



# **Integrated Community Based Risk Reduction (ICBRR) Programme Phase 3**

## **BASELINE SURVEY REPORT**

# ACKNOWLEDGEMENT

The Cruz Vermelha de Timor-Leste (CVTL) and the International Federation of Red Cross and Red Crescent Societies (IFRC) would like to express their sincere gratitude to the community leaders and members in the two municipalities and three target villages – Babulu and Mindelo in Manufahi Municipality, and Manelobas in Ainaro Municipality – for their cooperation and collaboration in providing valuable input and feedback throughout the facilitation of the Integrated Community-Based Risk Reduction (ICBRR) Programme formation and this baseline survey. Their insights and contributions from the ground form a vital foundation for the project’s success and help ensure that its benefits reach those who matter most—the community members themselves.

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## List of Abbreviations

APRO	Asia Pacific Regional Office
CAP	Community Action Plan
CCD	Country Cluster Delegation
CPA	Civil Protection Authority
CVTL	Cruz Vermelha de Timor-Leste
DRR	Disaster Risk Reduction
FGD	Focus Group Discussions
GoTL	Government of Timor-Leste
HIV	Human Immunodeficiency Virus
ICBRR	Integrated Community-Based Risk Reduction
IFRC	International Federation of Red Cross and Red Crescent Societies
KII	Key Informant Interview
KOICA	Korea International Cooperation Agency
MoH	Ministry of Health
MoFA	Ministry of Foreign Affairs
MoU	Memorandum of Understanding
PGI	Protection, Gender and Inclusion
RCCE	Risk communication and Community Engagement
SADDD	Sex, Age and Disability Disaggregated Data
SDG	Sustainable Development Goals
SDP	Strategic Development Plan
SEFOPE	Secretary State of Professional Training and Employment
STI	Sexually Transmitted Infection
WASH	Water, Sanitation, and Hygiene

# EXECUTIVE SUMMARY

This baseline study was undertaken to assess the current conditions of targeted communities under the Integrated Community-Based Risk Reduction (ICBRR) Programme. One of its main objectives was to establish a reference point to measure change, evaluate effectiveness, and assess the long-term impact of the project. Data collection combined both quantitative and qualitative methods, including household surveys and interviews. The findings provide a benchmark for future progress, inform midterm project adjustments, and enable effective monitoring and evaluation.

The study was conducted in two municipalities and three target villages: Babulu and Mindelo in Manufahi Municipality, and Manelobas in Ainaro Municipality. Data collection was carried out by the CVTL team with support from the IFRC between 2–5 May 2025. The overarching goal of the ICBRR programme is to strengthen community resilience, ensuring that communities are safer, healthier, and better prepared to face risks.

The assessment focused on community knowledge, attitudes, and practices across five thematic areas: health; Water, Sanitation, and Hygiene (WASH); Disaster Risk Reduction (DRR); livelihoods; and healthy youth. Cross-cutting issues such as gender, protection, and inclusion were also integrated throughout the study.

A total of 384 households were surveyed, comprising 46% male and 54% female respondents. In addition, 251 youth aged 12–25 years were interviewed across the three target communities.

The study identified the major hazards faced by Babulu, Manelobas, and Mindelo communities, including cyclones and storms, landslides, wildfires, and drought. Gender- and age-segregated data highlighted important differences in exposure and impact:

- Although communities are aware of key hazards such as cyclones, storms, and landslides, overall preparedness and participation in DRR activities remain low, with limited access to information and weak local structures highlighting the need for more inclusive and systematic community-based disaster management.
- Women, particularly mothers, bear the burden of fetching water amid limited access and difficult terrain, while inconsistent hygiene practices and weak WASH maintenance systems underscore the need for stronger community engagement and sustained behaviour change for lasting health and resilience.
- Men and youth, who primarily depend on agriculture for their livelihoods, face increasing challenges from climate-related crop failures and poor market access, resulting in unstable household incomes that undermine families' nutritional well-being and children's long-term development.
- Health promotion has led to positive but uneven behavioural change, with remote communities still lacking adequate knowledge, nutrition awareness, and access to preventive services—highlighting the need for stronger coordination and broader, community-level integration of health initiatives.
- There remains a critical need for continuous awareness-raising and capacity-building efforts across all sectors—climate resilience, disaster risk reduction including preparedness, health, and livelihoods—to reach and inclusively engage communities that have not yet benefited from previous phases of the ICBRR programme.

These findings underscore the urgent need for community-driven interventions that address both immediate risks and structural vulnerabilities. The baseline will serve as a critical benchmark to measure progress and adapt programme strategies over time.

# 1. INTRODUCTION

## 1.1 Background, Objectives

### Context

In 2015, the Government of Timor-Leste (GoTL) adopted the Strategic Development Plan (SDP) 2011–2030, which envisions transforming Timor-Leste from a low-income country into a medium-high-income nation by 2030. The SDP seeks to ensure a healthy, educated, and safe population that is prosperous and food self-sufficient. Guided by this vision, Timor-Leste has been working to improve living standards by leveraging political stability and its natural resource wealth. Revenues from oil and gas remain the backbone of the economy and the main driver of growth.

Significant progress has been made in social development. According to World Bank data, the maternal mortality ratio has decreased from 694 per 100,000 live births in 2000 to 142 in 2017. Despite these gains, challenges persist. The infant mortality rate remains high, at an estimated 34.5 deaths per 1,000 live births in 2021.

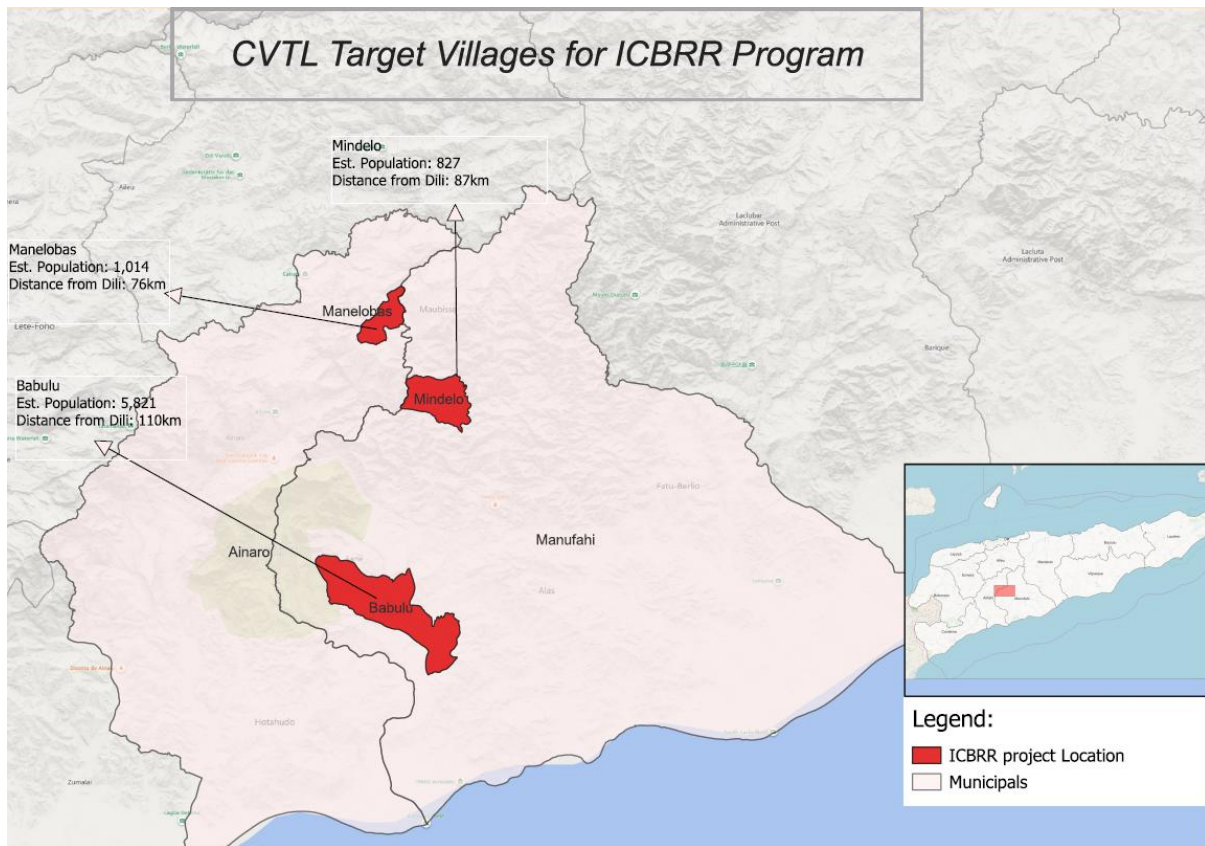
Infrastructure deficits continue to constrain both economic growth and service delivery, particularly in rural areas. Only about 50 per cent of the road network (approximately 3,000 km) has been developed, and even paved roads require constant rehabilitation due to heavy rainfall and frequent landslides in coastal and mountainous areas. As of 2019, 95 per cent of the population had access to electricity, with full coverage in urban areas and 92 per cent in rural areas.

Health and education systems remain under-resourced, with limited facilities and low service quality. Access to basic services is uneven: 74.7 per cent of households use improved drinking water sources, while only 57.1 per cent have access to improved sanitation facilities. Food insecurity is widespread, and chronic malnutrition continues to be a critical issue—around 50 per cent of children suffer from stunting.

### Integrated Community-Based Risk Reduction (ICBRR) Program

The Cruz Vermelha de Timor-Leste (CVTL), in partnership with the International Federation of Red Cross and Red Crescent Societies (IFRC), is implementing Phase 3 of the Integrated Community-Based Risk Reduction (ICBRR) Program—a two-year initiative running from August 2024 to August 2026. Building on the achievements of Phase 2, which focused on different geographic areas, this new phase expands support to additional communities identified as highly vulnerable and in need of strengthened resilience against climate-induced disasters such as floods, strong winds, landslides, heatwaves, and epidemics.

Phase 3 aims to enhance community resilience in three target areas: Mindelo and Babulu in Manufahi Municipality, and Manelobas in Ainaro Municipality. Using a participatory, community-led approach, the program integrates disaster risk management, health promotion, youth empowerment, and livelihood development to build safer and more resilient communities.



Picture 1: Project Target Areas

The ICBRR program is closely aligned with the IFRC Strategy 2030 and supports Timor-Leste's progress toward the Sustainable Development Goals (SDGs). In particular, it contributes to improved agricultural productivity, nutrition, education, vocational training, literacy, sanitation, and access to safe water. These integrated efforts aim not only to reduce the incidence of communicable and waterborne diseases but also to strengthen the foundations for sustainable and inclusive development.

By equipping communities with the skills to anticipate and respond to disasters, strengthening health outcomes, engaging youth as agents of change, and supporting sustainable livelihoods, the ICBRR program aims to build local capacity and foster long-term resilience. Ultimately, the ICBRR initiative seeks to empower communities to address vulnerabilities more effectively and create safer, healthier, and more sustainable futures.

Beyond community-level action, the program also enhances CVTL's role at municipal and national levels by fostering stronger collaboration with the Government of Timor-Leste and other partners. Through active participation in coordination platforms and joint planning, ICBRR advances resilience by improving disaster preparedness, expanding livelihood opportunities, enhancing community health, increasing access to safe water and sanitation, and empowering young people to drive change.

### Baseline study

To ensure evidence-based programming and accurately measure project progress, CVTL and IFRC conducted a baseline study to assess the conditions of the targeted communities against the key indicators outlined in the program's logical framework. The survey established benchmark data to

serve as a reference point for tracking progress and impact throughout the project. It also provides valuable insights into existing knowledge, behaviours, and practices related to disaster preparedness, health, nutrition, youth life skills, and livelihoods. By identifying gaps and opportunities across the target communities, the baseline will guide more tailored, responsive interventions and support adaptive planning through data-driven decision-making.

The survey, conducted in Ainaro and Manufahi municipalities, covered a wide range of thematic areas to capture the current realities of the target communities. The purpose of the baseline study is to establish benchmark data for key project indicators, which will:

1. Provide a reference point to measure progress and impact over time.
2. Identify existing knowledge, behaviours, and practices related to disaster preparedness, health, nutrition, youth life skills, and livelihoods.
3. Highlight gaps and opportunities for intervention across target communities.
4. Support adaptive project planning by offering data-driven insights.

The baseline assessment covered both direct beneficiaries and collected disaggregated data by sex (male and female), age group, and location. In addition, the study examined the following key areas of work within the municipalities of Ainaro and Manufahi:

1. **Disaster Risk Management:** Current preparedness levels, community plans, and disaster risk awareness.
2. **Health, Hygiene, and Sanitation:** Practices on safe drinking water, sanitation, handwashing, and hygiene behaviours.
3. **Youth Empowerment:** Youth engagement in health promotion, life skills, and community activities.
4. **Livelihoods and Income Generation:** Current income levels, access to livelihood support, and agriculture practices.
5. **National Society Capacity:** Coordination, community engagement, and program management within CVTL branches.

## 2. METHODOLOGY

The baseline survey employed a mixed-method approach, combining both quantitative and qualitative tools to capture a comprehensive understanding of community conditions. Household surveys using structured questionnaires were conducted to assess disaster preparedness, health practices, and livelihood activities, ensuring consistency with CVTL’s standardised tools. In addition, key informant interviews (KIIs) were carried out with Suco leaders, local authorities, and CVTL staff to gain perspectives on governance, coordination, and program implementation. The survey also included a document review of relevant policies, reports, and prior assessments to contextualise findings within broader frameworks. To ensure representativeness and inclusivity, data collection was based on a sampling strategy covering the four target sucos, with all information disaggregated by gender, age, and location, thereby providing a robust evidence base for program planning and monitoring.

### 2.1 Design, Area, Sampling, Enumerators

The baseline survey employed a community-based approach to assess the current situation across project areas and to establish reference values for key indicators of the ICBRR Program. Data were collected from a total of 384 respondents across three targeted villages—Babulu and Mindelo in Manufahi Municipality, and Manelobas in Ainaro Municipality.

The baseline survey design was carried out by a multidisciplinary team comprising representatives from various technical units of the CVTL Headquarters. The team included one PMER Manager, one ICBRR Senior Program Manager, one DRR Manager, one Health Manager, one PGI Officer, and one IFRC National Staff. Prior to data collection, the team conducted a series of preparatory meetings to design the survey instruments and methodology, which were further complemented by Key Informant Interviews (KII) to enrich the data and contextual understanding.

The target population for the programme is household in three the villages Babulu, Mindelo, and Manelobas with a total estimated population of 7,709 based on the Timor-Leste Census 2022. According to the census, these villages comprise 977 household with 678 households in Babulu, 96 households in Mindelo and 203 households in Manelobas.

The sampling frame consisted of Timor-Leste Census Report 2022, from which the 384 head of household was selected using a proportional distribution approach to ensure that the population characteristics of each village were adequately represented. Accordingly, 262 samples were collected from Babulu Village, 40 from Mindelo Village, and 82 from Manelobas Village.

A probability sampling approach using systematic interval sampling was employed. Households were ordered by village census lists, and the sampling interval “k” was calculated for each village using <https://www.surveylegend.com/> as illustrated below:

$K = \frac{\text{Total household}}{\text{Desired Sample}}$ <p>Babulu: <math>k = 678 / 262 \approx 2.59</math> (every ~3rd household) Mindelo: <math>k = 96 / 40 = 2.4</math> (every ~2nd-3rd household) Manelobas: <math>k = 203 / 82 \approx 2.48</math> (every ~2nd-3rd household)</p>
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Picture 2: Probability Sampling Calculation

A random starting point was selected between 1 and  $k$ , then every  $k$ -th household was chosen. The sampling interval was calculated as total household divided by desired sample size with 3<sup>rd</sup> households selected after random start point, yielding 262 from Babulu, 40 from Mindelo, and 82 from Manelobas. The below table illustrates exact percentages each village represents in the sample relative to the total population and within the sampling frame.

The total sample of 384 was determined using the SurveyMonkey sample size calculator with a 5% margin of error, 95% confidence level, and 50% response distribution (maximum variability) for the finite population of 977 households.

Village	Total Households	Sample Size	% of Total Households	% of Total Sample
Babulu	678	262	69.4%	68.2%
Mindelo	96	40	9.8%	10.4%
Manelobas	203	82	20.8%	21.4%
<b>Total</b>	<b>977</b>	<b>384</b>	<b>100%</b>	<b>100%</b>

Picture 3: Sample Size Calculation

Additionally, for the youth respondents, the desired sample of 257 youth respondents (ages 12–25 years old) was derived from the targeted youth beneficiaries of the ICBRR Programme. The sample size was calculated using the online survey calculation tool, [SurveyMonkey](#), and then allocated proportionally across the three villages according to the distribution of targeted youth (Babulu 128, Mindelo 33, Manelobas 95). A non-probability convenience sampling approach was used where surveyors approached eligible youth (12–35 years old) in households, schools, and community spaces and conducted interviews with those who consented until the village-specific targets were reached.

## 2.2 Survey, Tools

The baseline survey employed a structured questionnaire developed by CVTL Program Managers and Officers, focusing on key indicators aligned with the ICBRR program deliverables. The baseline team allocated two days for the design and finalisation of the questionnaire before uploading it into digital data collection tools. Data collection was conducted using the KoboCollect mobile application, which enabled real-time data entry and monitoring. The questionnaire was collaboratively developed by CVTL program staff across all sectors and subsequently validated through a pilot test conducted in one of the sample villages.

## 2.3 Key Informant Interviews

To complement the household survey data, Key Informant Interviews (KII) were conducted to gather qualitative feedback with identified representatives of local authorities, head of village / sub villages, sectoral stakeholders including Civil Protection Authority (CPA), and Secretary State

of Professional Training and Employment (SEFOPE). A total of six KIIs were completed across the three target villages.

## 2.4 Data Collection

Data collection was carried out from 2 - 5 May 2025 by trained staff and volunteers under the supervision of the ICBRR Program Managers. A total 27 personnel were engaged in the data collection process, comprising 19 volunteers (14 females and 5 males), two ICBRR Project Officers, three Managers, two thematic focal points (one Youth Officer and one PGI Officer), and one IFRC in-country staff.

Prior to field deployment, enumerators participated in a two-day orientation and field preparation workshop aimed at clarifying the objectives of the baseline survey and standardising data collection procedures. Following the training, the field deployment was organised into three operational clusters corresponding to the target villages to ensure effective supervision and comprehensive coverage. This structured approach enabled efficient coordination, close supervision, and consistent application of data collection standards across all sites,, as outlined below:

- **Mindelo Village Team:** Comprising six enumerators; which included four volunteers, one DRR Manager serving as supervisor, and one IFRC National Staff member providing technical support.
- **Babulu Village Team:** Consisting of thirteen enumerators; which included nine volunteers, one ICBRR Senior Program Manager and one Branch Coordinator serving as supervisors, and two Project Officers.
- **Manelobas Village Team:** Consisting of eight enumerators; which included six volunteers, one Health Manager, and one PGI Officer who served as supervisor.

For field logistics, enumerator teams deployed to Mindelo and Manelobas villages used CVTL vehicles to access the data collection sites. However, due to limited transportation availability, the Babulu team hired public transportation to reach the survey location demonstrating field flexibility and commitment to complete data collection under resource constraints.

All data were collected using the KOBO Toolbox application on mobile devices, applying a household sampling interval to ensure representative and reliable results.

## 2.5 Analysis

Quantitative and qualitative data from the household survey extracted from KOBO were subsequently cleaned and analysed using Microsoft excel. The data cleaning and analysis process focused on generating descriptives statistics such as frequencies and percentages to summarise key indicators.

The data cleaning process involved verifying key identifiers to ensure that the Head of Household listed in the data sheet matched the designated respondent. Duplicate entries were reviewed and deleted where two names or descriptions appeared to represent the same individual. Subsequently, empty or redundant columns were removed and incomplete "Other" responses which were not relevant were removed. Data anomalies and duplicates were reviewed carefully, with backups created before edits to ensure data integrity. Responses were standardised for consistency, and irrelevant or unreliable entries were excluded.

Following cleaning, the analysis phase focused on mapping questions to Logframe indicators, organising and reducing data for clarity, and summarising results through tables and key percentages. Charts and visuals were produced for critical indicators, while sex, age, and village-disaggregated analyses - Sex, Age and Disability Disaggregated Data (SADDD) helped identify gaps and patterns. Finally, cross-dataset comparisons between household and youth data provided deeper insights, and results were presented through clear visuals, narratives, and indicator-linked interpretations to inform programming and highlight trends for improvement.

## 2.6 Limitations

The targeted areas are characterised by rugged, mountainous terrain, and data collection coincided with the monsoon season marked by heavy rainfall that severely hampered access to the three villages. Community settlements are dispersed, typically clustered in small groups of five to 10 households, separated by considerable distances. This made it nearly impossible to apply the planned five-household interval sampling method effectively.

In addition, limited network connectivity posed major communication challenges between supervisors and enumerators. The Kobo data controller also faced significant difficulties in tracking real-time progress and verifying household coverage. The shortage of CVTL staff available to oversee and provide on-site guidance to enumerators further compounded these logistical and operational constraints.

Most staff and volunteers involved had limited prior experience and insufficient knowledge of data collection procedures, which affected the overall quality of engagement. As a result, some interviewees found it difficult to fully understand the questions, and both surveyors and respondents occasionally became confused during the interviews. Additionally, immediate technical or supervisory support was not always available in the field, with most issues only addressed during debriefing sessions or the following day's briefing.

The limited number of Key Informant Interviews (KIIs) and absence of Focus Group Discussions (FGDs), due to manpower constraints, reduced the qualitative input for the survey. While such insights would have enriched the findings, the quantitative results remain sufficient to provide a strong baseline for recommendations.

Delays in programme initiation caused by gaps in Human Resources and contractual procedures, affected plans to hire a consultant for the baseline study. As no consultant was available, CVTL, with support from the IFRC, conducted the survey internally. This led to a slight delay, as programme activities had already begun, and by the time the report is completed, it will coincide with the Community Action Plan (CAP) Review, which may need reconsideration in deliverables.

Additionally, since the baseline study, analysis, and report writing are conducted internally, the available capacity and manpower are limited. As a result, representatives from CVTL, the IFRC Indonesia Country Cluster Delegation (CCD), and the IFRC Asia Pacific Regional Office (APRO) had to be involved to provide additional manpower and technical support for data analysis and report writing — areas where internal expertise was lacking. This process was tedious and also time-consuming with staff having competing priorities.

### 3. FINDINGS

The findings presented in this baseline study are derived from household and youth surveys conducted across the geographic areas targeted under the ICBRR program. The data collection process employed a combination of quantitative survey methods and qualitative inputs obtained through Key Informant Interviews (KIIs), ensuring a balanced approach that captures both statistical trends and community narratives.

The primary objective of the baseline study is to generate reliable data that reflect the current realities and perceptions of the surveyed communities, thereby establishing a benchmark for program implementation, monitoring, and evaluation. The findings aim to identify existing strengths, ongoing challenges, and priority areas for improvement across the program’s core thematic components: Disaster Risk Reduction and Preparedness; Health, Hygiene, and Sanitation; Youth Life Skills and Livelihoods; and National Society Capacity on cross-cutting issues such as gender, protection, and inclusion.

The discussion in this section aims to identify key patterns and contextual factors that influence community resilience and vulnerability. By reflecting the experiences and perspectives of respondents, the baseline provides valuable insights to inform program design and planning. It also points to potential opportunities for targeted interventions that can be further developed during the program cycle to address community needs and strengthen overall resilience.

#### 3.1 Respondents’ Demographics

##### Sex and location by village of respondents

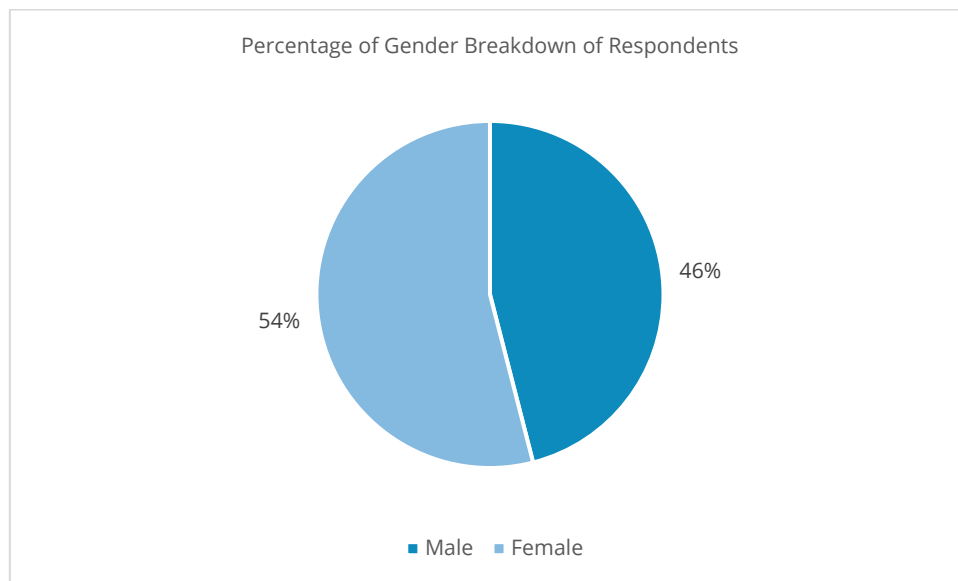


Figure 1: Sex of Respondents

### Breakdown of Respondent Numbers by Sex and Village

<b>Village</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
<i>Babulu</i>	109	153	<b>262</b>
<i>Manelobas</i>	45	37	<b>82</b>
<i>Mindelo</i>	24	16	<b>40</b>
		<i>TOTAL</i>	<b>384</b>

Table 1: Sex of Respondents by Village

The baseline survey covered three villages namely Babulu, Manelobas and Mindelo. The survey engaged 384 respondents in total, with females accounting for 54% (206 individuals) and males 46% (178 individuals) – a representation from both sexes with females comprising a slightly larger proportion of the total respondents. By village, Babulu had the highest number of respondents (262), comprising 109 males and 153 females. Manelobas followed with 82 respondents (45 males and 37 females), while Mindelo recorded the smallest sample, with 40 respondents (24 males and 16 females).

### Breakdown of Respondent Numbers by Age

<b>Age</b>	<b>Number of Respondents</b>
<i>below 30</i>	66
<i>30-49</i>	176
<i>50-69</i>	124
<i>70 above</i>	18
<i>TOTAL</i>	<b>384</b>

Table 2: Age of Respondents

The survey covered a broad age range, with respondents aged from below 30 to over 70 years. Most participants (176) were between 30 and 49 years old, followed by 124 respondents aged 50–69 years. Younger respondents below 30 years accounted for 66 participants, while the elderly group aged 70 and above comprised 18 respondents, representing the smallest segment of the sample. Overall, respondent ages ranged from 19 years to 105 years, with an average age of 44 years. Female respondents were slightly younger on average (42 years) compared to males (47 years), indicating a relatively balanced participation across both dependent and productive age groups.

## 3.2 Disaster Risk Reduction

### 3.2.1 Risk Awareness and Perception

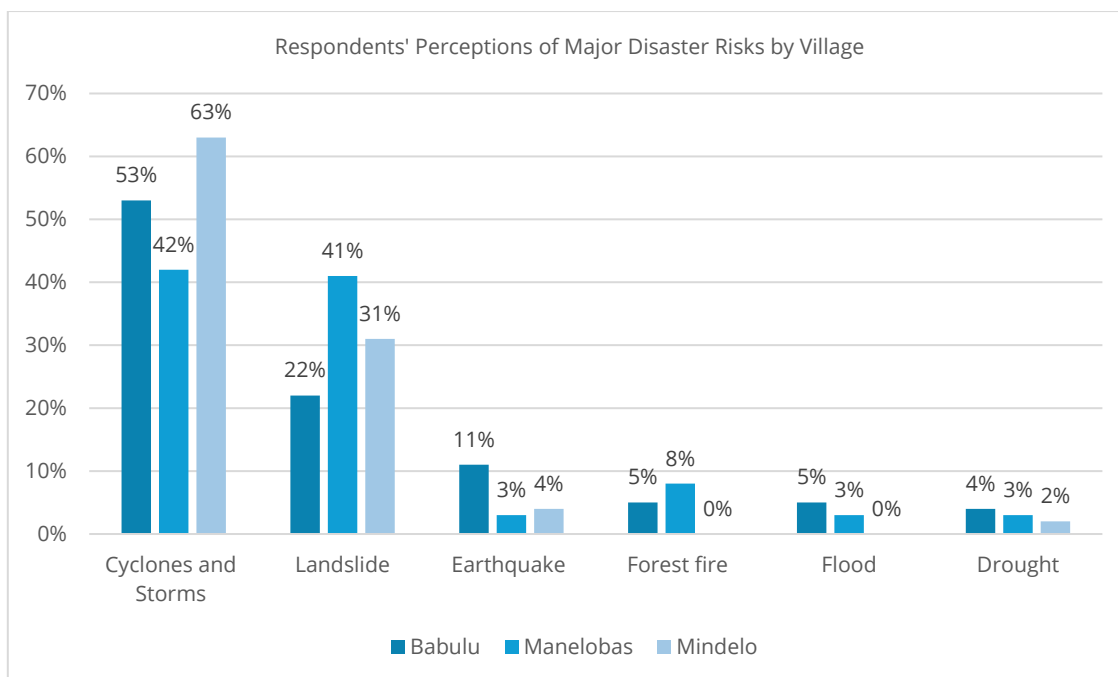


Figure 2: Percentage of Perception of Major Disasters

From the baseline survey question “What hazards that potentially/frequently happen in your area?”, the survey results reveal geographical differences in the types of hazards perceived as most common or threatening across the three villages. In Babulu, more than half of respondents (53%) identified cyclones or storms as the main hazard, followed by landslides (22%) and earthquakes (11%) dominant threats. The remaining 14% equally identified forest fires, floods and drought as threats.

Similarly, in Manelobas, both cyclones and storms (42%) and landslides (41%) were reported as major concerns. Additionally, the respondents identified forest fires (8%) and earthquake, floods and drought equally identified as threats by the remaining 9%.

Meanwhile, Mindelo showed the highest level of concern for cyclones and storms (63%), alongside a notable awareness of landslides (31%). The remaining 4% respondents identified earthquakes as a threat while 2% mentioned drought.

The findings suggest that cyclones and storms are the most widespread hazard across all three villages, while landslides represent a significant secondary threat.

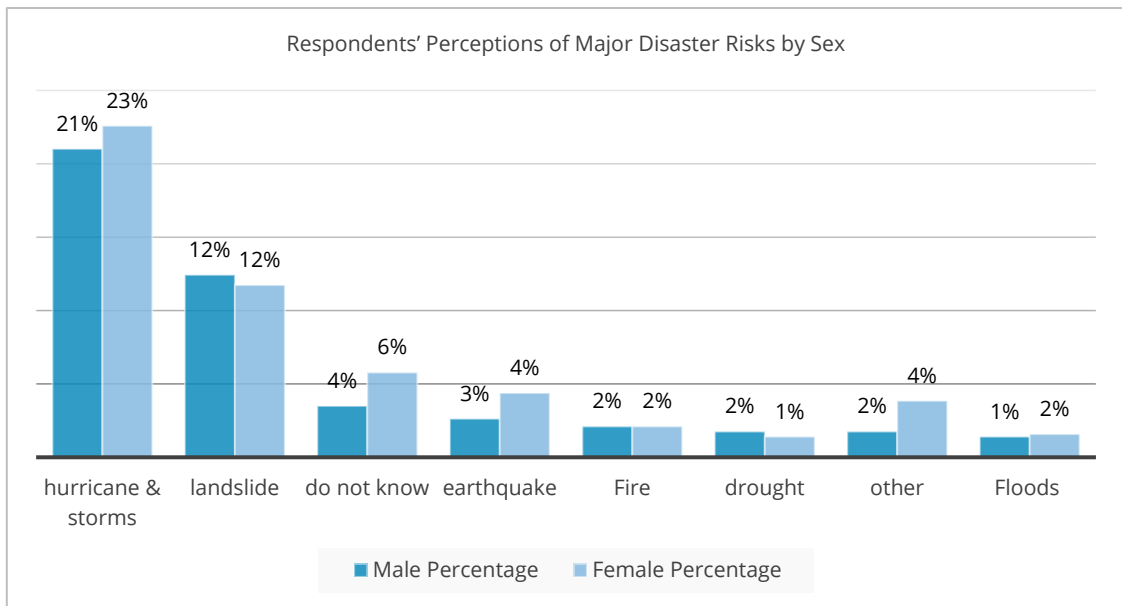


Figure 3: Percentage of Perception of Major Disasters

The survey also assessed community perceptions of major disaster risks, disaggregated by gender to understand potential differences in risk awareness and exposure. The data shows that both female and male respondents commonly identified cyclones and storms as the leading hazards in their areas, reported by 21% of male and 23% of female. This was followed by landslides with 12% of both female and male respondents respectively.

Smaller proportions of respondents identified other risks such as earthquakes (3% of male and 4% of female), fire (2% female and male respectively), and drought (2% male and 1% female), while 4% of male and 6% of female reported that they did not know which hazards posed the greatest risks. From the findings, there are suggestions that male and female respondents have very similar perceptions of disaster risks, with both groups consistently identifying cyclones and storms and landslides as the main threats. Differences between genders are minimal, suggesting that risk awareness is broadly shared across the community.

### 3.2.2 Disaster Preparedness

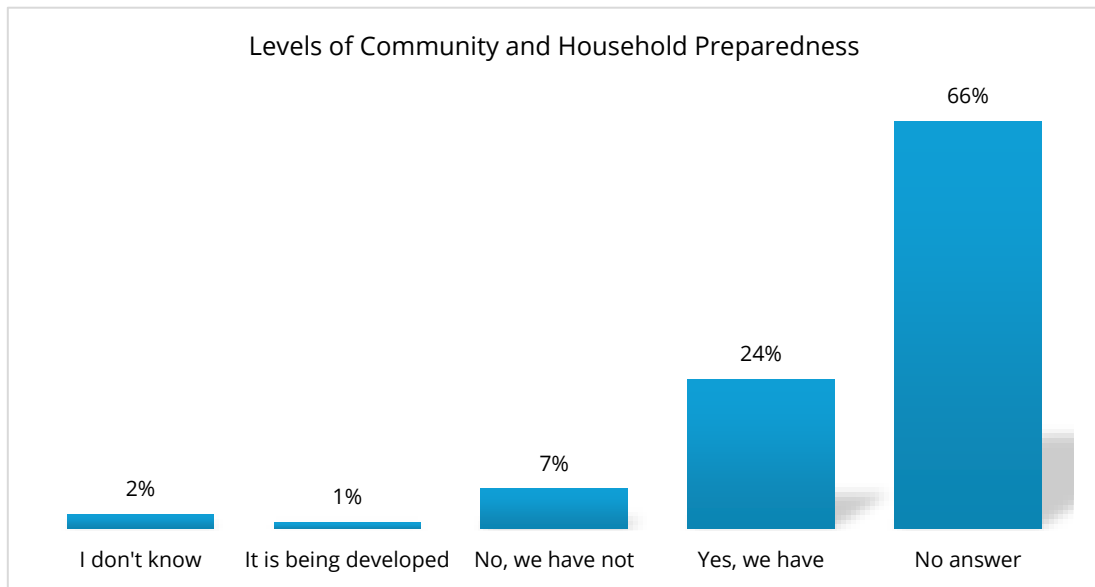


Figure 4: Percentage of Community and Household Preparedness

The survey explored the current level of household and community preparedness toward disaster within the ICBRR Program target areas. Findings revealed that only 24% of respondents reported having an existing household preparedness or disaster response plan, while 7% indicated they did not have one, and 1% stated that such a plan was still under development. A significant proportion of 66% of households left the question unanswered, suggesting limited understanding or awareness of preparedness planning as concept.

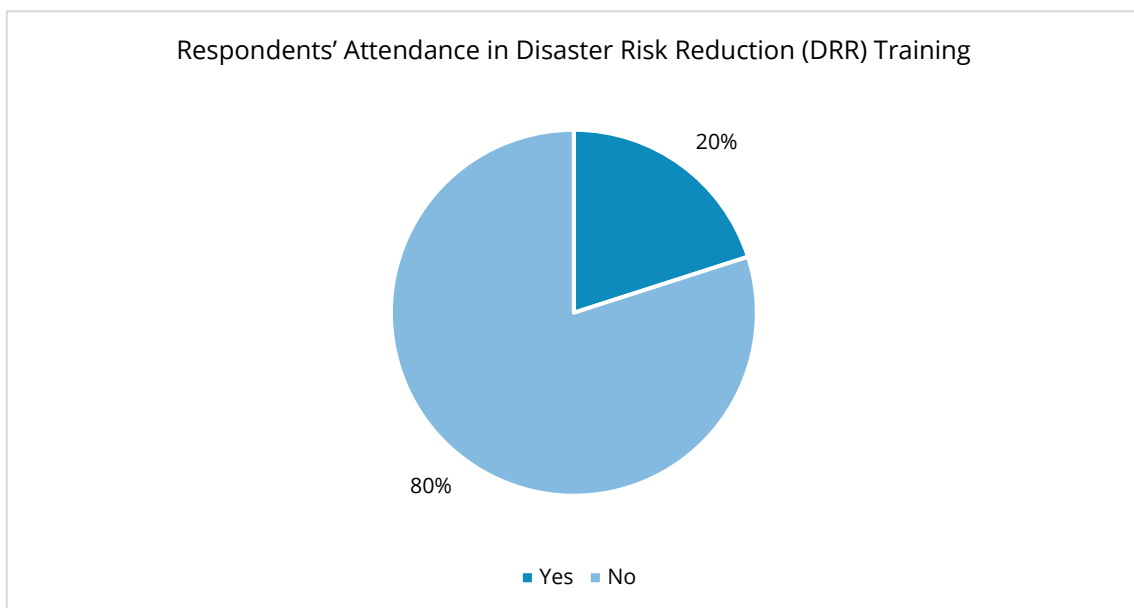


Figure 5: Percentage of Attendance for DRR Training

Furthermore, participation by respondents in disaster risk reduction (DRR) training remains relatively low. Only 20% of respondents had previously attended any DRR-related training organised by government institutions, NGOa or CVTL branches, while 80% had never participated in such initiatives.

### 3.2.3 KII Perspectives on DRR Initiatives

Six Key Informant Interviews (KIIs) were conducted, evenly distributed between Ainaro and Manufahi, with representatives of local authorities, head of village / sub villages, and representatives of identified sectoral stakeholders from each municipality. In Ainaro, respondents reported that there were 25 community volunteers, of whom 6 to 8 were women. All respondents mentioned that before the ICBRR programme intervention started, Vulnerability Capacity Assessment were done, and Community Action Plan (CAP) were developed in the villages.

*“We must not just carelessly cut down trees, it can increase the risk of disasters.”*

On Disaster Risk Reduction (DRR), respondents highlighted that DRR involves having a readiness plan, identifying and seeking safe areas to minimise impacts, ensuring that every family is prepared, and protecting the environment—such as avoiding unnecessary tree cutting—to reduce disaster risks. The main disasters identified in the area are landslides and strong winds. Respondents noted that strong winds occur annually and often cause damage to unsafe shelters.

## 3.3 Climate Change

### 3.3.1 Knowledge and awareness on climate change

The baseline findings reveal that community understanding of climate change remains partial and inconsistent. While 45% of respondents correctly identified climate change as long-term shifts in temperature patterns and 17% associated it with changing weather trends, a substantial 38% admitted having no knowledge of the concept—indicating significant gaps in awareness and understanding of climate change and its impacts among respondents.

*“Rain even during non-rainy seasons; long rainy seasons destroying our crops and bad climate resulting in bad food crops..”*

General responses on climate change from the respondents demonstrates that although some awareness is taking root at the community level, the concept is still largely perceived through a weather-centric lens rather than as a systemic, long-term environmental process. The findings underscore a pressing need for community-centered climate literacy initiatives, enabling participants to better distinguish between short-term weather events and long-term climatic variations. Furthermore, this highlights the importance of ongoing programmatic efforts in awareness building, knowledge enhancement, and advocacy to strengthen community understanding and preparedness. Such initiatives are crucial in helping communities anticipate, adapt to, and build resilience against the eventual impacts of climate-related disasters.

## 3.4 Livelihoods

### 3.4.1 Household Income and Livelihood profile

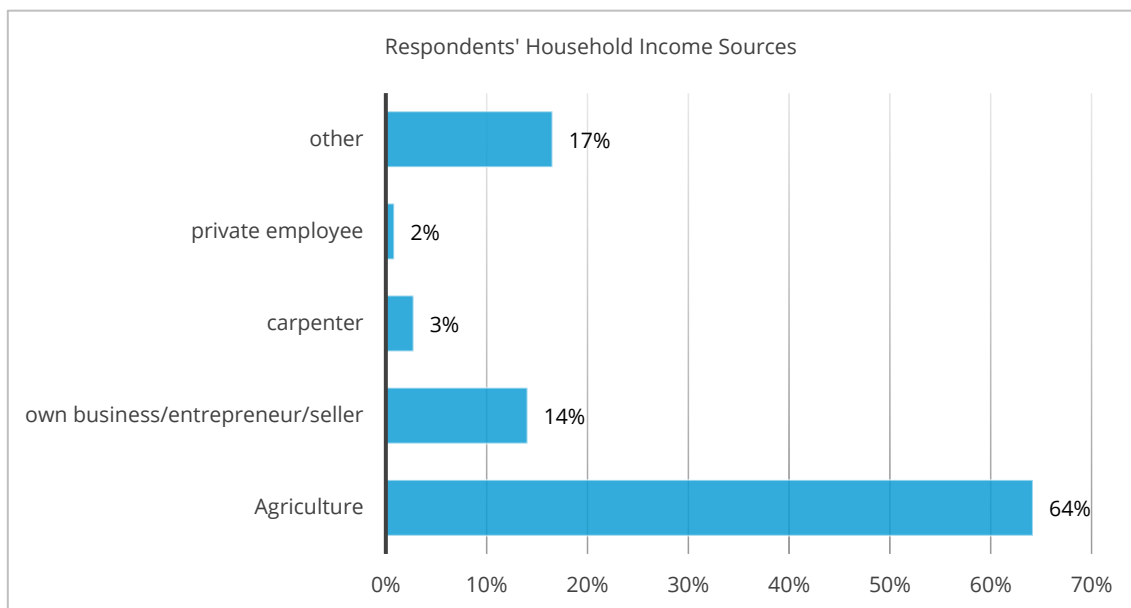


Figure 6: Respondents' Household Income Source

The baseline findings reveal that most surveyed households rely heavily on agriculture (64%) as their primary source of income. Other livelihood activities conducted by the respondents include small-scale business or trade (14%), carpentry (3%) and private employment (2%) while 17% reported other income sources such as daily labour and occasional informal work.

The income distribution among surveyed households indicates a high dependency on low-yield livelihoods, reflecting limited economic opportunities across the communities. A significant 37% of households reported to earn less than USD 60 per month. An additional 11% of households earn between USD 61 and 150 per month while only a small fraction—about 6%—reported earn a monthly income above USD 150. A substantial proportion—46%—of respondents did not answer the question. The findings indicate two possible issues. First, the generally low-income profile of the surveyed population may point to the need for livelihood-strengthening interventions and, second, the high non-response rate suggests that respondents may have had limited understanding or coherence regarding the question itself.

Survey results indicate very limited participation in savings and loan programs facilitated by organisations or agencies within the communities. Only 3% of respondents reported being part of such initiatives, while 67% stated they do not participate in any savings or loan groups. Additionally, 30% did not provide a response. These patterns point to low engagement in formal or community-based financial mechanisms. Thus, from the responses, there seems to be a need to improve financial literacy and expand access to community-based savings and loan programs to strengthen household financial resilience and support more sustainable economic coping strategies.

Only a small share of respondents reported positive changes in their income over the past six months. Just 11% indicated an increase in income, 7% said their income remained the same, and 4% reported a decrease. This suggests that most households are experiencing little to no income growth. Notably, 78% of respondents did not provide a response, which may indicate discomfort

discussing income, limited understanding of the question, or broader economic uncertainty. Additionally, income growth seems limited among households, and the extremely high non-response rate highlights potential sensitivities or challenges in accurately capturing household economic conditions.

### 3.4.2 Participation in Livelihood Support Program

From results of the baseline survey, engagement in livelihood support intervention remains limited. Only 21% of respondents reported to participate in any livelihood activity facilitated by external organisations such as poultry rearing, horticulture, or small-scale food production, while 79% had not yet accessed such assistance.

Respondents provided practical suggestions for disaster risk reduction (DRR) and resilience-building initiatives. They recommended promoting climate-smart livelihood options such as vegetable gardening, poultry, and horticulture to reduce vulnerability to climate shocks. Strengthening financial resilience through community savings and loan schemes was also suggested to help families cope during emergencies. Other key priorities include enhancing environmental protection through reforestation and soil stabilisation in hazard-prone areas, improving water systems to ensure safe and accessible water for households, and strengthening CVTL’s community services and Dial Center to improve early warning, coordination, and local disaster response.

In terms of education and awareness, respondents emphasised the need to increase participatory DRR education focusing on shelter safety, risk reduction, and preparedness—particularly among women and youth. They also recommended continuous awareness campaigns on climate change and disaster preparedness to close existing knowledge gaps and promote long-term community resilience.

## 3.5 Health and Nutrition

### 3.5.1 Health Awareness and Prevention

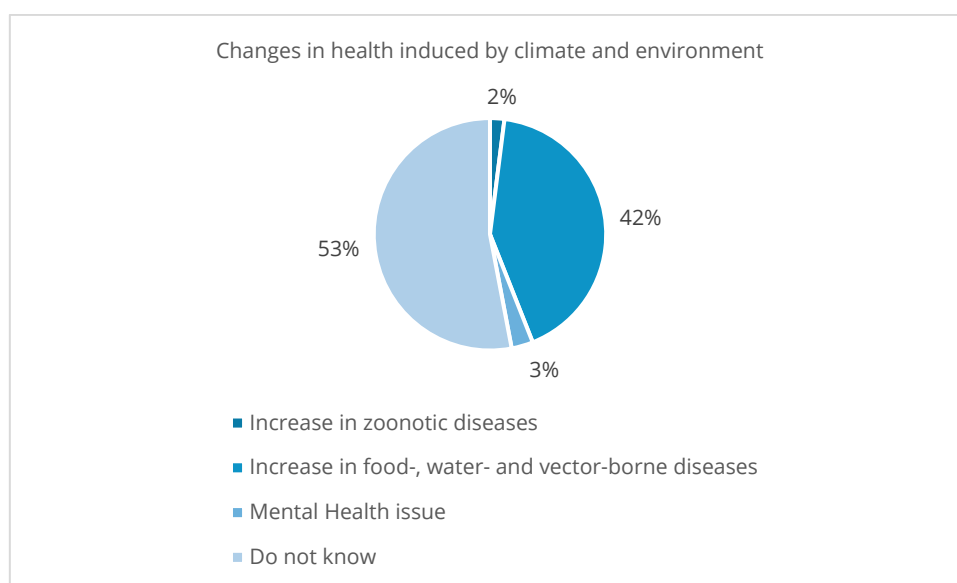


Figure 7: Percentage of Respondents Observing Health Changes Linked to Environmental and Climate Factors

On questions related to health and nutrition, in the past six months, households reported common ailments such as headaches (37%), influenza (21%), and dengue fever (20%) amongst community members, while chronic and waterborne diseases were apparently less frequent. Awareness of climate and environment-induced health changes remains limited, with 53% of respondents unable to identify any impacts. Among those aware of changes in health which were induced by climate or the environment, 42% observed increases in food-, water-, and vector-borne diseases, highlighting the tangible link between climate variability and community health.

When illness occurred, the majority of respondents (59%) sought formal medical treatment from doctors, clinics, or hospitals, while a substantial portion (33%) relied on herbal or traditional remedies. Only a small fraction reported not seeking any treatment (3%) or self-medication with common medicine (5%), suggesting generally strong health-seeking behaviour complemented by enduring traditional practices.

These findings underscore the importance of integrating climate-sensitive health education, preventive measures, and accessible medical services into disaster risk reduction programs. Strengthening these linkages will reduce climate-exacerbated health risks, promote timely care, and enhance overall community resilience.

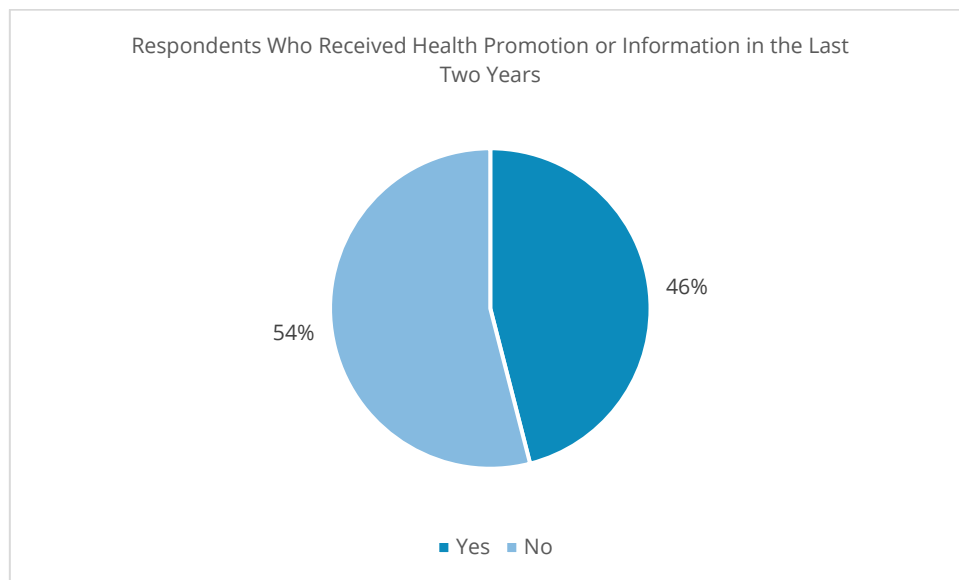


Figure 8: Percentage of Respondents Who Received Health Promotion or Information in the Last Two Years

The baseline assessed the extent to which target communities were exposed to health-related awareness and promotion in the two years preceding the study. Results show that 46% of respondents reported receiving some form of health promotion or dissemination, while 54% had not received any. Among those who did receive the information, the Government health agencies were identified as the primary source (52%) providing information and awareness, followed by CVTL (13%), and non-governmental organisations (3%). Another 29% cited other actors such as schools, churches, or local authorities, while 3% could not specify who conducted the activities.

These findings highlight that almost half of the surveyed population had not been reached through health promotion, and coverage remains uneven with significant gaps in outreach, particularly in remote or rural areas. This signals a strong opportunity for the ICBRR program outputs to reinforce partnerships with the Ministry of Health (MoH) and local service providers to ensure more systematic and sustained health messaging.

### 3.5.2 Nutrition Awareness and Behaviour Change

With regards to nutritional education, only 31% of respondents indicated that they or their family members had received training on nutrition and food preparation in the last two years, while a significant 69% had not participated in any related activities. Encouragingly, among those who received training, 28% reported having changed in their cooking practices as a result, suggesting positive behavior where exposure occurs. However, 3% said they had not made any such changes potentially suggesting that they had not attended such sessions or were not aware of what nutritional education entails.

The data suggests that when nutrition training is delivered, it yields tangible behavior shifts yet current coverage remains too limited to influence community-wide dietary habits. Expanding inclusive and practical nutrition education, particularly through women's groups and community-based volunteers, will be essential to strengthen household-level health resilience.

### 3.5.3 KII Perspectives on Health Initiatives

From the KIIs conducted, common disease outbreaks in the area include fever, cough, stomach aches, diarrhoea, dengue fever, and various skin diseases. Some respondents also mentioned ear infections and hearing-related problems, though these may be linked to both illness and injury.

When disasters or outbreaks occur, community members emphasised several key actions: establishing early warning systems and building the capacity of local authorities, planting trees and bamboo as preventive measures, preparing "go bags" for emergencies, referring sick individuals to the health post, and reporting disaster incidents to the Civil Protection Authority, Ministry of Social Solidarity, and the Police Department.

In the event of a disaster or outbreak, communities reported that they would seek help from formal authorities such as the Civil Protection Authority, Police, Firefighters, and the Ministry of Social Solidarity. They also mentioned support from humanitarian organisations such as CVTL, Mercy Corps, and Plan International. At the community level, assistance would be sought from the Head of Hamlet, Head of Village, and Head of School. For health-related issues, residents would refer patients to the local health post.

## 3.6 WASH

### 3.6.1 Access to safe drinking water

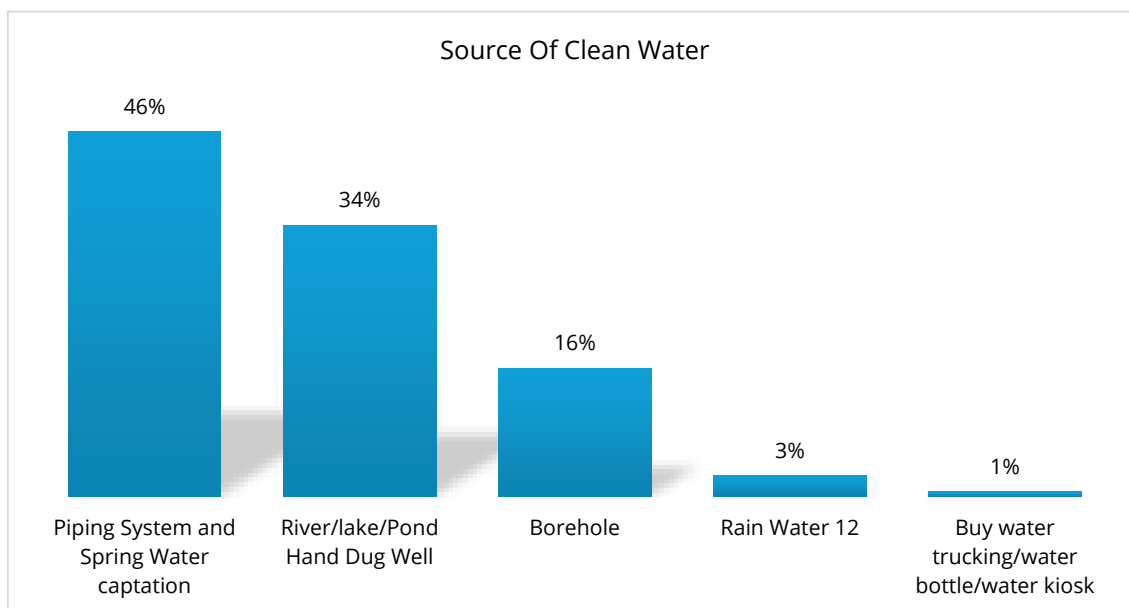


Figure 9: Respondents' Sources of Clean Water

The majority of respondents reported that they rely on piped systems or spring water (46%) as their main source of water, followed by rivers, lakes, or hand-dug wells (34%), and boreholes (16%). A smaller number of households depend on rainwater collection (3%) or purchased water (1%).

In terms of water quality, 61% of respondents rated their water as “good”, 27% as “excellent”, and 12% as “poor”. These results suggest that while nearly half of households have access to relatively improved water sources, a significant portion – approximately one-third – still depends on unsafe or unprotected natural sources, leaving them vulnerable to waterborne diseases and hazards associated with storms or prolonged droughts. The generally positive perceptions may reflect improvements in local water system upkeep or increased awareness of household water treatment practices. However, the 12% reporting poor water quality represent communities facing heightened risks of diarrheal illnesses and other health impacts linked to inadequate water safety.

### 3.6.2 Access to household sanitation facilities

The baseline findings demonstrate that 91% of surveyed households have access to their own latrine, while 9% still lack any form of private sanitation facility. This indicates commendable sanitation coverage within the ICBRR target communities but also highlights remaining gaps for the most vulnerable groups, particularly those in remote areas and households with low-income.

Among households with latrines, a variety of sanitation facilities were reported with the most common type being the compost latrine, used by 37% of households, followed by flush latrines with soakaway pits (26%) and simple pit latrines (21%). A smaller proportion (9%) reported having flush latrines connected to septic tanks, indicating relatively improved sanitation systems. Less common types included ventilated pit latrines (3%), latrines constructed over rivers (1%), and other unspecified types (4%).

Overall, the data suggest that while many households have access to basic sanitation facilities, a substantial share of respondents still rely on lower-tier or environmentally unsafe options, highlighting the need for continued improvement in sanitation infrastructure and hygiene practices.

### 3.6.3 Hygiene Behavior, Water Treatment, and Risk Communication

#### Handwashing behavior and practice

The handwashing data reveals a community with strong baseline hygiene intent but inconsistent practices across critical health protection moments. While the overwhelming majority (94%) wash hands before eating, hygiene behaviors tied to disease prevention remain substantially weaker. Handwashing *after using the latrine* (41%) and before preparing food (35%) falls below global minimum standards of household hygiene, heightening risks of diarrhea disease, food contamination, and child morbidity.

Practices linked to childcare and animal interaction such as handwashing *before feeding children* (25%), *after cleaning babies* (14%), and after touching animals (9%) are notably low. In agriculture heavy communities like Babulu, Mindelo, and Manelobas, these gaps are especially significant given higher exposure to livestock, soil contaminants, and zoonotic pathways.

The presence of 4% of respondents who *do not practice handwashing at all* signals a persistent segment requiring intensive, tailored behavior change interventions. Overall, the findings suggest that while the community value hygiene, awareness and consistent practice around critical moments remain incomplete, limiting the full health impact of WASH intervention

These results reveal encouraging hygiene habits overall, though handwashing frequency and timing still fall short of the full “critical moments” standard indicates limited awareness and practice of proper hand hygiene and highlight the need for targeted hygiene promotion and community education, particularly on washing hands after using the latrine, after handling animals, and before food preparation and eating. The significant number of respondents reportedly using soap demonstrates availability and acceptance of good practice, which can be built upon through continued behavior change communication.

#### Household and Water Treatment

The baseline findings show that a significant number of respondents demonstrate positive water safety behaviors, with 56% boiling and 36% filtering their water before drinking. Only 4% reported consuming untreated water, and smaller proportions used solar disinfection (2%), settling overnight (1%), or other sources including chemical treatment (1%). This indicates that water treatment practices are relatively well adopted at household level, particularly boiling and filtering, though a small segment of the population remains unprotected and vulnerable to waterborne diseases. Sustained community engagement and reinforcement of good hygiene habits remain essential to maintain and expand these practices

#### Water Storage and Maintenance Practices

Regarding household water container maintenance, the baseline findings reveal that 38% of respondents clean their containers only once a week. Meanwhile, 28% reported cleaning them daily, and 22% do so every few days. The remaining 12% clean their containers less frequently—ranging from once every two weeks to as seldom as once a year—which may increase the risk of water contamination. Overall, respondents demonstrate some positive hygiene practices, but the

frequency of container cleaning varies widely and remains inconsistent. The fact that 12% clean their containers only every few weeks—or even annually—highlights potential risks of water contamination. These findings underscore the need to strengthen and standardize safe water-handling behaviours through targeted Risk Communication and Community Engagement (RCCE) efforts, supported by the active participation of community volunteers.

## 3.7 Youth

### 3.7.1 Youth Respondents’ Demographics

#### Sex (disaggregation) and education levels of youth respondents

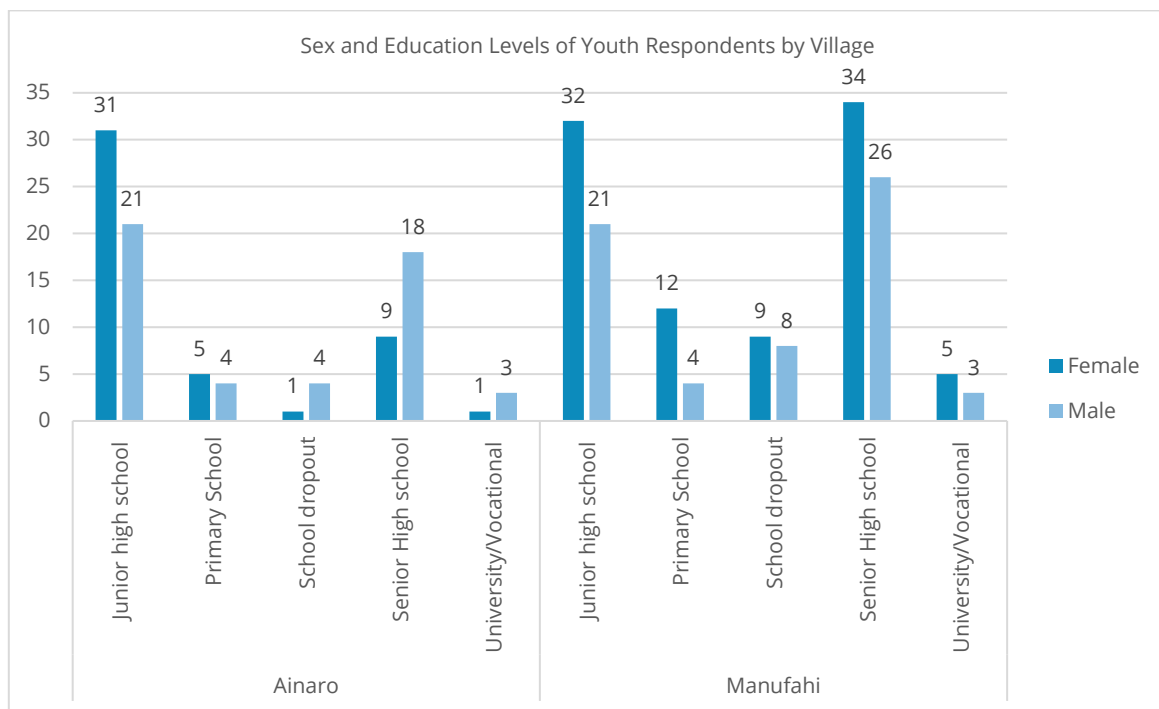


Figure 10: Sex and Education Levels of Youth Respondents

A total of 251 youth respondents participated in the baseline survey across the two target municipalities, comprising 139 females and 112 males. In Ainaro, 97 respondents were surveyed (47 females and 50 males), while in Manufahi, 154 respondents were covered (92 females and 62 males). In terms of educational background, the largest proportion of youth were enrolled in junior high school (105 respondents), followed by senior high school (87 respondents). A smaller number reported attending primary school (25 respondents) or pursuing university / vocational studies (12 respondents), while 22 respondents indicated that they had dropped out of school. This distribution highlights that the majority of youth respondents are concentrated in the junior and senior high school levels, with noticeable variations between the two municipalities (41% from Ainaro and 59% from Manufahi). Particularly in Manufahi, there is a notably higher number of youth respondents (61%) with a higher proportion of female respondents (60% female).

### Breakdown of Youth Respondent Numbers by Age

<b>Age</b>	<b>Number of Respondents</b>
<i>below 15</i>	63
<i>15-17</i>	76
<i>18-24</i>	101
<i>25 above</i>	11
<b>TOTAL</b>	<b>251</b>

Table 3: Age of Youth Respondents

From the 251 youth respondents, most were aged 18–24 years (101 respondents), followed by 76 respondents aged 15–17 years. A smaller group of 63 respondents were below 15 years, while only 11 respondents were aged 25 years and above. The average age of the youth respondents was approximately 17 years. When disaggregated by sex, the average age of female respondents was around 17.5 years, while that of male respondents was slightly higher at 18.0 years.

### Occupation of youth respondents

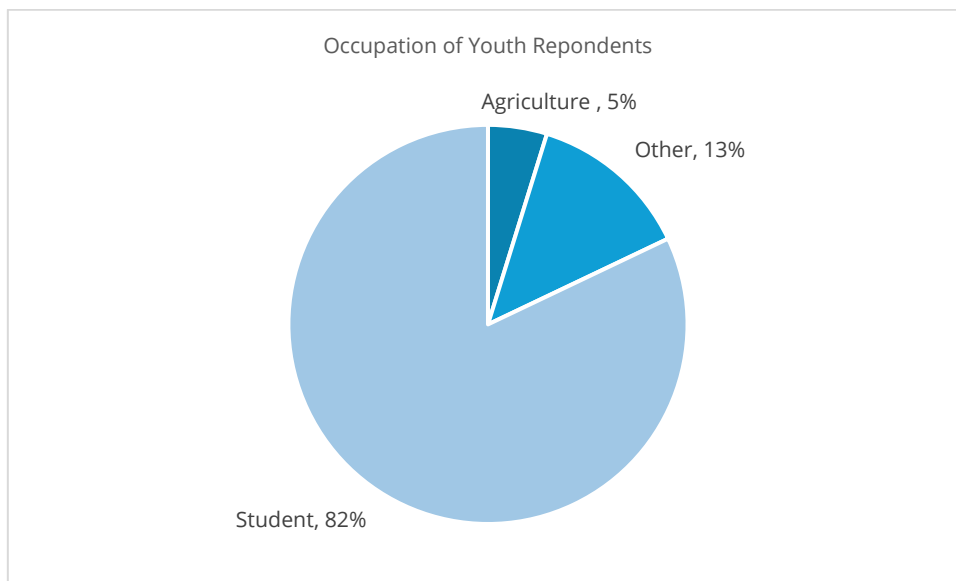


Figure 11: Percentage Distribution of Youth by Occupation

Out of the 251 youth respondents, the vast majority identified their current occupation as students (82%), reflecting that most youth are still in formal education. 5% of the respondents indicated that they were engaged in agriculture. A smaller proportion of respondents reported being engaged in other occupations (13%), which included attending courses or volunteering with CVTL, undertaking carpentry or other skilled work, assisting with household chores or farming, as well as roles such as housewives or youth who had dropped out of school and were currently not engaged in any activity.

Among students, females make up a notably larger proportion (46%) compared to males (35%), while in agriculture, males (3%) slightly outnumber females (2%). In the “other” occupations category, females (8%) are also slightly more represented than males (6%).

### Sex and participation in youth groups

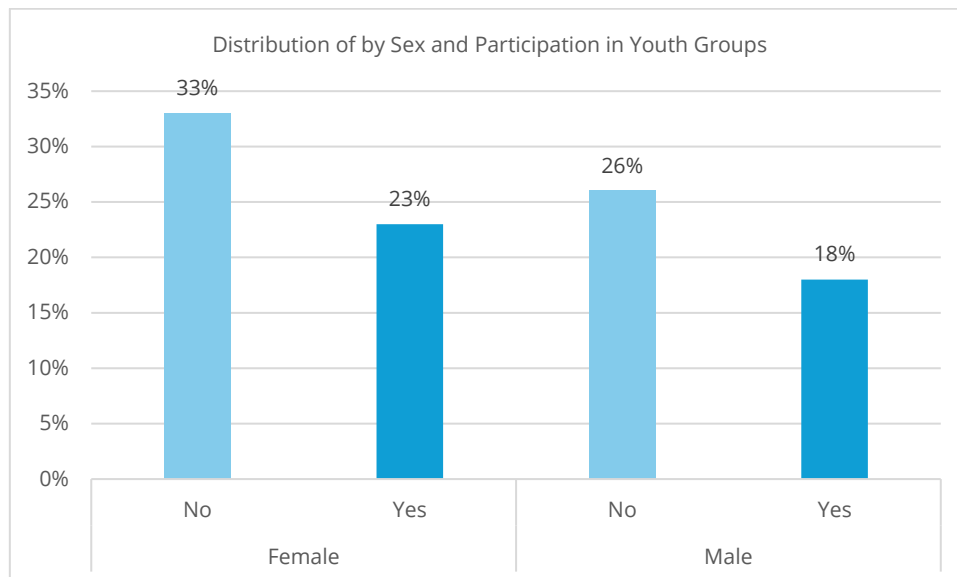


Figure 12: Percentage of Respondents' Participation in Youth Groups

Participation in youth groups supported by organisations or agencies was reported by 41% of respondents, while the remaining 59% indicated they were not involved. When disaggregated by sex, female respondents showed slightly higher participation, with 23% reporting membership in youth groups compared to 18% of males. However, a larger proportion of females (33%) than males (26%) reported not being engaged in such groups.

Amongst those who confirmed participation in youth groups, the largest proportion of youth reported being involved in school groups (31%), followed closely by sports groups (30%). Community groups attracted 23% of the youth, while church groups had the lowest participation at 16%.

### Leisure activities and skills

Most respondents spend their free time on physical activities and sports (49%), reading and writing (16%), or household and family support tasks like cooking and farming (15%), with smaller numbers totalling the balance 21% engaging in arts, education, social activities, or social media.

Their existing skills are strongest in culinary abilities (31%), business and entrepreneurship (18%), and sports (14%). 26% reported having digital, communications, arts and vocational skills, while 11% reported having no particular skill.

Moving forward, respondents are most interested in developing communication and public speaking (28%), culinary skills (23%), leadership and teamwork (19%), vocational and technical skills (14%), computer and digital skills (11%), and business and entrepreneurship (5%).

### 3.7.2 Youth Health

#### Health information and promotion

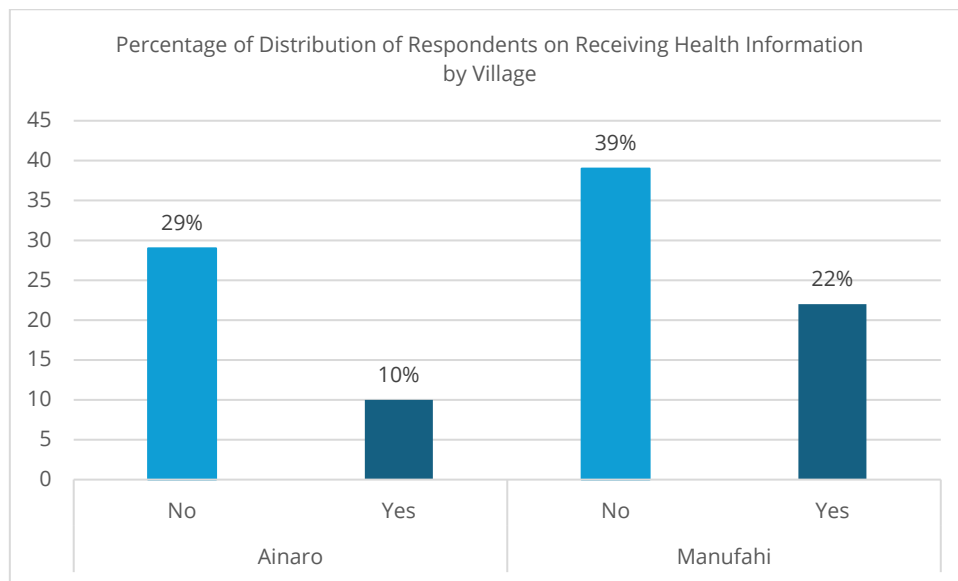


Figure 13: Recipients of Health Information

In the three months prior to conducting the survey, 68% of respondents in both villages reported not receiving any health information or promotion suggesting a need for more education and awareness initiatives. In Ainaro, out of 39% respondents, 29% respondents indicated they had not received health information, while only 10% had. Similarly, in Manufahi, 39% of respondents reported not receiving health information, compared to 22% who had. Among respondents who received health information and promotion, the majority (64%) were unsure of the source. Of those who could identify the source, 27% received information from government agencies, 7% from CVTL, and only 2% from other non-governmental organisations.

#### Medical treatment and first aid

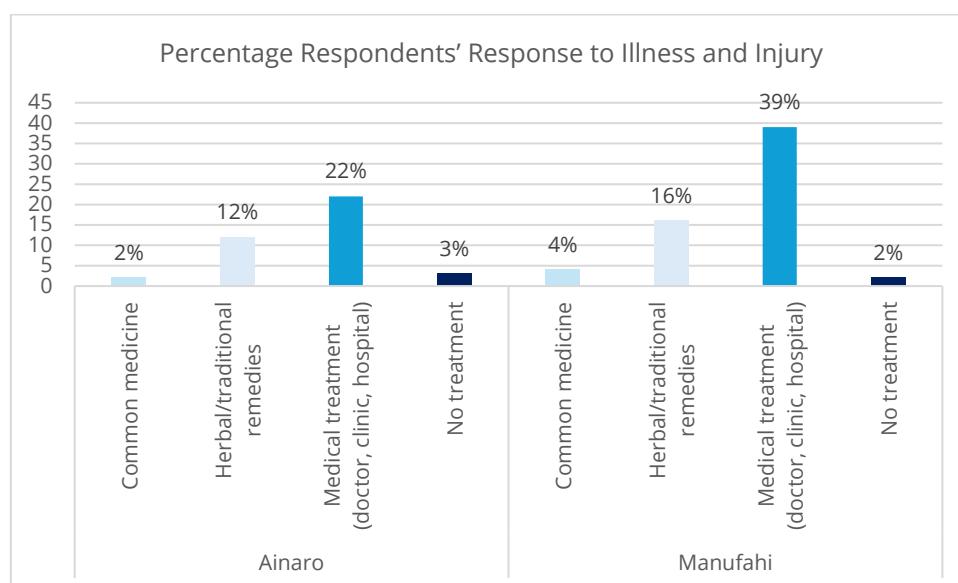


Figure 14: Respondents' Response to Illness and Injury

When asked how they would treat themselves if sick or injured, most respondents in both villages preferred medical treatment from doctors, clinics, or hospitals—22% in Ainaro and 39% in Manufahi. Herbal or traditional remedies were the second most common choice, with 12% in Ainaro and 16% in Manufahi relying on such practices. A smaller number reported using common medicine (2% in Ainaro, 4% in Manufahi), while a minority (5%) indicated they would not seek any treatment.

The results from the survey also show that 67% respondents responded positively to the question on knowing how to give first aid to someone who is sick or injured, while 33% do not know - a notable proportion who still lack the skills or confidence to provide basic assistance in emergencies.

### HIV and STI

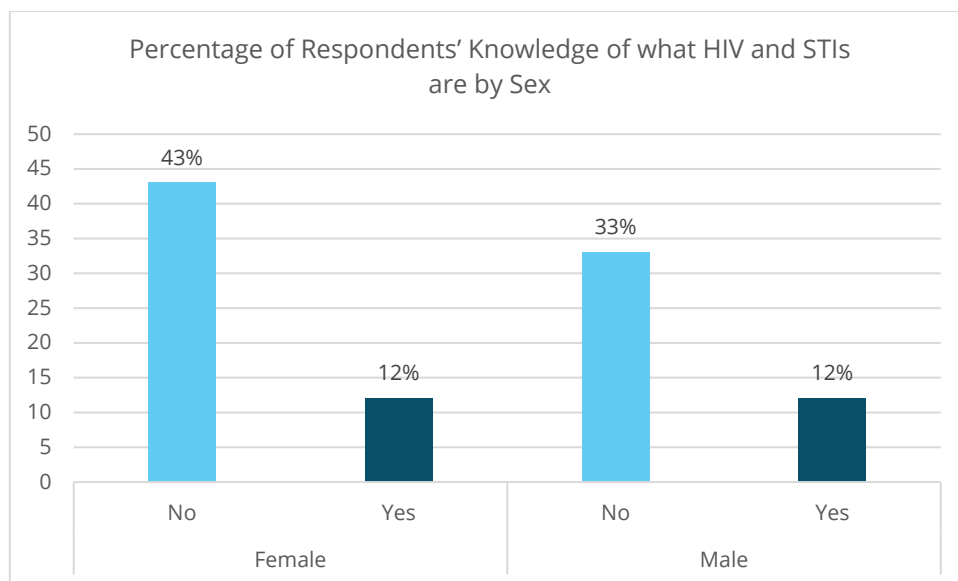


Figure 15: Knowledge of HIV and STIs Amongst Youth Respondents

Based on the responses, a majority of respondents (76%) reported not knowing what HIV and STI are with more females (43%) than males (33%) indicating a lack of knowledge. In contrast, only 24% of respondents demonstrated awareness, evenly distributed between females (12%) and males (12%). This suggests a generally low level of knowledge among respondents, with minimal gender differences in awareness.

Among the female respondents, the most common preventive measure reported was condom use (22%), followed by abstinence (8%), while fewer mentioned not sharing needles (3%) or being faithful to one partner (2%). 15% of the female respondents replied “do not know” to the question. Among males, condom use was also the most frequent response (37%), followed by faithfulness to one partner (7%) and abstinence (3%). 3% of the male respondents replied “do not know” to HIV and STI prevention. This highlights that the majority of respondents lacked knowledge about HIV and STIs, with limited awareness of prevention methods—condom use being the most commonly cited among both males and females.

## Menstrual hygiene

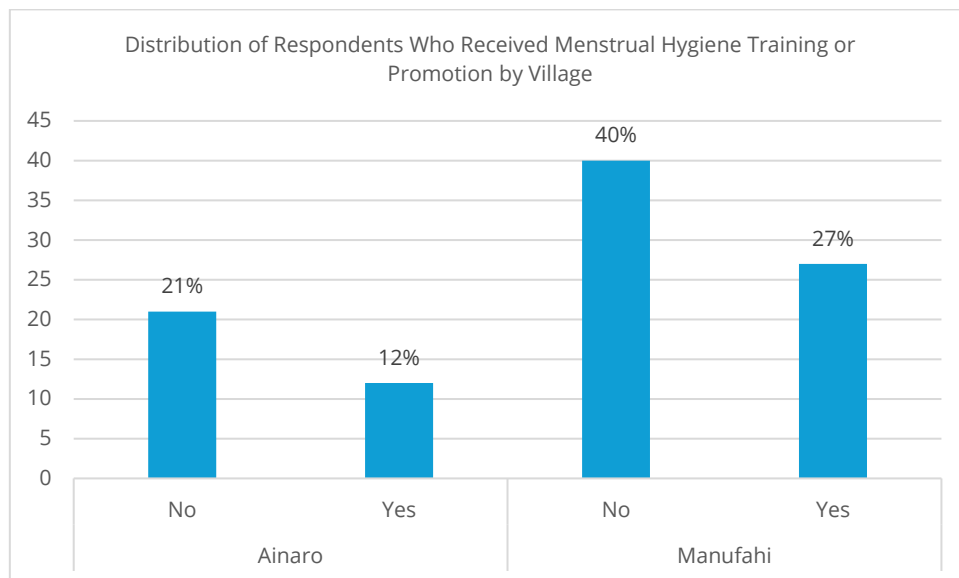


Figure 16: Recipients of Menstrual Hygiene Training or Promotion

Out of 139 female respondents, more than half reported not receiving any menstrual hygiene training or promotion in the last year, with 21% from Ainaro and 40% from Manufahi. In contrast, 53% respondents indicated having received such training, comprising 12% from Ainaro and 27% from Manufahi. From the respondents, Most respondents reported that menstrual hygiene promotion and dissemination is provided mainly by CVTL / Government (57%), followed by NGOs/Other organisations (28%), while 15% were unsure of the source. 86% of respondents use disposable sanitary napkins while 14% reportedly use re-usable or other materials.

## Handwashing

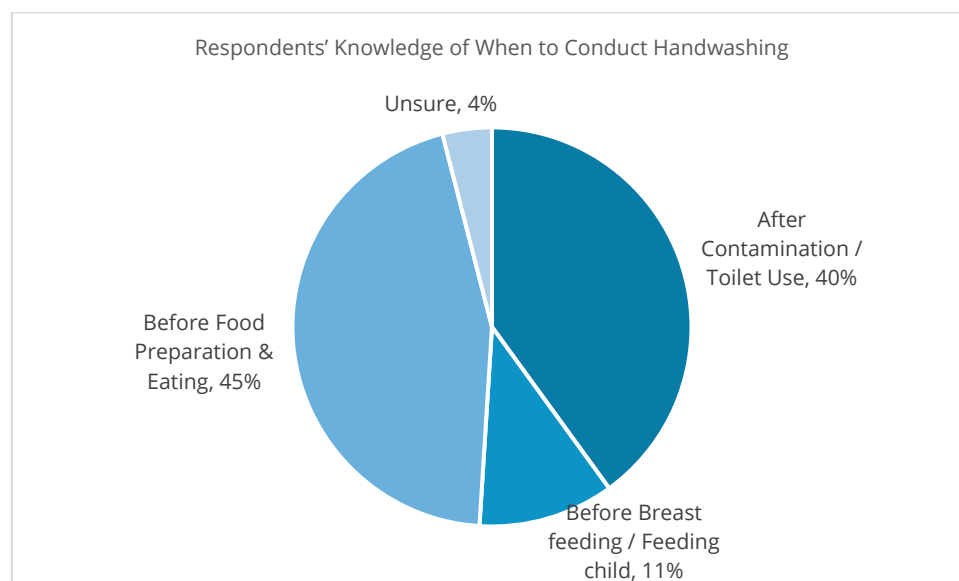


Figure 17: Percentage of Knowledge on Handwashing Amongst Youth Respondents

Based on the responses, 242 youth respondents responded to understand the importance of washing hands with soap, while only 9 do not. Based on this, the findings show that half of the respondents recognise key moments for handwashing, with 45% washing hands before food preparation and eating, and 40% after contamination or toilet use. Meanwhile, 11% highlighted the importance of handwashing before breastfeeding or feeding a child, while 4% remain unsure.

Collectively, the youth health findings indicate that while many young respondents demonstrate some awareness and exposure to health-related information—particularly on seeking medical care, first aid, STIs / HIV, menstrual hygiene, and handwashing practices—overall community health literacy remains uneven. Continued efforts are needed to enhance awareness and ensure equitable access to information, especially for youth in hard-to-reach or underserved areas.

### 3.7.3 Youth Social Behaviours

#### Smoking, drug use and alcohol consumption

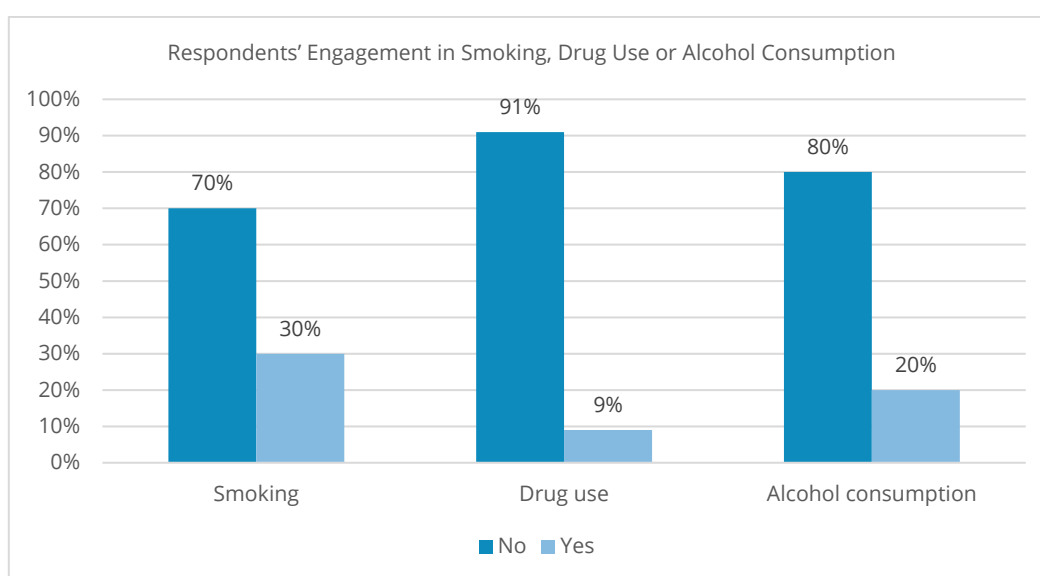


Figure 18: Percentage of Engagement in Social Habits

The survey results indicate that most respondents reported practicing healthier social behaviours in the past few months, with 70% not smoking, 91% not using drugs, and 80% not consuming alcohol. However, a notable proportion still engage in these behaviours, as 30% smoke, 9% use drugs, and 20% drink alcohol.

From responses to these social behaviours, the results indicate that amongst those who admitted to smoking, which is the most frequent behaviour, 43% admitted to smoking daily and 30% smoking several times a week, 12% smoking occasionally while 15% either rarely or never smoke.

From the responses who admitted to using drugs which seemed less common, 50% reported using weekly while the balance 50% reportedly used drugs occasionally or never, showing some regular use among a smaller group.

From the responses who admitted to alcohol consumption, 40% admitted to drinking frequently, 32% occasionally and 26% rarely.

The findings show that many respondents are exposed to certain social behaviours within their families or friends, with 87% reporting cigarette smoking, 22% reporting drug use, and 69% reporting alcohol consumption among their close circles.

92% of respondents reported consistently wearing helmets, while 8% said they do not always wear one. Similarly, 93% indicated they do not carry weapons, compared to 8% who reported that they do. Finally, 93% said they are not involved in conflicts, whereas 8% acknowledged involvement in conflicts.

When asked about respondents' participation in organised leisure activities in the last six months, most respondents participated in sports (31%), followed by music (20%) and reading (18%). A smaller portion engaged in performing arts (4%), while 27% did not participate in any organised leisure or recreational activities.

### Youth, women and disabled people's participation

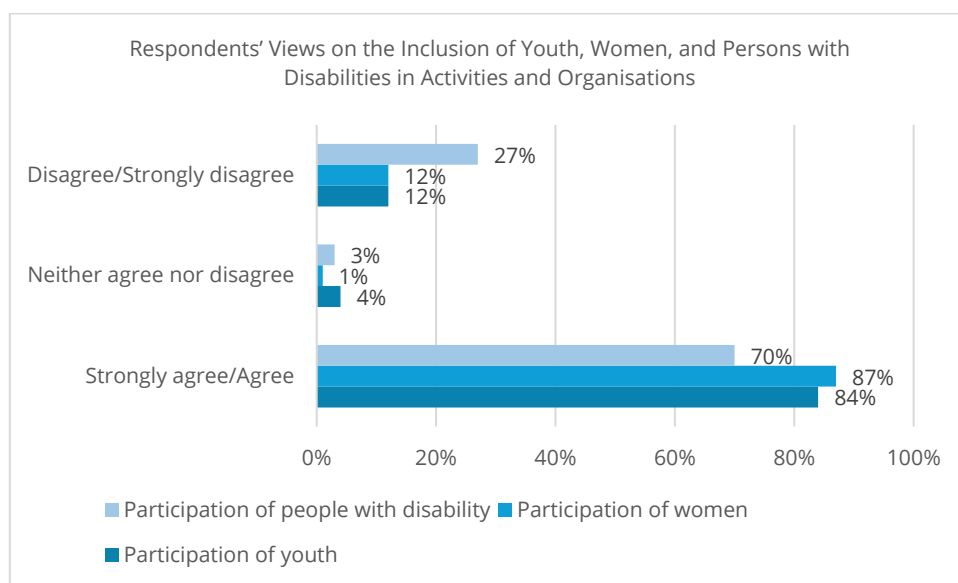


Figure 19: Percentage of Respondents' Attitudes Towards Inclusion of Youth, Women and Persons with Disabilities in Social Activities and Organisations

The results show generally positive attitudes toward inclusion, with most respondents agreeing or strongly agreeing that youth (84%), women (87%), and people with disabilities (70%) should participate in activities or organisations. However, while support is highest for youth and women, a notable 27% disagreed about participation for people with disabilities.

Youth, women, and people with disabilities are widely seen as benefiting from participation in activities. Common reasons include gaining knowledge, building capacity and confidence, developing skills, and character building. Participation is also viewed as a right, linked to equality and inclusion, and offers opportunities for leadership, decision-making, social contribution, and enjoyment. Inclusion of all groups is seen as important for both individual growth and broader community development.

*"It's not solely about physical ability, people with disability are still capable of contributing to society... and should be encouraged to participate in activities and organisations."*

The common reasons for disagreement for the participation of people with disabilities focuses mainly on the physical limitations of people with disabilities, such as difficulties in walking, seeing, or hearing, which some believe prevents them from participating effectively. Many responses noted challenges with mobility, access to activities, and ability to perform certain tasks, with majority having the perception that the physical condition of disabled people does not support active involvement.

## 3.8 National Society Capacity

### 3.8.1 Community Engagement

75% of respondents indicated that no other organisations besides CVTL are conducting youth support activities, while 25% reported that other organisations are also involved including a mix of government ministries (Health; Youth, Sport, and Culture), churches and church-based organisations, schools and educational institutions, local and international NGOs (e.g. Mercy Corps), community and individual initiatives, as well as arts, sports, and recreational groups.

*“We need CVTL’s contact number where community members can reach out to when disaster strikes; and more support should be provided to analyse potential hazards at communities and eliminate its potential for harm...”*

Perceptions of CVTL show that it is widely seen as a humanitarian and international organisation, actively supporting communities through disaster response, emergency aid, first aid, clean water projects, health promotion, and COVID-19 awareness. It is valued for helping vulnerable people, advocating community health, and working closely with both schools and the government, though some suggest it could further improve its services. Overall, CVTL is recognised for its consistent, voluntary, and community-focused support during crises and daily life.

Most respondents (83%) do not know how to contact CVTL for questions or information, while only 17% are aware of how to reach the organisation. The majority of respondents (89%) have never given feedback to CVTL regarding their services, while only 11% have provided feedback. Out of the 251 respondents, 28 reported having provided feedback to CVTL, and among them, only 23 indicated that they received a response. Feedback to CVTL is mainly delivered directly to staff or volunteers, but is also shared through community volunteers, community leaders, telephone or messages, and during community meetings, with a few instances via other unspecified channels.

### 3.8.2 Safeguarding

Most respondents (89%) have not observed any misconduct by CVTL staff or volunteers, while a small portion (11%) reported having seen misconduct, although no concrete scenarios on these misconducts were provided suggesting a possible of lack of understanding on what forms misconduct could look like. Feedback indicates that CVTL is generally perceived to perform its work well, particularly in community engagement, disaster risk communication, and health promotion. Staff and volunteers are noted for good behaviour, effective communication, and safety awareness, with some suggestions for continuous learning and further improvement in community service.

Additionally, respondents provided recommendations for CVTL to focus on continuing and expanding its services, particularly in clean water provision, health and reproductive education,

first aid training, youth capacity building, and community sensitisation. Additional suggestions include improving overall service quality, providing educational and recreational support (English, music, art, sport), recruiting new volunteers, and offering domestic latrines.

### 3.8.3 KII Perspectives on Stakeholder Engagement and Program Implementation

On the involvement of Government representatives in the program, the ICBRR program is seen as relatively new information for SEPFOPE (Secretary of State for Professional Training and Employment). During consultations, the CPA Director and Deputy Director indicated that they have very limited knowledge of the ICBRR programme. At the CPA Manufahi Municipality level, there is limited awareness that community disaster preparedness is part of CVTL's activities. However, the CPA is aware of the Memorandum of Understanding (MoU) between CVTL and CPA, which was recently extended in 2024.

However, after being introduced to the ICBRR program—particularly its focus on youth skills and capacity development—SEPFOPE expressed strong enthusiasm to collaborate with CVTL to enhance youth skills in the targeted areas. This collaboration could potentially be formalised through a Memorandum of Understanding (MoU).

The CPA in Manufahi has been a long-standing partner of CVTL, with both organisations cooperating for over a decade to help communities affected by disasters. The Deputy Director of CPA emphasised the importance of first identifying specific types of hazards in each area before establishing a Village Disaster Management Council. CPA expressed strong willingness to continue collaborating with CVTL in establishing the council and providing ongoing capacity-building support throughout the ICBRR project.

## 4. CONCLUSION

### 4.1 Recommendations

Based on the baseline findings, the following recommendations for each key area of work are proposed to address the identified gaps and challenges across the assessed sectors. The suggestions are designed to guide future program planning and implementation, ensuring interventions are evidence-based and respond to the needs of communities involved. The recommendations focus on strengthening community capacity, promoting behavioural change, and enhancing access to essential knowledge, awareness and services to improve resilience, health, and overall well-being of communities in Ainaro and Manufahi.

#### **Disaster Risk Reduction (DRR)**

While communities across all target areas identified cyclones, storms, and landslides as their main hazards, the overall level of preparedness remains limited. Awareness and participation in DRR activities are still low, with most households lacking preparedness plans and a significant number of respondents having never attended any DRR-related training. To strengthen community resilience, it is recommended that DRR education, simulation exercises, and preparedness drills be conducted regularly and inclusively. Strengthening local early warning systems and communication channels will enable timely disaster information sharing, while integrating traditional and local knowledge into DRR planning will enhance community ownership, cultural relevance, and the sustainability of preparedness efforts.

#### **Livelihoods**

Agriculture continues to be the main source of income across the surveyed communities, yet it remains highly vulnerable to climate variability and limited market access. Small-scale production, low diversification, and weak infrastructure contribute to income instability and economic vulnerability. To address these challenges, capacity building on climate-smart and sustainable agricultural practices should be prioritised. Livelihood diversification through vocational training and microenterprise development can expand economic opportunities within the communities. Strengthened collaboration with government institutions, cooperatives, and private sector actors will further improve market access and value chain participation. Integrating financial literacy, savings groups, and microfinance support into livelihood initiatives will also enhance household resilience and economic security.

#### **Health and Nutrition**

Although health promotion activities have yielded positive changes in awareness and practices, coverage remains uneven—especially in remote and hard-to-reach areas. Many households still lack access to preventive care, and nutrition knowledge is inconsistent. Strengthening community-based health promotion through trained volunteers and peer educators can help bridge these gaps. Close coordination with local health authorities is necessary to ensure integrated delivery of preventive, maternal, and child health services. Embedding nutrition and hygiene education within existing structures—such as schools, women’s groups, and youth clubs—will help reinforce consistent health practices.

#### **Water, Sanitation and Hygiene (WASH)**

Most households in the target communities have access to improved water sources and sanitation facilities; however, hygiene practices and maintenance of water containers remain inconsistent. Some households still rely on unsafe water sources or poorly maintained latrines, increasing exposure to waterborne diseases. To address these issues, targeted hygiene behaviour change

campaigns should be conducted to reinforce proper handwashing at critical times and safe water storage practices. Expanding access to safe water and sanitation infrastructure through community-managed initiatives will further improve living conditions and public health. It is equally important to strengthen local monitoring and maintenance systems to ensure the sustainability of WASH facilities. Integrating hygiene promotion within broader DRR and health programming will also enhance resilience to disease outbreaks and climate-related water challenges.

## **Youth**

Youth in the surveyed communities demonstrate awareness of health, first aid, and social issues, but structured opportunities for engagement, leadership, and skill development remain limited. Risk behaviours such as smoking and alcohol use are limited to a small proportion of respondents, but overall exposure to risk remains high, while participation in organised community activities is only moderate. To address these challenges, youth-focused programs should be strengthened through life skills and health education initiatives using peer-to-peer and participatory approaches building skills in communication and public speaking, culinary arts, leadership and teamwork, vocational and technical fields, computer and digital literacy, and business and entrepreneurship as identified by respondents. Engagement through sports, arts, and volunteerism can further promote positive behaviour, leadership, and community contribution. Ensuring the inclusion of youth with disabilities and marginalised groups will foster social cohesion and equality. Linking youth engagement activities with vocational training and livelihood development will also improve employability, self-reliance, and long-term empowerment.

## **4.2 Conclusion**

The baseline findings present a strong foundation for the Integrated Community-Based Risk Reduction (ICBRR) Programme, reflecting promising practices in areas such as hygiene awareness, health behaviours, and social inclusion. However, persistent gaps in knowledge, participation, and access to services continue to limit the full realisation of community resilience and well-being. Although notable progress has been achieved in service delivery and community awareness through CVTL's ICBRR programme in previous phases, outreach efforts have not yet reached all target groups, with some communities still requiring additional support and information. The results emphasise the need for targeted, inclusive, and participatory interventions that strengthen local capacity, improve service delivery, and build sustainable resilience across the DRR, livelihoods, health and nutrition, WASH, and youth sectors.

To ensure lasting impact, it is vital that program interventions remain continuous, adaptive, and community driven. Consistent outreach, follow-up, and engagement—especially in remote and vulnerable communities—will help sustain behavioural change and reinforce resilience. Strengthening coordination among CVTL, government authorities, civil society partners, and community structures will enhance coherence and efficiency of future initiatives. Integrating gender, protection, and inclusion principles throughout program implementation will also ensure equitable participation and responsiveness to diverse needs.

Ultimately, the baseline study reinforces that resilience cannot be achieved through isolated interventions but through coordinated, participatory, and sustained action. By investing in knowledge, livelihoods, and inclusive governance, the ICBRR Programme can drive meaningful transformation—empowering the communities of Ainaro and Manufahi to become safer, healthier, and better prepared to face future risks and challenges.

## 5. ANNEXES

### 5.1 Survey Questions per Indicators

	Questions from Survey	Baseline Survey Findings (%)
<b>Goal : Communities are more resilient, safer, and healthier with opportunities to thrive in the face of climate change.</b>		
% of community members who feel the support provided by the program is helping them to become more self-reliant / live without support in the future	30. Do you have Household Preparedness / Disaster Response Plan?	24% have Household Preparedness / Disaster Response Plan, 66% of households left the question unanswered
	71. How do you treat the water before drinking?	56% of community boil water and 36% filter water
% of surveyed youth who believe their views are considered in decisions made around the support they receive	54. Have you ever given feedback to CVTL related to their services? (youth)	89% have never given feedback to CVTL regarding their services
	56. Do CVTL respond to your feedback? (youth)	Out of the 251 respondents, 28 reported having provided feedback to CVTL, and among them, only 23 indicated that they received a response.
Average income of the targeted community	41. In what range the total income received by the family in one month?	37% of households reported earn less than USD 60 per month with an additional 11% of households earn between USD 61 and 150 per month
	42. Do you join livelihood activities assisted by any organisation? i.e. chicken rearing, horticulture	21% of community participated in Livelihood activities assisted by any organisation
	45. Do you participate in the Saving and Loans trained by any organisation or agencies?	67% of respondents indicated that they do not participate in any savings and loan groups
<b>Outcome 1: Communities have increased capacity to manage inclusive disaster risk reduction activities.</b>		
# of branches and communities that have developed community based disaster risk reduction (DRR) plans base on a vulnerability and capacity assessment		<i>Not applicable</i>

% of community members who get increased income as resulted from the livelihood support provided by the programme	38. What is the main income / occupation of the household?	73% of community's main income of household is from Agriculture
	41. In what range the total income received by the family in one month?	37% of households reported earn less than USD 60 per month and 11% of households earn between USD 61 and 150 per month
	44. Is there a change in your income in last 6 months?	3% of respondents reported an increase in income over the past six months
	45. Do you participate in the Saving and Loans trained by any organisation or agencies?	67% of respondents indicated that they do not participate in any savings and loan groups
<b>Output 1.1: Community is trained on Contingency Planning, Community based Early Warning System, Safe Shelter, etc</b>		
# of people trained in disaster risk reduction-related areas (vulnerability and capacity assessment or climate change adaptation, first aid, contingency planning, or emergency response)	22. Have you previously participated in any training on Disaster Risk Reduction from any organisation / agency?	20% of Community member have participated in DRR training
# of people reached by RCRC through disaster risk reduction public awareness messaging and public education campaigns (PAPE)		<i>Not applicable</i>
# of implemented environmental, or climate campaigns focused on behaviour change		<i>Not applicable</i>
# of vulnerability and capacity assessment conducted		<i>Not applicable</i>
<b>Output 1.2: Community is trained on sustainable agriculture practices and crop diversification</b>		
# of targeted households (and people) reached with essential services / information for income generation		<i>Not applicable</i>
# of targeted households (and people) reached with essential on-farm, off-farm and non-farm inputs / materials / tools for income-generation		<i>Not applicable</i>
# of households that have one or more alternative income generator that enable them to		<i>Not applicable</i>

maintain their livelihood or income stream		
<b>Output 1.3: Strengthened National Society capacity and partnership with stakeholders to promote disaster risk reduction</b>		
# of coordination meetings held with other stakeholders at National Level		<i>Not applicable</i>
#of joint action plan with other stakeholders		<i>Not applicable</i>
<b>OUTCOME 2: Community practices proper health, hygiene, nutrition, and sanitation behaviour.</b>		
% of the community who practiced safe drinking water and storage, using latrines or toilets and hand washing at crucial times.	75. Do your family has its own latrine?	91% have access to their own latrine
	76. What kind of latrine your family have?	Compost latrine (37%), flush latrines with soakaway pits (26%) and simple pit latrines (21%)
	67. What is your current main water source?	Piped systems or spring water (46%), rivers, lakes, or hand-dug wells (34%), and boreholes (16%)
	70. How is the water quality in the community currently?	61% of respondents rated their water as "good," 27% as "excellent," and 12% as "poor".
	71. How do you treat the water before drinking?	56% boil water and 36% filter water before drinking
	73.How often do you clean the water storage?	50% of respondents clean their water storage facilities once a week or less
	80. When do you WASH hands?	35% of respondents reported washing their hands before eating, 18% after working, and only 15% after using the latrine
% of soil-borne intestinal parasite infection rate.		<i>Not applicable</i>
# of available community waste management plan		<i>Not applicable</i>
<b>OUTPUT 2.1: The community have increased capacity for health, nutrition, and sanitation.</b>		
# of health promotion campaigns on prevention and, control of common infectious diseases in targeted communities.	55. Have you received any health promotion / dissemination in the last 2 year?	54% had not received any form of health promotion or dissemination

	56. Who give the health promotion / dissemination?	46% of Community received health Promotion from, Ministry of Health, NGO's and CVTL
# of people reached through RCCE for health and hygiene promotion activities.		<i>Not applicable</i>
# of households (and people) reached with messages on nutritional choices and food preparation.	57. Have you or your family member received any training on Nutrition and how to prepare nutritious food in the last 2 years?  59. Is there any change in your cooking practices learned from the training?	31% of households reached with messages on nutritional choices and food preparation  28% of them responded change in their cooking practices learned from the training
<b>OUTPUT 2.2: Household have improved access to water and sanitation facilities.</b>		
# of constructed household sanitation facilities	75. Do your family has its own latrine?  76. What kind of latrine your family have?	91% have access to their own latrine  Compost latrine (37%), flush latrines with soakaway pits (26%) and simple pit latrines (21%)
# of people provided with sanitation facilities (this is more than excreta disposal).	67. What is your current main water source?  70. How is the water quality in the community currently?  73. How often do you clean the water storage?	Piped systems or spring water (46%), rivers, lakes, or hand-dug wells (34%), and boreholes (16%)  61% of respondents rated their water as "good," 27% as "excellent," and 12% as "poor".  50% of respondents clean their water storage facilities once a week or less
<b>Output 2.3: Capacity of National Society volunteers in promoting health, nutrition and sanitation is strengthened</b>		
# of trained as Red Cross WASH (community health) Volunteers		<i>Not applicable</i>
# of health and sanitation training to the volunteers		<i>Not applicable</i>
<b>Outcome 3: enhance youth health and life skill development as agent of Change in the community</b>		
% of surveyed youth who believe their views are considered in	54. Have you ever given feedback to CVTL related to their services? (youth)	89% have never given feedback to CVTL regarding their services

decisions made around the support they receive	56. Do CVTL respond to your feedback? (youth)	Out of the 251 respondents, 28 reported having provided feedback to CVTL, and among them, only 23 indicated that they received a response.
% of target youth involved in the community meeting	12. Do you join youth group assisted by any organisation / agencies?	31% involved in school groups, 30% in sports groups, 23% in community groups
	43. Do you think that Youth should participate in activity / organisation?	Attitudes towards inclusion show that 84% agree on youth participation, 87% agree on women participation and 70% agree on participation of people with disabilities in activities or organisations.  27% disagreed about participation for people with disabilities
% of students performing health maintenance and promotion behaviours in school (such as hand washing)	26. When you have to wash your hand? (youth)	45% washing hands before food preparation and eating, and 40% after contamination or toilet use
<b>Output 3.1. Youth health in community is improved</b>		
# of youth reached with health promotion by community-based volunteers	17. In the last 3 months, have you received any health information and promotion?	68% of respondents in both villages reported not receiving any health information or promotion in the last three months.
# of training or health promotion session to youth conducted		<i>Not applicable</i>
# of girls, female adolescents and women reached by information dissemination sessions on menstrual hygiene management (MHM)		<i>Not applicable</i>
<b>Output 3.2. Youth life skill in community is improved</b>		
# of youth receiving life skills education provided by National Society in educational facilities or learning spaces in community		<i>Not applicable</i>
# of youth activities conducted in community to improve life skills		<i>Not applicable</i>

Output 3.3: Strengthened capacity and partnership in Youth Empowerment		
# of educational facilities or learning spaces who have partnership with National Society		<i>Not applicable</i>
# of community meeting that involve youth in the discussion		<i>Not applicable</i>
Outcome 4: National Society has increased capacity for program management		
Availability of established / feedback mechanism		<i>Not applicable</i>
Availability of PGI analysis to strategic sectoral intervention plan		<i>Not applicable</i>
# of coordination meetings held within CVTL at national and branch level		<i>Not applicable</i>
Output 4.1: Strengthened community engagement and inclusion integration in National Society programme implementation.		
# of staff, volunteers and leadership trained on community engagement and accountability (disaggregated by staff / volunteers / sex)		<i>Not applicable</i>
# Availability of established accountability / feedback mechanism.		<i>Not applicable</i>
# of people trained on implementing the PGI Minimum Standards		<i>Not applicable</i>
#PGI assessments conducted using the PGI Minimum Standards		<i>Not applicable</i>
Output 4.2: National Society has strengthened capacity for accountability and visibility to promote ICBRR		
# of people trained on implementing PMER		<i>Not applicable</i>
# of people trained on implementing finance and procurement.		<i>Not applicable</i>
# of people trained on communication.		<i>Not applicable</i>

## 5.2 Survey Questionnaire

### HOUSEHOLD QUESTIONNAIRE

1. Date:
2. Name of Enumerator; Municipal, Suco
7. Name of Respondent
8. Gender of respondent; Date of birth
13. How many female members are there in the family?
14. Are there any pregnant/breastfeed member in the family?
15. Are there any disability member in the family?
16. What type of disability? Other
17. What hazards that potentially/frequently happen in your area? If other, please specify
18. Do you and your family know what actions you take when a disaster occurs?
19. Can you mention these actions
20. Do you know which items you need to pack in an emergency bag?
21. When a disaster occurs, who should be evacuated first?
22. Have you previously participated in any training on Disaster Risk Reduction from any organisation/agency?
23. If yes, what training was it?
24. Are there any organisations/agencies have carried out disaster risk reduction activities in your village?
25. Which organisation or agencies?
26. What activities, can you mention it?
27. Do you feel these activities are valuable?
28. Are there any organisation or agencies did assistance on Preparedness/Disaster Response Plan?
29. Which organisation?
- 29b. If other please specify
30. Do you have Household Preparedness/Disaster Response Plan?
31. Do you know how to prevent landslide and storms?
32. How do you prevent the risk of landslides and storms?
33. What do you know about climate change (and not only weather)? Other
34. Do you see any difference in intensity and frequency of some (weather related) hazards? Other
35. Are there any organisation did dissemination/activity to tackle issue on climate change?
36. Which organisation, please mention it!
37. Do you find the dissemination/activity to tackle issue on climate change useful?
38. What is the main income/occupation of the household? Explain
39. Were there changes in the livelihood activities induced by climate changes? Could you mention them? Explain
40. Is there any female family member who also working?
41. In what range the total income received by the family in one month?
42. Do you join livelihood activities assisted by any organisation? i.e. chicken rearing, horticulture
43. Which organisation, please mention it! Other
44. Is there a change in your income in last 6 months?
45. Do you participate in the Saving and Loans trained by any organisation or agencies?
46. Which organisation, please mention it! Other
47. What are your suggestions or recommendations for improving DRR activities based on livelihoods in the future?
48. Are there any family member got sick in the last 6 month?
49. Was there any illness affecting your family in the last 6 months?
50. Within that last 6 months, how many times did the family members experience the illness?

51. Were there changes in health induced by climate changes? Could you mention them? Other
52. Since the last two years, if there are family members who were sick, how did you treat them?
53. In this last two years, how do you rate your knowledge to prevent illness and maintain health?  
Other
54. What thing the things you did to prevent illness and stay healthy? Other
55. Have you received any health promotion/dissemination in the last 2 year?
56. Who give the health promotion/dissemination? Other
57. Have you or your family member received any training on Nutrition and how to prepare nutritious food in the last 2 years?
58. Who gives the training? Other
59. Is there any change in your cooking practices learned from the training?
60. Is your knowledge on nutrition improved and impact on your family members?
61. How do you rate your knowledge on good hygiene behaviour currently?
62. Please mention good examples of practicing good hygiene behaviour.
63. Are there any female family member in menstrual age?
64. What Sanitary material they use for menstrual hygiene?
65. Are there any organisation assisted to construct piping system/water tank in your community?
66. Which organisation, please mention it!
67. What is your current main water source?
68. In what range the distance of water fetching points from your house?
69. Who do usually have duty to fetch the water in your family?
70. How is the water quality in the community currently?
71. How do you treat the water before drinking? Other
72. Where do you store your drinking water? Other
73. How often do you clean the water storage?
74. Water storage observation
75. Do your family has its own latrine?
76. What kind of latrine your family have? Other
77. Observe the latrine! Does it have.....
78. How often do you clean your latrine?
79. Where do your family defecate? Other
80. When do you WASH hands?
81. How do you WASH your hands with? Other
82. How do you dispose your garbage? Other
83. What do you know about CVTL?
84. Did you know how to contact CVTL if you have some questions or information?
85. Have you ever given feedback to CVTL related to their services?
86. If yes, how do you deliver your feedback? Other
87. Do CVTL respond to your feedback?
88. Do you have any feedback or recommendations to CVTL to improve their services?
89. Is there anyone in this community who can provide information on how to help a woman or child who has been abused? Other
90. Do you have the contact number of a referral network to refer the victim of violence who need help?
91. If any violence occurs, what assistance will you provide? Other
92. When the victims need help because they have experienced violence, do you know some organisations or institutions that can help? Other
93. When the victim need help because they have experienced violence, do you know some people in the community who can help? Other
94. In the last year, how many times have you helped someone who has experienced violence?

## YOUTH QUESTIONNAIRE

1. *Date of interview*
2. *Name of enumerator; Municipio, Suco, Geopoint*
7. *Name of respondent*
8. *Gender of respondent*
9. *Date of birth*
10. *What is your education level?*
11. *What is your current occupation? If other, please elaborate here*
12. *Do you join youth group assisted by any organisation/Agencies?*
13. *What groups do you belong to? If other, please elaborate here*
14. *What activities do you do in your free time? If other, please elaborate here*
15. *What skills do you already have? If other, please elaborate here*
16. *What skills do you want to develop more?*
17. *In the last 3 months, have you received any health information and promotion?*
18. *Who gives health information and promotion? If select other, please explain*
19. *How would you do to treat yourself if you are sick or get any accident? If select other, please explain*
20. *Do you know, what is HIV and STI*
21. *What can you do to prevent the transmission of HIV and STI?*
22. *In the last year, have you received any menstrual hygiene training/promotion?*
23. *Who give the menstrual hygiene promotion/dissemination? If other, please elaborate here*
24. *What Sanitary material you use for menstrual hygiene? If other, please elaborate here*
25. *Do you know the importance of washing hands with soap?*
26. *When do you have to wash your hand?*
27. *Do you Know how to give first aid to someone who is sick or injured?*
28. *What are some ways to help?*
29. *Have you received first Aid training from any organisation?*
30. *Which organisation?*
31. *Are there any of your friends or family who smoke cigarette?*
32. *In the last months, did you smoke?*
33. *How often do you smoke cigarettes?*
34. *Are there any of your friend or family use drugs/alcohol/substance illegal)?*
35. *In the last months, do you use drugs?*
36. *How often do you use any drugs or other substance?*
37. *Are there any of your friends or family who drink alcoholic beverage?*
38. *In the last months, did you drink alcoholic beverage?*
39. *How often do you drink?*
40. *Do you wear helmet when riding motorbike?*
41. *In the past months, how often did you carry a weapon for the purpose of self-defense?*
42. *In the past months, have you been involved in any conflict?*
43. *Do you think that Youth should participate in activity/organisation?*
44. *Why?*
45. *Do you think that Women should participate in activity/organisation?*
46. *Why?*
47. *Do you think that people with disabilities should participate in activity/organisation?*
48. *Why?*
49. *In the last 6 months, what organised leisure/recreational activities you participated in? If other, please elaborate here*
50. *Beside CVTL, are there any other organisation conducting support activity for the youth at the moment?*
51. *What organisation?*

52. *What do you know about CVTL?*
53. *Did you know how to contact CVTL if you have some questions or information?*
54. *Have you ever given feedback to CVTL related to their services?*
55. *If yes, how do you deliver your feedback? If other, please elaborate here8*
56. *Do CVTL respond to your feedback?*
57. *Do you see any misconduct by CVTL staff or volunteers?*
58. *If yes, please mention*
59. *Do you have any feedback or recommendations to CVTL to improve their services?*

#### KII QUESTIONNAIRE

1. *How many community volunteers of this village?*
2. *How many of them are women?*
3. *Before the intervention, has there been any vulnerability capacity assessment done and CAP developed in the village?*
4. *What do you know about disaster risk reduction?*
5. *What are the disasters that can happen in your area?*
6. *What are the disease outbreaks that can happen in your area?*
7. *Do your village know what need to do when disaster/outbreak happen?*
8. *Where will you seek help when disaster/outbreak happen?*
9. *Involvement in the ICBRR (Integrated Community Based Risk Reduction) Programme?*
10. *How did you begin to engage in the Program?*

### 5.3 Photos



*Enumerator Training in Manufahi Branch office  
(Photo: CVTL/2025)*



*KOBO Questionare field test prior to the data collection in Manufahi Branch office  
(Photo: IFRC/2025)*



*KII with Head of Nunufu Hamlet in Babulu Village, Manufahi Municipality  
(Photo: CVTL/2025)*



*KII interview with Civil Protection Authority in Manufahi Municipality  
(Photo: CPA [FB Page](#))*



*Interviewing youth in Manelobas Village for the Baseline Survey data collection  
(Photo: IFRC/2025)*



*Interviewing Head of Household by CVTL volunteer  
(Photo: IFRC/2025)*



*Interviewing youth female in Babulu Village for the baseline survey data collection  
(Photo: IFRC/2025)*



*Daily debrief session led by CVTL DRR Manager with enumerators post data collection  
(Photo: IFRC/2025)*