention: A key theme that emerged is the increased decision making ability of teen mothers on pregnancy prevention (limiting and spacing the number of children), as expressed in their strong agreement and disagreement on empowerment statements after their FP use.
  - FP adoption and continued use: Adolescent respondents had increased ability to independently decide over the use of FP methods (e.g., implants, IUD) to avoid repeat pregnancy.
- Misinformation about pregnancy prevention
  - When adolescent respondents were asked about the things they knew about sex, all of them expressed that they thought the withdrawal method during sexual intercourse could prevent pregnancy.
- Feelings/reactions about the pregnancy
  - The adolescent respondents said that they were scared and nervous that parents might get mad after learning about their pregnancy.
  - Parents were disappointed and upset that their children got pregnant at an early age.
- Learnings about the use of FP
  - The adolescent respondents stated that their key learnings were the use of FP to limit the number of children, various FP methods and commodities, and the side effects of FP methods.
- Advice to adolescents about preventing pregnancy
  - "*Huwag maging mapusok. Huwag magpapadala sa feelings kasi mahirap din*." (Don't be impulsive. Don't let your feelings cloud your judgement because it is difficult.)
  - "*Sana hindi sila matulad sa nangyari sakin. Alagaan ng mabuti ang pagiging babae sa hirap ng buhay ngayon. Umiwas sa sitwasyon kasi walang maidudulot na maganda*." (I hope they don't end up like what happened to me. Take good care of yourselves as women especially with how difficult life has been lately. Stay out of the situation because nothing good will come of it.)
- Factors contributing to teen pregnancy: LMC identified the following causes from its intake counseling sessions with the adolescents:
  - Absentee parents (e.g., overseas Filipino workers), and for those with parents, their lack of time, attention, and guidance to their adolescent children
  - Peer pressure
  - Desire for experimentation (sometimes among cousins)
  - Exposure to social media (e.g., text messaging) to find partners, meeting up and having unprotected sex
  - Lack of awareness and access to FP information among sexually active teens on how to protect themselves
- Enabling factors and barriers in empowering teens for pregnancy prevention

- Benefits received by adolescent mothers from facility-based assistance and services, including supportive LMC staff who provide FP counseling and quality service; and the Teen Parents' Clinic, which provides services to pregnant, postpartum, or post-abortion adolescents covering antenatal care, information and counseling on breastfeeding and FP, facility-based delivery, postpartum or post-abortion care, and postnatal care for adolescents aged 19 and below.
- ReachHealth capacity development support to LMC hospital staff and provision of innovative interventions such as the Reproductive Life Planning, IEC, and health teaching videos, and logistics support to avoid stockouts of FP supplies.

- Influence of family and peers
  - Significant impact of the parents' role and influence on adolescent voice and choice regarding family planning. Parents are heavily involved in the decision making of young mothers. They can be an enabler for pregnancy prevention for their teen daughters, as a front line source for sexuality education; or they can be a barrier, based on LMC's experience with parents who do not support modern FP methods.
  - Peers serve as a support system for the adolescent mothers for learning and exchange of knowledge and experience. However, peer pressure can also lead to risky behavior, such as sexual experimentation without any protection.
- Among the barriers are the following:
  - There are challenging provisions of the Responsible Parenthood and Reproductive Health Act of 2012 that require parental consent for accessing FP commodities and procedures by adolescents. This requirement may prevent adolescents from obtaining any FP protection once they become sexually active. Research studies such as the 2021 Young Adults Fertility and Sexuality Survey [30] showed that the first sexual encounter of adolescents is unprotected.
- Social norms
  - Social stigma was not an issue among the adolescent respondents, who noted that many other of their adolescent peers (including in their schools) are pregnant. Even if they heard negative comments like "*ang agang lumandi*" (too young to be a flirt) from others in their community, they did not allow themselves to be affected by these comments.
  - In relation to the lack of access to contraceptives, sex is a taboo topic in most traditional Filipino families. Hence in a culture where premarital sex is not widely accepted but increasingly practiced, and where open communication between parents and children about sex is rare, adolescent girls who face the most severe consequences for unprotected sex, both biologically and socially, continue to be disproportionately affected by the lack of access.
- Exposure to social media
  - During the KIIs, we found that none of the adolescent respondents mentioned social media as a source of FP information. This was surprising because exposure to social media (e.g., text messaging) was identified in the intake counseling interviews by the adolescents as a means to find partners, meet up and have unprotected sex.
  - As of January 2023, the number of social media users in the Philippines was 84.45 million.[31] This number means 72.5 percent of the country's population stays connected online. Gen Z, which includes the 18–19-year-old adolescent respondents, comprises the most significant

[30] 2021 Young Adults Fertility and Sexuality Survey, UP Population Institute.
[31] Sue Howe, Social Media Statistics in the Philippines, Digital 2023 Philippines, April 2023.

demographic of social media users, with 30.6 percent of total users aged 18–24 years old.[32] Hence one of the critical themes in pregnancy prevention is the need for a sex and age appropriate SBCC for pregnancy prevention.

- Adolescent male engagement in RH
  - From the FGDs, the respondents did not mention engaging adolescent boys as a target for pregnancy prevention. This one theme needs special attention to tap adolescent boys as enablers for pregnancy prevention.

6.3. TB (North Daang Hari Health Center, Taguig City)

HIGHLIGHTS: There is a clear and visible link between *benefit* and *empower* in TB recovery.

Reach:

- Recovered female TB patients were highly satisfied with good quality of TB treatment and services of trained staff (BHW and lab aides) under Come Alive/Be Alive.
- Demand increased with the creation of lab aides and TB task force in active case finding for lower-income groups.
- Assistance from TB Platforms directly contributed to high TB elimination and treatment success rate (90 percent), resulting in top LGU award.

Benefit:

- Improvements were found in recovered patients' health/well-being, including increased peace of mind, more confidence/self-esteem.
- Respondents expressed a high level of satisfaction with benefits received.
- Respondents reported increased knowledge on the cascade of TB screening, treatment, cure, and prevention.

Empower:

- Respondents reported improved capacity to better take control and care of themselves and their families.
- TB informants indicated a strong ability to make independent decisions on TB screening, treatment, and cure.
- Respondents expressed a high level of confidence to share their TB experience with others.

6.3.1. Background

Profile of the Health Center

The North Daang Hari Health Center in Taguig City is the local partner of TB Platforms to improve TB service delivery in Region IV, which is the second most populated region in the country. It is the city's satellite treatment center dedicated to patients suffering from multi-drug resistant TB and has a GeneXpert machine that can determine if a person is infected with multi-drug test resistant TB. In 2022,

[32] Ibid.

the DOH awarded Taguig City the Manuel L. Quezon Award for Most Outstanding Highly Urbanized City in Luzon in the fight against TB, as they achieved a 90 percent TB case detection and TB treatment success rate. Taguig City attributes their success to intensive case finding, committed health staff, and the city's all-out support.

As part of Taguig City's support, the North Daang Hari Health Center created the unique *plantilla* position of lab aides, former BHWs who are dedicated to TB work and serve as front liners in the health centers. Taguig City also organized TB Task Forces (composed of lab aides and BHWs) who conduct house-to-house information dissemination, identify TB patients, and monitor the completion of the patients' medication. There are more than 800 BHWs in job order positions working with the TB Task Forces who focus solely (*nakatutok*) on the concerns of TB patients in the city. One lab aide is assigned to one health center, but the ratio also depends on the population size of the health centers.

Taguig City's health centers conduct ACF by scheduling free chest X-rays for street sweepers, vendors, smokers, alcoholics, diabetics, senior citizens, construction workers, drivers, call center agents, students and public school teachers, and city hall employees. Their target is to screen 150 people per day, of which four to five are expected to be positive cases for TB. With these accomplishments on finding, treating, curing, and preventing TB, the LGU of Taguig City ranked first among the 17 cities in the National Capital Region in terms of TB treatment success rate of 90 percent.

The TB Task Force and lab aides provide services to TB female and male patients for treatment such as:

1. Counseling, providing encouragement and moral support to TB patients, helping remove perceptions of stigma
2. Constant monitoring of patients to avoid multidrug-resistant TB (treatment follow-up through calling, texting, and house visits)
3. Bringing medicine/vitamins to patients unable to go to health centers
4. Multi-tasking through helping with other programs such as immunization, nutrition, breast cancer, and deworming.
5. Collecting data and reporting
6. Assisting nurses and doctors in TB treatment

TB Platforms provided the following technical assistance to Taguig City:

1. Training of lab aides/BHWs on Come Alive/Be Alive. Those who were trained said that the technical and soft skills they learned help them in counseling and encouraging those who test positive after screening to get and complete their TB treatment.
2. ACF
3. TB screening (using a community screening form)
4. TB counseling (listening skills, information sharing)
5. Cell phone and load for electronic monitoring, reporting, and follow-up of patients with TB
6. Video recordings about TB and health information, one USB stick per health center (still pending)
7. IEC materials
8. Implementation of FAST (Finding TB Cases Actively, Separating Safely and Treating Effectively) strategy to stop the spread of TB; infection, prevention, and control; and support for *KERI*-up (an express delivery and errand to bring sputum to testing labs)

We conducted in-depth interviews with 15 female patients who underwent TB counseling, screening, testing, and completed TB treatment in the Taguig City health center, with technical assistance from TB Platform.

6.3.2. Socio-demographic Profile of TB Patients in Taguig City

The sample selected for the TB study consisted of 15 former TB patients who have fully recovered from TB and received assistance from the North Daang Hari Health Center in the whole regimen of TB treatment, from screening to complete recovery, over the past 12 months. These TB respondents had an average age of 47; with the majority (7 of 15; 46.7 percent) in the 46–55-year-old age group. The youngest was 33 and the oldest was 76. The majority (75 percent) have high school level education. Seven out of 15 are married, six have live-in partners, and two are widows. The average number of children was four; eight had three to four children and five had five to seven children. Eight of 15 (53 percent) were employed/self-employed, working as food vendors, or in small business, earning mostly below the minimum of P537 per day, and seven are housewives. In terms of religious affiliation, 11 of 12 (92 percent) are Catholic.

Among the husbands/partners, 14 of 15 (93 percent) were employed as construction workers, tricycle drivers, vendors, and employees of service occupations. Mosts earned more than the minimum wage.

6.3.3. GEWE Findings on *Reach* with TB Interventions

- On TB screening, almost all of the women respondents (14 of 15; 93 percent) were screened for TB by the BHWs at the BHS and lab aides based in the RHUs, who were both trained under the Come Alive/Be Alive program of TB Platforms. The BHWs/lab aides referred those who screened positive for TB for sputum testing and check-up at the health center.
- On BHW services, we asked about the responsiveness of the services the BHWs/lab aides provided. All the 15 TB respondents said that their BHWs/lab aides were accommodating and attentive and encouraged them to get treated because TB is a curable disease. Three of 15 (20 percent) said that the assigned BHW conducted house-to-house visits to check on them when they failed to get their TB medicines.
- On TB counseling and monitoring, 13 of the 15 respondents (87 percent) stated that their assigned BHWs/lab aides counseled them about the TB treatment process and general health advice, including nutrition and self-care. We asked how their BHW/lab aide assisted them in monitoring their TB treatment. All the respondents said that the BHWs/lab aides monitored their intake of medications after being diagnosed by the doctor; 14 of 15 (93 percent) were assisted by the assigned BHW in bringing sputum to the health center; 11 of 15 (73 percent) had their assigned BHW as their treatment partner.
- On the length of TB treatment, the majority of the respondents (14 of 15; 93 percent) said that the treatment lasted for six months, with all the services provided for free (including sputum monitoring and medicines).

- On access to TB information, the majority of the respondents (14 of 15; 93 percent) learned about TB from their TB counseling with the CHW/lab aide; 6 of 15 (40 percent) learned about the availability of TB services through leaflets and tarpaulins. None mentioned social media.
- On screening of household members, 11 of 15 respondents (73 percent) shared that other members of the family also got screened for TB; among them, 55 percent were convinced by a CHW/lab aide to get screened and 36 percent by the respondents themselves. The other family members who tested positive for TB were their children (47 percent) and their husband/partner (47 percent). The TB respondents assisted their family members to undergo treatment (47 percent) and accompanied them to the health center (47 percent).
- We asked the TB respondents their level of satisfaction with the services that they received. The respondents gave the Taguig health center a high average rating of 9.6 out of 10 points (range of 7–10), citing the good quality service of the staff—lab aides, BHWs and TB Task forces—who provided encouragement and were accommodating, attentive, and courteous to patients with TB. Twelve of 15 gave them the maximum rating of 10 points. The respondents also mentioned that they appreciated being reminded about their schedules for visiting the health center and for giving extra tablets beyond the next refill so that they would not skip taking the medications.

6.3.4. GEWE Findings on *Benefits* of TB interventions

- Almost all the TB respondents (14 of 15; 93 percent) observed positive changes in their overall well-being after obtaining TB services. The benefits included improved physical and mental health. They said they looked and felt better, gained weight, had better appetite, had no more body pains and night sweats, had more peace of mind, more self-confidence, and improved self-esteem with their full recovery from TB. They also mentioned that they were able to pursue their regular activities again, including socializing with their friends, without fear of stigma and infecting others.
- We also asked the respondents to rate their level of satisfaction with the benefits they received. All (15 of 15) gave the highest rating of 10 for the biggest benefit they received: their successful journey to TB recovery.

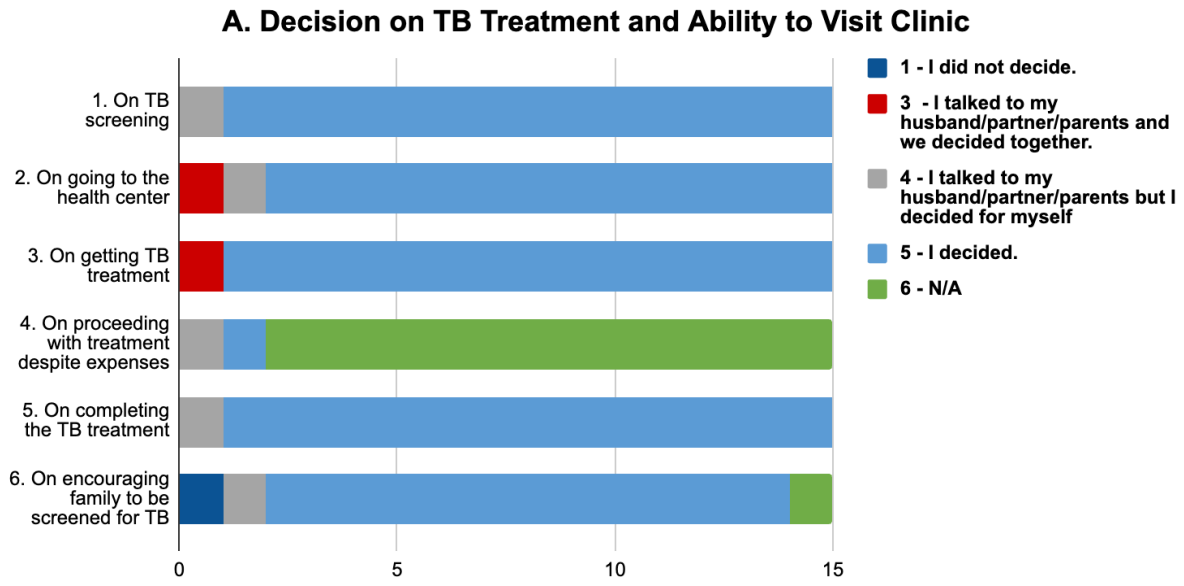
6.3.5. GEWE Findings on *Empowerment* from TB Interventions

Using the Reach-Benefit-Empower Framework, we examined the evidence and manifestations of women's empowerment in TB in three parts, similar to the approach and methodology that we adopted for the FP (Sindangan) and ARH (LMC) analysis. We analyzed the ability of the TB respondents to decide and act on their decisions from the time they were found positive for TB up to their recovery. We also compared the perceptions of TB respondents on statements that measure women's empowerment. To supplement the comparison of mean scores, we also analyzed the frequency and percentage distribution of responses that showed strong agreement or disagreement with the responses.

Part 1: Ability to decide and act on the decision

The data presented in **Figure 11** tell a good empowerment story of the agency, or the ability to define goals and act on them, and strong decision making ability of women who recovered from TB. The findings below clearly showed the TB respondents making decisions by themselves to get treatment and recover.

- TB screening—Almost all of the respondents (14 of 15; 93 percent) decided to have TB screening after they exhibited the typical symptoms of TB (persistent cough, weight loss, night sweats, and/or high fever). Only one said that she consulted with her husband/partner, but the decision was still hers.
- Visits to the health center—The majority of the respondents (13 of 15; 87 percent) independently decided to go to the health center for free TB care, including chest X-ray, medicines, and vitamins. The others decided after consulting with their husbands/partners. Beyond this sample group, the lab aides mentioned in the FGD that there were women with TB who wanted to be treated but did not want to go to the health center because they did not want other people to know about their illness.
- Getting and completing TB treatment—Almost all (14 of 15; 93 percent) of the respondents independently decided to access and complete TB treatment because of their concern that they could infect their husband and children. We asked if they would be willing to proceed with their treatment despite the expense. Only a few answered this question because of the free treatment from the health center, but those who responded mentioned that they were willing to proceed and actually paid for their chest X-rays.
- Encouraging and bringing their families to be screened for TB—Sixty percent (9 of 16) said that during their treatment for TB, they encouraged their family members to be screened for TB and consult at the health center. Two of 16 respondents consulted their husbands prior to undergoing treatment; the others who did not bring their family for screening had access to medical check-ups at work.
- Spending their free time and joining organizations—All the respondents decided on their own to spend their free time to rest or to meet and socialize with friends (14 of 15; 93 percent). On joining organizations, only 5 of 15 respondents (33 percent) are members of organizations; of the five, two are active members of work-related organizations and one occupies a board member position.



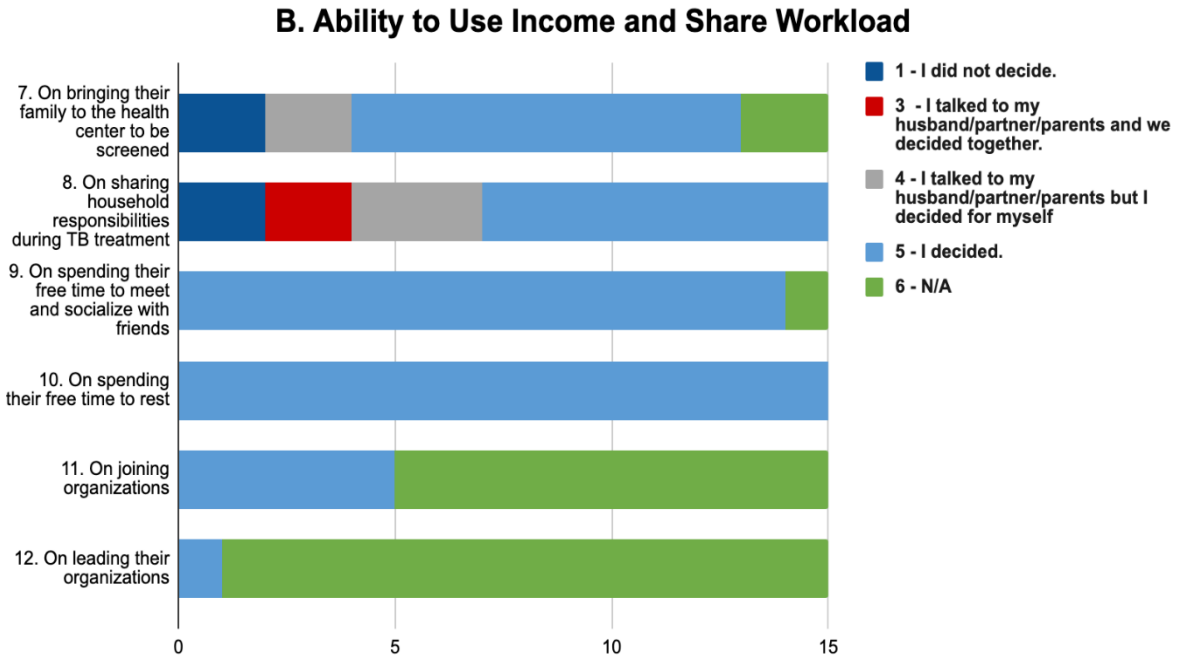


Figure 11. Part 1: Ability to Decide and Act on the Decision (TB) (N=15)

Part 2: Changes in perceptions of social norms, beliefs, and practices

Error! Reference source not found. presents the expressed opinions and perceptions of the r espondents on prevailing and traditional beliefs on what women could or could not do when they have TB. Below are the findings:

- Marriage of men and women with TB—We asked the respondents if they agree or disagree with the statements that men and women should not get married if they have TB. Whether before or after TB treatment, the TB respondents disagreed with the statement. The mean scores and percentage analysis, however, showed that slightly more respondents after TB treatment compared to before treatment (73 percent vs. 67 percent) disagreed that they should not get married, but added that it would be better if they complete the TB treatment first.
- Having children—Similarly, more TB respondents after TB treatment compared to before (60 percent vs. 53 percent) disagreed that women with TB should not have children. The respondents however, also added that it would be better to wait until after they have fully recovered, so that their children would not be infected.
- Outside employment—We asked if women with TB should not be gainfully employed. More TB respondents after treatment compared to before treatment (53 percent vs. 40 percent) disagreed with the statement, saying that women with positive TB can continue to work because they are no longer contagious two weeks after initiation of TB treatment.
- TB stigma—Whether before or after treatment, all the TB respondents (15 of 15) disagreed with the statement that it is more shameful for women to have TB, adding that TB is curable and acquiring the infection is not gender-dependent. On the other hand, the FGD with the lab aides

acknowledged that the stigma of TB among women is higher than among men and that their female patients with TB would try to conceal their illness from their neighbors (and sometimes their own husbands).

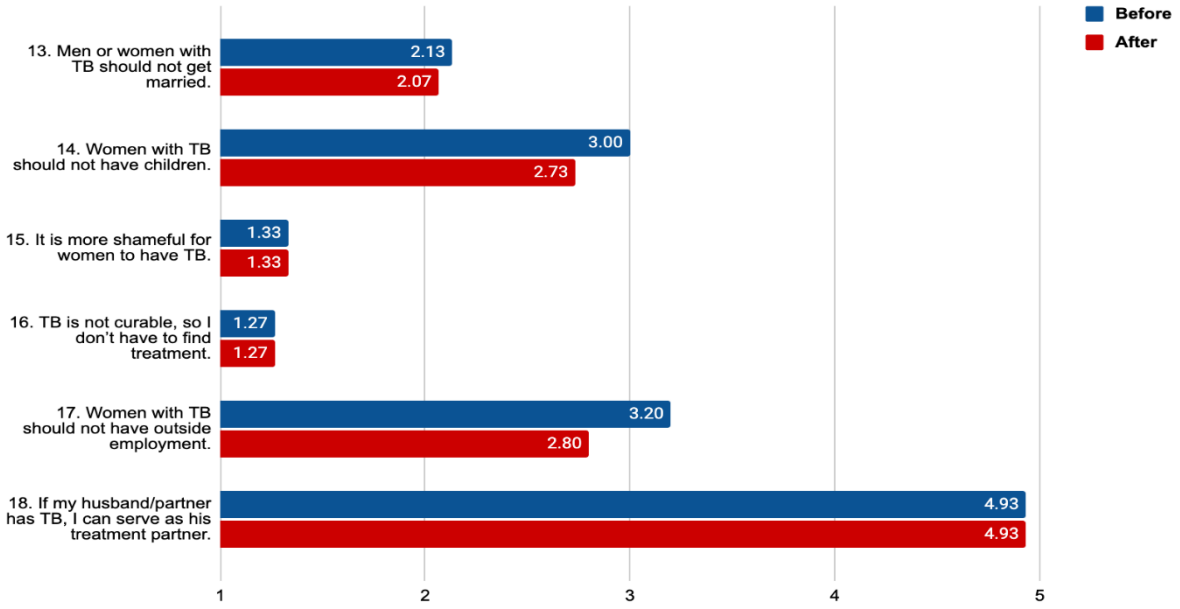


Figure 12. Part 2: Changes in Perceptions of Social Norms, Beliefs and Practices (TB)
Likert Mean Score (N=15)

Part 3: Changes in perceptions of women's voice (ability to speak out) and choice (ability to select options in given situations)

Error! Reference source not found. presents the findings on the respondents' ability to speak their o pinions and select options in some given situations, such as sharing of responsibilities in the household and willingness to serve as a treatment partner. Most of the findings show that regardless of their TB treatment, there are no changes in respondents' perceptions of their abilities to express their voices and choices.

- Right to express her opinion
  - Before treatment, 14 of 15 (93 percent) of the respondents agreed that a wife has a right to express her opinion when she disagrees with her husband who gives incorrect TB information. After treatment, all respondents agreed with this statement.
  - As to whether a wife can contradict her husband in public when he gives incorrect information about TB, slightly more respondents after TB treatment disagreed (10/15; 67 percent), compared to before (9/15; 60 percent). The respondents reasoned in both scenarios that they would rather contradict their husbands in private to keep peace at home.
  - Regardless of TB treatment, all respondents disagreed with the statement that a wife should obey her husband even if she disagrees with him regarding TB-related household decisions. All respondents also agreed that a woman's opinion is valuable and should always be considered in TB-related household decisions.

- Sharing responsibilities at home
    - We asked about the TB respondents' ability to ask their husbands/partner on the sharing of household responsibilities and workload at home while the wife is under treatment. About half (8 of 15; 53 percent) said that they have the ability to ask their husbands/partners, and the other half mentioned that they prefer to decide with their families on the division of chores.
    - Whether before or after TB treatment, all the respondents agreed that men should participate in child rearing and household chores when the wife is indisposed due to TB, and that men should be willing to sacrifice their own well-being to provide financially when their wives are sick with TB. All the respondents also agreed that if their husbands/partners have TB, they can serve as the treatment partner.

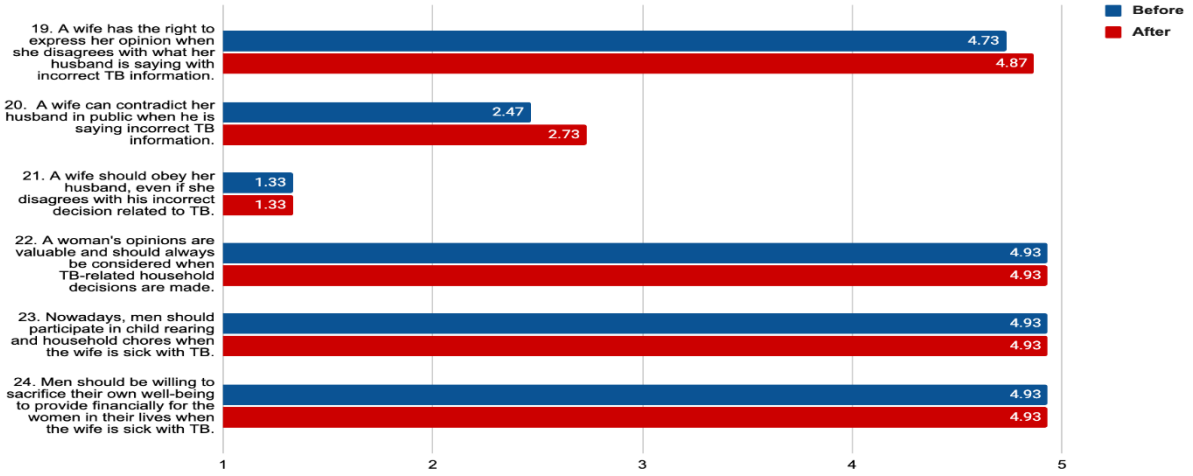


Figure 13. Part 3 - Changes in Perceptions of Women's Voice and Choice (TB) Likert Mean Score (N=15)

6.3.6. Findings from Content Analysis: TB

We also conducted a thematic analysis of the qualitative findings from our in-depth interviews with the female respondents with TB, FGDs and KIIs with the health facilities, and findings from the desk review. Below are some themes that emerged from the content analysis.

- Improvement in women's agency: ability to decide and act on the decision
    - The respondents demonstrated improved capacity to better take control and care for themselves. They showed strong ability in making their own decisions in being screened for TB and accessing treatment. Because of their desire to recover, they independently decided to consult at the health centers.
    - The respondents encouraged and brought their family members for TB screening. The respondents also encouraged those who screened positive for TB to get treated, and they themselves served as treatment partners.
- Enabling factors and barriers in TB recovery (for both female and male patients) are:
    - Strong motivation from the respondents to recover from TB to better care for their families, seek employment, or return to work.

- Good quality services from well-trained, committed, and encouraging health center staff who provide TB counseling, who assure them that TB is treatable and ensure that the patients understand and are aware of the diagnostic process and proper treatment. The benefits received from the services at the health center directly contributed to the empowering experiences of the TB respondents.
- Technical assistance provided by TB Platforms. The Come Alive training and mentoring program for the lab aides and BHWs have contributed significantly to the health center operations and staff, and to the respondents' high satisfaction rating of 10 out of 10. In the FGD at the health center, this was recognized by the facility head and lab aides, who added that they welcomed opportunities provided by TB Platforms and TBIHSS (another USAID IP working on TB) for innovations and experimentation.
- Full support by the LGU in the creation of lab aide *plantilla* positions, BHW job order positions, and a TB Task Force dedicated to TB work for the whole LGU to conduct ACF and ensure the availability of free TB medicines.

- Among the barriers identified, the TB respondents identified the problem relating to getting their medicines on a regular basis, because they perceived that missing even just a day of medication means they have to start all over. This was not an issue for TB respondents without young children (10 of 15; 67 percent), but it posed a problem for those (5 of 15; 33 percent) with young children or grandchildren, who faced logistical challenges in getting TB drugs such as needing to bring their children with them to the health center, possibly exposing them to TB; or needing to make arrangements with their family members or neighbors for childcare. The respondents were grateful to the health center staff who prioritized patients with young children, resulting in less waiting time in the clinic and less time away from home.
- Changes in perception of recovered women patients with TB
- Social stigma
  - Regardless of the disagreement expressed by the all the TB respondents that it is more shameful for women to have TB, the lab aides in the FGD indicated that most women patients with TB had internalized stigma and tried to isolate themselves and conceal their illness due to the fear of discrimination by others (e.g., neighbors, peers, friends, families). By isolating themselves, the women with TB felt that they were "protecting" other people from exposure to TB.
  - After treatment, there was a huge positive change in the ability of the TB respondents to meet and socialize with their friends.
  - After treatment, they were confident to share their experiences on TB care with other people, from diagnosis to treatment. This helped spread awareness and information about TB that it can be cured, and inspired others to seek treatment, especially those who are ashamed of their illness or are in denial.
- Roles of family and treatment partners
  - Families of the TB respondents, especially the supportive husbands, served as their source of strength and motivation to complete TB treatment. They also served as a support system during the treatment, both emotionally and as the women's *halili* (substitute) for housework and carework, especially when they have to go to the health centers to get their supply of TB medicines.

- Because of their family support, most of the TB respondents did not identify 'childcare' and 'household chores' as hindrances to pursue TB treatment. They also made decisions on the use of their free time to rest.
- Lab aides and the TB Task Force had a positive effect on the treatment of the TB women patients because they served as their pillar as treatment partners. Their regular visits, medication monitoring, and "*mabuting pakikitungo*" (good interpersonal relationship) helped the patients get through the whole regimen of TB treatment.

- Social norms and beliefs
- Perceptions on sharing household and care responsibilities with men
  - All the TB respondents strongly believed that men should share domestic work and responsibilities with women. Some of their quotes include the following:
    "*Lahat dapat nag tutulungan, hindi pwede isa lang.*" (Everyone should help, not just one.)
    "*Para alam din nila, yung kung paano magpalaki, mag alaga, magpa kain, mag puyat. [Para maranasan nila] yung hirap. Pag rest day nila, rest day nila. Ikaw naglalaba araw ng linggo.*" (The men themselves need to know and experience childcare and how difficult it is. Men's rest day on Sundays is their own; for women, there is no rest day, as they still do laundry on Sundays.)
- On the right to express their opinions
  - All the TB respondents strongly believed that women have the right to express their opinion when they disagree with her husbands on information about TB, and that women's opinions are valuable and should always be considered when TB-related household decisions are made. They said:
    "*Mas malawak pang unawa ng mga babae. Mas marami silang alam dahil sila nag iaalaga ng mga bata, ganun. Babae ang aware sa mga sakit. Malimit sa mga lalaki hindi nakatutok sa mga ganiyan, mas madalas busy sila.*" (Women have a broader perspective, more knowledge about child caring, more awareness about illnesses. Men do not mind these things, because they are always busy.)
- On getting married, having children, and finding work when men or women have TB.
  - Contrary to common beliefs, the respondents who were cured from TB believed that women and men with TB could get married, have children, and find work. The knowledge gained through TB counseling helped the respondents negate common beliefs. However, they advised it would still be better to defer these activities until they have been completely recovered.

- Sharing knowledge on TB with others
  - After TB treatment and cure, 8 of 14 (53 percent) said that their opinions were sought about their experience with TB, including signs and symptoms, process of getting TB treatment, side effects of TB medicines, and where to get treatment.
  - Fourteen of 15 (93 percent) of TB respondents expressed willingness to share their positive experience with TB in their barangay to raise awareness about TB; be an example to encourage and inspire other women and men to be treated for TB; tell others that TB can be treated; and that TB is not a cause of shame, especially for women.
  - When asked to rate their level of confidence in sharing their experience, the weighted mean score was 9.33 on a 10-point scale, with a range of 1 to 10. Only one respondent expressed her hesitancy; 12 of 15 rated their own level of confidence with the highest rating of 10 points.

6.4. Community-Based Drug Rehabilitation

HIGHLIGHTS: There is a clear and visible link between *benefit* and *empower* in CBDR

Reach:

- Recovered female PWUD have a high level of satisfaction with the CBDR treatment and rehabilitation services of Oro Wellness Development Center (OWC) and the barangay CBRD managers.
- Enablers include the effectiveness of the CBDR services in stopping use of drugs, accommodating and helpful staff who helped change their perspective about drug abuse as a health issue.
- The female PWUD decided independently to remain drug-free and undergo treatment and rehabilitation to clear their names from the drug list due to fear of jail time and to improve their own well-being for the sake of their family and children.

Benefit:

- Experience with CBDR has been highly positive in terms of overall improvement in their physical and mental state, family and social relationships, and a more positive outlook in life, compared to their chaotic lives before CBDR.
- The female PWUD benefited most from the CBDR program through the removal of their names from the watch list, enabling them to return to their normal lives prior to CBDR.
- After graduating from CBDR, the female PWUD regained the trust of their family and friends and became more capable in caring for their children.

Empower:

- The shift of mindset from drug use as a crime to drug use as a health issue further empowered the female PWUD and enabled them to recognize that recovery and change are possible.
- The CBDR program ended the discrimination experienced by women/LGBTQI PWUD from their families, particularly their children, who recognized their efforts in completing the program.
- Female PWUD have high confidence in sharing with others their journey of rehabilitation from the time they started up to their rehabilitation.

6.4.1. Background

The Oro City Government created the OWC, in partnership with the Catholic Church, in response to the drug war (*Oplan Tokhang*).[33] The OWC is the implementing arm of the City Anti-Drug Abuse

[33] Oplan Tokhang, aimed to reduce the demand and supply of illegal drugs, involved arresting drug suppliers and sending police to the homes of known users and asking them to voluntarily surrender and receive treatment.

Council (CADAC). The Center started in 2015, became fully operational in 2017 at the height of the rampant killings, and served as a one-stop shop for CBDR services.

The OWC has five staff, three in program operations, and two in administrative work. There are 35 community-based managers in the barangay who receive a monthly allowance of P1,500 from CADAC. The OWC provides services to 19 female PWUDs, including five who were jailed and released under plea-bargaining in court (i.e., jail time or undergo CBDR). Their female patients are 30–50 years old, are high school graduates, have five to six children, and work as vendors or househelp, with wages of P3,000–5,000 per month. The OWC provides screening and assessment services, drug testing, counseling, assistance in plea-bargaining in court, facilitation for in-patient rehabilitation, monitoring the conduct of barangay CBDR, financial assistance (for transport, food, doctors' fees), social welfare support (wrap-around services), after-care support, and the conduct of the monthly *Tabo* (agricultural products and food fair) that is supported by the LGU.

RenewHealth supported the OWC with the following: technical assistance in program implementation; provision of CBDR manuals of operation and capacity building of the OWC staff and community-based managers as facilitators for all the modules of the CBDR programs—GINHAWA, KKDK, and Yakap Bayan After Care; and training of counselors on motivational interviewing. During the FGD, the OWC staff said that because of the RenewHealth assistance, the number of barangays joining CBDR have multiplied.

RenewHealth provided technical assistance in implementing the Client Flow Cascade, developing the manual of operations for the programs in the client cascade below, training the OWC staff and community-based managers on the use of the manuals, and motivational interviewing. The Client Flow Cascade has 6 strategies:

- Reach: Reaching out to PWUD, families, local leadership to de-stigmatize PWUD
- Screen: Conducting drug testing to determine the level of dependency in terms of risk: low, moderate, high, or severe dependency
- Treat:
    - Low-risk users: Participation in the GINHAWA program for one month
    - Moderate-risk users: Participation in KKDK program for three months
    - High-risk users: Referral to doctors for drug dependency evaluation: if mild (three months CBDR); moderate (six months CBDR); or severe (in-patient at the DOH Treatment and Rehabilitation Center)
- Support and Sustain: *Yakap Bayan* After-Care Program with the DSWD (six months), wrap-around services for women and men.
- Institutionalize: Worked with the LGU for the passage of Cagayan de Oro City Drugs Code

6.4.2. Socio-demographic Profile of CBDR Patients in Oro Wellness and Development Center

The sample selected for the CBDR study consisted of nine rehabilitated female PWUD who had graduated from the CBDR program and received assistance from the OWC, following the Client Cascade of Care. Of the nine female PWUD, seven are heterosexual and two are lesbians, and the

average age was 44 years (range: 26–76 years). Five of the nine women have high school level education, and three have college education. Six are married, two are widows, and one is single. The average number of children was 4.4 (range: 3–7). Five of the women were employed/self-employed as a food vendor, kitchen staff, cashier, laundry worker, or delivery rider. Most of the working women received pay that was above the minimum wage of P405 per day. Four of the women are housewives. In terms of religious affiliation, eight of the nine are Catholics.

Among the husbands/partners, five were employed, with four receiving within or above the minimum wage. Only one (a fisherman) earned a wage below the minimum wage requirement.

6.4.3. GEWE Findings on *Reach* of CBDR Interventions

- OWC services—All the female PWUD respondents learned about OWC and its services because they were on the watch list of drug users and hence referred by the barangay CBDR. They all received assistance for drug testing, briefing, and orientation on drug use, and participated in the activities of the GINHAWA, KKDK, and *Yakap* Aftercare rehabilitation programs.
- Decision on treatment and rehabilitation—Seven of the nine female PWUD decided on treatment and rehabilitation on their own because they wanted to clear their names in the watch list, avoid incarceration, lessen their shame and guilt for being a drug user, and improve their own and their family's well-being.
- Three of the female PWUD said that their husbands influenced them to use drugs. Nonetheless, they and their husbands jointly decided to avail of the screening at the OWC. One of the women PWUD said that they made a promise to each other to continue their treatment for the sake of their children.
- We asked the female PWUD to rate their level of satisfaction in obtaining services from the OWC and the barangay CBDR. The respondents rated them highly, at 9.11 out of 10 (range: 5–10). The reasons for the high ratings included the effectiveness of the CBDR services in stopping drug use, and accommodating and helpful staff who helped them change their perspective about drug abuse as a health problem.

6.4.4. GEWE Findings on *Benefit* of CBDR Interventions

- Six respondents stated that there had been positive changes in their physical, mental health, and social relationships as a result of participating in and obtaining rehabilitation services. These women, including the lesbian PWUD, mentioned that their sleep improved, their body weight increased, and they had more energy and motivation to fulfill their obligations. When they were still using drugs, they reported having headaches, anxiety, and being irritable; after CBDR, they became more clear-headed. Prior to CBDR, they experienced discrimination from their friends and families and were ashamed. After graduating from CBDR, they regained the trust of their family and friends and became more capable in caring for their children.
- Seven of the PWUD respondents said that after CBDR, their overall well-being significantly improved and they developed a more positive outlook in life, compared to their chaotic situation prior to CBDR. They also mentioned that they had more motivation to improve themselves so that

their names would be removed from the watchlist and help guide their families against using illegal drugs.

- We asked about the problems they encountered in availing CBDR. Four stated that they had problems relating to their absences from some of the modules in CBDR programs due to work and child rearing responsibilities, and the temptation to use drugs again during rehabilitation. Two of the respondents mentioned that since they were mistakenly tagged as drug users, they were forced to take CDBR to get their names off the watchlist. In the end however, they were thankful for having attended because their knowledge increased from participation in the OWC programs.
- All the female PWUDs gave the OWC a composite rating of 9.11 out of 10 (range: 6–10), because of the positive changes in their lives due to CBDR. Five of nine felt happier with their increased well-being from their successful recovery from drug addiction.

6.4.5. GEWE Findings on *Empowerment* from CBDR Interventions

Using the RBE framework, we examined the evidence and manifestations of women's empowerment in CBDR, similar to the approach and methodology that we adopted in other project sites. We analyzed the ability of the CBDR respondents to decide and act on their decisions from the time they started their drug rehabilitation up to their recovery. We also compared the perceptions of CBDR respondents on statements that measure women's empowerment.

Only nine women who had fully recovered from drug use participated in the GEWE assessment. Therefore, we conducted more in-depth qualitative data collection and focused on stories about the women's lives and their journey of empowerment from the time they started taking illegal drugs, getting caught under *OPlan Tokhang*, having rehabilitation under CBDR, recovering from drug use, and finally getting reintegrated back into their families and communities. More than counting the numbers, we focused on the thematic or content analysis of the women's empowering experiences. Because of the small sample size, we decided to use the comparison of changes in the Likert mean scores, instead of percentage analysis.

6.4.6. Findings of the Content Analysis

The CBDR experience tells a powerful empowerment story that shows the journey of the female PWUD from their chaotic lives and difficult relationships to their rehabilitation and returning to their families and communities. The themes in the content analysis focused on their experience with drug use, experience under CBDR, and GBV.

- Experience with drug use: life situation of female PWUD before they joined the CBDR
    - Before CBDR, the women referred to their lives as chaotic and their relationship with their families as difficult. Married PWUD reported constantly fighting with their husbands, who also used illegal drugs. Two of the female PWUD were beaten by their husbands and family members. Their children's needs were compromised because the female PWUD and their husbands preferred to buy drugs over food, baby supplies, and schooling. They did not think or care about their future. The relationship between the single PWUD and their parents was strained when the parents discovered that their children were using drugs. When the PWUD's

siblings and some relatives knew of the condition, they were shocked and felt ashamed about having a relative who was a drug user.
    - Family factors played a role in the use of drugs by female PWUD, such as having a male partner who was also a PWUD.
    - Reasons for using drugs: peer pressure, influenced by a drug user husband, lack of parents' attention, for fun, work (to stay awake), and escaping problems.
- Experience with and motivations for joining the CBDR
    - All respondents decided independently on treatment and rehabilitation to clear their names from the drug list due to fear of jail time and to improve their own well-being for the sake of their family and children.
    - The majority of PWUD (six of nine) rated the barangay CBDR services 10 out of 10, for the following reasons:
        - "CBDR was helpful. We were encouraged to stop using drugs."
        - "The barangay CBDR facilitator is very good."
        - "I've learned a lot about drugs due largely to CBDR."
        - "The staff provided clarity and change in perspective to PWUD."
        - The discrimination experienced by women/LGBTQI PWUD from their families ended when their families, particularly their children, recognized their efforts in attending and graduating from the CBDR program.
- Gender-based violence

  Some women users recounted experiences of violence and abuse from their husbands and families:
    - "In times of trouble with my husband, my escape was through drugs."
    - Mariel (not her real name) started using drugs in the 1980s. Mariel admitted that she and her husband, a police officer, frequently fought after she discovered that he was cheating on her. Her friends influenced her drug use, and she used it to avoid conflict with her husband.
    - "...I'm okay with my friends, but I've been beaten by my family."
    - Nanay Milagros, not her real name, 76 years old, is the only interviewee that never had used drugs but was a collateral victim of the drug war when the police raided her house at the time her son was a drug supplier. Her son is still in jail. Her name was inadvertently added to the watch list, and she was advised to take the CBDR to clear her name. She is currently living with her children and shared that when she has disagreements with them, they frequently beat her.
    - "I got to the point where I reported my husband to the barangay because he was beating me. I was also able to report him to the police and have him arrested."
    - Cristina (not her real name) narrated her story. "I was unhappy and constantly fought with my husband when he was still alive. When I noticed that our motorcycle was missing and I discovered that he sold it to a friend to buy drugs, I realized that my husband's drug addiction was getting worse. I became intrigued by the effects that drugs had on him. When one of his friends came to our house, I got tempted to use drugs. My children were aware that we were using drugs. My eldest son would always tell me to stop using drugs because they are worried and afraid of us. I was ashamed. I felt discriminated against by my neighbors. When my husband and I started fighting, and he was beating me, I heard our neighbors say, "*Sabog na. Init ang ulo ana kay wala nay kuan*…" meaning, "They must be disoriented and irritable because they don't have drugs."

- Ability to decide and act on the decision
  In this part of the gender assessment, we examined the decision making ability of the rehabilitated female PWUD given a set of post-CBDR life choices, as discussed below, and presented in **Figure 14**.
  - The majority (at least six of nine) decide independently to remain drug-free; engage in livelihood activities; join community organizations and social groups and take on leadership in organizations; participate in local community events and activities; speak out in family and group-based decision making; and use their free time for rest.
  - For other decision areas, such as going back to school or skills training, using their free time for socialization, and sharing workload and childcare during the drug rehabilitation, responses were more mixed, with several of them saying that they would talk with their husbands or parents and decide together.
- Change in perception of social norms, beliefs, and practices of respondents
  We examined the changes in the perceptions of female PWUD before and after CBDR relating to social norms, beliefs, and practices, and their agreement or disagreement with statements about substance abuse, abusive behavior, stigma, and drug use as a crime or a health issue. **Figure 15** presents the Likert mean scores of the female PWUD before and after CBDR.
  - When the women were still using drugs, more agreed that substance abuse could be a reason to sexually harass, abuse, or rape another, but their beliefs changed after they recovered and went through CBDR rehabilitation (mean scores of 3.13 before vs. 2.0 after CBDR)
  - Whether before or after CBDR, most (seven of nine) disagreed that it is justifiable for their husband to be abusive because he is not in his right mind as a drug user (mean scores of 1.88 before vs. 1.75 after CBDR)
  - There were more women who agreed after CBDR than before CBDR that the feeling of shame and stigma is higher for women due to social norms and expectations of acceptable behavior for women in light of their reproductive role in the family (mean scores of 4.0 before vs. 4.38 after CBDR)
  - Many continued to view drug use as a crime rather than a health issue because of the strong link to the *Tokhang* program and the trauma of police forces visiting their homes. Some women said that their fear of the police lessened after they recovered (mean scores of 4.5 before vs. 4.63 after CBDR).
  - More agreed after CBDR that drug use is an illness due to the physical, mental, and social changes they manifested (mean scores of 3.8 before vs. 4.5 after CBDR).
  - Some of the changes are quoted below:
    - Physical: "I used to feel ugly when I was using drugs. I was thinner and couldn't sleep well."
    - Mental: "I used to be irritable and stressed when I was still using drugs."
    - Social: "My family had previously been affected. They no longer trust me."

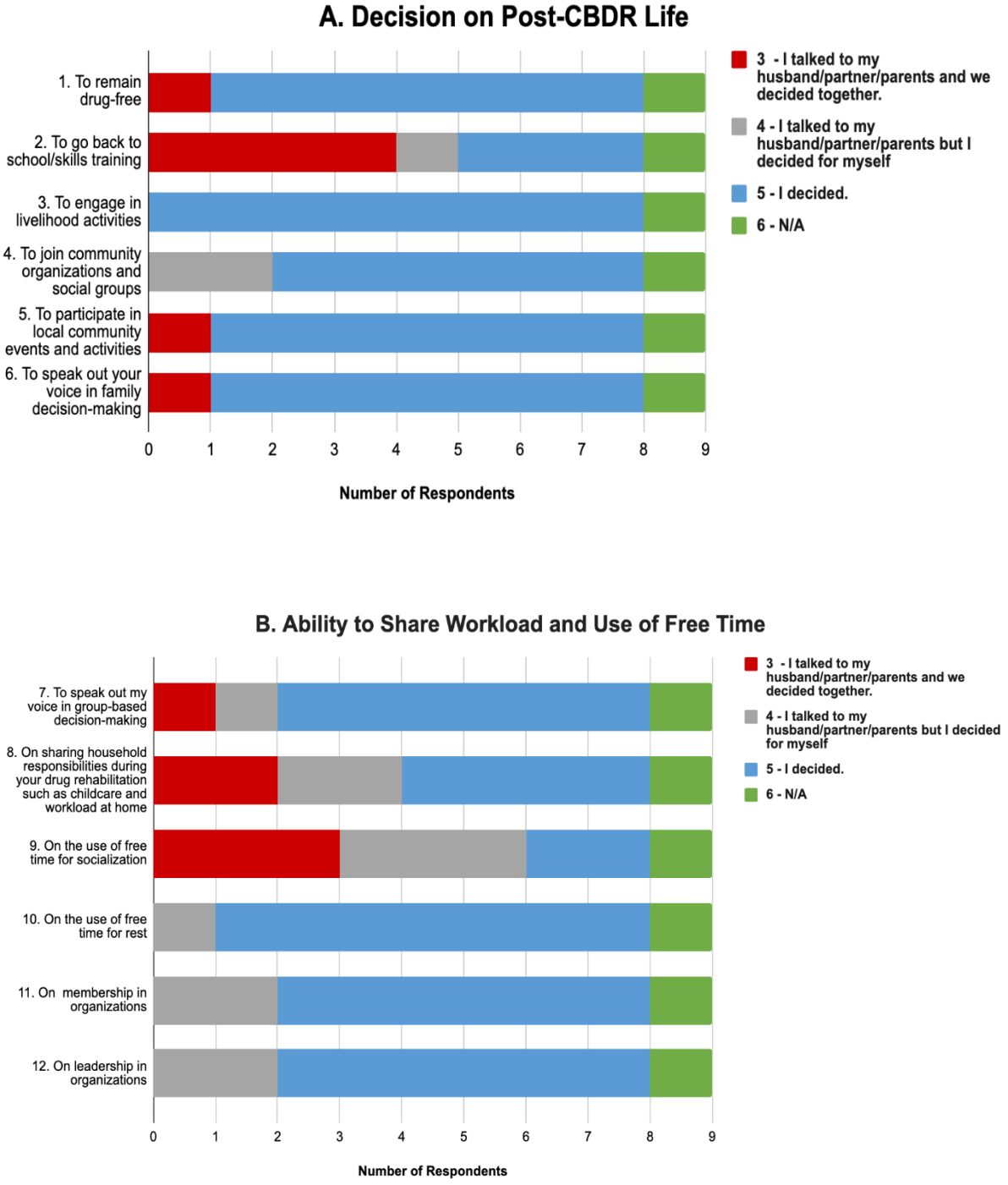


Figure 14. Part 1: Decision-making and Women's Ability (CBDR), N=9

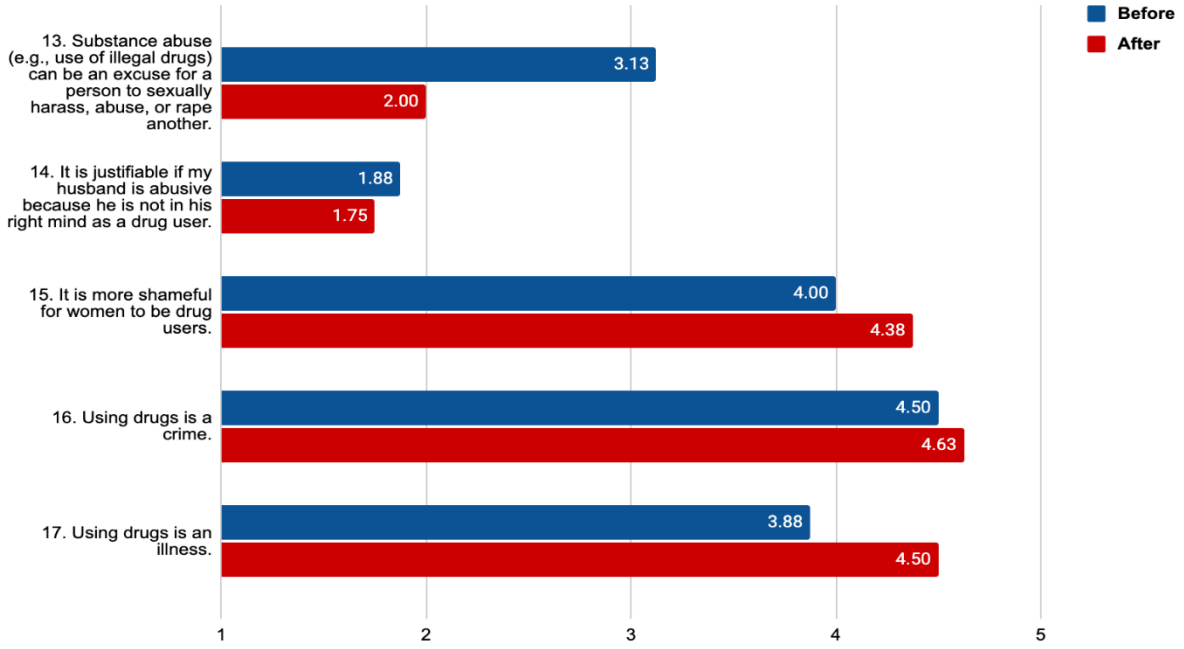


Figure 15. Part 2: Changes in Perceptions of Social Norms, Beliefs and Practices (CBDR) Likert Mean Score (N=9)

We also compared the changes in respondents' perceptions on their ability to speak out (voice), ability to select options in given situations (choice) using statements relating to the right to express women's opinion; obeying her husband even if she disagrees with him; sharing responsibilities at home; and men's willingness to sacrifice their own well-being for financial provisions for their wife and children (**Figure 16**).

- Female PWUD after CBDR were more able to express their opinion when they disagree with their partner's incorrect statements about drug rehabilitation information, compared to before CBDR (mean scores 4.38 vs. 4.75)
- Female PWUD after CBDR were more able to contradict their husbands in public about drug rehabilitation information (mean score 4.13 vs. 4.25)
- After CBDR, female PWUD had stronger disagreement that they should obey their husbands, even if they disagreed with his decision on drug rehabilitation (mean scores 1.63 vs. 1.25)
- More female PWUD believed after CBDR compared to before CBDR that their opinion is valuable and should always be considered when rehabilitation decisions are made (mean scores 4.75 vs. 4.5)
- Whether before or after CBDR, female PWUD believe that parents should maintain stricter control over their daughters than their sons. They related it to their own personal experiences and would not want their daughters to engage in wrongdoings like illegal drug use (same mean scores of 4.13)
- Female PWUD in both before and after scenarios strongly believe that men should participate in child rearing and household chores when the wife is under drug rehabilitation. (mean scores of 4.75 vs 4.88)

- Slightly more female PWUD believe after CBDR that men should be willing to sacrifice their own well-being to provide financially for the women in their lives when women are under drug rehabilitation (mean scores of 4.0 vs. 4.13)
- Slightly more female PWUD after CBDR agreed that after a fight or argument about drug rehabilitation, the wife should reconcile the problem first to maintain peace in the household (mean scores of 3.88 vs 3.75).

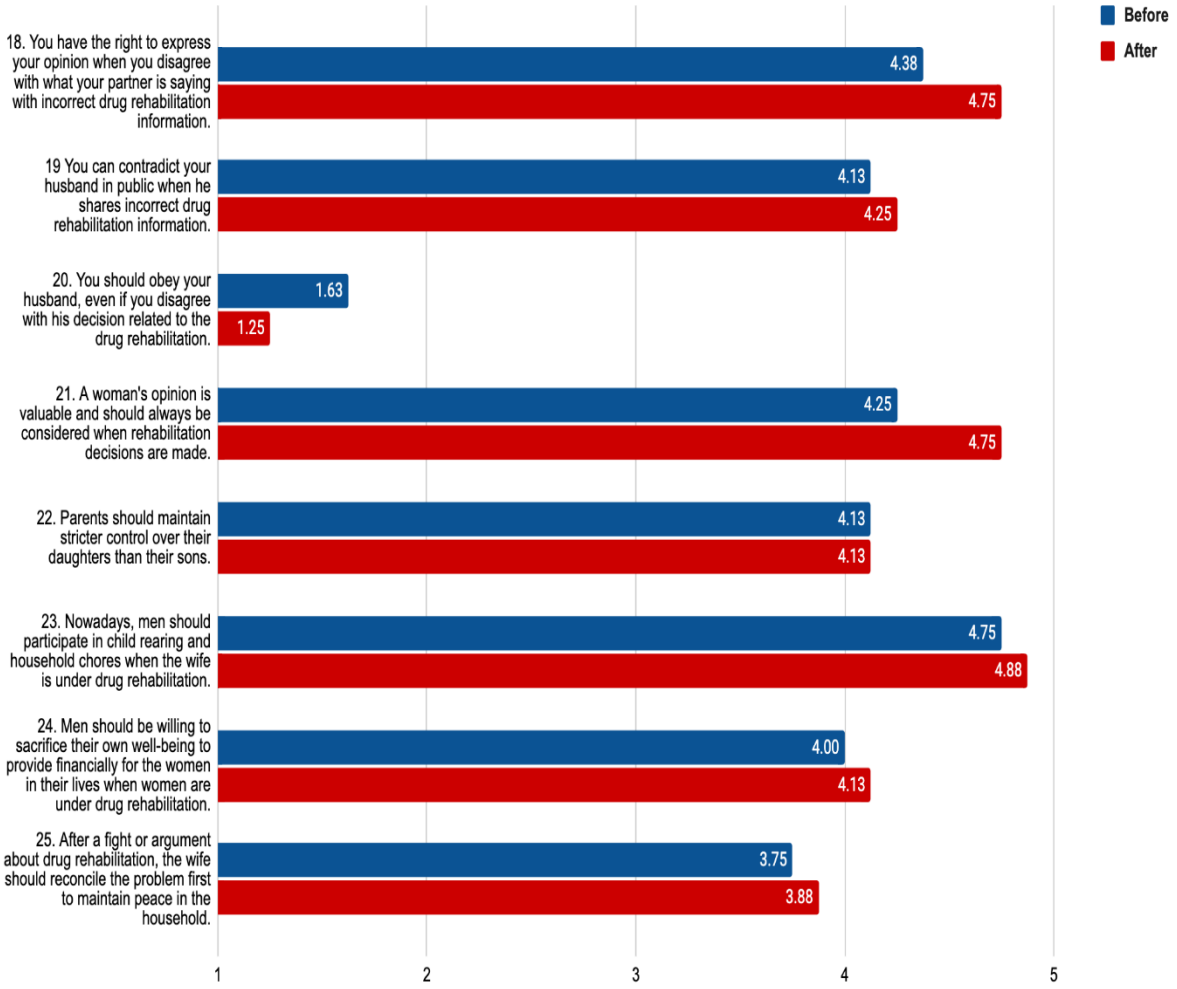


Figure 16. Part 3: Changes in Perceptions of Women's Voice and Choice (CBDR) Likert Mean Scores (N=9)

- Female PWUD willingness to share experiences with others
  - PWUD who have recovered become empowered advocates who are willing to share their experiences and to give hope to others that change is possible:

    "In the church, I shared my life experiences and asked for their prayers."

    "To give inspiration and education to others."

    "For them to recover in the future."

- Eight of nine rated their self-assessed level of confidence for sharing at 8.8 out of 10 points.
- Seven of nine stated that other people have sought their opinions about the negative effects of drug use to one's health and general well-being and their experience with CBDR.

7. DATA VALIDATION

7.1. Tracking System: Data Collection, Monitoring, Verification and Reporting

Based on our review of the AMEL plans of the IPs and the KIIs, IPs have trained staff dedicated to monitoring and evaluation (M&E), led by experienced senior M&E staff. The M&E staff we interviewed generally showed understanding of M&E processes and the context in which the data were being collected. However, we noted that some M&E staff have not received training on gender sensitivity at the time of the KIIs.

To ensure data quality, IPs stipulated guidelines on internal data quality assurance in their AMEL plan, although the level of detail of these data quality assurance initiatives vary. Based on the KIIs, we noted that IPs have multi-layered validation processes. In general, the IP field staff collects information from their partners (e.g., civil society organization [CSOs] partners, local health facilities), then submits the data to provincial/regional officers. The provincial/regional officers, in turn, submit the information to the IP's central M&E staff. At each level, the IP staff review and validate the data and call the attention of the individuals who submitted the data if they find any discrepancy. For instance, if the central M&E staff of TB Innovations find discrepancies in the data, they contact field implementation officers and immediately reflect the changes in the affected databases. For RenewHealth and BARMMHealth, we noted that many of the internal validation processes that the IPs described during the KIIs were not explicitly stated in the AMEL plans. A good practice is the data management flow diagrams that ReachHealth included in its AMEL plan that show how the data are reported.

The KIIs also provided us insights on the data management systems of the IP partners. The partners of the FP IPs have similar data quality assurance activities such as quarterly data quality checks, which are generally led by the local FP coordinator, as in the case of LMC. Oversight on the work of FP coordinators differ by type of facility. Provincial health offices review the data from CHOs and RHUs quarterly, while the head of the Obstetrics and Gynecology Department of LMC reviews the records annually. On the other hand, the Taguig CHO receives monthly data from nurses and lab aides (who are mostly BHWs and underboard or unlicensed midwives and nurses), then reviews the data and communicates with the nurse or lab aide who submitted the data through Facebook Messenger if there are data discrepancies.

For CBDR, OWC receives electronic copies of paper-based forms that LGUs use through Facebook Messenger, then encodes the data in Excel files. A RenewHealth staff deployed in the area assists OWC in reviewing the data before sharing them with RenewHealth. If there are discrepancies, OWC communicates with the concerned LGU (barangay). Because there are only two personnel who handle the data, the risk for unauthorized changes on the data is negligible. However, having only two people for this task also results in encoding backlogs. Additionally, there are data security concerns because

LGUs submit the forms through Facebook Messenger, and the Excel files used by OWC are not password-protected.

7.2. Compliance with Data Quality Standards

At the country level, the GNDR-6 allows Missions to identify programmatic gaps through the analysis of the number and types of people who were reached by GBV services/interventions based on the Gender Indicator Reference Sheet (IRS) from the U.S. Foreign Assistance Library. On the other hand, GNDR-8 measures the output of USG-supported capacity-building initiatives to support long-term, sustainable progress toward GEWE. As such, IPs are expected to use the information generated for this indicator to monitor and report their accomplishments that are linked to broader GEWE outcomes. The FP IPs (ReachHealth and BARMMHealth) report on GNDR-6, while both the FP IPs and TB IPs (TB Platforms and TB Innovations) report on GNDR-8.

7.2.1. GNDR-6: Number of people reached by a USG-funded intervention providing GBV services (e.g., health, legal, psychosocial counseling, shelters, hotlines, other)

ReachHealth obtains the information for this indicator from two sources: health facilities and civil society grantees that provide GBV services. Provincial/city technical officers collect data from the records of health facilities that provide GBV services through field visits or telephone interviews. CSO grantees submit data directly to the project coordinator at ReachHealth's central office. We did not find discrepancies in our document reviews, although we noted that a considerable percentage of beneficiaries did not have their sex data recorded (42 percent as of Q3 FY 2022 records). We also noted that ReachHealth's PIRS for the indicator appears to be consistent with the GNDR-6 IRS from the U.S. Foreign Assistance Library.[34] However, it is indicated in the PIRS in ReachHealth's AMEL Plan version 13 that the indicator is reported annually, even though the IP reports the indicator quarterly.[35] We also noted that the PIRS does not indicate the reports of CSO grantees as one of the data sources for GNDR-6.

Based on our KIIs and the response to our follow-up questions, BARMMHealth obtains data for GNDR-6 from RHUs and schools through the Home, Education/Employment, Activities, Drugs, Sex and relationships, Self-harm and depression, Safety, and abuse (HEADSSS) screening forms and the FP form 1. HEEADSSS screening forms for adolescents have questions on the experience of abuse while the FP Form 1 has a section on GBV risk screening. BARMMHealth provincial M&E staff collect the data from the accomplished HEADSSS forms and FP Form 1, then send the data through the BARMMHealth-initiated database for the consolidated report. Based on our document reviews, we noted that BARMMHealth reports GNDR-6 quarterly, even though the PIRS indicates annual reporting in the PIRS.

[34] While our review of the data suggests that ReachHealth did not include accomplishments from mass media campaigns for GNDR-6, ReachHealth should still reflect in their PIRS that individuals reached by mass media are not counted by GNDR-6 to be consistent with the GNDR-6 IRS from USAID Washington.

[35] This was already corrected in ReachHealth's AMEL Plan version 14. However, AMEL plan version 14 applies to FY 2023 which is not covered by the gender data validation activity.

Additionally, the indicator is not disaggregated by sex in the PITT and quarterly progress reports. We also noted that BARMMHealth does not reflect the actual data sources for GNDR-6 in the PITT.

Based on our document reviews, KIIs, and follow-up correspondence with the IPs, the data on GNDR-6 generally appear to adhere to the data quality standards of USAID. However, the lack of sex-disaggregated data in the reports and the considerable number of beneficiaries who did not have their sex recorded limit our ability to analyze the number and types of people who were reached by services/interventions. This could be due to the non-reporting or self-identification of the gender identity of the GBV victims, which in turn limits our ability to analyze programmatic gaps in relation to GEWE.

7.2.2. GNDR-8: Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations

For GNDR-8, ReachHealth reports the training data from the attendance sheets of their training activities that cover gender sensitivity and 4Rs for GBV victims.[36] Based on our document reviews, we noted that ReachHealth's PIRS is consistent with the GNDR-8 IRS and only found a minor inconsistency between ReachHealth's Q3 FY 2022 progress report (185)[37] with the Q3 FY 2022 PITT (186). Additionally, we noted that "project monthly accomplishment report" instead of "attendance sheets" is listed as the data source in the PIRS.

For the Bangsamoro Autonomous Region of Muslim Mindanao (BARMM), BARMMHealth reports those who were trained on FP Competency-Based Training (FPCBT) 1 and 2, and AJA as accomplishments under GNDR-8. Based on our KIIs and follow-up correspondence with BARMMHealth staff, BARMMHealth integrated modules on gender concepts, human sexuality, GBV recognition, supportive response, and referral in FPCBT 1 and 2, and AJA. Based on our document reviews, BARMMHealth reported zero accomplishment from Q1–Q3 FY 2022 but reported an accomplishment of 284 (120 percent of the annual target) in Q4 FY 2022.[38] We also noted that the PIRS for GNDR-8 in BARMMHealth's AMEL plan had the following missing information: 1) details (such as the indicator definition) found in the GNDR-8 IRS from USAID Washington, 2) attendance sheets as a data source, and 3) does not indicate sex in the disaggregation. However, our assessment for BARMMHealth on GNDR-8 is limited because we did not receive copies of the attendance sheets and their training inventory file/validated training data set from BARMMHealth.

Accomplishments on GNDR-8 of TB Platforms and TB Innovations come from their training activities on gender integration within TB programming. TB Platforms conducted face-to-face training while TB Innovations conducted virtual training activities. Based on our document reviews, we noted that the GNDR-8 PIRS in the AMEL plans of TB Platforms and TB Innovations do not contain the important information in the definition in GNDR-8 IRS from USAID/Washington. Additionally, the PIRS of the TB

[36] USAID's ReachHealth Q3 FY 2022 Progress Report, p.103.
[37] USAID's ReachHealth Q3 FY 2022 Progress Report, p.101.
[38] Q4 FY 2022 is not covered by the data validation activity.

IPs does not reflect that the indicator should be reported quarterly, provide sex disaggregation, and indicate their actual data sources.[39]

We also observed some data discrepancies in our review of the documents from the TB IPs. Specifically, based on the narrative on GNDR-8 of the Q3 FY 2022 report of TB Platforms,[40] there were inconsistent reports of health workers who were trained on gender integration within TB programming. The Q3 FY 2022 report states that 68 health workers were trained; Table 10 of the same report[41] indicated an accomplishment of 67; and the training inventory and attendance sheets indicated 73 attendees for Q3 FY 2022.[42]

For TB Innovations, based on the Q1 FY 2022 report, 121 individuals were provided an overview of gender and its integration into TB programming during the fourth batch of Integrated Training on National Tuberculosis Control Program Manual of Procedures, National Action Plan, and FAST.[43] However, only 76 were reported as trained, according to the updated validated gender dataset, and FY 2022 PITT of TB Innovations. TB Innovations staff explained that the discrepancy duplications among the 121 trainees reported in Q1 FY 2022 a well as those who did not list their affiliation.[44] TB Innovations did not report GNDR-8 explicitly in their quarterly reports, but only in their annual reports.

Based on the review of training materials, training designs, and attendance sheets, the IPs reporting GNDR-8 generally adhered to the definition of GNDR-8 IRS from USAID/Washington. However, IPs should clearly reflect the guidance from GNDR-8 IRS in their PIRS. Additionally, IPs should ensure that their progress reports reflect validated data with identified data sources.

7.2.3. Other indicators

We also reviewed the indicators associated with the GEWE initiatives of the IPs covered by the GEWE assessment.

For RenewHealth, on the indicator, number of PWUD who participated and completed CBDR services, we noted that while RenewHealth's written data workflow procedure only includes a forward collection and reporting system, the KIIs revealed that there are data validation and feedback mechanisms at every level of reporting. However, the frequency of data quality assurance of RenewHealth is unclear in its AMEL plan. Additionally, RenewHealth was not able to report disaggregated data (e.g, for sex, LGU, type of facility), which they had specified in their PIRS and data capture forms. Additionally, the running total for the year in Q2 FY 2022 (2,809) of RenewHealth is greater than the running total in Q3 FY

[39] The data sources for TB Platforms are the attendance sheets while the data source for TB Innovations should be the list of attendees of the online training,

[40] USAID's TB Platforms Q3 FY 2022 Progress Report, p.18.

[41] Ibid.

[42] The discrepancies are below the threshold of +/- 10 percent.

[43] USAID's TB Innovations Q1 FY 2022 Progress Report, p.30.

[44] According to GNDR-8 IRS from Washington, the individual must have been trained in their role as an actor within a public or private sector institution or organization to be counted under the indicator. Persons who were trained in their individual capacity should not be counted.

2022 (1,765).[45] RenewHealth's data may also have limitations in terms of validity and integrity because their local partner, OWC, has encoding backlogs that can result in incomplete data and inadequate data protection measures.

For ReachHealth, we reviewed the indicator, number of new FP acceptors from community demand generation activities. Based on our interviews, ReachHealth utilizes tracking forms to check the number of participants. Based on the filled-out forms we reviewed, we also found that *Usapan*/outreach forms captured important information about the attendees, such as sex, address, desire for more children, and previous and current FP use. The *Usapan*/outreach forms also allowed health workers to document whether the client was counseled, provided FP method, a new acceptor or current user, and whether the patient was referred to other facilities. We also reviewed ReachHealth's filled-out data collection tools and internal database on adolescents accessing ARH services. We found that the data collection tool and database captured the type of facility where adolescents accessed ARH services, the age group of adolescents (10–14 and 15–19 years) and the sex of the adolescents. We did not find discrepancies in the documents we reviewed. However, we noted blank items in ReachHealth's data collection form on adolescents accessing ARH services, which are specifically marked as "to follow."

For TB Platforms, we reviewed the number CHWs trained under the Come Alive/Be Alive Program. We reviewed attendance sheets from Taguig, Malabon, Quezon, Cavite, and Zambales that TB Platforms provided. The attendance sheets captured basic information about the trainees such as name, age, sex, designation, and affiliation. Based on our interviews, the lab aides in Taguig City who were trained by TB Platforms on Come Alive/Be Alive specifically found the training useful and effective in supporting their TB work.

8. CONCLUSIONS & RECOMMENDATIONS

8.1. Part 1. Gender Assessment

8.1.1. General Conclusions

1. Even if GEWE is not a stated or explicit objective of the IP activities, there are notable and visible findings that USAID's assistance, through IPs, directly contributed to the benefits that helped empower women.
2. The high ratings provided by all the respondents in FP, ARH, TB, and CBDR in their level of satisfaction with the services and benefits they obtained in the health facilities are direct and strong evidence of the improvements in their overall well-being.
3. While the direct link between *benefit* and *empower* following the RBE framework may not be conclusive because of the marginal differences in perceptions on empowerment, there are small empowering changes in perceptions that are visible after receiving benefits from the IP interventions.
4. While in many cases, the empowering experiences may have been influenced by other enabling factors, such as the presence of committed and dedicated health facility staff and strong support of

[45] It is likely that the data were updated in Q3 FY 2022.

LGUs, the IPs have made a significant client impact in terms of high satisfaction ratings that they received from the women beneficiaries across FP, ARH, TB and CBDR.

5. The analysis of the differences of mean scores showed higher perception of empowerment among the TB and CBDR respondents, compared with the FP and ARH respondents, as shown by the higher differences in mean scores of the former compared to the latter two. Between the FP and ARH respondents, there was a higher perception of empowerment in decision making among the FP users in Sindangan than among the adolescent mothers in LMC, mainly because decision making on RH services is made by the parents. The difference may also have been contributed by the age of the respondents, where the FP users had an average age of 32 and the adolescent mothers had an average age of 20 years.
6. Whether before or after FP, ARH, TB and CBDR interventions, the women respondents had strong perceptions (mean scores >4 out of a scale of 5) that reflect prevailing social norms about women's obligation to take care of their family and their children. Even if the respondents agreed that they have the ability to ask their husbands/partners to share responsibilities and workload at home, they would rather take on the load because they are responsible for household work (this particularly applies to FP users). This normative belief reinforces the reproductive and productive divide that perpetuates gender inequality and disempowerment of women and girls.
7. Social media (online) as a source of information for FP, ARH, TB and CBDR was not mentioned by the women respondents. Rather, most derived their information directly from the BHWs in their respective communities, from health workers in the facilities, and from tarpaulins in health centers that provide information on health services.
8. Counseling is a highly effective empowerment intervention across programs that increases women's agency. Providing the women respondents with access to knowledge about interventions, services, treatment protocols, methods, and side effects empowers them to make independent decisions, reduces feelings of stigma, and changes mindsets on negative social norms and traditional beliefs. Counseling would be more effective if there is joint male and female participation and more male involvement, especially among adolescent boys in ARH, and men who are higher prevalence in contracting TB infection.
9. The findings are based on a limited sample of respondents for FP, ARH, TB, and CBDR, and the conclusions may not be comparable with studies with bigger samples.
10. Most of the findings of the gender assessment aligned with the research findings from the review of literature relating to other countries' experiences in empowering women after their involvement in the FP/ARH, TB, and CBDR programs.

Presented below are specific conclusions and recommendations per health sector. The conclusions are presented following the RBE framework and the dimensions of women's empowerment—decision making, access to resources, division of labor and gender roles, time use, and leadership (voice and choice).

8.1.2. Family Planning

Conclusions

Whether before or after use, the FP users perceived that they have a strong ability to make FP-related decisions (mean scores > 4.5). Even if the differences in perceptions are marginal, there are visible changes after FP use, which may be linked to the benefits derived from USAID IPs' assistance to the health center and its health workers. For FP, the link cannot be attributed to the FP intervention associated with the community theater and its related demand generation activities, because none of the FP respondents participated in the community theater which had not resumed at the time of this study. The benefits could instead be linked to the highly rated services of the health center staff who were trained and assisted by ReachHealth, and to the support of the LGU leadership, which adopted FP as one of its priority programs.

- *Reach* and *Benefit*
  - Women respondents had a positive experience overall with using FP methods and services, and high levels of satisfaction from health facility services and benefits received.
  - Prior to COVID-19, the RHU conducted an effective demand generation for FP through its three-pronged approach of community theater, *Usapan,* and FP Caravan in each barangay However, during the GEWE assessment, this strategy, paused with the onset of the pandemic, has not been resumed. Hence, there is no link among the RBE dimensions with the community theater.
- *Empower*
  - Decision-making
    - The FP respondents showed increased ability after FP use to decide when to have children, what FP methods to use, continue to use modern FP methods, and ask their husbands to use protection (e.g., condoms) whenever they have sex or say no to sex if their husbands or partners refuse to use a condom.
    - While the benefits from FP use increased the women respondents' overall well-being and risk protection from unplanned pregnancy, some respondents said that the use of FP reduced the women's ability to refuse their husbands/partners to have sex, because they have protection from the risk of pregnancy.
    - There were positive changes after FP use in perceptions of social norms, beliefs, and practices, e.g., that it is not only women who are responsible for FP; that it is not wrong for unmarried women to avail of birth control devices; and that abusive behavior by spouses is never justifiable.
    - There are entrenched traditional beliefs that have not changed, such as forgiving a cheating husband to keep the family together; that it is the wife's obligation to have sex with her husband, even if she does not want to; and that after a fight or argument about family planning, the wife should reconcile and settle the problem first to maintain peace in the household.
  - Access to and control over resources
    - The stockout of free FP commodities in health centers is disempowering women, because it has caused unintended pregnancies and added financial burden to buy their own contraceptives.
  - Division of labor, gender roles, and time use
    - Perceptions of social norms, beliefs, and practices reinforce women's reproductive roles in childcare, because FP services mainly target women, making FP use predominantly a

women's issue. This normative approach can backfire against women and discourage joint responsibility in FP.
    - More FP users believe that men should participate in child rearing and household chores and should be willing to sacrifice their own well-being to provide financial support for their wives and children. After FP use, more respondents believe that they have the ability to ask their husband or partners to share responsibilities and workload at home.
- Leadership (voice and choice) and group membership
    - The knowledge gained from FP counseling may have contributed to the strong belief of FP users that a wife has the right to express her opinion when she disagrees with her husband who gives incorrect FP information. However, the women respondents hesitate to contradict their husbands in public about family planning, saying that they would rather do this in private.
    - Most respondents are members of community organizations and have a high level of confidence to share their positive experience with FP and encourage other women in its use.

Recommendations

- Incorporate GEWE topics in FP counseling sessions, including joint responsibility of husbands and wives for FP, sharing of workload childcare and domestic work in the household, and increased ability of women clients to make decisions about their body autonomy.
- Provide gender sensitivity training to health workers to help break gender social norms that reinforce gender inequality and disempower women and adolescent girls
- Support the resumption of the community theater in support of the following outcomes: 1) generating demand for FP and advocacy in support of preventing teen pregnancy; 2) eliminating GBV in its many forms (physical, psychological, emotional, economic, or non-support), including discrimination and stigma against LGBTQIAs; 3) involving more males in FP/RH; 4) transforming social norms that reinforce gender inequality (such as gender norms that result in women's disproportionate domestic burden); and 5) supporting the norm of women as leader.

8.1.3. Adolescent Reproductive Health

Conclusions

Similar to FP users, the differences in the changes in perceptions of adolescent respondents before and after use are marginal. However, there are visible differences in their increased ability in making FP-related decisions, particularly on the FP methods to use and postponing pregnancies, which could be linked to the benefits they derived from FP counseling services at LMC.

- *Reach* and *Benefit*
    - The FP counseling and reproductive life planning increased the knowledge and ability of the adolescent respondents to make independent decisions on FP use, and their preferred FP methods in preventing repeat pregnancies.
    - The FP in Hospitals program is effective and successful in providing long-acting reversible FP methods to prevent repeat pregnancies among teens.

- The key benefit to FP use by teens is overall well-being and peace of mind after obtaining FP services and not getting pregnant. The level of satisfaction of the adolescent mothers is high due to the good quality service of the staff.

- *Empower*
  - Decision making
    - There are five empowerment statements where the positive shifts in perceived abilities of adolescent respondents after FP use are highly visible, even at their young age: 1) when and what methods to use; 2) to continue using modern FP methods; 3) limiting the number of children and postponing pregnancy; 4) asking their partners to use protection whenever they have sex; and 5) refusing to have sex if done without protection. The FP counseling may have contributed directly to these results.
    - However, even with the perceived abilities of the adolescent respondents, their parents made the major decisions for their daughters (teen mothers) on FP use and access to RH services, where parents and relatives, rather than the adolescents, served as signatories to these services. Parents also played a big role in the removal of implants because of their religious beliefs that allow only the use of natural FP methods.
  - Access to resources
    - Constraints adolescents faced in obtaining ARH services included lack of access to FP information to prevent pregnancy, lack of parental guidance, and ineffective communication on sexuality.
    - Similar to FP users, , the stockout of FP supplies has resulted in unplanned repeat pregnancies among the adolescent respondents.
    - More adolescent respondents after FP use believe in their perceived ability to use their family income and their own incomes for their needs and for going to the health center.
  - Division of labor, gender roles and time use
    - Whether before or after use, the adolescent respondents strongly believe in the normative expectations of women's reproductive role: that they should stay at home and focus on taking care of their children; that their husbands are expected to support the family; and that they should be willing to sacrifice their own well-being to earn income for the family.
    - Almost all the adolescent respondents however, agreed that domestic work is a shared responsibility and that men should participate in child rearing and household work. They believe that they have the ability to ask their husbands and partners to share workload at home.
  - Leadership (voice and choice)
    - Even before FP use, the adolescent respondents already have empowered opinions against negative social norms, implying that this finding may have no bearing on FP use. They strongly believe that it is not justifiable for drunken husbands to hit their wives; that parents should not be the ones to decide on their access to RH services; that it is not the wife's obligation to have sex with their husbands if they do not want to; that it is not only the women's responsibility to avoid getting pregnant; that it is not wrong for unmarried women to avail of birth control services; and that women should reconcile the problem first, after a fight or argument with their husbands about FP or sexual intercourse, to maintain peace in the household.

- There were also no changes before and after FP use in the perceptions of the adolescent respondents who strongly agreed that a wife has the right to express her opinion when she disagrees with what her husband says about FP; a wife can contradict her husband in public about FP if he provides incorrect information; and if there is a disagreement about FP, the woman should have the final say because she bears the child.

Recommendations

- In light of the continuing rise of unplanned teen pregnancy, develop practical and actionable strategies for pregnancy prevention that could be implemented and scaled up in local health facilities. This may include building and strengthening partnerships with DepEd in implementing its Comprehensive Sexuality Education program; with the local health facility staff to serve as resource persons to deliver sex and age-appropriate information on SRH in schools; and with parent-teacher associations to educate parents and teachers on adolescent sexuality. Expand CSE coverage to also include adolescents who are members of the LGBTQIA community, who have specific RH and mental health needs.
- Continue technical assistance to LMC to get accreditation as an FP Training Center and enable the center to spread its good practices to other health facilities.
- Continue assistance in the supply chain management of FP commodities to LMC to avoid stockouts and ensure the timely delivery of FP commodities.
- In five years, conduct an evaluation on the impact of reproductive life planning and FP counseling with adolescent clients to provide a larger body of evidence on its effectiveness and transformative outcomes.
- Segment SBCC sexuality messages according to the parents' generation, e.g., baby boomers, Gen X, and Y to effectively advocate action to promote FP and ARH. Consider the parental factors that contribute to adolescent pregnancy, such as the need for attention and guidance from parents.
- Work with Adolescent Friendly Facilities to broaden the reach of teen-friendly services (dental, career counseling services, others) to encourage use of the facilities for both sexually and non-sexually active female and male adolescents.
- Use the findings of the GEWE assessment to develop gender -transformative SBCC messages, particularly in changing negative social norms that promote gender inequality and disempower women and adolescents. Recognize and reinforce their increased abilities after FP use to make independent FP-related decisions.
- Additionally, scale-up *Konektado Tayo* for parents to help reduce pregnancy, in collaboration with parents-school associations and with the Family Development sessions under the 4Ps.
- Develop a FP counseling program for adolescent fathers to encourage their involvement and joint responsibility in FP and RH; support equality in their relationship and valuing women's opinions in decision making in the household; and help change mindsets on negative socially prescribed behaviors, such as justifying domestic violence and cheating on their wives.
- For future ARH projects, use the RBE framework to build empowerment dimensions into the design of technical assistance activities. Ensure that proposed activities go beyond the *benefit* dimension of the framework and develop metrics to measure women's empowerment.

8.1.4. Tuberculosis

Conclusion

There is strong evidence of women's empowerment among recovered TB patients in their abilities to make TB-related decisions and the positive changes in their perceptions about TB, demonstrating a clear and visible link between *benefit* and *empower* in TB recovery. These could be attributed to the services and benefits that they derived from the health facility and their well-trained, committed, and encouraging staff.

- *Reach* and *Benefit*
  - All the TB respondents were highly satisfied with the good quality services that they obtained from the Taguig City health center, giving the facility the highest rating of 10/10.
  - The level of client satisfaction with the Taguig Health Center's TB services is impressive. This performance is also reflected in the recognition of the Taguig Health Center's top performance for TB services among 17 National Capital Region cities.
  - The Come Alive/Be Alive training provided by TB Platforms and its implementation by the Taguig Lab Aides was recognized as an enabling factor that contributed to the high client satisfaction rating of the Taguig Health Center.
  - Among the benefits that the TB respondents derived are improvements in their well-being, peace of mind about their TB recovery, increased knowledge of TB, increased self-esteem, and self-confidence to share their journey of treatment and cure with other women and willingness to serve as TB champions in their communities.
- *Empower*
  - Decision making
    - The TB respondents demonstrated strong ability in making independent decisions on TB screening and completing treatment; in encouraging their husbands and family members to be screened for TB; and in bringing those who screened positive for TB to the health center for treatment. These decisions showed the improved capacity of the recovered TB respondents to better take control and care for themselves and their families. The ability to make independent decisions may also have been influenced by their age groups; the average age was 47 years.
    - The TB respondents have strong beliefs that women and men with TB should be able to get married, have children, and have outside employment, but added that it would be better to wait until they have fully recovered from TB.
    - All the TB respondents believed that it is not shameful for women to have TB, adding that TB is curable and acquiring the infection does not choose gender. However, some TB respondents felt an inner stigma due to fear of discrimination by their peers, neighbors, and family members, and fear of infecting others.
  - Access to resources
    - On access to TB information, almost all the TB respondents learned about TB from their TB counseling with the CHW/lab aide; others learned about the availability of TB services through leaflets and tarpaulins posted at the health center. None mentioned social media as a source of TB information.

- The health center provides free TB screening, treatment, and medications. Some respondents mentioned that they were willing to spend for treatment, such as the cost of X-rays.

  - Division of labor and gender roles
    - The TB respondents are divided on their perceived ability to decide on the sharing of household responsibilities with their husbands during TB treatment. While half believe that they can decide independently, the other half believe that they need to decide with their families on the division of household chores, because of the normative expectation that housework is a woman's reproductive role.
  - Leadership (voice and choice)
    - The TB respondents expressed willingness and high level of confidence to share their positive experience with TB in their barangay to raise awareness about TB, be an example to encourage and inspire other women and men to be treated for TB, tell others that TB can be treated, and promote the message that TB is not a cause of shame, especially for women.

Recommendations

- Conduct a case study of Taguig as a model health center for replication and scaling up in other high-burden TB communities, following its unique and pioneering good practices such as the creation of lab aides and TB Task Force at the barangay, and full LGU support, in actively finding, treating, and curing marginalized groups of men and women, and their exemplary practices in counseling and tracking TB cases. The study could also focus on their ACF strategy to reach the male members of the marginalized groups—tricycle drivers, construction workers, among others.
- Consider replicating the Come Alive/Be Alive training program as a high-impact TB intervention in line with the TB Roadmap Framework of TB Platforms and enhancing the program with the inclusion of gender-responsive and culture-sensitive content (e.g., removing perceptions of stigma that disempower women, addressing the low health-seeking behavior of men who have a higher prevalence rate of TB than women).
- Include women's empowerment in TB counseling, including joint responsibility in TB treatment, sharing of household work to reduce the workload of women, and misperceptions that limit women's opportunities, e.g., women should not work when they have TB.
- Mobilize women who recover from TB to play the role of effective partners in the treatment process of other women patients, and as companions in overcoming difficulties during the treatment journey, as it can empower others to follow their lead.
- Tap the enthusiasm of recovered women TB patients, many of whom are willing to share their journey towards recovery and serve as champions for TB elimination campaigns. Giving former women TB patients the opportunity to take part in advocacy and social mobilization activities is empowering. Through this opportunity, women TB patients are given the avenue to model a positive image for persons affected by TB and how TB care and treatment are being provided.

8.1.5. Community Based Drug Rehabilitation

Conclusions

Similar to the women TB respondents, the female PWUD demonstrated strong links with the benefits derived from CBDR and the empowering experiences, as shown by their life stories.

- *Reach* and *Benefit*
  - The women PWUD respondents are highly satisfied with the CBDR treatment and rehabilitation services of OWC and the barangay CBRD managers. Their experience with CBDR was highly positive in terms of overall improvement in their physical and mental state, and family and social relationships. They have a more positive outlook in life compared to their chaotic lives before CBDR.
  - The female PWUD benefited most from the CBDR program through the removal of their names from the watch list, enabling them to return to their normal lives prior to CBDR.
  - The level of satisfaction has a high score of 9.11 (on a scale of 10), which is reflective of the positive feedback on the CBDR program of OWC. At the same time, the female PWUD also rated the services directly provided to them by the barangay CBDR managers (BCM) 10/10. The BCMs were trained by RenewHealth and OWC. The reasons included the effectiveness of the CBDR services in stopping them from using drugs, and accommodating and helpful staff who helped them change their perspective to viewing drug abuse as a health issue.
- *Empower*
  - Decision making and experience with CBDR
    - The female PWUD decided independently to remain drug free and undergo treatment and rehabilitation to clear their names from the drug list due to fear of jail time and to improve their own well-being for the sake of their family and children. Most of the female PWUD respondents are in their mid-life (average age is 44 years) and have more than four children on average.
    - The female PWUD also decided independently to engage in livelihood activities, join community organizations and social groups and take on leadership in organizations, participate in local community events and activities, speak out in family and group-based decision making, and use their free time for rest.
    - Experience with drug use showed that family factors played a key role, such as having a male partner who is also a PWUD. The female PWUD also played a key role in encouraging their male partners to undergo rehabilitation.
    - The PWUD's completion of the CBDR program ended the discrimination experienced by women/LGBT PWUD from their families, particularly their children, who recognized their efforts in completing the CBDR program.
    - After completing the CBDR program, PWUD respondents have regained the trust of their family and friends and have become more capable of caring for their children.
    - For female PWUD who were mistakenly added to the *Tokhang* list, the CBDR experience was disempowering because of the discrimination and stigma attached to drug users.
  - Experience with GBV

- Three of the nine women experienced GBV prior to CBDR. One had a husband who was a police officer who cheated on her and beat her up; the second one was a 76-year-old woman who experienced elder abuse from her family; and the third had a violent drug-addict husband. In two cases, the female PWUD used illegal drugs to escape their realities. The CBDR experience helped these women cope with violence as they got rehabilitated.
- Other studies have shown that majority of female PWUD suffer from depression and sexual abuse. However, no respondents from the GEWE assessment had these experiences.

- Perceptions of social norms relating to drug use
  - More female PWUD believe that substance abuse is not a reason to sexually harass, abuse, or rape another; and that it is not justifiable for their husband to be abusive because he is not in his right mind as a drug user.
  - Shame and stigma are higher for women due to social norms and expectations of acceptable behavior for women in light of their reproductive role in the family.
  - Female PWUD believe that parents should be stricter with their daughters to prevent them from engaging in drug use.
  - Despite their experience with CBDR, female PWUD continued to view drug use as a crime rather than a health issue, because of the trauma from *Oplan Tokhang*, although some of the female PWUD said that their fears have lessened after CBDR.
  - After experiencing CBDR, more female PWUD agreed that drug use is an illness due to the physical, mental, and social changes they manifested.

- Sharing experience with others
  - Almost all the female PWUDs said that they are willing to share with others their journey of rehabilitation from the time they started up to their rehabilitation. The reasons for sharing include inspiring others to undergo treatment and rehabilitation by telling them about their life experiences, and showing that positive change is possible.

Recommendations

- Include the ability to deal with GBV among female PWUD when providing counseling or motivational interviewing in CBDR, and develop partnerships with referral networks that provide GBV services.
- Identify and capacitate empowered and recovered female PWUD as champions to educate and advocate against illegal drug use.
- Conduct communications research to design and adopt gender-sensitive and data-informed SBCC approaches to de-stigmatize PWUD, especially women who experience greater stigma and discrimination.

8.2. Part 2: Data Validation

Conclusions

Overall, the USAID IPs have dedicated M&E teams that are staffed by personnel with adequate training and experience on M&E. IPs generally have multi-layered data validation and feedback mechanisms, and the gender indicator data that IPs are reporting generally adhere to the data quality standards of USAID. Limitations include the following:

- Because there was no sex disaggregation of GNDR-6, the analysis of programmatic gaps with respect to GEWE is constrained.
- The IPs' data on GNDR-8 appeared to adhere to the guidance from USAID/Washington on GNDR-8 but the said guidance is not always clearly reflected in the PIRS, and we noted some data discrepancies.
- In terms of reported number of PWUD who completed treatment, possible incomplete data affect the validity of findings, and data security concerns affect the data integrity.

Recommendations

- For USAID OH
  - As USAID develops gender-responsive projects, there is a need to ensure that GEWE is integrated starting from conceptualization and design, with clear and explicit transformative objectives and performance measurements that are embedded in the IP's M&E databases.
  - As online social media as an advocacy and demand generation was not identified as a source of information in the interventions assessed here, there is a need for research and evidence-based approaches in developing targeted SBCC strategies for GEWE.
- For USAID IPs
  - USAID IPs need to exercise due diligence in complying with USAID DQA requirements for sex and gender disaggregation of all people-level indicators in progress reports and the PITT, as mandated by USAID gender policies. IPs should also comply with the USAID gender guidance in the PIRS on data collection and reporting of gender data for GNDR 6 and GNDR 8.
  - Reflect details from the GNDR-8 IRS from USAID Washington as well as the actual data sources in the PIRS.
  - Work in collaboration with DOH, on how to capture data of people with diverse sexual orientation, gender identity and expression and sexual characteristics (SOGIESC) from data source forms, such as attendance sheets (by creating a data item for gender identity) and WPCU reports in health facilities.
  - Include data management diagrams for each indicator in the AMELPs.
  - Regularly report sex disaggregation in the progress reports and PITT to meet the USAID gender guidance in the PIRS on data collection and reporting of gender data for GNDR 6 and GNDR 8.
  - Ensure that the data are validated for duplicates and incomplete information before they are reported in the progress reports.
  - Work with LGUs and other government agencies in developing information systems with relevant fields to capture disaggregation specified in the PIRS.
  - Explore other data sharing systems and develop password-protected templates.

REFERENCES

Alimoradi, Z., Kariman, N., Simbar, M., & Ahmadi, F. (2017). Empowerment of Adolescent Girls for Sexual and Reproductive Health Care. *African Journal of Reproductive Health / La Revue Africaine De La Sante Reproductive*, 21(4), 80–92. https://doi.org/https://www.jstor.org/stable/10.2307/26570623

Countdown 2015 Europe. (n.d.). Fact sheet 2012: Family planning saves lives and improves health. Retrieved from https://www.countdown2030europe.org/storage/app/media/IPPF_FactSheet-4_Health.pdf

Hunter, et. al. (2012). Factors of Empowerment for Women in Recovery from Substance Use. *American Journal of Community Psychology*, 51(1-2), 91–102. https://doi.org/10.1007/s10464-012-9499-5.

Macq, J. (2007). *Empowerment and involvement of tuberculosis patients in tuberculosis control: Documented experiences and interventions* (pp. 1–36).

Malapit, H., Quisumbing, A., Meinzen-Dick, R., Seymour, G., Martinez, E. M., Heckert, J., Rubin, D., Vaz, A., & Yount, K. M. (2019). Development of the project-level Women's Empowerment in Agriculture Index (pro-WEAI). World Development, 122, 675–692. https://doi.org/10.1016/j.worlddev.2019.06.018.

Reach-Benefit-Empower-Transform (RBET) Framework. CGIAR Gender Platform. (n.d.). Retrieved from https://gender.cgiar.org/tools-methods-manuals/reach-benefit-empower-transform-rbet-framework

Sangar, S. (2018). Bringing women's perspective to family planning. *Current Science*, 115(4), 633–637. https://doi.org/ https://www.jstor.org/stable/10.2307/26978270

USAID, (2022). USAID/Philippines Health Project Multiyear Whole-of-Project Performance Evaluation (2018–2021). Manila, Philippines. February 2022.

USAID Learning Lab, (2021). How-to Note: Conduct a Data Quality Assessment. Bureau for Policy, Planning, and Learning. USAID Health Project Appraisal Document, 2017.

ANNEXES

Annex A. Table of Likert Mean Scores for Empowerment

Family Planning (N=17)
Sindangan Rural Health Unit, Zamboanga del Norte

Empowerment Part 1	**Before**	**After**	**Difference**	**Standard Deviation**	
				Before	**After**
1.I decided when to have children.	4.47	4.82	0.35	0.72	0.39
2. I decided when and what FP methods to use.	4.53	4.71	0.18	0.94	0.59
3. I decided to continue using modern FP methods.	4.65	4.76	0.11	0.79	0.56
4. I can ask my husband/partner to use protection (e.g., condom) whenever we decide to have sex.	3.94	4.06	0.12	1.14	1.03
5. I can refuse to have sex if it will be done without protection.	4.53	4.41	-0.12	0.72	0.87
6. I decided to limit the number of children or postpone subsequent pregnancies	4.53	4.59	0.06	0.72	0.62
7. I decided to go to the local health unit (RHU) on my own without asking permission from anyone.	4.71	4.65	-0.06	0.47	0.61
8. I can ask my husband/partner to go with me for medical check- ups (prenatal, post-natal, illness consultation).	4.47	4.29	-0.18	0.72	0.85
9. I can ask my spouse/partner to share responsibilities and workload at home.	3.94	4.53	0.59	1.25	0.72
10. I decided to use the family income for my needs (e.g. transportation to go to health clinics, buy medicines.)	4.53	4.53	0.0	0.62	0.72
11. I decided to use my income for my needs (e.g. transportation to go to health clinics, buy medicines), without telling my husband/partner.	4.24	4.29	0.059	0.90	0.92
12. I can say no to having sex with my husband if he refuses to use a condom.	4.71	4.88	0.18	0.59	0.33
Empowerment Part 2	**Before**	**After**	**Difference**	**SD Before**	**SD After**
13.It is only a woman's responsibility to avoid getting pregnant.	3.94	4.24	0.29	1.53	1.30
14. If a man and woman disagree about family planning, the woman should have the final say because she bears the child.	4.35	4.36	0	1.22	1.17
15. It is a wife's obligation to have sex with her husband even if she does not want to.	4.65	4.76	0.12	1.63	1.77

16. I don't have to ask my husband's permission to get birth control services.	4.06	3.47	-0.59	1.25	1.59
17. It is wrong to avail of birth control services unless you are a married woman.	3.18	2.59	-0.59	1.67	1.70
18. RH services must be accessible and affordable or free.	4.76	4.65	-0.35	0.56	0.86
19. I should forgive my husband even if he cheated on me because I need to keep my family together.	3.24	3.35	0.12	1.75	1.62
20. It is justifiable if my husband hits me because he is drunk.	1.57	1.65	0.06	1.06	1.06
21.I should focus on taking care of my children instead of working outside the home.	3.29	4.06	0.76	1.61	1.30
Empowerment Part 3	**Before**	**After**	**Difference**	**SD Before**	**SD After**
22.A wife has the right to express her opinion when she disagrees with what her husband is saying about family planning.	4.53	4.71	0.18	1.01	0.59
23.A wife can contradict her husband in public about family planning.	3.353	3.53	0.18	1.37	1.50
24. Nowadays, men should participate in child rearing and household chores rather than leaving it all to the women.	4.76	4.82	0.06	0.56	0.39
25. Parents should maintain stricter control over their daughters than their sons.	4.06	3.764	-0.29	1.30	1.52
26. Men should be willing to sacrifice their own well-being to provide financially for the women in their lives.	4.47	4.47	0	0.87	1.180.87
27. After a fight or argument about family planning, or sexual intercourse, the wife should reconcile the problem first to maintain peace in the household.	4.24	4.06	-0.18	1.35	1.14

Adolescent Reproductive Health (N=12)
Laguna Medical Center, Sta. Cruz, Laguna

Empowerment Part 1	**Before**	**After**	**Difference**	**Standard Deviation**	
				Before	**After**
1. I can decide when to have children.	4.33	4.50	0.17	1.11	0.76
2. I can decide when and what FP methods to use.	3.92	4.58	0.66	1.26	0.76
3. I can decide to continue using modern FP methods.	4.25	4.83	0.58	1.36	0.55
4. I can ask my husband/partner to use protection (e.g., condom) whenever we decide to have sex.	3.58	4.08	0.50	1.61	1.19
5. I can refuse to have sex if it will be done without protection.	3.91	4.45	0.54	1.58	0.78

6. I can decide to limit the number of children or postpone subsequent pregnancies	3.67	4.58	0.91	1.37	0.76
7. I can decide to go to the local health unit (RHU) on my own without asking permission from anyone.	4.17	4.42	0.25	1.14	0.76
8. I can ask my husband/partner to go with me for medical check-ups (prenatal, post-natal, illness consultation).	4.92	4.92	0.00	0.28	0.28
9. I can ask my spouse/partner to share responsibilities and workload at home.	4.42	4.50	0.08	1.19	1.19
10. I can decide to use the family income for my needs (e.g. transportation to go to health clinics, buy medicines.)	4.17	4.42	0.25	1.28	1.19
11. I can decide to use my income for my needs (e.g. transportation to go to health clinics, buy medicines), without telling my husband/partner.	4.22	4.44	0.22	1.31	1.26
12. I can say no to having sex with my husband if he refuses to use a condom.	4.33	4.83	0.50	1.18	0.37
Empowerment Part 2	**Before**	**After**	**Difference**	**SD Before**	**SD After**
13. It is only a woman's responsibility to avoid getting pregnant.	2.83	2.67	-0.16	1.70	1.61
14. If a man and woman disagree about family planning, the woman should have the final say because she bears the child.	4.50	4.42	-0.08	1.17	1.24
15. It is a wife's obligation to have sex with her husband even if she does not want to.	2.00	2.08	0.08	1.35	1.38
16. I don't have to ask my husband's permission to get birth control services.	3.42	3.58	0.16	1.83	1.78
17. It is wrong to avail of birth control services unless you are a married woman.	2.17	2.08	-0.09	1.59	1.44
18. Your parents must decide if you should access RH services.	2.00	2.08	0.08	1.35	1.51
19. RH services must be accessible and affordable or free.	4.67	4.67	0.00	0.49	0.49
20. I should forgive my husband even if he cheated on me because I need to keep my family together.	3.17	3.25	0.08	1.95	1.86
21. It is justifiable if my husband hits me because he is drunk.	1.75	1.75	0.00	1.29	1.29
22. I should focus on taking care of my children instead of working outside the home.	4.50	4.50	0.00	1.00	1.00
Empowerment Part 3	**Before**	**After**	**Difference**	**SD Before**	**SD After**
23. A wife has the right to express her opinion when she disagrees with what her husband is saying about family planning.	4.33	4.33	0.00	0.98	0.98
24. A wife can contradict her husband in public about family planning.	3.75	3.75	0.00	1.42	1.42

25. Nowadays, men should participate in child rearing and household chores rather than leaving it all to the women.	4.42	4.42	0.00	1.38	1.38
26. Parents should maintain stricter control over their daughters than their sons.	4.33	4.33	0.00	1.07	1.07
27. Men should be willing to sacrifice their own well-being to provide financially for the women in their lives.	5.00	5.00	0.00	0.00	0.00
28. After a fight or argument about family planning, or sexual intercourse, the wife should reconcile the problem first to maintain peace in the household.	2.00	1.92	-0.08	2.00	1.92

Tuberculosis (N=15)
North Daang Hari Health Center, Taguig City

Empowerment Part 1	**Mean Scores (After Recovery)**	**SD**
1. Who decided on your TB screening/testing? (X-ray, sputum)	4.92	0.26
2 Who decided for you to go to the health center?	4.77	0.56
3. Who decided on your TB treatment?	4.85	0.52
4. If TB treatment is not free, who decided on proceeding with the treatment despite expenses?	4.50	0.71
5. Who decided for you to complete the TB treatment?	4.92	0.26
6. Who decided on encouraging your family to be screened for TB?	4.58	1.08
7. Who decided on bringing your husband/family to be screened for TB?	4.09	1.48
8. Who decided on sharing household responsibilities, such as childcare and workload at home, during your TB treatment?	4.15	1.41
9. Who decided on spending your free time to socialize and meet with friends?	5.00	0.00
10. Who decided on spending your free time to rest?	5.00	0.00
11. Who decided for you to join organizations?	5.00	0.00
12. Who decided for you to lead your organization/s?	5.00	0.00

Empowerment Part 2	**Before**	**After**	**Difference**	**SD Before**	**SD After**

13. Men or women with TB should not get married.	2.13	2.07	0.06	1.41	1.49
14. Women with TB should not have children.	3.00	2.73	0.27	1.73	1.71
15. It is more shameful for women to have TB.	1.33	1.33	0.003	0.49	0.49
16. TB is not curable, so I don't have to find treatment.	1.27	1.27	0	0.46	0.46
17. Women with TB should not have outside employment.	3.20	2.80	0.40	1.52	1.61
18. If my husband/partner has TB, I can serve as his treatment partner.	4.93	4.93	0.003	0.26	0.26
Empowerment Part 3	**Before**	**After**	**Difference**	**SD Before**	**SD After**
19. A wife has the right to express her opinion when she disagrees with what her husband is saying with incorrect TB information.	4.73	4.87	-0.14	0.59	0.35
20. A wife can contradict her husband in public when he is saying incorrect TB information.	2.47	2.73	-0.26	1.64	1.71
21. A wife should obey her husband, even if she disagrees with his incorrect decision related to TB.	1.33	1.33	0	0.49	0.49
22. A woman's opinions are valuable and should always be considered when TB-related household decisions are made.	4.93	4.93	0	0.26	0.26
23. Nowadays, men should participate in child rearing and household chores when the wife is sick with TB.	4.93	4.93	0	0.26	0.26
24. Men should be willing to sacrifice their own well-being to provide financially for the women in their lives when the wife is sick with TB.	4.93	4.93	0	0.26	0.26

Community-Based Drug Rehabilitation (N=9)
Oro Wellness Development Center, Cagayan de Oro City

Empowerment Part 1	**Mean Score (after rehabilitation)**	**SD**
1. Who decided for you to remain drug-free?	4.75	0.71
2 Who decided for you to go back to school/skills training?	3.87	0.99
.3. Who decided for you to engage in livelihood activities?	5	0.00
4. Who decided for you to join community organizations and social groups?	4.75	0.46
.5. Who decided for you to participate in local community events and activities?	4.75	0.71

6. Who decided for you to speak out your voice in family decision making?	4.75			0.71	
7. Who decided for you to speak out your voice in group-based decision making?	4.62			0.74	
8. Who decided on sharing household responsibilities during your drug rehabilitation such as childcare and workload at home?	4.25			0.89	
9. Who decided on the use of free time for socialization?	3.87			0.83	
10. Who decided on the use of free time for rest?	4.87			0.35	
11. Who decided on the membership in organizations?	4.75			0.46	
12. Who decided on the leadership in organizations?	4.75			0.46	
Empowerment Part 2	**Before**	**After**	**Difference**	**SD Before**	**SD After**
13. Substance abuse (e.g., use of illegal drugs) can be an excuse for a person to sexually harass, abuse, or rape another.	3.13	2.00	-1.13	1.81	1.85
14. It is justifiable if my husband is abusive because he is not in his right mind as a drug user.	1.88	1.75	-0.13	1.36	1.39
15. It is more shameful for women to be drug users.	4.00	4.38	0.38	1.60	1.41
16. Using drugs is a crime.	4.50	4.63	0.13	0.76	1.06
17. Using drugs is an illness.	3.88	4.50	0.63	1.55	1.41
Empowerment Part 3	**Before**	**After**	**Difference**	**SD Before**	**SD After**
18. You have the right to express your opinion when you disagree with what your partner is saying with incorrect drug rehabilitation information.	4.375	4.75	0.37	0.74	0.46
19 You can contradict your husband in public when he shares incorrect drug rehabilitation information.	4.13	4.25	0.12	0.64	0.46
20. You should obey your husband, even if you disagree with his decision related to the drug rehabilitation.	1.62	1.25	-0.37	1.19	0.71
21. A woman's opinion is valuable and should always be considered when rehabilitation decisions are made.	4.25	4.75	0.5	1.16	0.46
22. Parents should maintain stricter control over their daughters than their sons.	4.13	4.13	0	1.36	1.36
23. Nowadays, men should participate in child rearing and household chores when the wife is under drug rehabilitation.	4.75	4.88	0.13	0.46	0.35

24. Men should be willing to sacrifice their own well-being to provide financially for the women in their lives when women are under drug rehabilitation.	4.0	4.13	0.13	1.41	1.36
25. After a fight or argument about drug rehabilitation, the wife should reconcile the problem first to maintain peace in the household.	3.75	3.88	0.13	1.75	1.81

Annex B. Informed Consent Form for the In-Depth Interview

Note: This Informed Consent Form is intended for women and girls who obtained services from selected USAID health projects in family planning, adolescent reproductive health, TB, and community-based rehabilitation and will participate in this research study. The interviews will be conducted in three project sites in Zamboanga del Norte, Cagayan de Oro, and Metro Manila.

Part I: Information sheet

Introduction

[Greetings]

My name is Fatima Verzosa, Senior Consultant and Team Leader working for the CLAimDev Project. With me are the members of our team [cite names] who will join us in this interview. We are conducting a research study to assess how its programs in family planning, adolescent reproductive health, TB, and community-based drug rehabilitation resulted in benefits that contributed to gender equality and the empowerment of women and girls as beneficiaries of these programs. These programs were implemented in your municipality through the Rural Health Unit or Barangay Health Station.

You are invited to participate in this interview as one who has obtained health services that USAID supported. We would like your permission to gather information from you today and use this information to better design activities that promote gender equality between women and men. The interview may last for two hours. Your participation in this study is voluntary, and you are not forced to participate. You can choose to leave at any time. We can stop anytime if you have questions that you may want us to explain before you respond.

Purpose of the Study

The purpose of the study is to learn about your experience in participating in any activities under these programs, such as obtaining health services in the use of family planning methods, information, or counseling on your health problems. We would also like to know about the benefits that you derived from the health services provided by the RHU or BHS and if there are any changes in your capacities, health practices, and decision making that resulted from your participation in these programs.

Please know that all the information we get from you will not be used for purposes other than this research, and we will treat all the information in confidence. We would also like to record this conversation for note-taking purposes, but we will not share the recording with anyone after this conversation.

Reimbursements

With your participation in the interview, we will reimburse a total of Php250 (Php150 for meals and Php100 for transportation expenses).

Right to Refuse or Withdraw

You do not have to participate in this research if you do not wish to do so. You may stop participating in the interview whenever you wish. We will give you an opportunity at the end of the interview to review your remarks, and you can ask to modify or remove portions of those if you do not agree with our notes or if we did not understand you correctly.

Who to Contact

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me as the Senior Consultant and Team Leader at fatimaverzosa@gmail.com or 09178303434.

Ethics Review and Approval

This proposal has been reviewed and approved by a Philippine Health Ethics Research Board (PHREB) accredited ethics review committee Saint Cabrini Medical Center-Asian Eye Institute Ethics Review Committee, which is a committee whose task is to ensure that research participants are protected from harm. If you want to know more about the ethics approval process, you may reach them at SCMC-AEI ERC Secretariat through **scmc-aeierc@asianeyeinstitute.com** or contact our research team for assistance.

Risks

We ask you to share some very personal and confidential information with us, and you may feel uncomfortable talking about some of the topics. You do not have to answer any questions or participate in the interview if you don't wish to do so, which is also acceptable. You do not have to give us any reason for not responding to any question or refusing to participate in the interview.

Conflict of Interest

Even if this research is USAID-funded, we assure you that impartiality and objectivity will be the utmost concern of the principal investigator and the research team. Hence, we assure you that the results of the study will be based on the data and evidence we will gather and that we will remain objective in the analysis and completion of this study, regardless of funding source, in order to avoid any semblance of conflict of interest. This disclosure is made so that you can decide if this information on the funding source will affect your willingness to participate in this study.

Benefits

Your participation in this interview will hopefully help you appreciate more the meaningful impact of the family planning, adolescent reproductive health, TB, and community-based drug rehabilitation interventions you received as beneficiaries and how they empowered you as members of the community. Moreover, your participation is likely to help us find out more about which interventions were the most helpful and which need further improvement to maximize their ability to empower you. What you will share in the interview will allow us to understand what efforts can be made in the future to help other members of the community to attain gender equality and empowerment.

Confidentiality

We will not share information about you with anyone outside the research team. The information that we collect from this research project is confidential and will be kept private. Any information about you will have an alias instead of your name. Only the researchers will know your alias, and we will ensure proper storage of all information gathered. It will not be shared with or given to anyone except the principal investigator and the interviewer. In writing and disseminating the report, your name will not be included as a respondent to the study or cite statements as coming from our interview with you.

Sharing the Results

Nothing you tell us today will be shared with anybody outside the Research Team, and nothing will be attributed to you by name. However, the knowledge that we get from this research will be shared with the implementers of the programs so that other interested people may learn from the research.

Contact Information

If you have questions or concerns about this study, you can contact the CLAimDev Research Team, composed of the following members: (list names below, email, and office contact number).

Part II: Certificate of Consent

Consent:

I voluntarily give my consent to participate in this study. I have read the information above, or the said information was read to me.

Name: _____ Signature _____

Date: _____ Location: _____

Annex C. Informed Consent Para sa Pagsasagawa ng Panayam

Paalala: Ang Informed Consent From na ito ay para sa mga kababaihan at mga dalagita na nakatanggap ng mga serbisyo mula sa mga proyekto ng USAID sa family planning, adolescent reproductive health, TB, and community-based rehabilitation na napiling kalahok sa pag-aaral na ito. Ang mga panayam ay isasagawa sa tatlong lugar, kasama ang Zamboanga del Norte, Cagayan de Oro, and Metro Manila.

Part I: Information sheet
Panimula
[Greetings]
Ako po si Fatima Verzosa, Senior Consultant at Team Leader na nagtatrabaho para sa CLAimDev Project. Kasama ko ang mga miyembro ng aking grupo na sina [pangalanan] na makakasama natin ngayon. Kami ay nagsasagawa ng isang pag-aaral kung paano nagresulta ang mga programa nito sa family planning, adolescent reproductive health, TB at community-based drug rehabilitation sa mga benepisyo na nag-ambag sa pagkakapantay-pantay ng kababaihan at kalalakihan o gender equality and mas mataas na kakayahan or empowerment ng mga kababaihan at babaeng bata or dalagita.
Kayo po ay napili sa pag-aaral na ito dahil kayo ay nakatanggap ng serbisyo mula sa mga programang ito sa inyong Rural Health Unit or Barangay Health Station. Nais namin na humingi ng iyong pahintulot na kumalap ng impormasyon mula sa inyo at gamitin ang impormasyon na ito upang mas mapabuti ang mga programa ng kalusugan na nagsusulong ng pagkakapantay-pantay ng mga kababaihan at kalalakihan. Ang panayam ay maaaring tumagal ng dalawang oras. Ang iyong participation sa pag-aaral na ito ay boluntaryo at hindi kayo pinilit na lumahok. Maaari kayong umalis sa kahit anong oras. Maaari tayong magtapos kahit kailan o kaya ay tumigil kung sakaling kayo ay may mga katanungan na nais mong ipaliwanag namin bago kayo sumagot.

Layunin ng Pag-aaral
Ang layunin ng pag-aaral ay upang matutunan ang iyong mga karanasan sa paglahok sa mga programang ito, katulad ng pagkuha ng mga pangkalusugang serbisyo sa paggamit ng mga family planning method, impormasyon o counseling tungkol sa iyong mga problema sa kalusugan. Nais din namin na malaman ang mga benepisyo na iyong nakuha mula sa mga serbisyong pangkalusugan na ibinigay ng RHU o BHS, at kung nagkaroon ng mga pagbabago sa iyong kapasidad, mga kasanayan pangkalusugan, at pagdedesisyon na nagresulta dahil sa iyong participation sa mga programang ito.

Nais namin na malaman mo na ang lahat ng impormasyon na aming makukuha mula sa iyo ay hindi gagamitin sa kahit anong layunin bukod sa pag-aaral na ito at ituturing namin ang lahat ng impormasyon ay confidential. Nais din sana naming i-rekord ang pag-uusap na ito bilang pagtatala ngunit hindi namin ibabahagi ang pag-uusap na ito kanino man.

Reimbursements
Dahil sa iyong paglahok sa panayam na ito, kami ay magbibigay ng kabuong halaga na Php250 (Php150 para sa iyong pagkain at Php100 para sa iyong pamasahe).

Karapatan na Tumanggi o Umalis

Hindi mo kinakailangang lumahok sa pag-aaral na ito kung hindi mo ninanais. Maaari kang tumigil sa paglahok sa panayam kahit kailan mo gusto. Bibigyan ka namin ng pagkakataon sa pagtatapos ng panayam na ito na suriin ang iyong mga sinabi, at maaaring mong baguhin o tanggalin ang ilang bahagi kung hindi ka sumasang-ayon sa aming pagtatala o kung hindi ka namin naintindihan ng tama.

Kanino Maaaring Makipag-ugnayan

Kung ikaw ay may mga katanungan, maaari mo na itong itanong ngayon o mamaya. Kung nais mo rin magtanong mamaya, maaari kang makipag-ugnayan sa akin bilang Senior Consultant at Team Leader sa fatimaverzosa@gmail.com o 09178303434.

Ethics Review and Approval

Ang pag-aaral na ito ay nasuri at naaprubahan ng isang PHREB accredited ethics review committee (Asian Eye), isang komite na naatasan na siguruhin na ang mga lumalahok sa mga pag-aaral ay mapoprotektahan ang kanilang karapatan. Kung nais mong mas malaman ang tungkol dito, maaari kang makipag-ugnayan sa kanila sa SCMC-AEI ERC Secretariat **scmc-aeierc@asianeyeinstitute.com** or i-contact ang aming Research Team.

Mga Ala-alanin

Kami ay humihingi sa iyo na magbahagi sa amin ng ilan sa mga personal at confidential na impormasyon at maaari hindi ka maging komportable na pag-usapan ang ilan sa mga paksa. Hindi mo kinakailangang sumagot sa kahit anong tanong o lumahok sa panayam na ito kung hindi mo ninanais, at iyon ay ayos lang. Hindi mo kinakailangang magbigay sa amin ng dahilan sa hindi pagsagot sa kahit anong katanungan o pagtanggi na lumahok sa panayam.

Conflict of Interest

Kahit na ang pag-aaral na ito ay pinondohan ng USAID, sinisiguro namin sa iyo na priority ng principal investigator at ng Research Team na panatilihin ang impartiality at objectivity. Kaya naman, tinitiyak namin sa iyo na ang mga resulta ng pag-aaral ay ibabatay sa datos at ebidensyang makakalap namin at mananatili kaming objective sa pagsusuri at pagkumpleto ng pag-aaral na ito, anuman ang pinagmumulan ng pondo, upang maiwasan ang anumang conflict of interest. Ang pagsisiwalat na ito ay ginawa upang makapagpasya ka kung ang impormasyong ito sa pinagmumulan ng pagpopondo ay makakaapekto sa iyong pagpayag na lumahok sa pag-aaral na ito.

Mga Benepisyo

Ang iyong participation sa panayam na ito ay inaasahang makakatulong upang mas iyong pahalagahan ang mga naging makabuluhang epekto ng mga serbisyo sa family planning, adolescent reproductive health, TB at community-based drug na iyong natanggap bilang benepisyaryo at kung paano ka nito binigyan ng kapangyarihan bilang miyembro ng komunidad. Gayundin, ang iyong participation ay makakatulong sa amin upang alamin kung anong mga serbisyo ang pinaka nakatulong sa iyo at kung alin ang kailangan pang pagbutihin upang mas makapag-ambag pa ito sa iyong empowerment. Ang mga ibabahagi mo sa panayam na ito ay magbibigay-daan sa amin na maunawaan kung anong mga pagsisikap ang maaaring gawin sa hinaharap upang matulungan ang ibang miyembro ng komunidad na makamit ang gender equality at empowerment.

Confidentiality
Hindi namin ibabahagi ang mga impormasyon tungkol sa iyo sa labas ng pag-aaral na ito. Ang impormasyon na makokolekta namin ay confidential at mananatiling pribado. Ang kahit anong impormasyon tungkol sa iyo ay magkakaroon ng palayaw imbes na ang iyong pangalan. Tanging ang Research Team ang makakaalam ng iyong palayaw at sisiguruhin namin ang maayos na pagtatago ng lahat ng impormasyong makakalap. Hindi ito ibabahagi or ibibigay kanino man bukod sa principal investigator at interviewer. Sa pagsusulat at pagpapakalat ng report, hindi ilalagay ang iyong pangalan bilang kalahok ng pag-aaral o maglalagay ng pahayag na nagsasabing mula ito sayo sa pagsasagawa naming ng panayam na ito.

Pagbabahagi ng Resulta
Walang anumang sasabihin mo sa amin ngayon ang ibabahagi sa sinuman sa labas ng research study na ito. Walang maiuugnay sa iyo sa pamamagitan ng iyong pangalan. Gayunpaman, ang kaalaman na makukuha namin mula sa pananaliksik na ito ay ibabahagi sa mga nagpapatupad ng mga programa upang ang ibang mga taong interesado ay matuto mula sa pag-aaral na ito.

Impormasyon sa Pakikipag-ugnayan
Kung mayroon kang mga tanong o alalahanin tungkol sa pag-aaral na ito, maaari kang makipag-ugnayan sa CLAimDev Research Team, na binubuo ng mga susunod na miyembro: (list names below, email and office contact number).

Part II: Certificate of Consent
Pagpayag:
Kusang-loob kong ibinibigay ang aking pahintulot na lumahok sa pag-aaral na ito. Nabasa ko ang impormasyon sa itaas o ang nasabing impormasyon ay binasa sa akin.

Pangalan: _____ Pirma _____
Petsa: _____ Lugar: _____

Annex D. Informed Consent Form Para sa In-Depth Interviews

Note: Kining Informed Consent Form kay para alang sa mga babaye ug dalagita nga nakakuha og mga serbisyo gikan sa pinili nga mga health projects sa USAID sa family planning, adolescent reproductive health, TB, ug community-based rehabilitation ug moapil niini nga research study. Ang mga interbyu ipahigayon sa tulo ka project sites sa Zamboanga del Norte, Cagayan de Oro, ug Metro Manila.

Part I: Information sheet
Pasiuna
[Greetings] Maayong Buntag/Hapon/Gabii
Ang akong ngalan mao si Fatima Verzosa, Senior Consultant ug Team Leader nga nagtrabaho para sa CLAimDev Project. Kauban nako ang mga miyembro sa among team [cite names] nga moapil kanamo niini nga interbyu. Nagpahigayon kami ug research study aron masusi kung giunsa ang pagpatuman sa mga programa niini sa family planning, adolescent reproductive health, TB, and community-based drug rehabilitation nga nakabase sa komunidad nga miresulta sa mga benepisyo nga naka tabang sa pag abot sa gender equality ug women empowerment sa mga edaran na babae ug sa mga batan-on na babae ingon mga benepisyaryo sa kini nga mga programa. Kini nga mga programa gipatuman sa inyong munisipyo pinaagi sa Rural Health Unit o Barangay Health Station.
Gidapit ka sa pag-apil niini nga interbyu isip usa nga nakakuha og health services nga gisuportahan sa USAID. Among gi-hangyo ang imong pagtugot sa pagkolekta sa impormasyon karong adlawa ug gamiton kini nga impormasyon sa mas maayong pagdesinyo sa mga kalihokan nga nagpasiugda sa gender equality tali sa mga babaye ug lalaki. Ang interbyu mahimong molungtad og duha ka oras. Ang imong pag-apil niini nga pagtuon boluntaryo, ug dili ka pugson sa pag-apil. Mahimo nimong pilion nga mobiya bisan unsang orasa. Mahimo kaming mohunong bisan unsang orasa kung aduna kay mga pangutana nga gusto nimo nga among ipasabut saimo sa dili ka pa motubag.

Katuyoan sa Research
Ang katuyoan sa pagtuon mao ang pagkat-on bahin sa imong kasinatian sa pag-apil sa bisan unsang mga kalihokan sa ilawom sa kini nga mga programa, sama sa pagkuha sa mga health services sa paggamit sa mga pamaagi sa family planning methods, kasayuran, o pagtambag sa imong mga problema sa kahimsog. Buot usab namo nga mahibaw-an ang mahitungod sa mga benepisyo nga imong nakuha gikan sa mga health services nga gihatag sa RHU o BHS ug kung adunay mga pagbag-o sa imong mga kapasidad, mga pamaagi sa panglawas, ug paghimog desisyon nga resulta sa imong pag-apil niini nga mga programa. Gusto namo na mahibal-an nimo na, ang tanan nga impormasyon nga among makuha gikan kanimo dili gamiton alang sa mga katuyoan gawas sa kini nga research, ug among tagdon ang tanan nga impormasyon na pribado. Gusto usab namo nga irekord kini nga panag-istoryahanay alang sa mga katuyoan sa pagkuha og nota, apan dili namo ipaambit ang recording bisan kinsa human niini nga panag-istoryahanay.

Reimbursements
Uban sa imong pag-apil sa interbyu, mag hatag me ug kinatibuk-an na Php 250 (Php 150 para sa imong pagkaon ug Php 100 para saimong pamasahe).

Katungod sa Pagdumili o Pag-atras

Dili nimo kinahanglan nga moapil sa ani nga research kung dili nimo gusto nga buhaton kini. Mahimo kang mohunong sa pag-apil sa interbyu bisan kanus-a nimo gusto. Hatagan ka namo og higayon sa pagtapos sa interbyu aron masusi ang imong mga komento, ug mahimo nimong hangyoon nga usbon o tangtangon ang mga bahin niana kung dili ka mouyon sa among mga nota o kung wala ka namo nasabtan ug husto.

Who to Contact
Kon duna kay mga pangutana, mahimo nimo pangutan-on karon o sa ulahi pag human sa interbyu. Kung gusto ka mangutana sa text, tawag, o e-mail, mahimo nimo akong kontakon isip Senior Consultant ug Team Leader sa fatimaverzosa@gmail.com o 09178303434.

Ethics Review and Approval
Kini nga sugyot gisusi ug giaprobahan sa usa ka PHREB accredited ethics review committee Saint Cabrini Medical Center-Asian Eye Institute Ethics Review Committee, nga usa ka komite nga nasugo sa pagsiguro ug pag protekta sa mga katungod sa mga partisipante. Kung gusto nimo mahibal-an ang dugang bahin sa proseso sa pag-apruba sa etika, mahimo nimo silang maabot sa SCMC-AEI ERC Secretariat pinaagi sa scmc-aeierc@asianeyeinstitute.com o kontaka ang among Research Team alang sa tabang.

Risks
Kami gahangyo ka nimo nga magpaambit kanamo ug pipila ka personal ug kompidensyal nga impormasyon, ug mahimong dili ka komportable nga maghisgot bahin sa pipila ka mga hilisgutan. Dili nimo kinahanglan nga tubagon ang bisan unsang mga pangutana o moapil sa interbyu kung dili nimo gusto buhaton, nga madawat usab. Dili nimo kinahanglan nga hatagan kami bisan unsang hinungdan sa dili pagtubag sa bisan unsang pangutana o pagdumili sa pag-apil sa interbyu.

Conflict of Interest
Kini nga pagtuon gipondohan sa USAID apan ang prayoridad sa principal investigator ug sa tig-interbyu ang pagmintinar sa partiality ug objectivity. Ikaw adunay katungod sa pagpangutana mahitungod sa kini nga pondo. Kini nga pagbutyag gihimo aron makahukom ka kung kini nga impormasyon makaapekto sa imong kaandam nga moapil niini nga pagtuon.

Mga Benepisyo
Ang imong pag-apil niini nga interbyu hinaut nga makatabang kanimo nga mas tagaan ug importansya ang mga makahuluganon nga epekto sa family planning, adolescent reproductive health, TB, and community-based drug rehabilitation nga imong nadawat isip benepisyaryo ug sa pamaagi na nakapahatag nimo ug gahum isip miyembro sa komunidad. Dugang pa, ang imong pag-apil makatabang kanamo nga mahibal-an ang dugang bahin sa kung unsang mga interbensyon ang labing makatabang ug kung unsa ang nanginahanglan pa ug dugang nga pag-uswag aron mapadako ang ilang abilidad sa paghatag gahum kanimo. Ang imong ipaambit sa interbyu magtugot kanamo nga masabtan kung unsa pa ang among pwede na mahimo sa umaabot aron matabangan ang ubang mga miyembro sa komunidad nga makab-ot ang gender equality ug women empowerment.

Confidentiality
Dili namo ipaambit ang impormasyon bahin kanimo bisan kinsa gawas sa Research Team. Ang mga impormasyon nga among makolekta gikan ani nga research project magpabilin nga confidential ug

pribado. Ang bisan unsang impormasyon bahin kanimo adunay alyas imbes sa imong ngalan. Kami, na mga researcher ra ang makahibalo sa imong alyas, ug among sigurohon ang husto nga paghipos sa tanan nga impormasyon nga among nakolekta. Dili kini ipaambit o ihatag bisan kinsa gawas sa principal investigator ug interviewer. Sa pagsulat ug pag-apod-apod sa report, dili iapil ang imong ngalan isip partisipante sa pagtuon o mag butang sa usa ka pahayag na nag ingon na gikan saimo sa among pag himo ani nga interbyu.

Pagpaambit sa mga Resulta

Walay bisan unsa nga imong isulti kanamo karon ang among ipaambit sa bisan kinsa sa gawas sa Research Team, ug dili namo gamiton ang imong tinood na pangalan sa among research. Bisan pa niana, ang mga resulta nga among makuha gikan ani nga research kay among ipaambit sa mga nagpatuman sa mga programa aron ang ubang mga interesado nga tawo makakat-on gikan ani na research.

Impormasyon sa Kontak

Kung naa kay mga pangutana bahin sa kini nga pagtuon, mahimo nimong kontakon ang CLAimDev Research Team, nga gilangkuban sa mga mosunod nga miyembro: (lista ang mga ngalan sa ubos, email, ug numero sa kontak sa opisina).

Part II: Certificate of Consent

Pag-uyon:

Ako boluntaryong mohatag sa akong pagtugot sa pag-apil niini nga pagtuon. Akong nabasa ang impormasyon sa ibabaw, o ang maong impormasyon gibasa kanako.

Pangalan: _____ Pirma _____

Petsa: _____ Lokasyon: _____

Annex E. Interview Guide Questions

KEY INFORMANT INTERVIEW GUIDE (Adolescent Reproductive Health) - English and Tagalog

Reminders:

Explain the background of the proposed study and the purpose of the interview:

Ako po si _____ at _____, kami po ay gumagawa ng research tungkol sa mga health services, katulad ng FP. Gusto po naming malaman kung paano kayo natulungan, anong benefits ang inyong natanggap at kung paano ang tulong sa inyo ay nakadagdag sa inyong kakayahan o nakapagbago sa inyong opinion (pananaw) tungkol sa mga paniniwala sa kakayahan ng mga kababaihan.

Kayo ay napili sa research na ito dahil kayo may experience sa pag-konsulta tungkol sa family planning sa Laguna Medical Center. Gusto sana naming humingi ng iyong permiso para makakuha ng information tungkol sa inyong experience para mas mapabuti ang mga health services tulad ng FP na mas mapapakinabangan ng mga kababaihan. Ang interview natin ay maaaring tumagal ng mahigit isang oras. Ang iyong participation sa interview na ito ay voluntary at hindi namin kayo pinipilit na lumahok. Pwede po kayong umalis sa kahit anong oras. Pwede rin tayong tumigil kung gusto ninyong linawin ang mga tanong namin, bago kayo sumagot. Pwede rin tayong tumigil kahit anong oras kung magdesisyon ka na hindi mo na gustong ituloy ang ating interview.

1. Informed Consent
2. Humingi ng pahintulot na i-dokumento o irekord ang panayam at kung nais nilang manatiiling anonymous.

INTERVIEWEE INFORMATION

Pangalan (optional): _____

Edad: _____

Address: _____

Marital Status:

_____ Walang asawa (Single)

_____ May asawa (Married)/_____ Kinakasama

Edad (age): _____

Trabaho (occupation): _____

Edukasyon (education): _____

_____ Hiwalay (Separated)

_____ Balo (Widow)

Education level:

_____ Elementarya

_____ Highschool

_____ Kolehiyo (College)

_____ Vocational course

Trabaho: _____

Personal income

_____ Below minimum wage (below 350)

_____ Minimum (350-470)
_____ Above minimum (above 470)

Husband/partner income

_____ Below minimum wage (below 350)
_____ Minimum (350-470)
_____ Above minimum (above 470)

Relihiyon: _____

Bilang ng anak: _____

Kinabibilangang Organisasyon at Posisyon (ilista):

1. _____
2. _____

INTERVIEWEE REACH PROFILE (ARH)

1. Have you heard of the term family planning? If yes, can you describe what it is?
   Narinig mo na ba ang salitang family planning?
   _____ Oo
   _____ Hindi
   Kung oo, pwede mo bang ikwento sa amin kung ano ito?
   _____
   _____
   _____
   _____
   Did you hear about it before or after you got pregnant?
   Narinig mo ba ito bago o pagkatapos mong mabuntis?
   _____ Bago mabuntis
   _____ Pagkatapos Mabuntis

2. How did you hear about the FP services?
   Paano mo nalaman o narinig tungkol sa FP services?
   _____ Referral. Pangalan ng nag refer: _____
   _____ Social media (Facebook at iba pa)
   _____ Leaflets, pamphlets
   _____ CHW
   _____ Empleyado sa RHU/health facility
   _____Iba pa _____
3. What information was provided to you as an adolescent?
   Anong mga impormasyon ang ibinigay sa iyo?
   _____
   _____
   _____
   _____What services did you receive from LMC? (pre-natal, delivery, post-natal, post-partum, FP in hospital) And how frequently did you access the FP health services?
   Anong mga serbisyo ang natanggap mo mula sa LMC? (pre-natal, delivery, post-natal, post-partum, FP in hospital)

_____

_____

_____

At gaano kadalas mo nagamit ang serbisyong ito? _____

4. If you were asked to rate your satisfaction in obtaining the services (delivery) from Laguna Medical Center on a scale of 1-10 with 10 as the highest, what would be your rating? Why?

Kung hihilingin sa iyo na i-rate ang iyong kasiyahan sa pagkuha ng mga serbisyo, sa sukat na 1-10, 10 bilang pinakamataas, ano ang magiging rating mo? _____
Bakit?

_____

_____

_____

Before you got pregnant, did you get any FP counseling to prevent pregnancy?
Bago ka nabuntis, nakatanggap ka ba ng counseling services at suporta para hindi ka mabuntis? Galing sa:

	Counseling*		**Suporta****	
	Nakakuha (yes)	**Hindi nakakuha (no)**	**Nakakuha (yes)**	**Hindi nakakuha (no)**
Laguna Medical Center				
Barangay Health Station (BHS) or through the Barangay Health Care Workers				
Rural Health Center (RHU)				
School/**Eskuwelahan**				
Friends/**Kaibigan**				
Parents/**Magulang**				
Others				

**tulad ng sex education*

***tulad nang emotional, financial, psychological, moral support*

5. Before you got pregnant, can you recall any pregnancy programs or events, or activities at Laguna Medical Center to prevent pregnancy that you were invited to attend? What was it?

Bago ka nabuntis, naalala mo pa ba kung nakapunta ka sa mga teen pregnancy programs ng Laguna Medical Center para hindi mabuntis agad ang mga kabataan? Anong programa kaya ito?

_____

_____

_____

After you got pregnant, did you go for prenatal care? Where did you have your prenatal services? Who accompanied you? How many visits did you have before you delivered? Would you recall who attended to you? What was your experience with the first antenatal visit? How did you feel?

Noong nabuntis ka, nagpa-pre-natal check-up ka ba?

_____Oo

_____Hindi

Saan ka pumunta?

_____ Lying in clinic

_____ Barangay Health Station

_____ Rural Health Center

_____ Laguna Medical Center

_____ Other health facilities _____

At sino ang sumama sa iyo? _____

Nakailan ka na pre-natal check-up? (During the pre-natal, services include giving of vitamins, checking of the vitals, ultrasound, and others) _____

Sino ang tumingin sa iyo? (check all applicable)

____ Doktor

_____ Nurse

_____ Midwife

_____ CHW

_____ Iba pa _____

Ano ang naging pakiramdam mo noong unang prenatal check-up?

_____

_____

_____

_____

_____

6. If you were asked to rate your satisfaction in obtaining prenatal services on a scale of 1-10, 10 as the highest, what would be your rating? Why?

Kung hihilingin sa iyo na i-rate ang iyong kasiyahan sa pagkuha ng mga serbisyo, sa sukat na 1-10, 10 bilang pinakamataas, ano ang magiging rating mo? _____

Bakit?

_____

_____

Why did you decide to obtain the prenatal services?

Bakit mo naisipan and paano ka nagdesisyon na magpa-prenatal?

_____

_____

_____

Have you heard of Adolescent Friendly Facilities?

Narinig mo ba ang tungkol sa Adolescent Friendly Facilities?

_____ Oo

_____ Hindi (move to the next question to # 12)

If yes, have you availed of the services (teen counseling, information materials such as brochures, pamphlets) from Adolescent Friendly Facilities?

Kung oo, nakapag-avail ka ba ng mga serbisyo mula sa Adolescent Friendly Facilities?

_____ Oo

_____ Hindi (move to the next question to # 12)

If yes, what services were provided to you?

Kung oo, anong mga serbsiyo ang ibinigay sa inyo?

_____

_____

_____

What are the challenges, issues, and problems you faced during your pregnancy? For example, how did your parents/family or your boyfriend or your friends or classmates or your school react to you when they found out about your pregnancy? If in school, did you stop schooling? Are you back in school?

Ano ang mga problema ang iyong kinakaharap tungkol sa pagbubuntis? (probe)

_____

_____

_____

After you delivered, did you also go for a postnatal check-up? Where did you go? Who accompanied you? How many times after delivery did you go for antenatal?

Pagkatapos mong manganak, nagpa-post natal check-up ka ba?

_____ Oo

_____ Hindi

Saan ka pumunta?

_____ RHU. Pangalan ng health facility:_____

_____ Laguna Medical Center

_____ Iba pa _____

Sino ang kasama mo?

_____ Magulang

_____ Ibang kamag-anak (tiyahin, lola, at iba pa)

_____ Kaibigan

_____ Nakabuntis na kapareha

Ilang beses kang nagpacheck-up?

_____ Isang beses

_____ Dalawang beses

_____ Tatlong beses

_____ Apat na beses

7. Who decided to obtain FP health services? By yourself, your husband, or joint decision, or others?

Sino ang nagdesisyon na kumuha ng FP services?

_____ Ikaw mismo
_____ Asawa/kinakasama
_____ Parehas nagdesisyon
_____ Iba pa _____

8. Were the FP contraceptives provided free and were you able to get supplies when you need it?

Ang mga contraceptives ba ay ibinigay ng libre?

_____ Oo
_____ Hindi

Meron ba laging contraceptives sa health facility at nakakakuha ka ba kung kailangan mo?

_____ Meron lagi
_____ Minsan nauubusan
_____ Nauubusan lagi
_____ Hindi ko alam

9. Who decided for you when you went to the health facility? Who accompanies you in obtaining contraceptives? (For example spouses, partner/boyfriend, mother, mother-in-law, other family members), or do you go there on your own? Do you ask anyone for permission to seek health services? Why?

Sino na ang nagdesisyon para sa iyo na pumunta ng health facility?

_____ Asawa/kinakasama/boyfriend (encircle which one)
_____ Nanay
_____ Biyenan/Nanay ng kinakasama/Nanay ng boyfriend (encircle which one)
_____ Ibang kamag-anak (tiyahin, lola, at iba pa) (encircle which one)
_____ Nagdedesisyon mag-isa

Sino na ang sumasama sa iyo sa pagkuha ng mga contraceptives?

_____ Asawa/kinakasama/boyfriend (encircle which one)
_____ Nanay
_____ Biyenan/Nanay ng kinakasama/Nanay ng boyfriend (encircle which one)
_____ Ibang kamag-anak (tiyahin, lola, at iba pa) (encircle which one)
_____ Pumupunta mag-isa

Nagpapaalam ka ba sa kahit na sino para makakuha ng mga FP services?

_____ Oo
_____ Hindi

Bakit?

_____

_____

_____

If you were asked to rate your satisfaction in obtaining post-natal services on a scale of 1-10, with 10 as the highest, what would be your rating? Why?

Kung hihilingin sa iyo na i-rate ang iyong kasiyahan sa pagkuha ng mga serbisyo, sa sukat na 1-10, at 10 bilang pinakamataas, ano ang magiging rating mo? _____

Bakit?

INTERVIEWEE BENEFIT PROFILE (ARH)

1. Have you observed any changes in your health condition after participating in and obtaining FP services? If yes, what are these changes or outcomes? If your experience is negative, will you be switching to another FP method?

May naobserbahan ka bang anumang mga pagbabago sa iyong kalusugan pagkatapos na makakuha ng mga FP services?

_____ Merong pagbabago
_____ Walang pagbabago

Kung oo, ano ang mga pagbabago o kinalabasan na ito? (Positibo, negatibo, wala lang: physical at mental health, peace of mind)

_____

_____

_____

_____

Kung negatibo ang naranasan mo sa paggamit mo ng FP method, gusto mo bang baguhin ang FP method na ginagamit mo?

_____

_____

_____

_____

_____

2. If you were asked to rate your satisfaction with the benefits you received, on a scale of 1-10 with 10 as the highest, what would be your rating? Why?

Kung hihilingin sa iyo na i-rate ang iyong kasiyahan sa pagkuha ng mga serbisyo, sa sukat na 1-10, 10 bilang pinakamataas, ano ang magiging rating mo? _____

Bakit?

_____

_____

_____

_____

What were the problems that you encountered when availing of FP services? How did you address these problems?

Ano ang mga problemang naranasan mo sa paggamit ng FP meethods? (Halimbawa: accessibility such as facilities are far, no doctors, availability such as if FP commodities are not available, affordability such as if there are out-of-pocket expenses for FP/ARH, acceptability such as unavailable FP commodities that you prefer)

_____

_____

_____

_____

Paano mo natugunan ang mga problemang ito?

_____

_____

What did you learn from the RH services provided to you? What support did you receive from the facility? Did you receive counseling including sexuality education?

Anong natutunan mo sa mga serbisyong binigay sayo?

Anung suporta ang nakuha mo sa health facility? May binigay bang sexual education counseling sayo?

3. What is the effect in your relationship with your sexual partner now that you are using an FP method?

Ano ang epekto sa inyong relasyon ng iyong asawa/boyfriend/kinakasama dahil gumagamit ka na ng FP method?

If you were asked to rate your satisfaction with the benefits you received, on a scale of 1-10 with 10 as the highest, what would be your rating? Why?

Kung hihilingin sa iyo na i-rate ang iyong kasiyahan sa pagkuha ng mga serbisyo, sa sukat na 1-10, 10 bilang pinakamataas, ano ang magiging rating mo? _____

Bakit?

INTERVIEWEE EMPOWERMENT PROFILE (ARH)

Instructions: Ask all the BEFORE questions first, then once all, proceed with all the AFTER questions.
PAGBABAGO SA PANANAW SA PAGDEDESISYON AT KAKAYAHAN NG MGA KABABAIHAN
Magbabanggit ako ng ilang mga pahayag at mangyaring sabihin mo sa akin kung may mga pagbabago sa iyong mga pananaw bago ka nagkonsulta ng FP/ARH services at pagkatapos mong mag konsulta. Mangyaring ihambing mo ang mga pahayag at i-rate mo ang iyong mga pananaw sa scale ng:
5: Ako ang nagdedesisyon
4: Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon
3: Naguusap kami ng asawa/kinakasama/magulang para kami ang gumawa ng desisyon
2: Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon
1: Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon)

Statements: Changes in Perceptions on Decision-Making and Women's Ability (Agency)	**Before (Indicate 1-5)**	**After (Indicate 1-5)**
I can decide when to have children. **Kaya kong magpasya kung kailan magkakaanak.**		
I can decide when and what FP methods to use. **Kaya kong magpasya kung anong pamamaraan ng FP ang gagamitin ko.**		
I can decide to continue using modern FP methods. **Kaya kong magpasya na magpatuloy sa paggamit ng mga modernong pamamaraan ng FP.**		
I can ask my husband/partner to use protection (e.g., condom) whenever we decide to have sex. **Kaya kong hilingin sa aking asawa/kinakasama na gumamit ng proteksyon (hal., condom) sa tuwing magpapasya kaming makipagtalik.**		
I can refuse to have sex if it will be done without protection. **Kaya kong tumanggi na makipagtalik kung gagawin ito nang walang proteksyon.**		
I can decide to limit the number of children or postpone		

Statements: Changes in Perceptions on Decision-Making and Women's Ability (Agency)	**Before (Indicate 1-5)**	**After (Indicate 1-5)**
subsequent pregnancies **Kaya kong magpasya na limitahan ang bilang ng mga anak o ipagpaliban ang mga magkasunod na pagbubuntis**		
I can decide to go to the local health unit (RHU) on my own without asking permission from anyone. **Kaya kong magpasya na mag-isang pumunta sa local health unit (RHU) nang hindi humihingi ng pahintulot sa sinuman.**		
I can ask my husband/partner to go with me for medical check-ups (prenatal, post-natal, illness consultation). **Kaya kong hilingin sa aking asawa/kinakasama na sumama sa akin para sa mga medikal na pagsusuri (prenatal, post-natal, illness consultation).**		
I can ask my spouse/partner to share responsibilities and workload at home. **Kaya kong hilingin sa aking asawa/kinakasama na tumulong sa mga responsibilidad at gawain sa bahay.**		
I can decide to use the family income for my needs (e.g. transportation to go to health clinics, buy medicines.) **Kaya kong magpasya na gamitin ang kita ng pamilya para sa aking mga pangangailangan (hal. transportasyon para makapunta sa klinika, pambili ng gamot).**		
I can decide to use my income for my needs (e.g. transportation to go to health clinics, buy medicines), without telling my husband/partner. **Kaya kong magpasya na gamitin ang aking kita para sa aking mga pangangailangan (hal. transportasyon para makapunta sa klinika, pambili ng gamot), nang hindi sinasabi sa aking asawa o kinakasama.**		
I can say no to having sex with my husband if he refuses to use a		

Statements: Changes in Perceptions on Decision-Making and Women's Ability (Agency)	**Before (Indicate 1-5)**	**After (Indicate 1-5)**
condom. **Maaari kong tumanggi sa pakikipagtalik sa aking asawa kung tumanggi siya na gumamit ng condom.**		

5: Strongly agree
4: Moderately agree
3: No opinion/Neutral
2: Moderately agree
1: Strongly disagree

Statements: Perceptions of Social Norms, Beliefs and Practices	**Before (Indicate 1-5)**	**After (Indicate 1-5)**
It is only a woman's responsibility to avoid getting pregnant. **Pananagutan lamang ng babae ang umiwas na mabuntis.**		
If a man and woman disagree about family planning, the woman should have the final say because she bears the child. **Kung ang isang lalaki at babae ay hindi magkasundo tungkol sa paggamit ng family planning, ang babae dapat ang may huling salita dahil siya ang nagdadalang tao.**		
It is a wife's obligation to have sex with her husband even if she does not want to. **Obligasyon ng babae na makipagtalik sa kanyang asawa kahit ayaw niya.**		
I don't have to ask my husband's permission to get birth control services. **Hindi ko kailangan humingi ng permiso sa aking asawa para makakuha ng serbisyo para sa birth control.**		
It is wrong to avail of birth control services unless you are a married woman. **Mali na gumamit ng mga serbisyo para sa birth control maliban na lamang kung ikaw ay babaeng ikinasal.**		
Your parents must decide if you should access RH services. **Ang mga magulang mo ang dapat na magpasya kung dapat mong i-access ang mga serbisyong RH.**		
RH services must be accessible and affordable or free.		

Statements: Perceptions of Social Norms, Beliefs and Practices	**Before (Indicate 1-5)**	**After (Indicate 1-5)**
Ang mga serbisyong pang RH services ay dapat na accessible at abot-kaya o libre.		
I should forgive my husband even if he cheated on me because I need to keep my family together. **Dapat kong patawarin ang aking asawa kahit na niloko niya ako dahil kailangan kong panatilihing buo ang aking pamilya.**		
It is justifiable if my husband hits me because he is drunk. **Makatuwiran kung sasaktan ako ng aking asawa dahil siya ay lasing.**		
I should focus on taking care of my children instead of working outside the home. **Dapat kong pagtuunan ng pansin ang pag-aalaga sa aking mga anak sa halip na magtrabaho.**		

Statements: Changes in Perceptions of Women's Voice and Choice	**Before (Indicate 1-5)**	**After (Indicate 1-5)**
A wife has the right to express her opinion when she disagrees with what her husband is saying about family planning. **Ang asawang babae ay may karapatang magpahayag ng kanyang opinyon kapag siya ay hindi sumasang-ayon sa sinasabi ng kanyang asawa tungkol sa family planning.**		
A wife can contradict her husband in public about family planning. **Ang asawang babae ay maaaring kontrahin ang kanyang asawa sa harap ng publiko tungkol sa family planning.**		
Nowadays, men should participate in child rearing and household chores rather than leaving it all to the women.		

Statements: Changes in Perceptions of Women's Voice and Choice	**Before (Indicate 1-5)**	**After (Indicate 1-5)**
Sa panahon ngayon, ang mga lalaki ay dapat lumahok sa pagpapalaki ng anak at mga gawaing bahay sa halip na ipaubaya ang lahat sa mga kababaihan		
Parents should maintain stricter control over their daughters than their sons. **Dapat panatilihin na ang mga magulang ang mas may mahigpit na kontrol sa kanilang mga anak na babae kaysa sa kanilang mga anak na lalaki.**		
Men should be willing to sacrifice their own well-being to provide financially for the women in their lives. **Ang mga lalaki ay dapat na handang isakripisyo ang kanilang sariling kapakanan upang matustusan ang pinansyal na pangangailangan para sa mga kababaihan sa kanilang buhay.**		
After a fight or argument about family planning, or sexual intercourse, the wife should reconcile the problem first to maintain peace in the household. **Pagkatapos ng isang away o pagtatalo tungkol sa family planning or sex, ang asawang babae ang dapat na unang mag-ayos ng problema para panatilihin ang magandang pagsasama.**		

7. Do other individuals in your community seek your opinion about important matters? If yes, about what matters?

Humihingi ba ang ibang mga miyembro sa iyong komunidad ng iyong opinyon tungkol sa mahahalagang bagay?

____ Oo

____ Hindi

Kung oo, tungkol saan?

_____

_____

_____

8. Do you actively participate in or are you a member of any social, political, or religious organizations? What do you do?

Aktibong nakikilahok ka ba o miyembro ka ba ng anumang mga organisasyong panlipunan, pampulitika, o relihiyon?

____ Oo. Posisyon: _____

____ Hindi

Kung oo, ano ang ginagawa mo?

_____

_____

_____

KEY INFORMANT INTERVIEW GUIDE (Family Planning) - English and Bisaya dialect

Reminders:

Explain the background of the proposed study and the purpose of the interview.

My name is _____, we are conducting a research study to assess how its programs in, FP, resulted in benefits that contributed to gender equality and the empowerment of women and girls as beneficiaries of these programs. These programs were implemented in your municipality through the Rural Health Unit or Barangay Health Station.

You are invited to participate in this interview as one who has obtained health services that USAID supported. We would like your permission to gather information from you today and use this information to better design activities that promote gender equality between women and men. The interview may last for two hours. Your participation in this study is voluntary and you are not forced to participate. You can choose to leave at any time. We can stop anytime if you have questions that you may want us to explain before you respond.

1) Informed Consent

2) Ask for permission to record the interview

Ako si _____ ug ang akong kauban si _____, naa mi ginahimo nga research/pagtulun-an bahin sa serbisyo sa panglawas, pareho sa FP. Gusto unta namo mahibaluan kung paunsa ka natabangan, ug unsang mga benepisyo imong nadawat, ug paunsa kini nakatabang sa imohang abilidad o nakapagpabag-o sa imohang opinyon o panglantaw bahin sa abilidad o kapasidad sa mga babaye.

Ikaw napili aning research kay naa kay kaagi sa pagkonsulta bahin sa family planning sa Sindangan Rural Health. Mangayo unta mi sa imoha og permiso para makakuha og impormasyon bahin sa imong kaagi aron mapaayo pa ang mga serbisyo sa panglawas pareho sa FP nga mas mapahimuslan sa mga babaye. Ang ato ang interview modagan og kapin sa usa ka oras. Ang imohang partisipasyon sa kaning interview kay boluntaryo ug dili ka namo pugson nga muapil. Pwede ka muhawa bisag unsang orasa. Pwede pud ka muhunong bisag unsang orasa kung naa kay gusto nga klaruhon sa among mga pangutana, usa ka mutubag. Puwede pud ka muhunong bisag unsang orasa kung makadesisyon ka nga dili ipadayon ang interview.

1) Gipahibalo nga pagtugot

2) Mananghid kung pwede nga idokumento o irekord ang maong interview, o kung gusto nila magpabilin nga wala mailhi

INTERVIEWEE INFORMATION

Pangalan (optional): _____

Edad: _____

Pinuy-anan: _____

_____

Marital Status:

_____ Walay Asawa/Dili Minyo (Single)

_____ Minyo (Married)/_____ Naay Kapuyo (Live-in)

Edad: _____

Trabaho/panginabuhian: _____

Edukasyon/nahuman sa pag eskwela: _____

_____ Bulag (Separated)

_____ Balo (Widow)

Nahuman or naabot sa pag eskwela:

_____ Elementarya

_____ Highschool

_____ Kolehiyo (College)

_____ Vocational course

Trabaho/panginabuhian: _____

Personal/Kaugalingon nga kita matag adlaw:

_____ Below minimum wage (below 350)

_____ Minimum (350-470)

_____ Above minimum (above 470)

Kita sa bana/pares sa matag adlaw:

_____ Below minimum wage (below 350)

_____ Minimum (350-470)

_____ Above minimum (above 470)

Relihiyon: _____

Pila kabuok ang anak: _____

Giapilan nga organisayon ug position (ilista):

_____

_____

_____

_____

_____

INTERVIEWEE REACH PROFILE (FP)

1) What is the FP method you are currently using?
Unsa ang imohang FP method nga ginagamit sa pagkakaron?

_____

2) What is your reason for using family planning?
Unsay rason nimo sa pagamit ug family planning?

_____
_____
_____
_____
_____

3) How did you hear about the FP services? [Referral by whom, social media, leaflets, CHW, RHU staff, during Family Development Session, other channels of communication]
Paunsa nimo nahibaluan ang kabahin serbisyo sa FP?

_____ Referral. Pangalan ng nag refer:_____
_____ Social media (Facebook at iba pa)
_____ Leaflets, pamphlets
_____ CHW
_____ Empleyado sa RHU/health facility
_____ Ug lain pa: _____

4) What information was provided to you?
Unsa nga mga impormasyon ang gihatag sa imoha?

_____
_____
_____
_____
_____

5) What services did you receive from RHU/BHS? (pre-natal, post-natal, post-partum, FP in hospital) And how frequent did you access the FP health services?
Unsa nga mga serbisyo imong nadawat gikan sa RHU/BHS? (pre-natal, post-partum, FP) Ug kapila ka nibalik aron makakuha sa FP?

_____
_____
_____
_____
_____

6) Before you got pregnant, can you recall any pregnancy programs or events, or activities at RHU/BHS to prevent pregnancy that you were invited to attend? What was it?
Sa wala pa ka naburos, nakahinumdom ba ka og programa o panghitabo, ug kalihukan sa RHU/BHS para malikayan ang pagburos, nga naimbitahan ka para mutambong? Unsa kini?

_____
_____
_____

_____

_____

7) After you got pregnant, did you go for prenatal? Where did you have your prenatal services? Who accompanied you? How many visits did you have before you delivered? Would you recall who [doctor, nurse, midwife, CHW] attended to you? What was your experience with the first antenatal visit? How did you feel?

Sa katong naburos na ka, nagpa prenatal ba ka?

_____ Oo

_____ Hindi/Dili

Asa ka nagpa prenatal?

_____ Lying in clinic

_____ Barangay Health Station

_____ Rural Health Center

_____ Laguna Medical Center

_____ Other health facilities: _____

Kinsa ang niuban sa imoha? _____

Kapila ka beses ka nagpa prenatal usa ka nanganak? _____

Kahinumdom ba ka kung kinsa ang niatiman nimo (Doctor, nurse, midwife, BHW)?

_____ Doktor

_____ Nurse

_____ Midwife

_____ CHW

_____ Ug lain pa: _____

Unsa imohang gibati/nasinati katong una nimong prenatal?

_____

_____

_____

_____

_____

8) Why did you decide to obtain the prenatal services?

Nganong naka desisyon man ka nga magpa prenatal?

_____

_____

_____

_____

_____

9) What are the challenges, issues, and problems you faced during your pregnancy?

Unsa ang imong mga problema nga nasinati kadtong naburos ka? (Paki detalye)

_____

_____

_____

_____

_____

10) After you delivered, did you also go for a postnatal check-up? Where did you go? Who accompanied you? How many times after delivery did you go for antenatal?

Human ka nanganak nagpa post-natal check-up ba ka?

_____ Oo
_____ Hindi/Dili

Asa ka niadto?

_____ RHU. Pangalan ng health facility: _____
_____ Laguna Medical Center
_____ Ug lain pa _____

Kinsa imong kauban?

_____ Ginikanan
_____ Laing paryente (tiyahin, lola, at iba pa) laing paryente
_____ Amiga/barkada
_____ Kaparehong naburos

Pila ka beses nagpacheck up?

_____ Kausa
_____ Ikaduha
_____ Ikatulo
_____ Ika upat

11) Who decided to obtain FP health services? By yourself, your husband, or joint decision, or others?

Kinsa ang nagdesisyon nga magpa FP ka?

_____ Ako
_____ Bana/pares
_____ Amoang desisyon
_____ Ug lain pa: _____

12) Were the FP contraceptives provided free and were you able to get supplies when you need it?

Ang mga contraceptives gihatag ba nga libre?

_____ Oo
_____ Hindi/Dili

Naa ba permi stocks sa contraceptives sa RHU/BHS, ug makakuha ba ka dayon kung ikaw manginahanglan?

_____ Naa pirmi
_____ Usahay mahutdan
_____ Mahutdan pirmi
_____ Wala ko kabalo

13) Who decided for you when you went to the health facility? Who accompanies you in obtaining contraceptives? (For example spouses, partner/boyfriend, mother, mother-in-law, other family members), or do you go there on your own? Do you ask anyone for permission to seek health services? Why?

Kinsa ang nagdesisyon nga muadto ka og health center?

_____ Bana/pares/uyab (bilogi kung asa)
_____ Nanay inahan
_____ Ugangan/inahan sa uyab (bilogi kung asa)
_____ Laing kapamilya (tiyahin, lola, ug lain pa (bilogi kung asa)

_____ Ako lang ang nagdesisyon

Kinsa ang gauban nimo sa pagkuha ug contraceptives?

_____ Bana/pares/uyab (bilogi kung asa)
_____ Nanay inahan
_____ Ugangan/inahan sa uyab (bilogi kung asa)
_____ Laing kapamilya (tiyahin, lola, ug lain pa (bilogi kung asa)
_____ Ako lang isa muadto

Naa ba kay gipananghiran para makakuha ug FP nga services?

_____ Huo
_____ Wala

Ngano?

_____
_____
_____
_____
_____

14) If you were asked to rate your satisfaction in obtaining FP services from RHU/BHS on a scale of 1-10 with 10 as the highest, what would be your rating? Why?

Kung pahatagon ka og grado bahin sa imohang kasinatian sa pagkuha sa serbisyo sa FP gikan sa RHU/BHS gikan 1-10 ug ang 10 ang pinaka taas, unsay grado imong mahatag?

_____

Ug ngano?

_____
_____
_____
_____
_____

INTERVIEWEE BENEFIT PROFILE (FP)

1) Have you observed any changes in your health condition after participating in and obtaining FP services? If yes, what are these changes or outcomes? If your experience is negative, will you be switching to another FP method?

Naa ba kay naobserbahan nga naay pagbag-o sa imohang panglawas paghuman nimo makakuha ug FP nga serbisyo?

Kung oo, unsay mga pagbag-o? (positibo, negatibo, wala lang: physical, pangisip, ug kalinaw sa huna huna)

_____

_____

_____

_____

_____

Kung negatibo ang imong nasinati sa pagamit og FP nga pamaagi, gusto ba nimo kini bag-uhon o ilisan kining FP method nga imohang ginagamit?

_____

_____

_____

_____

_____

2) If you were asked to rate your satisfaction with the benefits you received, on a scale of 1-10 with 10 as the highest, what would be your rating? Why?

Kung pahatagon ka og grado bahin sa imohang kasinatian sa pagkuha sa serbisyo sa FP gikan sa RHU/BHS gikan 1-10 ug ang 10 ang pinaka taas, unsay grado imong mahatag?_____

Ug ngano?

_____

_____

_____

_____

_____

3) What were the problems that you encountered when availing of FP services? How did you address these problems?

Unsang mga problema imohang nasinati sa pagamit sa FP methods? (kalayo sa pasilidad, walay doctor, walay gamit o tambal para sa FP, mahal ang bayad sa FP)

_____

_____

_____

_____

_____

Paunsa nasolbad kining mga problemaha?

_____

_____

_____

4) What did you learn from the RH services provided to you? What support did you receive from the facility? Did you receive counseling including sexuality education?

Unsay imohang nakat-unan sa mga serbisyo nga gihatag sa imoha?

Unsa ang mga suporta nga gihatag sa health facility sa imoha? Naa ba sila gihatag nga sexual education counseling sa imoha?

5) What is the effect in your relationship with your sexual partner now that you are using an FP method?

Naa bay epekto sa imohang relasyon sa imohang bana/uyab/pares sa imohang pagamit og FP?

6) If you were asked to rate your satisfaction with the benefits you received, on a scale of 1-10 with 10 as the highest, what would be your rating? Why?

Kung pahatagon ka og grado bahin sa imohang kasinatian sa pagkuha sa serbisyo sa FP gikan sa RHU/BHS gikan 1-10 ug ang 10 ang pinaka taas, unsay grado imong mahatag?

Ug ngano?

INTERVIEWEE EMPOWERMENT PROFILE (FP)

Instructions: Ask all the BEFORE questions first, then once all, proceed with all the AFTER questions.
Lantaw usa sa walang bahin ang mga pangutana, dayon lantawa usab ang inyong mamahimong tubag sa BEFORE (SA WALA PA) ug AFTER (SA PAGKAHUMAN NA) .

PAGBAG-O SA PANGLANTAW SA PA DESISYON UG KAPASIDAD SA MGA BABAYE

Magbabanggit ako ng ilang mga pahayag at mangyaring sabihin mo sa akin kung may mga pagbabago sa iyong mga pananaw bago ka nagkonsulta ng FP/ARH services at pagkatapos mong mag konsulta. Mangyaring ihambing mo ang mga pahayag at i-rate mo ang iyong mga pananaw sa scale ng:

Naa koy ipang ingon nga istorya o panghitabo, iingon sa akoa kung unsa ba nga mga nibag-o sa imohang panglantaw sa wala pa ka nagpa FP, ug katong nakakuha naka og FP?

5: Ako ang nagdesisyon
4: Nag istorya mi sa akoang bana/pares/ginikanan pero ako ang nagdesisyon
3: Nag istorya mi sa akoang bana/pares/ginikanan para kami ang magdesisyon
2: Nag istorya mi sa akoang bana/pares/ginikanan pero sila ang nagdesisyon
1: Bana/pares/ginikanan ang nagdesisyon, dili ako

Statements: Changes in Perceptions on Decision-Making and Women's Ability (Agency) *Pagbag-o sa panglantaw sa pagbuhat og desisyon ug ang abilidad sa usa ka babayi*	Before (Indicate 1-5) *Sa wala pa*	After (Indicate 1-5) *Pagkahuman na*
1) I decided when to have children. **Ako ang mag desisyon kung kanus-a nako gusto magka anak.**		
2) I decided when and what FP methods to use. **Ako ang magdesisyon kung kanus-a ug unsa nga FP method akoang gamiton.**		
3) I decided to continue using modern FP methods. **Ako ang magdesisyon kung ipadayon nako ang pagamit sa FP.**		
4) I can ask my husband/partner to use protection (e.g., condom) whenever we decide to have sex. **Kaya nako sultihan akong bana/pares nga mugamit og proteksyon (hal. Condom) kung mag sex/makipaghilawas kami.**		
5) I can refuse to have sex if it will be done without protection. **Kaya nako nga mudili nga makipag sex kung dili mugamit og proteksyon.**		
6) I decided to limit the number of children or postpone subsequent pregnancies		

Statements: Changes in Perceptions on Decision-Making and Women's Ability (Agency) *Pagbag-o sa panglantaw sa pagbuhat og desisyon ug ang abilidad sa usa ka babayi*	Before (Indicate 1-5) *Sa wala pa*	After (Indicate 1-5) *Pagkahuman na*
Kaya nako magdesisyon kung pila kabuok ang mahimong anak o dili sa magburos.		
7) I decided to go to the local health unit (RHU) on my own without asking permission from anyone. **Kaya nako muadto og RHU/BHS nga akoa lang ug dili mangayo og permiso bisan kay kinsa.**		
8) I can ask my husband/partner to go with me for medical check-ups (prenatal, post-natal, illness consultation). **Ako masultihan akong bana/pares nga kuyugan ko magpa check-up (prenatal, post-natal, illness consultation).**		
9) I can ask my spouse/partner to share responsibilities and workload at home. **Kaya nako sultihan akong bana nga mutabang sa mga responsiblidad sa mga trabahuon/kalihukan sa panimalay.**		
10) I decided to use the family income for my needs (e.g. transportation to go to health clinics, buy medicines.) **Kaya nako magdesisyong nga gamiton ang kita sa pamilya para sa pamalit ug panginahanglan (hal. Transportasyon para makuha og tambal sa klinika, ug pamalit ug tambal).**		
11) I decided to use my income for my needs (e.g. transportation to go to health clinics, buy medicines), without telling my husband/partner. **Kaya nako magdesiyon na gamiton ang akoang kita para sa pamalit ug panginahanglan (hal. Transpotasyon para makaadto sa klinika, ipamalit ug tambal), nga dili musulti sa bana/pares.**		
12) I can say no to having sex with my husband if he refuses to use a condom. **Puwede ko muingon nga dili ko makipag sex sa akoang bana/pares kung dili siya mugamit og condom.**		

5: Strongly agree **Uyon kaayo**
4: Moderately agree **Kasagaran uyon**
3: No opinion/Neutral **Walay opinyon**
2: Moderately disagree **Kasagaran dili uyon**
1: Strongly disagree **Dili uyon**

Statements: Perceptions of Social Norms, Beliefs and Practices *Panglantaw sa mga naandan nga mga tinuuhan.*	Before (Indicate 1-5) *Sa wala pa*	After (Indicate 1-5) *Pagkahuman na*
13) It is only a woman's responsibility to avoid getting pregnant. **Responsibildad lang sa babaye nga dili siya maburos**		
14) If a man and woman disagree about family planning, the woman should have the final say because she bears the child. **Kung ang lalake ug babaye dili magkasinabot sa FP, ang babaye ang dapat masunod kay siya ang maburos**		
15) It is a wife's obligation to have sex with her husband even if she does not want to. **Obligasyon sa babaye nga makipag sex sa iyang bana bisan dili siya gusto**		
16) I don't have to ask my husband's permission to get birth control services. **Dili nako kinahanglan ang permiso sa akong bana/pares para magkuha og serbisyo bahin sa birth control.**		
17) It is wrong to avail of birth control services unless you are a married woman. **Dili maayo nga magkuha og birth control nga serbisyo, kung dili ka minyo**		
18) RH services must be accessible and affordable or free. **Ang RH nga serbisyo dapat libre lang**		
19) I should forgive my husband even if he cheated on me because I need to keep my family together. **Dapat nga pasayloon nako ang akong bana bisag gilimbungan ko niya, para dili mabungkag ang pamilya**		
20) It is justifiable if my husband hits me because he is drunk. **Puwede ko pasakitan sa akong bana kay hubog siya.**		
21) I should focus on taking care of my children instead of working		

Statements: Perceptions of Social Norms, Beliefs and Practices *Panglantaw sa mga naandan nga mga tinuuhan.*	Before (Indicate 1-5) *Sa wala pa*	After (Indicate 1-5) *Pagkahuman na*
outside the home. **Dapat mag atiman na lang ko sa akong mga anak kay sa magtrabaho**		

Statements: Changes in Perceptions of Women's Voice and Choice *Pagbag-o sa Panglantaw sa tingog ug pagpili sa mga babaye*	Before (Indicate 1-5) *Sa wala pa*	After (Indicate 1-5) *Pagkahuman na*
22) A wife has the right to express her opinion when she disagrees with what her husband is saying about family planning. **Ang asawa nga babaye naay katungod nga moistorya sa iyahang opinyon kung dili siya musugot sa mga ginasulti sa iyang bana kabahin sa family planning**		
23) A wife can contradict her husband in public about family planning. **Ang asawa nga babaye pwede mo kontra sa iyang bana bisan sa publiko bahin sa FP.**		
24) Nowadays, men should participate in child rearing and household chores rather than leaving it all to the women. **Sa karong panahuna ang mga lalaki dapat muapil sa pagpadako sa iyang mga anak ug sa mga kalihukan sa panimalay, kaysa isalig ang tanan sa mga babaye**		
25) Parents should maintain stricter control over their daughters than their sons. **Dapat mas istrikto sa pagkontrol sa mga anak nga babaye kay sa anak nga lalake**		
26) Men should be willing to sacrifice their own well-being to provide financially for the women in their lives. **Ang mga lalake ang dapat magsakripisyo sa ilahang kaugalingon para mahatag ang financial nga panganihanglan sa mga babaye**		
27) After a fight or argument about family planning, or sexual intercourse, the wife should reconcile the problem first to maintain		

Statements: Changes in Perceptions of Women's Voice and Choice *Pagbag-o sa Panglantaw sa tingog ug pagpili sa mga babaye*	Before (Indicate 1-5) *Sa wala pa*	After (Indicate 1-5) *Pagkahuman na*
peace in the household. **Human sa nahimong away bahin sa FP o sex ang asawa ang dapat makipa-uli/ mag ayo sa problema para malinawon ang panimalay**		

28) Do other individuals in your community seek your opinion about important matters? If yes, about what matters?

Sa inyohang komunidad naa ba nangayo sa imohang opinyon bahin sa mga importante nga butang?

_____ Naa

_____ Wala

Kung naa, bahin sa asa?

_____

_____

_____

_____

_____

29) Do you actively participate in or are you a member of any social, political, or religious organizations? What do you do?

Aktibong nakikilahok ka ba o miyembro ka ba ng anumang mga organisasyong panlipunan, pampulitika, o relihiyon? Ga apil ba ka sa mga organisayon? Unsa imohang posisyon organisasyon?

_____ Oo. Posisyon: _____

_____ Hindi?Dili

Kung gaapil, unsa imong ginahimo?

_____

_____

_____

_____

_____

30) Are you willing to share your experience in the use of FP methods with other people?

Gusto ba ka mag share sa imohang kaagi bahin sa pagamit sa FP method?

_____ Oo

_____ Hindi/Dili

Ug ngano?

_____

_____

_____
_____
_____

31) What is your level of confidence in sharing your experience, on a scale of 1-10, with 10 as highest?
Unsa ang level sa imong pagsalig sa pagshare sa imohang kaagi, kung kani imo paga graduhan gikan sa 1 hangtod sa 10, kung asa ang 10 ang pinakataas. _____
Ug ngano?

_____
_____
_____
_____
_____

KEY INFORMANT INTERVIEW GUIDE (TB) - English and Tagalog

Reminders:

Explain the background of the proposed study and the purpose of the interview.

My name is _____, we are doing research about health services, such as TB. We would like to know how you have been helped, what benefits you have received, and how they have helped to add to your ability or change your opinion (perspective) about beliefs about women's ability.

You were selected for this research because you have experience in consulting about tuberculosis in Taguig City. We would like to ask your permission to get information about your experience that can be used to improve health services such as TB that will benefit women more. Our interview may last more than an hour. Your participation in this interview is voluntary and we are not forcing you to participate. You can leave at any time. We can also stop if you want to clarify our questions before you answer. We can also stop at any time if you decide that you no longer want to continue our interview.

1) Informed Consent

2) Ask for permission to record the interview

Ako po si _____ at _____, kami po ay gumagawa ng research tungkol sa mga health services, katulad ng TB. Gusto po naming malaman kung paano kayo natulungan, anong benefits ang inyong natanggap, at kung paano nakatulong ang mga ito upang makadagdag sa inyong kakayahan o makapagbago sa inyong opinion (pananaw) tungkol sa mga paniniwala sa kakayahan ng mga kababaihan.

Kayo ay napili sa research na ito dahil kayo ay may experience sa pag-konsulta tungkol sa tuberculosis sa Taguig City. Gusto sana naming humingi ng iyong permiso para makakuha ng information tungkol sa inyong karanasan na magagamit upang mas mapabuti ang mga health services tulad ng TB na mas mapapakinabangan ng mga kababaihan. Ang interview natin ay maaaring tumagal ng mahigit isang oras. Ang iyong participation sa interview na ito ay voluntary at hindi namin kayo pinipilit na lumahok. Pwede po kayong umalis sa kahit anong oras. Pwede rin tayong tumigil kung gusto ninyong linawin ang mga tanong namin, bago kayo sumagot. Pwede rin tayong tumigil kahit anong oras kung magdesisyon ka na hindi mo na gustong ituloy ang ating interview.

1. Informed Consent
2. Humingi ng pahintulot na i-dokumento o irekord ang panayam at kung nais nilang manatiiling anonymous.

INTERVIEWEE INFORMATION

Pangalan (optional): _____

Edad: _____

Address: _____

Marital Status:

_____ Walang asawa (Single)

_____ May asawa (Married)/ _____ Kinakasama

Edad: _____

Trabaho: _____

Edukasyon: _____

_____ Hiwalay (Separated)

_____ Balo (Widow)

Education level:

_____ Elementarya
_____ High School
_____ Kolehiyo (College)
_____ Vocational course

Trabaho:

_____

Personal income:

_____ Below minimum wage (below 500)
_____ Minimum (500-537)
_____ Above minimum (above 537)

Husband/partner income:

_____ Below minimum wage (below 500)
_____ Minimum (500-537)
_____ Above minimum (above 537)

Relihiyon: _____

Bilang ng anak: _____

Number of children	**Babae**	**Lalake**	**Edad ng anak**
1			
2			
3			
4			
5			

4Ps member

_____ Oo
_____ Hindi

Interviewee the one attending the Family Development Sessions

_____ Oo
_____ Hindi

WARM UP QUESTIONS

1. How did you know you were infected with TB? What did you feel physically? What was your apprehension when you found out you had TB?

Paano mo nalaman na may TB ka?

_____
_____
_____
_____
_____

Ano ang mga naramdaman mo na nangyayari sa katawan mo? (weight loss, fever, cough for two weeks, body aches, and others such as flaky skin, fatigue)

_____

_____

_____

_____

_____

Ano ang iyong naging alinlangan/agam-agam nung nalaman mong may TB ka? (fear of income/work loss, fear of stigma, discrimination, and others such as fear of infecting family members especially the children)

_____

_____

_____

_____

_____

2. (If 4Ps member and the one attending FDS for the family; check answers above) Did you learn anything about TB during the FDS? What are these?

Meron ka bang natutunan tungkol sa TB mula sa Family Development Session?

_____ Meron

_____ Wala

Kung meron, anu-ano ang mga ito?

_____

_____

_____

_____

_____

3. How did other people react to you when they found out you had TB? How did you feel about their reactions?

Noong nalaman ng ibang tao na ikaw ay may TB, ano ang naging reaksyon nila?

_____

_____

_____

_____

_____

Ano ang naramdaman mo tungkol sa reaksyon nila?

_____

_____

_____

_____

_____

4. Were you working before you were diagnosed with TB? Did you stop working when you were diagnosed with TB? If yes, how long? How much was the income loss per month? What were your reasons for stopping?

Nagtatrabaho ka ba bago ka nagka TB??

_____ Oo
_____ Hindi

Tumigil ka bang magtrabaho nung nagka TB ka?

_____ Oo
_____ Hindi

Kung tumigil ka sa trabaho, gaano katagal? Ilagay ilang buwan _____

Magkano kada buwan ang kita na nawala sayo noong tumigil ka sa pagtatrabaho?

_____

_____

Tumigil ka ba sa trabaho dahil sa?

_____ Masama ang pakiramdam na dahil sa epekto ng gamot
_____ Dahil nagiba ang tingin ng mga tao dahil may sakit ka ng TB
_____ Ibang dahilan (itanong ang dahilan)

_____

_____

_____

_____

_____

INTERVIEWEE REACH PROFILE (TB)

Mga Katanungan Tungkol sa Karanasan sa Pagkuha ng Health Service

SCREENING

1. Were you assisted by a Barangay Health Worker (BHW) in your area for TB screening?
   Ikaw ba ay natulungan ng inyong BHW para ma screen sa TB?
   _____ Oo
   _____ Hindi
2. How did the BHW assist you in TB screening? (wait for them to answer, then probe using the choices below):
   Paano ka tinulungan ng BHW para ma screen sa TB? (wait for them to answer, then probe using the choices below):
   _____ Symptoms screening (ubo ng 2 linggo, namamayat, persistent na lagnat, weight loss)
   _____ Referral for sputum submission to the barangay health station/health center
   _____ Referral for a check-up at the health center
   _____ Others
   _____
3. Can you describe your relationship with your assigned BHW? What topics do you discuss with the BHW related to TB?
   Kamusta naman ang relasyon mo sa BHW na naka assign sayo?
   _____
   _____
   _____
   _____
   _____
   _____
   Ano-ano ang mga pinag uusapan niyo ng BHW tungkol sa TB?
   _____
   _____
   _____
   _____
   _____

TB TREATMENT

4. How did the BHW assist you in monitoring your TB treatment? (not mutually exclusive)

Paano ka tinulungan ng BHW sa pagmonitor ng iyong TB treatment? (not mutually exclusive)

_____ Pagdala ng gamot
_____ Pagmonitor kung iniinom ng gamot
_____ Treatment partner
_____ Pag assist sa pagdadala ng sputum sa health center
_____ Iba pa _____

5. How often does the BHW visit you?

Gaano ka kadalas binibisita ng BHW?

_____
_____

_____
_____
_____
_____

6. Who were the other healthcare workers who assisted you in the health center? (For example: doctor, nurse, midwife, CHW)

a. TB screening
b. Initiation of treatment
c. Monitoring

Sino pa ang nagbigay sayo ng serbisyong pang TB sa health center (RHU or BHS)? (Halimbawa: doktor, nurse, kumadrona, CHW)

a. TB screening:
_____ Midwife
_____ Nurse
_____ Doctor
_____ Iba pa _____
b. TB diagnosis:
_____ Midwife
_____ Nurse
_____ Doctor
_____ Iba pa _____
c. Initiation of treatment:
_____ Midwife
_____ Nurse
_____ Doctor
_____ Iba pa _____
d. Monitoring:
_____ Midwife
_____ Nurse
_____ Doctor
_____ Iba pa _____

7. Who decided for you to access TB services? obtain health services? By yourself, your husband, or joint decision?

Sino ang nagdesisyon na magkonsulta o magpagamot ka?

_____ Ikaw mismo
_____ Asawa/kinakasama
_____ Parehas nagdesisyon
_____ Iba pa _____

8. Who accompanies you in obtaining services? (For example spouses, partner/boyfriend, mother, mother-in-law, other family members), or do you go there on your own?

Sino ang sumasama sa iyo sa pagkonsulta o pagpapagamot?

_____ Asawa/kinakasama/boyfriend (encircle which one)
_____ Kamag-anak
_____ Pumupunta mag-isa

9. Do you ask anyone for permission to seek TB health services? Why?

Nagpapaalam ka ba sa kahit na sino para makakuha ng mga serbisyong pang TB?

____ Oo

____ Hindi

Bakit?

_____

_____

_____

_____

_____

_____

10. How long was your TB treatment? Are the services free?

Gaano ka katagal ginamot para sa TB? (answer should be 6 months): _____

Lahat ba ng TB services ay nakuha mo ng libre?

TB diagnosis (sputum analysis via GeneXpert; dapat libre)

_____ Oo

_____ Hindi

Sputum monitoring (sputum analysis via GeneXpert; dapat libre)

_____ Oo

_____ Hindi

Libre din ba ang gamot?

_____ Oo

_____ Hindi kasi walang supply sa health center so kailangan kong bumili sa botika

11. How did you know about the availability of health services? (not mutually exclusive)

Paano mo nalaman na mayroong serbisyo sa paggamot ng TB? (not mutually exclusive)

_____ Social media

_____ Leaflets

_____ health center staff (nurses, etc)

_____ CHW

_____ During Family Development Session ng mga 4Ps

_____ Iba pa _____

12. What information was provided to you? Were you given counseling? Who gave the counseling?

Anong mga impormasyon ang nakuha mo tungkol sa pagpapagamot bilang isang babae na may TB? Halimbawa: TB at pagbubuntis?

_____

_____

_____

_____

_____

_____

Binigyan ka ba ng counseling tungkol sa TB?

_____

_____

_____

_____
_____
_____

Sino ang nagbigay ng counseling?

_____ Midwife
_____ Nurse
_____ Doctor
_____ CHW
_____ Iba pa _____

13. What other health activities did you participate in?

Ano pa ang ibang mga health programs or events or activities ang iyong nilahukan? (halimbawa: World TB Day)

_____
_____
_____
_____
_____
_____

14. Are there any other members of the family who also availed of the screening? Who asked them to be screened? Were your family members TB positive as well and who are they?

May iba pa bang miyembro ng pamilya na nagpa- screen din ng TB?

_____ Oo
_____ Wala

Kung wala, bakit?

_____
_____
_____
_____
_____
_____

Sino ang nagsabi sa kanila na magpa screen ng TB? (probe)

_____ Ako mismo
_____ CHW
_____ Doctor
_____ Nurse
_____ Iba pa _____

Kung may TB positive din sa pamilya mo, sino-sino sila?

_____ Asawa/kinakasama
_____ Magulang
_____ Anak
_____ Iba pa _____

Kung may TB positive din sa pamilya mo, ano ang ginawa mo para magpagamot sila? (not mutually exclusive)

_____ Pinagsabihang magpagamot/ni lecturan

_____ Dinala sa health center
_____ Binigyan ng pamasahe para pumunta sa health center
_____ Iba pa _____

15. If you were asked to rate your satisfaction in accessing TB services on a scale of 1-10, with ten (10) as the highest, what would be your rating? Why?

Kung iyong irarate ang natanggap na TB services mula sa health center, ano ang score mo? Mula 1-10, 10 bilang pinakamataas:

_____

Bakit?

_____

_____
_____
_____
_____
_____

INTERVIEWEE BENEFIT PROFILE (TB)

1. Have you observed any changes in your health condition after participating in and obtaining TB services? If yes, what are these changes or outcomes? If you were asked to rate your satisfaction with the benefits you received, on a scale of 1-10 with 10 as the highest, what would be your rating? Why?

May naobserbahan ka bang anumang mga pagbabago sa iyong kalusugan pagkatapos na makakuha ng mga serbisyong pang TB?

_____ Merong pagbabago
_____ Walang pagbabago

Kung oo, ano ang mga pagbabagong ito? (Positibo, negatibo, wala lang, physical at mental kalusugan, tumaba na ulit, bumuti ang lung health, gumanda na ulit ang balat, peace of mind)

_____

_____
_____
_____
_____
_

Kung hihilingin sa iyo na i-rate ang iyong kasiyahan sa pagkuha ng mga serbisyo, sa sukat na 1-10, 10 bilang pinakamataas, ano ang magiging rating mo? _____

Bakit?

_____

_____
_____
_____
_____
_

2. What were the problems that you encountered when availing of such services? How did you address these problems? (probe)

Ano ang mga problemang naranasan mo bilang isang babae sa pagkuha ng TB services - pagpapa-konsulta at pagpapagamot ng TB sa health facility. [Halimbawa: childcare, gawain sa bahay, walang kasama sa pagpunta, pamasahe]

Mga problema related sa mga gawain sa umaga:

_____

_____
_____
_____
_____
_

Mga problema related sa mga gawain sa tanghali:

_____

_____

_____

_____

_____

_

Mga problema related sa mga gawain sa hapon at gabi:

_____

_____

_____

_____

_____

_

Paano mo natugunan ang mga problemang ito? (probe)

_____

_____

_____

_____

_____

_

3. Do you think being able to avail of such services made you feel less discriminated against or less stigmatized?

Sa palagay mo, nang ikaw ay nagsimulang magpagamot at nalaman ng mga tao na may TB ka, naramdaman mo ba na iniiwasan ka nila?

_____ Oo
_____ Hindi
_____ Hindi ko alam/napansin

Naramdaman mo ba na mas natatanggap ka nila dahil ikaw ay nagpapagamot na?

_____ Mas natanggap
_____ Hindi natanggap
_____ Hindi ko alam/napansin

Nagbago ba ang pananaw nila nung gumaling ka na?

_____ Oo
_____ Hindi
_____ Hindi ko alam/napansin

4. Which of these benefits did you experience because you recovered from TB?

Alin sa mga benepisyong ito ang naranasan mo dahil ikaw ay gumaling sa TB?

_____Nakabalik sa trabaho
_____ Bumalik sa dating kinaugalian ng pamilya (magkatabi na ulit sa pagtulog, magkakasama na ulit sa pagkain, at iba pa)
_____ Bumalik ang self-confidence (kumpiyansa)
_____ Hindi na iniiwasan ng mga kakilala

_____ Iba pa _____

INTERVIEWEE EMPOWERMENT PROFILE (TB)

Instructions: Magbabanggit ako ng ilang mga pahayag, at sabihin mo sa akin kung ano ang ginawa mo noong ikaw ay nagpapagamot ng TB.

PART I. ABILITY TO DECIDE AND ACT ON THE DECISION

1. Who decided on your TB screening/testing? (X-ray, sputum)

Sino ang nagdesisyon para kayo ay magpa TB screening/TB test? (X-ray, sputum o plema o dahak)

_____ Ako ang nagdedesisyon para magpa-screen ng TB.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon para ako ay magpa screen ng TB.
_____ Naguusap kami ng asawa/kinakasama/magulang para kami ang gumawa ng desisyon para ako ay magpa screen ng TB.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para ako ay magpa screen ng TB.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para ako ay magpa screen ng TB.

2. Who decided for you to go to the health center?

Sino ang nagdesisyon para magpunta ka sa health center?

_____ Ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdedisyon para sa akin.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para sa akin.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para sa akin.

3. Who decided on your TB treatment?

Sino ang nagdesisyon para sa iyong pagpapagamot sa TB?

_____ Ako ang nagdedesisyon para ako ay magpagamot.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon para ako ay magpagamot.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdedisyon para ako ay magpagamot.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para ako ay magpagamot.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para ako ay magpagamot.

4. If TB treatment is not free, who decided on proceeding with the treatment despite expenses?

Kung hindi libre ang TB treatment, sino ang nagdesisyon para magpatuloy ka sa pagpapagamot kahit may gastusin?

_____ Ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdedisyon para sa akin.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para sa akin.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para sa akin.

5. Who decided for you to complete the TB treatment?

Sino ang nagdesisyon para sayo na kumpletuhin mo ang iyong pagpapagamot?

_____ Ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdedisyon para sa akin.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para sa akin.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para sa akin.

6. Who decided on encouraging your family to be screened for TB?

Sino ang nagdesisyon na hikayatin ang iyong pamilya na magpa screen para sa TB?

_____ Ako ang nagdesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdesisyon.
_____ Ibang tao ang nagdesisyon.

7. Who decided on bringing your husband/family to be screened for TB?

Sino ang nagdesisyon na dalhin ang iyong asawa/kinakasama/magulang para magpa screen sa TB?

_____ Ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdedisyon para sa akin.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para sa akin.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para sa akin.

Division of labor

8. Who decided on sharing household responsibilities, such as childcare and workload at home, during your TB treatment?

Sino ang nagdesisyon sa pag-hati ng gawaing bahay, tulad ng pag-alaga ng bata at iba pa, habang ikaw ay nagpapagamot?

_____ Ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdedisyon para sa akin.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para sa akin.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para sa akin.

Time use

9. Who decided on spending your free time to socialize and meet with friends?

Sino ang nagdesisyon na sa iyong mga libreng oras, ikaw ay makihalubilo sa iyong mga kaibigan?

_____ Ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdedisyon para sa akin.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para sa akin.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para sa akin.

10. Who decided on spending your free time to rest?

Sino ang nagdesisyon na ang iyong libreng oras ay maaari mong gamitin upang makapagpahinga?

_____ Ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdedisyon para sa akin.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para sa akin.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para sa akin.

11. Who decided for you to join organizations?

Sino ang nagdesisyon sa iyong paglahok/pagsali sa mga organisasyon/grupo?

_____ Ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdedisyon para sa akin.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para sa akin.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para sa akin.

12. Who decided for you to lead your organization/s?

Sino ang nagdesisyon na maging lider ka sa iyong mga organisasyon?

_____ Ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero ako ang nagdedesisyon.
_____ Naguusap kami ng asawa/kinakasama/magulang ko at kami ang nagdedisyon para sa akin.
_____ Naguusap kami ng asawa/kinakasama/magulang ko pero sila ang nagdedesisyon para sa akin.
_____ Asawa/kinakasama/magulang ko ang nagdedesisyon (Hindi ako ang nagdesisyon) para sa akin.

PART II. PERCEPTIONS OF SOCIAL NORMS, BELIEFS AND PRACTICES (PANANAW SA MGA SOCIAL NORM, PANINIWALA AT GAWI)

(Note to RAs: Ask all BEFORE statements, then once done, proceed with asking the AFTER statements.)

Magbabanggit ako ng ilang mga pahayag at mangyaring sabihin mo sa akin kung may mga pagbabago sa iyong mga pananaw bago ka nagkonsulta ng TB services at pagkatapos mong mag konsulta. Mangyaring ihambing mo ang mga pahayag at i-rate mo ang iyong mga pananaw sa scale ng:

5: Strongly agree **/ Lubos na sumasangayon**
4: Moderately agree **/ Sumasang Ayon**
3: No opinion **/ Walang opinyon**
2: Moderately disagree **/ Hindi sumasang ayon**
1: Strongly disagree **/ Lubos na hindi sumasang ayon**

Statements	**Before (Indicate 1-5)**	**After (Indicate 1-5)**
Men or women with TB should not get married. **Ang mga lalake o babae na may TB ay hindi dapat magpakasal.**		
Women with TB should not have children. **Ang mga babaeng may TB ay hindi dapat magkaanak.**		

Statements	Before (Indicate 1-5)	After (Indicate 1-5)
It is more shameful for women to have TB. **Mas nakakahiya sa mga babae na magkaroon ng TB.**		
TB is not curable, so I don't have to find treatment. **Ang TB ay hindi nagagamot, kaya't hindi ko kailangan maghanap ng gamot.**		
Women with TB should not have outside employment. **Ang mga babaeng may TB ay hindi dapat magtrabaho sa labas.**		
If my husband/partner has TB, I can serve as his treatment partner. **Kung ang asawa/kinakasama ko ay may TB, maaari akong magsilbing katuwang niya sa gamutan.**		

PART III. CHANGES IN PERCEPTIONS OF WOMEN'S VOICE AND CHOICE (PAGBABAGO SA PANANAW, BOSES AT PAGPILI NG MGA KABABAIHAN)

Were there any changes in your ability to make decisions and act on them before and after your participation as a beneficiary of the health services for TB?

May mga pagbabago ba sa iyong kakayahan na magdesisyon at umaksyon bago at pagkatapos ng iyong partisipasyon bilang benepisyaryo ng mga pangkalusugang serbisyo para sa TB?

Statements	Before (Indicate 1-5)	After (Indicate 1-5)
A wife has the right to express her opinion when she disagrees with what her husband is saying with incorrect TB information. **Ang asawang babae ay may karapatang magpahayag ng kanyang opinyon kapag siya ay hindi sumasang-ayon sa sinasabi ng kanyang asawa tungkol sa maling paniniwala sa TB.**		
A wife can contradict her husband in public when he is saying incorrect TB information.		

Statements	Before (Indicate 1-5)	After (Indicate 1-5)
Ang asawang babae ay maaaring kontrahin ang kanyang asawa sa harap ng publiko tungkol sa kanyang maling paniniwala sa TB.		
A wife should obey her husband, even if she disagrees with his incorrect decision related to TB. **Ang asawang babae ay dapat na sumunod sa kanyang asawa kahit na hindi siya sumasang-ayon sa sinasabi nito tungkol sa TB.**		
A woman's opinions are valuable and should always be considered when TB-related household decisions are made. **Ang opinyon ng isang babae ay mahalaga at dapat na palaging isinasaalang-alang sa pagbuo ng mga desisyon sa bahay kaugnay sa TB.**		
Nowadays, men should participate in child rearing and household chores when the wife is sick with TB. **Sa panahon ngayon, ang mga lalaki ay dapat lumahok sa pagpapalaki ng anak at mga gawaing bahay kapag ang babaeng asawa ay may TB.**		
Men should be willing to sacrifice their own well-being to provide financially for the women in their lives when the wife is sick with TB. **Ang mga lalaki ay dapat na handang isakripisyo ang kanilang sariling kapakanan upang matustusan ang pinansyal na pangangailangan ng mga kababaihan sa kanilang buhay kung ang babaeng asawa ay may TB.**		

7. Do other individuals in your community seek your opinion about matters related to TB treatment? If yes, about what matters?

   Humihingi ba ang ibang mga miyembro sa iyong komunidad ng iyong opinyon tungkol sa TB?

   ____ Oo
   ____ Hindi

Kung oo, tungkol saan?

_____

8. Do you actively participate in or are you a member of any organizations related to TB? What do you do?
   Aktibo ba ang iyong pakikilahok o miyembro ka ba sa mga organisasyong para sa TB?
   ____ Oo. Posisyon: _____
   ____ Hindi
   Kung oo, ano ang ginagawa mo?

   _____
   _____
   _____
   _____
   _____
   _____

9. What major life lessons have you learned now that you are TB-free?
   Anong mga pangunahing aral sa buhay ang natutunan mo ngayong wala ka nang TB?

   _____
   _____
   _____
   _____
   _____
   _____

10. Are you willing to share your experience in TB treatment with other people?
    Handa ka bang ibahagi sa ibang tao ang iyong karanasan sa paggamot sa TB?
    ____ Oo
    ____ Hindi
    Bakit?

    _____
    _____
    _____
    _____
    _____
    _____

11. What is your level of confidence in sharing your experience, on a scale of 1-10, with 10 as highest?
    Ano ang lebel ng iyong kumpiyansa sa pagbabahagi ng iyong karanasan, mula 1-10, 10 ang pinakamataas?

    _____
    Bakit?

    _____
    _____
    _____
    _____
    _____
    _____

KEY INFORMANT INTERVIEW GUIDE (Community-Based Drug Rehabilitation) - English and Bisaya

Reminders:

Explain the background of the proposed study and the purpose of the interview.

I am _____ and _____, we are conducting research on Community-Based Drug Rehabilitation. We would like to know how you have been helped, what benefits you have received and how the help has increased your ability or changed your opinion (view) about beliefs about the ability of women.

You have been selected for this research because you have experience at Oro Wellness Center. We would like to ask for your permission to obtain information about your experience in order to improve/improve the services available at Community-Based Drug Rehabilitation. Our interview may last more than an hour. Your participation in this interview is voluntary and we will not force you to participate. You can leave at any time. We can also pause if you want to clarify our questions before you answer. We can also stop at any time if you decide that you no longer want to continue with our interview.

1) Informed Consent

2) Ask for permission to record the interview

Ako si _____ ug _____, nagpahigayon kami of research kabahin sa Community-Based Drug Rehabilitation. Buot gusto namong mahibal-an kung giunsa ka natabangan, unsa nga mga benepisyo ang imong nadawat ug kung giunsa ang tabang nga imong nadugang sa imong abilidad o nabag-o ang imong opinyon (panan-aw) bahin sa mga pagtuo bahin sa abilidad sa mga babaye.

Napili ka alang niini nga panukiduki tungod kay ikaw adunay kasinatian sa Oro Wellness Center Gusto namo nga mangayo sa imong permiso nga makakuha ug impormasyon bahin sa imong kasinatian aron mapausbaw/mapalambo pa ang mga serbisyo nga anaa sa Community-Based Drug Rehabilitation. Ang among interbyu mahimong molungtad og sobra sa usa ka oras. Ang imong pag-apil niini nga interbyu boluntaryo ug dili ka namo pugson sa pag-apil. Mahimo kang mobiya bisan unsang orasa. Mahimo usab kami mohunong kung gusto nimo nga klarohon ang among mga pangutana, sa dili pa nimo tubagon. Mahimo usab kami mohunong bisan unsang orasa kung magdesisyon ka nga dili na nimo ipadayon ang among interbyu.

1) Informed Consent

2) Humingi ng pahintulot na i-dokumento o irekord ang panayam at kung nais nilang manatiiling

INTERVIEWEE INFORMATION

Pangalan (optional): _____

Edad: _____

Address: _____

Marital Status:

_____ Walay Asawa (Single)

_____ May asawa (Married)/_____ Kinakasama

Edad: _____

Trabaho: _____

Edukasyon: _____

_____ Bulag (Separated)
_____ Balo (Widow)

Education level:

_____ Elementarya
_____ Highschool
_____ Kolehiyo (College)
_____ Vocational course

Trabaho:

_____

Personal income:

_____ Below minimum wage
_____ Minimum (390)
_____ Above minimum

Husband/partner income:

_____ Below minimum wage
_____ Minimum (390)
_____ Above minimum

Relihiyon: _____

Bilang ng anak: _____

Number of children	**Babae**	**Lalake**	**Edad ng anak**	**Edad ng nanay nung nanganak**
1				
2				
3				
4				
5				

Kinabibilangang Organisasyon at Posisyon (ilista):

_____
_____
_____
_____
_____

Warm-up Question

Before going to rehab

1) How are you feeling today?

Kumusta ka karon?

_____
_____

2) What was your life like? How was your relationship with your family, husband, and peers/friends/social?

Unsa man ang imong kinabuhi sa una? Kumusta ang imong relasyon sa imong pamilya, bana, ug sa imong mga higala?

3) Tell us about your experience in using drugs. How did you find out about your drug addiction?
Palihug isugilon kanamo ang imong kasinatian sa paggamit sa mga droga. Giunsa nimo pagkahibalo bahin sa imong pagkaadik sa droga/drug dependence? (use the term drug dependence)

4) What was your reason or motivation for using drugs before rehabilitation? [Probe - how did other people react to you when they found out you had DA? How did you feel about it?
Unsa ang imong rason/hinungdan/motibasyon sa paggamit sa droga sa wala pa ang rehabilitasyon? [Probe - unsa ang reaksyon sa ubang mga tawo kanimo sa dihang nahibal-an nila nga ikaw adunay DA? Unsay imong gibati bahin niini?]

5) Did you complete the treatment you need to undergo? If yes, when did you complete the treatment? How long did it take you to recover?
Nakompleto ba nimo ang pagtambal nga gikinahanglanon para maayo ka og mahilayo sa pagka-adik? Kung oo, kanus-a nimo nahuman ang pagtambal? Unsa ka dugay nga naulian ka nga dili na magdepende o ma-adik sa droga?

INTERVIEWEE REACH PROFILE (CBDR)

1) How did you find out about Oro Wellness Center and its services? How did you know about the availability of the services in Oro Wellness Center? Referral by whom?
Giunsa nimo pagkahibalo bahin sa Oro Wellness Center ug sa mga serbisyo niini? Giunsa nimo pagkahibalo bahin sa mga serbisyo nga naa sa Oro Wellness Center? Referral ni kinsa?

_____ Social media
_____ Leaflet
_____ CHW
_____ RHU staff
_____ Other channels of communication: _____

2) What services did you obtain from the Oro Wellness Center? What other rehabilitation activities did you participate in? (input OWC services)

Unsa nga mga serbisyo ang imong nadawat gikan sa Oro Wellness Center? Unsa pa nga mga kalihokan sa rehabilitasyon ang imong giapilan?

_____
_____
_____
_____
_____

3) How long did you receive the services from the Oro Wellness Center?

Unsa ka dugay nimo nadawat ang mga serbisyo gikan sa Oro Wellness Center?

_____
_____
_____
_____
_____

4) How did you decide to have treatment and rehab? Did you decide on your own, or did others decide for you?

Giunsa nimo pagdesisyon nga magpatambal ug magpa-rehab? Nagdesisyon ka ba sa imong kaugalingon, o ang uban ba ang nagdesisyon alang kanimo?

_____
_____
_____
_____
_____

5) Who accompanies you in obtaining the rehab service? (For example: spouses, partner/boyfriend, mother, mother-in-law, other family members), or do you go there on your own? Do you ask anyone for permission to seek health services? Why?

Kinsa ang nag-uban kanimo sa pagkuha sa serbisyo sa rehab? O nag-inusara ka nga moadto didto?

_____ Imong kapikas sa kinabuhi
_____ Partner/boyfriend
_____ Inahan
_____ Ugangan nga babaye
_____ Ubang membro sa pamilya
_____ Sa imong kaugalingon

Nangayo ka ba sa uban miembro sa imong pamilya, imo mga higala o uban pa alang sa pagtugot sa pagpangita sa mga serbisyo sa kahimsog? Ngano man?

_____
_____
_____
_____
_____

6) Who provided the health service in Oro Wellness Center?

Mga si kinsa nga mga tao ang naghatag sa health na serbisyo sa Oro Wellness Center? (e.g. staff, doctor, nurse, etc.)

_____
_____
_____
_____
_____

7) Are there any other members of the family who also availed of the screening? If yes, who are they? Were you able to help them get treated? Are there other family members who use drugs? [Spouse?]

Naa bay ubang miyembro sa pamilya nga nanginahanglan og nakadawat usab sa serbisyo sa drug-screening? Kung oo, palihug, kinsa man nga miembro sa imong pamilya?

_____
_____
_____
_____
_____

Nakatabang ba ka nga makadawat pud sila sa serbisyo sa drug rehab? Naa bay ubang membro sa pamilya nga naggamit ug droga? [Kapikas?]

_____
_____
_____

_____

_____

8) If you were asked to rate your satisfaction in obtaining the services on a scale of 1-10, with 10 as the highest, what would be your rating? Why?

Kung hangyoon ka nga i-rate ang imong katagbawan/satisfaction sa pagdawat sa mga serbisyo sa sukdanan nga 1-10, nga ang 10 maoy pinakataas, unsa ang imong rating?

_____

Ngano man?

_____

_____

_____

_____

_____

INTERVIEWEE BENEFIT PROFILE (CBDR)

1) Have you observed any changes in your physical and mental health, and social relationship/acceptance after participating and obtaining rehab services?

Nakaobserbar ka ba sa bisan unsang mga pagbag-o sa imong pisikal ug mental nga kahimsog/health, ug sosyal nga relasyon/pagdawat human sa pag-apil ug pagkuha sa mga serbisyo sa rehab?

_____ Oo
_____ Hindi

If yes, what are these changes or outcomes?

Kung oo, unsa kini nga mga pagbag-o o sangputanan?

Physical

_____
_____
_____
_____
_____

Mental

_____
_____
_____
_____
_____

Social

_____
_____
_____
_____
_____

Others

_____
_____
_____
_____
_____

2) How do you feel about these changes?

Unsay imong gibati bahin niini nga mga kausaban?

_____
_____

3) After availing of the rehab services, do you think your well-being positively improved? In what way?

Human makadawat sa mga serbisyo sa rehab, sa imong huna-huna positibo ba nga milambo ang imong kahimtang o panglawas? Sa unsa nga mga pamaagi?

4) What were the problems that you encountered when availing of such services?

Unsa ang mga problema nga imong naagian o natagam-taman sa dihang nag-avail sa maong mga serbisyo?

5) How did you address these problems? (Solicit lessons learned)

Giunsa nimo pagsulbad sa mga problema? (Pangita og mga leksyon nga nakat-unan)

6) Do you think being able to avail of such services made you feel less discriminated against or less stigmatized?

Sa imong hunahuna ang pagdawat sa maong mga serbisyo nakapabag-o ba kanimo nga wala kaayoy diskriminasyon o dili kaayo stigmatized? (Or nakabati ka ba og diskriminasyon adtong nagkuha/niapil ka sa mga serbisyo?)

7) If you were asked to rate your satisfaction with the benefits you received, on a scale of 1-10 with ten (10) as the highest, what would be your rating? Why?

Kung hangyoon ka nga i-rate ang imong kalipay/satisfaction sa mga benepisyo nga imong nadawat, sa sukod nga 1-10 nga ang (10) ang pinakattaas, unsa ang imong rating?

_____

Ngano man?

_____
_____
_____
_____
_____

INTERVIEWEE EMPOWERMENT PROFILE (CBDR)

PART 1. ABILITY TO DECIDE AND ACT ON THE DECISION

1) Who decided for you to remain drug-free?

Kinsay nagdesisyon nga magpabilin kang drug-free/dili na magdroga?

_____ Ako ang ga desisyon
_____Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

2) Who decided for you to go back to school/skills training?

Kinsa ang nagdesisyon nga mobalik ka sa pagskwela/pagbansay sa kahanas?

_____ Ako ang gadesisyon
_____Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

3) Who decided for you to engage in livelihood activities?

Kinsa ang nagdesisyon nga moapil ka sa mga kalihokan sa panginabuh-ani?

_____ Ako ang gadesisyon
_____Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

4) Who decided for you to join community organizations and social groups?

Kinsa ang nagdesisyon nga moapil ka sa mga organisasyon sa komunidad ug mga grupo sa katilingban?

_____ Ako ang gadesisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

5) Who decided for you to participate in local community events and activities?

Kinsa ang nagdesisyon sa pag-apil sa lokal nga mga kalihokan sa komunidad ?

_____ Ako ang gadesisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

6) Who decided for you to speak out your voice in family decision making?

Kinsa ang nagdesisyon nga imong ipagawas ang imong tingog sa paghimog desisyon sa pamilya?

_____ Ako ang gadesisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

7) Who decided for you to speak out my voice in group-based decision making?

Kinsa ang nagdesisyon nga ipagawas ang imong tingog sa paghimog desisyon nga nakabase sa grupo?

_____ Ako ang gadesisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

Division of Labor

8) Who decided on sharing household responsibilities during your drug rehabilitation such as childcare and workload at home?

Kinsa ang magdesisyon sa pagpaambit/share sa mga responsibilidad sa panimalay sa panahon sa imong rehabilitasyon sa droga sama sa pag-atiman sa bata ug trabaho sa balay?

_____ Ako ang gadesisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

Time use

9) Who decided on the use of free time for socialization?

Kinsa ang nagdesisyon sa paggamit sa libre nga oras alang sa sosyalisasyon?

_____ Ako ang gadesisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

10) Who decided on the use of free time for rest?

Kinsa ang nagdesisyon sa paggamit sa libre nga oras sa pagpahulay?

_____ Ako ang gadesisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

11) Who decided on the membership in organizations?

Kinsa ang nagdesisyon sa pagpamiyembro sa mga organisasyon?

_____ Ako ang gadesisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

12) Who decided on the leadership in organizations

Kinsa ang nagdesisyon sa pagpangulo sa mga organisasyon?

_____ Ako ang gadesisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero ako ang mohimo sa mga desisyon
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan para makadesisyon mi
_____ Ga istoryahanay mi sa akong bana/kauban/ginikanan pero sila ang ga himo sa mga desisyon
_____ Ang akong bana/kauban/ginikanan ang ga himo sa desisyon (dili ako ang ga himo sa desisyon)

PART 11. PERCEPTIONS OF SOCIAL NORMS, BELIEFS AND PRACTICES (PANANAW SA MGA SOCIAL NORM, PANINIWALA AT GAWI)

(Note to RAs: Ask all BEFORE statements, then once done, proceed with asking the AFTER statements).

Are there changes in your perceptions of the following statements before and after obtaining health services for CBDR? (Scaling 1-5; disagree/agree)

Aduna bay mga kausaban sa imong panglantaw sa mosunod nga mga padayag sa wala pa ug human sa pagkuha sa mga serbisyo sa panglawas alang sa CBDR?

Statements	**Before (Indicate 1-5)**	**After (Indicate 1-5)**
Substance abuse (e.g., use of illegal drugs) can be an excuse for a person to sexually harass, abuse, or rape another. **Ang pag-abuso sa substansiya (pananglitan, paggamit sa ilegal nga droga) mahimong usa ka pasangil/rason alang sa pagbuhat og seksuwal nga pagpanghasi, pag-abuso, o paglugos sa laing tawo**		
It is justifiable if my husband is abusive because he is not in his right mind as a drug user. **Makataronganon kung ang akong bana abusado tungod kay wala siya sa iyang saktong panghuna-huna tungod siya kay drug user.**		
It is more shameful for women to be drug users. **Mas makauulaw sa mga babaye nga mahimong tiggamitan og droga/drug users**		
Using drugs is a crime. **Ang paggamit sa droga usa ka krimen.**		
Using drugs is an illness. **Ang paggamit sa droga usa ka sakit.**		

Changes in Perceptions of Women's Voice and Choice (same format in TB)

Were there any changes in your ability to make decisions and act on them before and after your participation as a beneficiary of the health services for CBDR?

Isip usa ka benepisaryo, aduna bay bisan unsang mga pagbag-o sa imong abilidad sa paghimo og mga desisyon ug paglihok niini sa wala pa ug sa pagkahuman sa imong pag-apil sa mga serbisyo kabahin sa CBDR?

Statements	**Before (Indicate 1-5)**	**After (Indicate 1-5)**
You have the right to express your opinion when you disagree with what your partner is saying with incorrect drug rehabilitation information. **Naa kay katungod sa pagpahayag sa imong opinyon kung dili ka mouyon sa gisulti sa imong partner mahitungod sa mga sayop nga impormasyon sa rehabilitasyon**		
You can contradict your husband in public when he shares incorrect drug rehabilitation information. **Mahimo nimong ipadayag ang exacto nga informasyon sa imong bana ngadto sa publiko kung mopaambit siya sa dili sakto nga impormasyon sa rehabilitasyon sa droga.**		
You should obey your husband, even if you disagree with his decision related to the drug rehabilitation. **Kinahanglang tumanon nimo ang imong bana, bisan og dili ka uyon sa iyang desisyon nga may kalabotan sa drug rehabilitation.**		
A woman's opinion is valuable and should always be considered when rehabilitation decisions are made. **Ang opinyon sa usa ka babaye bililhon ug kinahanglan kanunay nga paminawon sa paghimo og mga desisyon sa rehabilitasyon.**		
Parents should maintain stricter control over their daughters than their sons. **Ang mga ginikanan kinahanglang maghupot ug mas estrikto sa mga pahinumdum sa ilang mga anak nga babaye kay sa ilang mga anak nga lalaki.**		
Nowadays, men should participate in child rearing and household chores when the wife is under drug rehabilitation. (probe questions)		

Statements	Before (Indicate 1-5)	After (Indicate 1-5)
Karong panahona, ang mga lalaki kinahanglan nga moapil sa pagpadako sa bata ug mga buluhaton sa balay kung ang asawa kay nagpadrug rehabilitation. (mga pangutana sa pagsusi)		
Men should be willing to sacrifice their own well-being to provide financially for the women in their lives when women are under drug rehabilitation. **Ang mga kalalakin-an kinahanglang andam nga mosakripisyo sa ilang kaugalingon nga kaayohan aron mahatagan ug pinansyal ang mga babaye sa ilang kinabuhi kung ang mga babaye kay nagpadrug rehabilitation.**		
After a fight or argument about drug rehabilitation, the wife should reconcile the problem first to maintain peace in the household. **Human sa away o panaglalis bahin sa drug rehabilitation, ang asawa kinahanglang makig-uli/mapagpasaylo una sa problema aron mamintinar ang kalinaw sa panimalay.**		

1) Do other individuals in your community seek your opinion about important matters? If yes, about what matters?

Ang ubang mga tawo ba sa imong komunidad gapangutana basa imong opinyon mahitungod sa importante nga mga butang? Kung oo, unsa ang hinungdanon?

____ Oo
____ Hindi

Kung oo, mahitungod sa asa?

_____
_____
_____
_____
_____

2) Do you participate in or are you a member of any social, political, or religious organizations?

Miapil ka ba o miyembro ka sa bisan unsang sosyal, politikal, o relihiyoso nga mga organisasyon?

____ Oo. Posisyon: _____

____ Hindi

Kung oo, unsa imo katungdanan (responsibility) o position?

_____
_____
_____
_____
_____

3) What major life lessons have you learned now that you are drug-free?

Unsa nga mga lesksyon sa kinabuhi ang imong mga nakat-on, karon nga wala ka na sa droga?

_____
_____
_____
_____
_____

4) Are you willing to share your experience in drug use and rehabilitation with other people?

Andam ka bang ipaambit sa ubang mga tawo ang imong kasinatian sa paggamit og droga sa pag-apil sa rehabilitasyon?

____ Oo

____ Hindi

Ngano?

_____
_____
_____
_____
_____

5) What is your level of confidence in sharing your experience, on a scale of 1-10, with 10 as highest? Why?

Sa sukod nga 1-10, nga ang 10 maoy dako, palihug ko sukod sa imong lebel sa pagsalig sa pagpaambit sa imong kasinatian sa maong program? _____

Ngano?

_____
_____
_____
_____
_____

Annex F. Interview Guide Questions for IPs and Service Providers

KEY INFORMANT INTERVIEW GUIDE

Assessment of Select USAID Office of Health Project Activities (Family Planning, Adolescent Reproductive Health, Tuberculosis and Community-based Drug Rehabilitation) and their Contribution to Gender Equality and Women Empowerment

Reminders:

1. *Explain the background of the proposed study and the purpose of the interview.*

   "My name is Fatima Verzosa, Senior Consultant and Team Leader working for the CLAimDev Project. With me are the members of our team [cite names] who will join us in this interview. We are conducting a research study to assess how its programs in family planning, adolescent reproductive health, TB, and community-based drug rehabilitation resulted in benefits that contributed to gender equality and the empowerment of women and girls as beneficiaries of these programs. These programs were implemented in your hospital with the assistance of ReachHealth, a project of USAID. Our contact person for this project is their local staff Mr, Jericho_____.

   You are invited to participate in this interview as a health service provider who participated in the activities that are supported by ReachHealth We would like your permission to gather information from you today and use this information to better design activities that promote gender equality between women and men. The interview may last for about one hour.

   Please note that your participation in this study is voluntary, and you are not forced to participate. You can choose to leave at any time. We can stop anytime if you have questions that you may want us to explain before you respond."
2. *Informed Assent*

3. *Ask permission to record the interview.*

Name of [Health Center/Facility] _____
Address: _____
No. of Staff: _____ Doctor: _____Nurse:_____ Psychologist _____Psychiatrist _____
Others: _____
No. of years facility in operation: _____
Name of Respondent: _____ _____
Position_____
Age_____ Education_____ No. of years working in facility _____
Marital Status: Married _____Single_____ Others: _____

[If FGD: Use Attendance Sheet below]

Name	Position	Age	Education	Marital Status	No. of Years

					working in facility

Warm-up Question: How are you? Thank you again for agreeing and finding time for this [interview or FGD]. Please tell us about the Laguna Medical Center (history and purpose, mandates, if affiliated with DOH as a hospital, services provided, how many patients, and staff composition).

A. Interview Questions for Health Facility Staff

1. In your position as [_____], what are your designated functions in the health facility? If FGD, what are the functions of your positions?

2. What are the services that the LMC provides to your adolescent patients? Example, counseling, others?)

3. What are the problems or challenges that you encounter in the delivery of these services?

3.1. How do you address these problems/challenges?

4. What is the profile of most of your women patients?

Age_____, Educational level_____, Ave. no. children_____,
4Ps member_____[Y/N], Employed_____[Y/N], If employed, type of work_____
Income profile: Minimum wage_____, Below minimum_____Above minimum_____

5. What are the common issues of the women and adolescents (if any) that are brought to your Center?

5.1. How do you address them?

6. What kinds of assistance does ReachHealth provide to your Center?

6.1. If training, what kind of training?

6.2. Do you recall what topics are covered?

6.3. Was there a session on gender awareness and sensitivity?

6.4. What part of the training was most useful to you?

7. Are there activities (e.g. health promotion events, FP advocacy campaigns to prevent teen pregnancy or repeat pregnancies, others) that LMC conducts?

7.1. If yes, what are these activities?

7.2. Does LMC get support from ReachHealth for these activities? What kinds of support?

7.3. Do they provide IEC materials (posters, leaflets)? How are they distributed? [Get samples or photos of posters.]

8. Are the adolescent patients provided with counseling on family planning, and reproductive health? Who is the staff responsible for counseling? [Interview the staff separately]. Is the HEADDSS used as intake form for adolescents (get sample).

8.1. Is it done with the patient alone or together with the parents or husband/partners?

8.2. What topics are covered? (Ask the same question from the FP Coordinator).

9. If counseling training is provided to the staff, what topics are covered? Who provides the training? Is support for this training provided by ReachHealth?

9.1. How are the staff using what they learned from counseling training? Are they able to do this with adolescents?

9.2. What areas or topics are covered during counseling? [Probe: Are these counseling sessions on how to improve their well-being and decision making abilities? Explain the concept of women's empowerment – kakayahang gawin at sundin ang sariling decisions.]

9.3. . How often are the counseling sessions done? Do the adolescents come on their own, or with others (parents, husband/partners).

9.4. in terms of decision making, are adolescents able to make them on their own, for example, preference for FP contraceptives to use when presented with options? If not on their own, who often decides for them?

10. On the whole, what indicators do you use to measure the improvement of your patients? (Dr. Villa

10.1. Who follows up with them to check on their wellness? Do you have any working relationship with RHUs and BHWs?

11. What is the ratio of health care workers (doctor, nurse, psychologist, psychiatrist) per patient. What is the ideal and actual ratio?

Doctor: Ideal _____ Actual _____

Nurse: Ideal _____ Actual _____

Psychologist Ideal _____ Actual _____

Psychiatrist: Ideal _____ Actual _____

12. Are you aware of incentives or awards provided by the DOH for good performance of the hospitals? If yes, what are they?

DATA VALIDATION: Suggested Questions

13. Who collects information from clients?

14. How are the data verified - is there a process for data verification?

15. What information is reported to the province/regions/national? What data are requested by Reachhealth?

16.Who collects in the facility: _____Frequency of collection:_____

17. How collected: _____ (forms for recording and reporting; samples)

B. Interview Questions for Local IP Staff – ReachHealth

[Introduction, explain the purpose of the project and the concept of women's empowerment – kakayahang gawin at sundin ang sariling decisions.]

1. Please tell us about the ReachHealth activities in LMC/project sites.

2. What are the problems that your project seeks to address?

3. What are the project objectives and target results/outcomes?

4. What indicators do you use in monitoring performance?

5. Please tell us about your work here as a local IP staff. How long have you been working here and what functions do you perform?

6. What assistance is provided by ReachHealth to LMC/RHUs/BHWs [e.g. training, technical assistance, counseling, others]

6.1. If training, what kind of training? What topics are covered. Is there a session on gender awareness and sensitivity?

6..2. Are there activities, events or life skills training that are participated in by adolescent patients in LMC?

6.3. If counseling training is provided to the LMC staff, what topics are covered in the training?

6.4. Are you able to monitor the results of the counseling training?

6.5. If counseling is given to adolescent patients, how often are the counseling sessions done? [Probe: Are these counseling sessions on how to improve their well-being and decision making abilities? Explain again the concept of women's empowerment – kakayahang gawin at sundin ang sariling decisions.]

6.6. Are there empowerment-related observations that you have seen or reported to you like the ability of the adolescents to make decisions on their own or state preferences of FP methods after the counseling on FP methods, decide to bring their husband/partners on the use of FP methods, decide to go back to school, or decide to find work.

7. How often do you visit LMC? How would you assess your relationship with the LMC? Do they often come to you for any requests or advice?

8. What are the challenges/problems you encounter in the delivery of your project assistance to LMC if any?

8.1. How do you address these challenges?

9. Do you provide IEC materials to LMC? (Examples)

10. Are you aware of incentives provided by the DOH for good performance of the hospital? What are they?

DATA VALIDATION Suggested Questions:

10. Are there monitoring reports that you submit to ReachHealth?

11. What information do you collect from LMC for reporting to ReachHealth?

12. Who collects the data in the facility: _____

12.1. Frequency of collection: _____

12.2. Forms for recording and reporting; samples)

13. How are data reported verified? Is there a process for data verification that the ReachHealth project implements? Please describe.

Other notes from the interview:

C. Interview Questions for the FP Coordinator

1. In your opinion, what are the causes of teen pregnancy in your area?
2. Is the trend increasing? How many are the adolescent deliveries per year?
3. Post-partum, who decides on the use of FP; on what method to use?
4. What is the influence of parents on these decisions? Do the adolescent husbands/partners have a say in these decisions?
5. What do you think are the approaches that work to prevent teen pregnancy?
6. Are counseling services provided to adolescents to guide them on decision making on family planning, and reproductive health, going back to school, nutrition, and maternal health?
   6.1. Is it done with the patient alone or together with the parents or husband/partners?
   6.2. What topics are covered? (Ask the same question from the FP Coordinator).
   6.3. Is the HEADDSS used as an intake form for adolescents (get sample).
7. What is the state of health of pregnant adolescents? Are they nutritionally-at-risk?
8. In your estimate, were they able to access prenatal services?
9. Talking about women's empowerment - – [kakayahang gawin at sundin ang sariling decisions.] Do you have any observations if the adolescent respondents/pregnant have this capacity in terms of decisions on FP use, stopping or going back to school, go for prenatal check-ups, dealing with stigma of being pregnant, e.g. in school, community, family).
10. Are there assistance requests that you would like to convey to ReachHealth?

D. Interview Questions for Adolescents with Repeated Pregnancies

Name: Optional
Age:
No. of Children:
Civil status:
Education:
In-school: Yes _____ No_____ (why did schooling stop?):
_____
_____
_____
(who decided?)
_____

Intro and assurance of confidentiality.

1. Can you tell me about you starting from the time you reached puberty up to the present?
2. When did you start having interest in boys?
3. What topics were you curious about? What about sex topics?
   3.1. What did you know about it?
   3.2. Where did you get your information?
4. When did you first have a boyfriend _____and when did you start having sex_____, and when did you get pregnant_____?

5. What did you feel when you found out you were pregnant?
   5.1. Who did you tell it to first?
   5.2. What advice did you get, from whom?
   5.3. What was the reaction of your parents?

   5.4. What was the reaction of your school and classmates (if in school). What were their comments?
6. What kind of support did you get during your pregnancy
   6.1. From partner:
   6.2. From parents:
   6.3. From friends:
7. Did you receive any information or have knowledge about preventing pregnancy or use of FP methods before you got pregnant?
   7.1. If yes, what was the source of your information?
8. After your first pregnancy, how did you learn above FP methods?
   8.1. From whom? _____
   8.2. What did you learn about the use of FP?
9. Before your second pregnancy, did you know about FP?
   How soon after the first child did you have your second child?
10. When did you decide to use FP methods?
   10.1. Was it you who decided _____ or someone else?
   Who? _____
11. What would you advise your fellow teenagers about preventing pregnancy?
12. If you knew about this, would you have decided against having a child at that time?