MINISTRY OF HEALTH

# TIMOR-LESTE NATIONAL NUTRITION STRATEGY 2014-2019

## ACKNOWLEDGEMENTS

This National Nutrition Strategy 2014-2019 was made to address nutrition challenges of the country through inter-sectoral action and to align targets to the National Development Plan 2012-2030.

This strategy's development was led by the Ministry of Health with technical support from UNICEF. The process was informed by literature review and consultation with stakeholders at all levels. The technical views and opinions were generated from, government line ministries linked to the 2010 Comoro Declaration, national organisations and institutions, UN agencies, development partners, national associations, eminent personalities and community members.

On behalf of the Government of Timor-Leste, I thank all those who contributed to this strategy development with technical ideas, inputs, and recommendations. I thank UNICEF for providing technical and financial assistance to develop this strategy.

I urge all government ministries and partners to align their nutrition related actions and resources to this strategy implementation. I have confidence that this strategy will contribute to bring significant improvement in the nutritional status of children and women of Timor-Leste.

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## ACRONYMS

| | |
|---|---|
| ARI | Acute Respiratory Infection |
| BMI | Body Mass Index |
| BSP | Basic Service Package |
| CBOs | Community-based Organisations |
| CCT | Conditional Cash Transfers |
| CHC | Community Health Centre |
| CMAM | Community-based Management of Acute Malnutrition |
| CRS | Church Relief Services |
| CVTL | Cruz Vermelha Timor-Leste (Timor-Leste Red Cross) |
| DHS | Demographic and Health Survey |
| DFAT | Department of Foreign Affair and Trade |
| DPs | Development Partners |
| EU | European Union |
| FAO | Food and Agricultural Organisation |
| HFA | Height-for-Age |
| HINI | High Impact Nutrition Intervention |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome |
| HMIS | Health Management Information System |
| IDD | Iodine Deficiency Disorders |
| IEC | Information Education Communication |
| IFA | Iron-folic Acid |
| IMCI | Integrated Management Childhood Illnesses |
| IMCN | Inter-Ministries Committee on Nutrition |
| INGOs | International Non-governmental Organisations |
| ITN | Insecticide Treated bedNet |
| IYCF | Infant and Young Child Feeding |
| GoTL | Government of Timor-Leste |
| M&E | Monitoring and Evaluation |
| MAF | Ministry of Agriculture and Fisheries |
| MCH | Maternal and Child Health |
| MCIE | Ministry of Commerce, Industry, and Environment |
| MDG | Millennium Development Goals |
| MDG-F | Millennium Development Goals – Funds |
| MdM | Medicos du Mundo |

| | |
|---|---|
| MNP | Micro-Nutrient Powder |
| MoF | Ministry of Finance |
| MoH | Ministry of Health |
| MoED | Ministry of Economic and Development |
| MSG | Mother Support Group |
| MSS | Ministry of Social Solidarity |
| MTCI | Ministry of Tourism, Commerce, and Industry |
| NA | Not Available |
| NBFA | National Breast Feeding Association |
| NCDs | Non-communicable Diseases |
| NGO | Non-Governmental Organization |
| NHSSP | National Health Sector Strategic Plan |
| NNS | National Nutrition Strategy |
| PdC | Pastoral da Criansa |
| PLW | Pregnant and Lactating Women |
| PM | Prime Minister |
| SDP | Strategic Development Plan |
| *SISca* | Servisu Integradu Saude Comunitaria |
| SUN | Scaling-Up Nutrition |
| TAIS | Timor-Leste Asistencia Integradu Saúde |
| TBD | To Be Defined |
| TGR | Total Goiter Rate |
| TL | Timor-Leste |
| TL-DHS | Timor-Leste Demographic Health Survey |
| TL-SLS | Timor-Leste Survey of Living Standards |
| UN | United Nations |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| USI | Universal Salt Iodisation |
| VPM | Vice Prime Minister |
| WFA | Weight-For-Age |
| WFH | Weight-For-Height |
| WHO | World Health Organisation |

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## EXECUTIVE SUMMARY

Malnutrition "is globally the most important risk factor for illness and death"[1] and nutrition-related factors together are reported to be responsible for about 35% of child deaths and 11% of the total global disease burden[2]. Under-nutrition is associated with shorter adult height, less schooling, reduced economic productivity, and for women lower offspring birth weight. Low birth weight or stunting in the first 2 years of life leads to irreversible damage, including shorter adult height, lower attained schooling, reduced adult income, and decreased offspring birth weight[3]. Poverty, through its causal link to malnutrition and economic loss as a consequence of malnutrition, is both a cause and an outcome of poor human development. Therefore, prevention of maternal and child undernutrition is a sound investment for socio-economic development of a country.

Government of Timor-Leste made its first National Nutrition Strategy in 2004, introduced evidence based nutrition interventions, established nation-wide programme and made progress in some key indicator but the nutrition situation of the country overall remains poor with 50.2% stunting, 11% wasting and 37.7% underweight in children under five years of age. This document called the National Nutrition Strategy 2014-2019 (NNS 2014-19) outlines the approach for translating national commitments on nutrition to actions and results and aligns the nutrition targets and actions towards the National Development Plan 2011-2030. This strategy provides a stronger framework for multi-sectoral action to address the immediate, under-lying and basic causes of malnutrition. The process of developing this strategy was led by the Ministry of Health with technical assistance of UNICEF. The process was participatory, consultative and inclusive where all nutrition related line ministries and partners were consulted and their views incorporated.

The vision of the Timor-Leste National Nutrition Strategy (TL-NNS) 2014-2019 is to contribute to sustainable achievement of national socio-economic and human development goals by improving quality and productivity of its human capital. The goal of the TL-NNS 2014-2019 is to improve the nutritional status of Timorese population. The purpose of the TL-NNS 2014-2019 is to accelerate reduction of maternal and child under nutrition through implementation of nutrition specific and nutrition sensitive interventions. The overall objective of the strategy is to reduce malnutrition and micronutrient deficiency among children and women.

[1] Olaf Müller and Michael Krawinkel, Malnutrition and health in developing countries, CMAJ 2005;173(3):279-86
[2] Black et al, 2008, Maternal and child undernutrition: global and regional exposures and health consequences, Lancet 2008; 371: 243–60
[3] Cesar G Victora, Linda Adair, Caroline Fall, Pedro C Hallal, Reynaldo Martorell, Linda Richter, Harshpal Singh Sachdev Maternal and child undernutrition: consequences for adult health and human capital. Lancet 2008. Maternal and Child Nutrition Series; 371: 340–57

The priorities identified by the National Nutrition Strategy 2014-2019 are to 1) Improve nutrients intake by mothers, children and adolescent Girls; 2) Improve care for mothers and children; 3) Improve food security at household, community, and national Levels; 4) Improve hygiene practices and access to water and, sanitation; 5) Promote optimal nutrition behaviour and practices; 6) Improve policies and capacity for multi-sectoral nutrition action

The strategy prioritizes focus on pregnant women and under two year children in order to optimally use the "window of opportunity of 1000 days from Pregnancy to 24 months" to reduce burden of malnutrition.

The strategy aims to achieve the following three outcomes:

1. Increased coverage of Nutrition Specific interventions[4]
2. Increased coverage of Nutrition Sensitive Interventions[5]
3. Enabling national policies, programmes and coordination mechanism

A results chain (figure 1) articulates outputs to achieve the above three outcomes and guides the development of logical framework, monitoring and evaluation plan and an operational plan. The M&E plan and the operational plan are expected to contribute to ensure that the strategy is adequately funded, implemented and monitored. The operational plan for implementing this strategy assumes contribution of relevant sectors' strategies and plans in improving coverage of nutrition sensitive interventions, addresses the gaps identified in situation analysis and programme, policy and partnership analysis and outlines clearly outputs and actions to improve coverage of nutrition specific interventions.

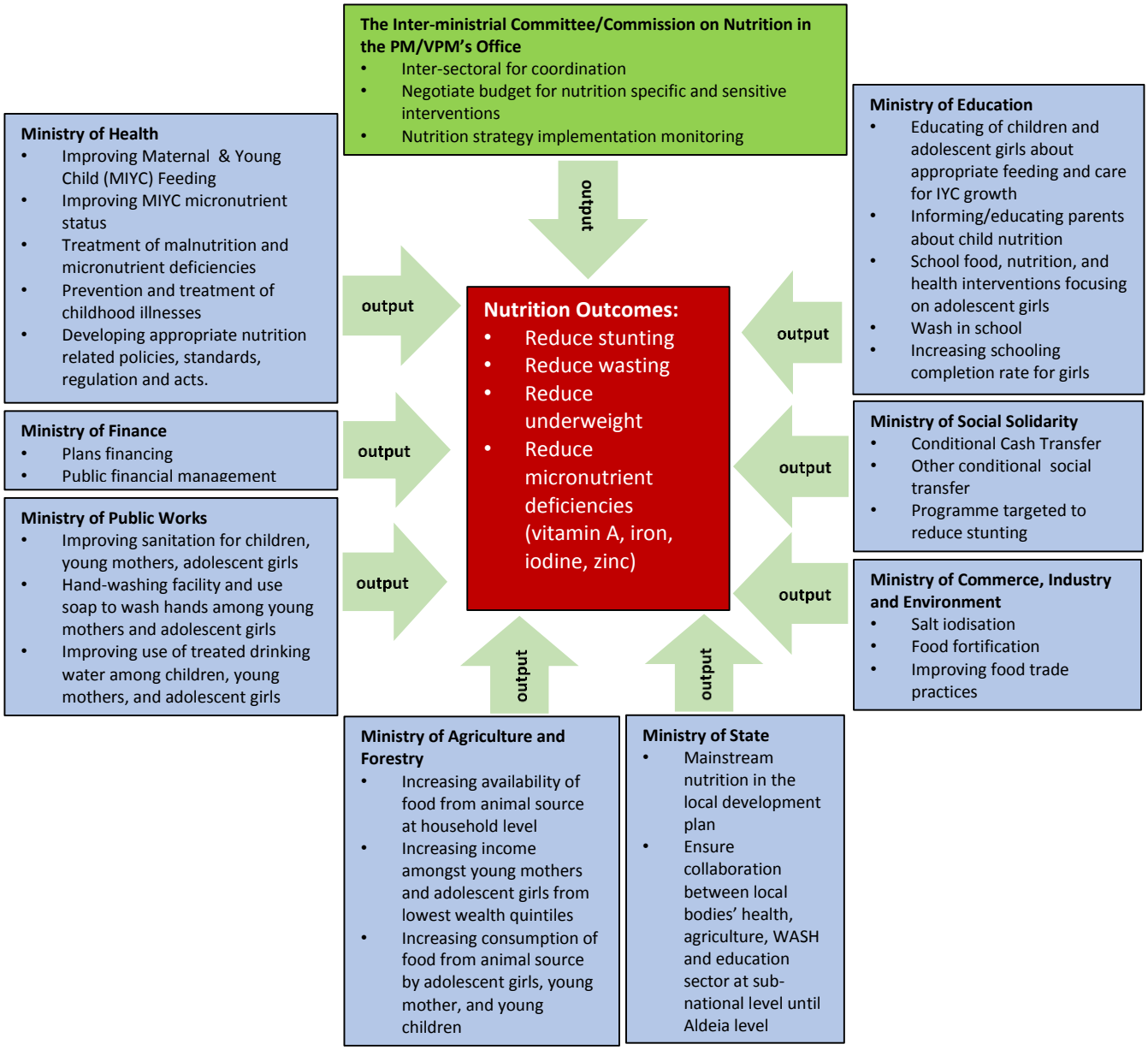
The implementation of actions for achieving nutrition outputs, will be through respective line ministries with respective ministries budgets and formal inter-sectoral coordination mechanism established at national, district and Suco level. Nutrition specific interventions such as feeding and care practices promotion and protection from illnesses will be implemented mainly through health sector. Nutrition sensitive interventions for improving food availability, affordability, access, quality, utilization by families and communities access to Water Sanitation and Hygiene (WASH) interventions will be implemented mainly through non-health sectors i.e. Agriculture, Education, Local Development, Social Solidarity, and WASH related sectors .

[4] Nutrition Specific Interventions are "interventions or programmes that address the immediate determinants of fetal and child nutrition and development—adequate food and nutrient intake, feeding, caregiving and parenting practices, and low burden of infectious diseases"

[5] Nutrition sensitive interventions are "interventions or programmes that address the underlying determinants of fetal and child nutrition and development". These include food security; adequate caregiving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment

Overview of approach to achieve nutrition results is shown in figure-1

**Figure-1: Overview of NNS implementation and coordination arrangement.**




This strategy identifies key cross cutting actions to support implementation including role of Konssantil, the Inter-Ministerial Commission on Food and Nutrition Security and Sovereignty in Nutrition strategy implementation and monitoring and enhancing role of the Nutrition Technical Working Group (NTWG) to make it Nutrition Technical Advisory Group (NTAG) to make it effective in developing required technical guidelines and resources needed for strategy implementation. The strategy also identifies approaches and actions for: a) inter-sectoral coordination at all levels, coordination within the sectors' departments, coordination with partners; b) advocacy, social mobilization and behavior change communication; c) national capacity development for nutrition and nutrition human resource management; d) nutrition commodities and logistics management; e)

resource mobilization; f) policy linkages necessary for achieving and sustaining results; and g) Nutrition Strategy implementation monitoring, Nutrition Information Management System, Nutrition Surveillance, Survey and Research.

While the ongoing efforts are expected to continue in all districts, joint working arrangement for improving services and community mobilization will be rolled out and scaled-up in a phased manner taking into account the capacity gaps and attention required in building capacity. All sectors will concentrate efforts in the same Sucos of same districts initially for synergy and incrementally scale-up to reach all Sucos and all districts by end of third year.

After the endorsement of this strategy following steps towards roll-out will be implemented:

- National and district level dissemination of this strategy;
- Signing a Memorandum of Understanding (MoU) between Ministries engaged in implementing this strategy to re-affirm joint commitment to implement this strategy;
- Reformulation of the current Nutrition Working Group to enable it to take expanded role as an Nutrition Technical Advisory Group (NTAG);
- Strengthening of the Directorate of Nutrition in the MoH, and as relevant of other Ministries' departments responsible for nutrition to enable them to take enhanced roles.
- Development of a Costed National Nutrition Strategy Operational Plan (C-NNS-OP) and development of a schedule for roll-out and scale-up;
- Development of and securing of budget by relevant sectors for implementing C-NNS-OP;
- Establishment of technical and sub-technical working groups of the NTAG to carry out tasks of developing standards, guidelines etc.;
- Establishment and operationalization of district level and sub-district level coordination mechanism
- Implementation of budgetary, institutional change, capacity development, service delivery, community mobilization and monitoring and evaluation actions;
- Periodic joint monitoring and joint review;
- Mid-term evaluation of strategy implementation, and course change if needed; and End-line evaluation and formulation of new strategy.

# 1 INTRODUCTION

The commitment of The Government of Timor-Leste to address under-nutrition is evident in the 2004 National Nutrition Strategy and is also seen in form of the currently on-going interventions and other declarations and statements. The country has introduced evidence based nutrition interventions and the past and present Health Sector's Strategic Plans also support delivery of evidence based nutrition interventions. Series of other actions such as developing a Nutrition Behavior Change Communication Strategy, draft of Breastfeeding Promotion Policy, Infant and Young Child Feeding Guidelines, and other and support materials, guidelines for supplementary feeding, introduction and scaling up of Community Management of Acute Malnutrition, training of Family Health Promoters on nutrition etc. had been done. Nutrition is increasingly recognized as an important part of the national development agenda and the government support for nutrition has increased in the recent years. Nutrition programme is thus well established and has made some progress in some nutrition interventions coverage but the nutrition situation of the country overall remains poor.

The need to develop this document called the Timor-Leste National Nutrition Strategy 2014-2019 (TLNNS 2014-19) was felt because of the recognition that the current nutrition efforts were inadequate and a new strategy was needed to provide a stronger framework for multi-sectoral action to address the immediate, under-lying and basic causes of malnutrition. There was also a felt need to accelerate efforts to address malnutrition and contribute to socio-economic development in line with Timor-Leste's Vision for 2030[6,7] and to align the nutrition targets and actions towards the National Development Plan 2011-2030, In addition, there is a renewed interest to scale up a set of High Impact Nutrition Interventions (HINI) and to focus efforts on the "1000 days window of opportunity" a period from pregnancy and first two years of child's life where maximum impact can be achieved[8].

The Process of developing this TLNNS 2014-2019 was led by the Ministry of Health with support from UNICEF and Department of Foreign Affairs and Trade (DFAT) Government of Australia. The strategy development process was participatory, consultative and inclusive and included desk review, interviews of related line ministries, development partners, donor agencies, eminent personalities, including religious leaders and series of consultative meetings with partners. The feedbacks from the

[6] The Strategic Development Plan of Timor-Leste, 2011-2030
[7] The National Health Sector Strategic Plan of Timor-Leste: Towards a Healthy East Timorese People in a Healthy Timor-Leste. 2011- 2030.
[8] Scaling Up Nutrition (SUN): Framework for Action. World Bank. 2010.

consultations were incorporated and the draft strategy was circulated among partners. The draft strategy was revised taking into account inputs from partners and again discussed in a validation workshop. Additional comments and inputs were received at and after the validation workshops. These comments/suggestions were incorporated to make the current version of the document which then went through formal review and endorsement process within the government. List of individuals consulted in the process is in ***Annex 6.***

This strategy presents nutrition situation analysis, vision, goal, purpose, objectives, and strategic priorities, outcomes, outputs, implementation and coordination structures and functions, approach to cost and finance the strategy and monitoring, evaluation and research to support the strategy implementation. It provides a basis for policy, strategic and programmatic actions at all levels. The strategy opts for a lifecycle approach which gives recognition to the fact that nutrition interventions should starts during pregnancy, continue after delivery for the new-born baby, continue into early childhood and the years of schooling to adolescence and adulthood, and finally into the elderly years. To effectively support the implementation of nutrition actions, the strategy describes the structures for nutrition leadership, management, coordination and multi-sectoral linkages and provides guidance on advocacy and social mobilisation actions. In addition, the strategy identifies actions to ensure that the implementation and results are appropriately monitored and evaluated. The strategy is recognizes that malnutrition is a complex challenge that requires broad approaches that incorporate both direct and indirect nutrition interventions that address immediate, underlying and basic causes of malnutrition.

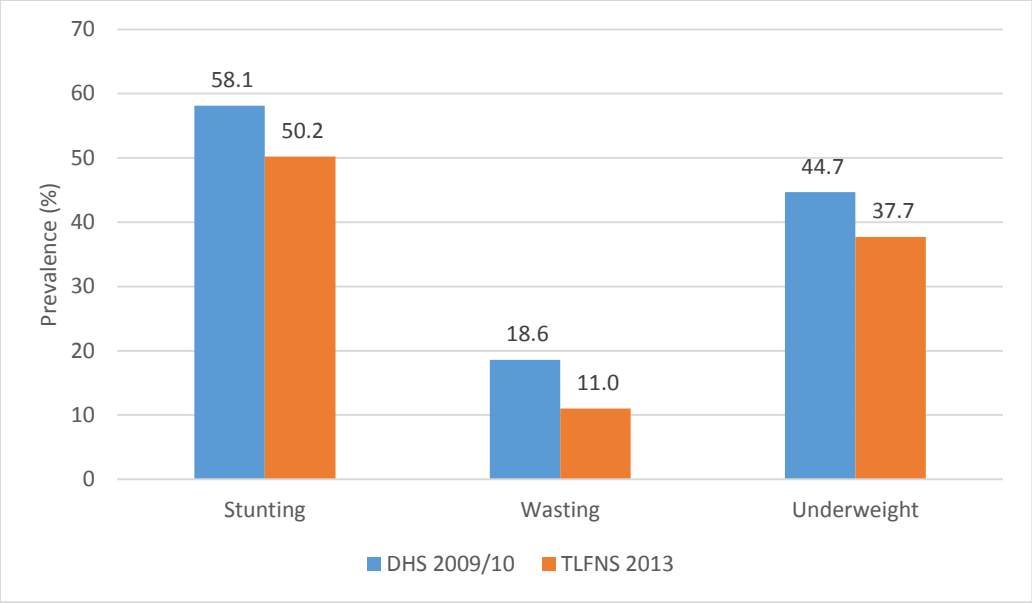
# 2 NUTRITION SITUATION IN TIMOR LESTE

## 2.1 Malnutrition and Micronutrient Deficiency Status and Trend

*Persistent High rates of child malnutrition:* Findings of Timor-Leste Food and Nutrition Survey 2013 showed some decline in the prevalence of malnutrition as compared to the Demographic 2009-2010 (Figure-2). However, child malnutrition in Timor-Leste is still very high. One among two Timorese under-five children are stunted (too short for their age), 11% of under-five children have either moderate or severe acute malnutrition (are too thin for their height) and 38% of the under-fives are underweight (have a combination of stunting and wasting). Despite the decline, the prevalence of the stunting remains a severe public health problem and the prevalence of wasting and underweight remain above the WHO defined threshold for considering it a public health problem[9].

[9]WHO, 2012.Classification of nutrition indicators.http://www.who.int/nutgrowthdb/about/introduction/en/index5.html

**Figure 2: Change in nutritional status of under-five year old children in Timor-Leste between 2010, (TLDHS 2009-2010)[10], and 2013 (TLFNS 2013)**




High prevalence of malnutrition among under-five children is evident is all districts. The highest stunting prevalence was found in Ermera (65%), highest wasting prevalence in Covalima (17.4%) and highest underweight prevalence in Oecusse (50.3%). Higher prevalence of stunting was evident among poorer households (59.3%) as compared to the richer households (39.1%) but the prevalence across quintiles is still high to very high[11]. Overall, Timor-Leste has the highest level of malnutrition among the countries in the Asia-Pacific region and has shown less than adequate level of improvement and consequently there have been no progress on the Millennium Development Goal 1, target c which is to *"Halve, between 1990 and 2015, the proportion of people who suffer from hunger"*.

*High rate of maternal malnutrition:* TLFNS 2013 reported that 24.8% women of reproductive age were thin (had Body Mass Index <18.5)[12], which is an improvement as compared to the 27% thinness reported by TLDHS 2009/10. However the prevalence of thinness is higher than the WHO benchmark of 20% for considering malnutrition prevalence in women a serious public health problem[9]. Prevalence of maternal thinness among rural women are higher (27.1%) than in urban women (19.3 %). Ermera district has the highest percentage of undernourished women (39.8%) compared with Baucau district, which has the lowest percentage (18%). The percentage of women who are thin declines as level of education and household wealth increases. An undernourished mother is likely to

[10] Data from DHS 2003 was recalculated using the new WHO Child Growth Reference Standards 2006, for comparison with DHS 2009/2010
[11] Wealth quintile uses information on household ownership of various consumer items, ranging from household assets like television, means of transport like a bicycle, and ownership of land and farm animals, to dwelling characteristics, such as source of drinking water, sanitation facilities, and type of building materials used in the construction of the housel.
[12] Body Mass Index (BMI) defined as weight in kilograms divided by height squared in meters (kg/m2)

give birth to a low birth weight baby and the high maternal undernutrition could be propagating malnutrition from one generation to another.

*High Prevalence of Micronutrient Deficiencies:* The 2013 TLFNS reported that 62.5% of children 6-59 months old and 38.9% of women of reproductive age as anaemic. The TLFNS 2013 reported that 26.6% non-pregnant women had inadequate level of urinary iodine excretion. A survey conducted in 1991[13] found that Timor-Leste has a Total Goitre Rate (TGR) above 5% among school children; a level considered by WHO as indicative of a mild public health challenge. However, 7 out of 13 districts had TGR above 20% of which indicates a severe public health problem. The 2013 TLFNS reported that 26.9% of women of reproductive age had inadequate iodine measured by Urinary Iodine Excretion (UIE< 100 µg/L).

Zinc deficiency is known to be associated with stunting. The high rate of stunting is indicative of possible high level of zinc deficiency. The 2013 TLFNS reported that 33.3% of children under-five Zinc deficient (zinc level < 8.7 µmol/L).

## 2.2 Consequences of Malnutrition and Micronutrient Deficiencies

Malnutrition "is globally the most important risk factor for illness and death"[14]. The 2008[15] and 2013[16,17] Lancet Maternal and Child Nutrition reported that globally, stunting, severe wasting, and intrauterine growth restriction together are responsible for 2·2 million deaths. Deficiencies of vitamin A and zinc are estimated to be responsible for 0·6 million and 0·4 million deaths, respectively. Maternal short stature and iron deficiency anaemia increase the risk of death of the mother at delivery, accounting for at least 20% of maternal mortality. Malnourished children score 7% lower in math tests and are 19% less likely to be able to read at age of 8 years. A combination of poor health and education limit job prospects. Childhood malnutrition cuts future earnings by at least 20%. Nutrition-related factors together are reported to be responsible for about 35% of child deaths and 11% of the total global disease burden. Under-nutrition has direct health consequence and indirect consequence on a nation's human capital and gets propagated from one generation to another. The maternal and child undernutrition study group[18] reported that undernutrition was strongly associated

[13]University of Udayana 1998.Final Report on Goitre Prevalence Survey and Mapping in Provinces Bali, Nusa Tenggara Barat and East Timor. Ministry of Health Republic of Indonesia. Jakarta
[14] Olaf Müller and Michael Krawinkel, Malnutrition and health in developing countries, CMAJ 2005;173(3):279-86
[15] Black et al, 2008, Maternal and child undernutrition: global and regional exposures and health consequences, Lancet 2008; 371: 243–60
[16]Bhutta ZA et al. 2013. What works? Interventions for maternal and child undernutrition and survival. The Lancet Series of Maternal and Child Nutrition, p417-440.
[17] Black RE et al. 2013. Maternal and child undernutrition and overweight in low-income and middle-income countries. The Lancet Series of Maternal and Child Nutrition, p1-25.
[18] Cesar G Victora, Linda Adair, Caroline Fall, Pedro C Hallal, Reynaldo Martorell, Linda Richter, Harshpal Singh Sachdev Maternal and child undernutrition: consequences for adult health and human capital. Lancet 2008. Maternal and Child Nutrition Series; 371: 340–57

with shorter adult height, less schooling, reduced economic productivity, and for women lower offspring birth weight. Low birth weight or stunting in the first two years of life leads to irreversible damage, including shorter adult height, lower attained schooling, reduced adult income, and decreased offspring birth weight. Children who are undernourished in the first two years of life and who put on weight rapidly later in childhood and in adolescence are at high risk of chronic diseases related to nutrition. High rate of child malnutrition thus has a potential to add to the double burden of diseases.

Malnutrition contributes to maternal mortality by increasing susceptibility to infections, reducing tolerance of blood loss during delivery and also heightens the risk of adverse pregnancy outcomes. A woman with poor nutritional status, as indicated by a low body mass index (BMI), short stature, anemia, or other micronutrient deficiencies, has a greater risk of obstructed labor, dying from postpartum haemorrhage and having a baby with a low birth weight and experiencing illness for herself and her baby.

Micronutrient deficiencies have profound effects on the health and well-being of individuals their productivity. Young children and pregnant and lactating women need higher levels of minerals and vitamins but some of these are not found in sufficient quantities in the diet of the general population. Anemia among women of reproductive age is associated with reduced work performance, low birth weight and higher risks of mortality during pregnancy. Anaemia is associated with greater morbidity and mortality and is a marker of poor health and nutrition for both women and children. Anaemia in young children is associated with impaired psychomotor and cognitive development. Iodine deficiency leads to poor brain development and intellectual impairment. Severe iodine deficiency during pregnancy can cause causes cretinism, severe mental and physical retardation and may cause stillbirth and miscarriage.

Poverty, through its causal link to malnutrition and economic loss as a consequence of malnutrition, is both a cause and an outcome of poor human development. Malnutrition in Timor-Leste is estimated to be cause of 34% of childhood mortality and cost the national economy loss of US$ 41 million annually, equivalent to 1.0% of GDP and 2.0% of non-oil GDP[19]. Therefore, investment in prevention of maternal and child undernutrition is a sound investment for socio-economic development of a country.

[19] Jack Bagriansky, Findings of Economic Burden of Malnutrition in Timor-Leste, Final Report June 2014

## 2.3 Causes of Malnutrition in Timor-Leste

### 2.3.1 Conceptual Framework of Malnutrition

Figure-3 below, an adaptation of UNICEF's "Conceptual Framework of Malnutrition" provides conceptual framework for causal analysis of malnutrition in Timor-Leste.

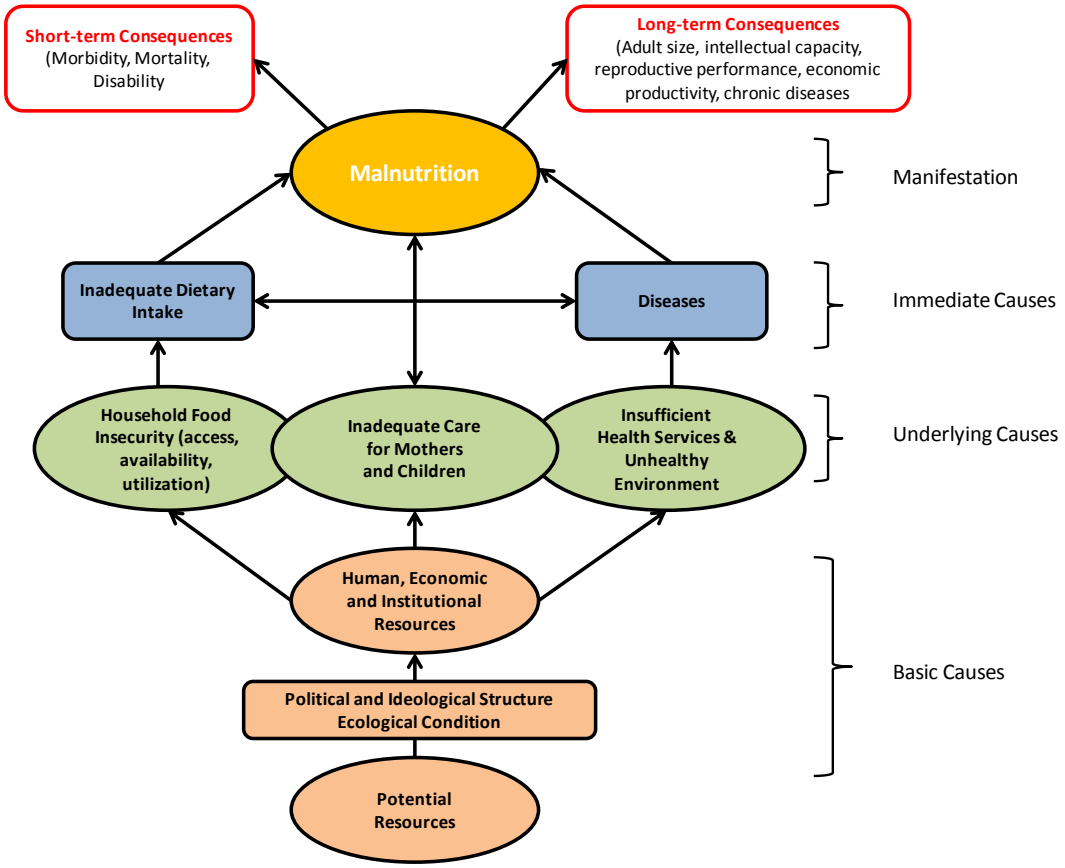



**Figure 3: Conceptual Framework on Causes of Malnutrition in Timor-Leste**

The conceptual framework shows series of interlinked determinants of malnutrition at the basic, underlying and immediate levels and the relationships between these factors. It therefore presents a useful understanding of how malnutrition is a manifestation of the broader developmental problem. The immediate causes of malnutrition are inadequate intake of nutrient and diseases, which are caused by the underlying causes, namely, inadequate access to food, healthy environment and inadequate access to health services. Caring practices for children and mothers, contribute to both immediate causes as it interacts with inadequate access and with inadequate access to a healthy environment and health services. The immediate, underlying and basic causes are described in detail in following section.

### 2.3.2 Immediate causes

*Inadequate dietary intake (Inadequate Infant and Young Child Feeding Practices):* Inadequate intake of calories, proteins and fats often lead to under-nutrition (stunting, wasting, underweight) among children under-five and chronic energy deficiency (low Body-Mass-Index) among women of reproductive age. A significant lack of dietary diversity leads to micronutrient deficiencies. The most serious deficiencies relate to the low intake of iron, folic acid, iodine and zinc, which are especially significant public health problem among children under-five and women of reproductive age. Exclusive breast-feeding, continuing breast-feeding beyond two years and timely and appropriate complementary feeding are essential to ensure adequate nutrition during infancy and early childhood. Exclusive breastfeeding rate among infant 0-6 months in Timor-Leste has gone up from 52% (TLDHS 2009/10) to 62% (TLFNS 2013) but considering the close to universal breast-feeding practices, there is room for improving exclusive breast-feeding rates further. WHO recommends introduction of complementary feeding from age 6 months, the age at which breast-milk alone cannot meet nutritional requirement of babies. The TLFNS showed that 79.2% of children 6-23 months met minimum meals frequency but only 28.2% adherence to recommended infant and young child feeding practices, 27.5% met minimum dietary diversity and only 17.6% met minimum acceptable diet.

The 2013 TLFNS reported that majority of the households (61.3%) had acceptable household food consumption score but only 24.3%of children 6-23 months old consumed flesh/meat, 22.5% consumed eggs, and 25.5% consumed dairy product. Among children 24-59 months 50.6% had adequate meal frequency, 40.6% had adequate dietary diversity and 25.1% had adequate diet. The same survey. This indicates that the low level of adequate dietary intake by children is more likely to be related more to practices than to food availability in the households.

The proportion of children aged 6-59 months who received vitamin A supplementation is 53%. (TLFNS2013). The coverage of iron containing multiple micronutrients among children introduced district Ailieu was 72%. About 40% of the salt used in Timor Leste is locally produced by small scale producers and the current salt iodization efforts convert about 15% of this to iodized salt. There is yet no regulation or law to ensure that the salt produced, imported and traded is iodized.

*High prevalence of childhood illnesses:* Illnesses such as acute respiratory infections (ARI), diarrhea, and measles are identified as the immediate causes of malnutrition among young children. The TLFNS 2013 reported 32.6% of children under- 5 years of age having had fever in the past two weeks preceding the survey. The incidence of diarrhoea among under-five children two weeks preceding the TLFNS 2013 was 16.7%. This, on average, equals to each child having about four episodes of diarrhoea each year. The prevalence of fever with cough Acute Respiratory Infection (ARI) was 37%.

The above mentioned immediate causes of malnutrition tend to create a vicious cycle. Malnutrition lowers the body's ability to resist infection by undermining the functioning of the immune-response mechanisms. This leads to longer, more severe and more frequent episodes of illness; and these illnesses drain the nutrition status of children, aggravating malnutrition. When a malnourished child falls ill the malnutrition worsens. Children who enter this malnutrition-infection cycle can quickly fall into a potentially fatal spiral as one condition aggravates the other.

### 2.3.3 Underlying causes

*Household food insecurity:* Household food security depends on availability of food and on access to food through financial, physical and social means. A food secure household has sufficient quantity and quality of food including energy, protein and micronutrients and ensures adequate intake for all members of the family. There may be abundant food in the market, but if vulnerable households cannot afford it, they will be food insecure. The 2008 World Bank report on "Poverty in a Young Nation" noted that the percentage of population with per capita food consumption below the food poverty line increased from 31.2% in 2001 to 42.1% in 2007. The Timor-Leste Survey of Living Standards (TLSLS) 2007 identified 72.9% of households with "at least one month of low food consumption" and that the number of months in a year with low food consumption averaged 3.2 months[20]. Food shortages and household food insecurity are particularly severe during the periods of October to March and particularly in upland areas. Covalima, Bobonaro, Ermera, Manatuto, Baucau, Lautem and Oecusse are reported as the most food-insecure districts in the country and the subsistence farmers and female-headed households are the most food insecure ones. The TLFNS 2013 reported that majority of the households (61.3%) had 'acceptable' Food consumption Score (FCS) and 21.6% household experienced shocks in the last 12 months and 13.3% experienced difficulties in obtaining food in the last 30 days.

*Poor caring practices for children and mothers:* Caring practices are strong determinants of women's and child's nutritional status. The extent to which care is provided depends on the available resources, knowledge, skills, and cultural beliefs of the caregivers and community. Inadequate care practices can hinder the proper utilization of food even if it is available and accessible and also affects health seeking behavior, especially for women. The TLFNS 2013 reported that 62% of infants 0-6 months being exclusively breastfed; and only 17.6% of children of age 6-23 months being fed according to all the recommended Infant and young child feeding practices. While 93.4% of new born are breastfed within first hour of birth, 7.9% are given harmful prelacteal feed in the first three days of life. Estimated

[20] Timor-Leste Standard of Living Survey 2007. Dili, Timor-Leste

85.2% children with illness were taken to a health facility for treatment. However, only 5.3% of children who suffered from diarrhoea were provided more fluids to drink during the diarrheal episode; 10 % of children were given breastmilk only; and only 23.8% were given increased fluids and continued feeding as recommended. Only 29.9% children who were diarrhea received treatment with recommended combination of ORS and zinc. These inadequate caring practices put Timorese infants at risk entering into the cycle of infections and malnutrition.

*Limited access to and utilization of preventive and promotive health services:* Utilization of appropriate treatment for diarrhoea and fever remains low across all quintiles. Antenatal Care contacts offer opportunity for providing nutrition interventions including micro-nutrient supplementation, detection and treatment of maternal conditions, counseling for maternal nutrition and preparation for breast-feeding. The coverage of four recommended antenatal care visit is 81.9% but only about one-third (31.7%) of pregnant women take iron-folic acid (IFA) supplement for the recommended 90 days or more during pregnancy (TLFNS 2013). Child immunization is the most widely accepted preventive health intervention and 86.5% children 12-24 months are fully vaccinated (TLFNS 2013). This sows that access to preventive health services is fairly high but the coverage of preventive maternal and child health interventions is less than desirable and this increases vulnerability to malnutrition.

*Inadequate environmental conditions:* Lack of access to safe water, poor sanitation and the unhygienic handling of food have significant implications for the spread of infectious diseases, notably diarrhoea and ARI which drain nutritional status of children. Estimated 50%% of households have no toilet facilities, and less than 60% of households have hand washing facility (TLFNS 2013).

*Low level of knowledge and skills of care providers and families:* When caregivers do not have adequate information, knowledge and skills about infant and child feeding, appropriate hygiene practices and the importance of playing and stimulating a young child, the child is deprived of care, suffers growth faltering and consequences of low resistance to infection. The sub-optimal infant and young child feeding, inadequate home health care and care seeking during illness reported above indicate that the level of knowledge and skills are inadequate. Stunting, the most common manifestation of malnutrition in children is also not perceived by parents as a problem and this implies that there is lack of awareness about stunting and its implication. The lack of dietary diversity reported above is also contributed by lack of knowledge about what constitute acceptable diet.

### 2.3.4 Basic Causes

*Poverty:* The 2013 TLFNS reported higher prevalence of stunting among poorest households (58.5%) as compared to the richest households (41.9.%) and prevalence of malnutrition among women is higher among those in the poorest household (33.7%) than those in the richest households (17.2%).. Poverty not only limits access to adequate and nutritious food but also reduces access to other resources needed for providing adequate care of children and women, such as home health care, access to health care, environmental sanitation etc. Timor-Leste's MDG report 2010[21] reported national poverty rate of 49.9% in 2007 with a 26% decline in average consumption. It states that poverty in some areas of the nation almost doubled between 2001 and 2007. The 2008 World Bank report titled "Poverty in a Young Nation" states that the percentage of population with per capita food consumption below the food poverty line increased from 31.2% in 2001 to 42.1% in 2007[22].

*High food price, inflation and diminishing buying power of poor:* Timor-Leste is dependent on food import and this dependence exposes the Timorese people to the impact of global food price increase, making the imported food unaffordable to poor families. This problem is compounded by the high rates of inflation (Ministry of Finance 2011)[23], further reducing the buying power of poor families. The high import dependent food price in the market prompts poor farmers to sell good quality food they produce to meet other household needs and opt for low nutrient value cereals and roots. High food price is likely to have a worsening effect on already malnourished children and women of poor households, through its impact on child malnutrition, it is likely to have long term effects on the poorer segment of the population.

*Illiteracy:* An educated mother is known to have better control of resources, higher ability to acquire knowledge and skills and translate them into self-care and care to their children, which are important determinants of good nutritional status. The TLFNS 2013 reported that stunting among children is higher (57.2%) among those whose mothers are illiterate as compared to those whose mothers are literate (46.6%). Women with secondary and higher level of education are less likely to be malnourished compared to women who have no education. Maternal malnutrition is higher among mothers who are illiterate (29.4%) than those literate (24.1%).

*Women status and gender issues:* Gender relations play an important role on nutritional status at the household and community levels. Women are the primary nutrition caregivers in households. They are the food growers, the cooks and the care-providers of their children and families. How they carry out nutrition related activities and control resources are critical determinants of the nutritional status

[21] Government of Timor-Leste, MDG report 2010: Where are we now! Where we want to be in 2015?
[22] Timor-Leste: Poverty in a Young Nation. 2008. World Bank and Directorate of National Statistics, Dili. Timor-Leste
[23] 2011 Fragile State Principles Survey – Draft Timor-Leste Country Chapter the National Directorate for Aid Effectiveness (NDAE). 2011. Ministry of Finance, Timor-Leste

of themselves and those under their care. Timor-Leste is reported to have "strong remnants of the traditional patriarchal system. Due to the dowry system, husbands adopt the strong view that their wives are their subordinate property".[24] The patriarchal society grants lower status to women who get discriminated against in the ownership of assets and participation in making decisions affecting their lives and that of their children. The 2013 TLFNS reported a high level of undernutrition among women of reproductive age (15-49 years) with 24.8% being classified as malnourished. Malnourished mothers are known to give birth to low birth weight (LBW) babies and low birth weight female babies could remain stunted in childhood, become a malnourished mother and have LBW babies leading to intergenerational propagation of malnutrition.

*Inadequate programme and policy effort for addressing burden of malnutrition:* The level of malnutrition in the country makes it a big development challenge and a resources drain to the nation. There is strong stated national commitment to Nutrition but due to lack of explicitly defined National Nutrition Policy nutrition failed to get adequate attention is national target setting and in the past. The 2004 National Nutrition Strategy was not costed and the national budget does not have nutrition specific budget line. There is yet no breast-feeding policy that guarantees food security to the most vulnerable, the 0-6 months old Timorese, who will be the human capital to fuel future development of the country. Timor-Leste is yet to adopt a code for marketing of breast milk substitute that safeguards breast-feeding. There is no mechanism to monitor imported salt and there are no law and regulation regulating production, import and trade of salt, all essential for ensuring consumption of iodized salt. The country is dependent on food import but is yet to have a programme to regulate food quality, including food fortification.

*Others basic causes:* General isolation and lack of infrastructure, poor access to adequate irrigated farmland, poor access to income generating activities outside of agriculture have been attributed as causes of food insecurity in Timor Leste[25]. Timor-Leste is mostly mountainous and has limited land suitable for intensive agricultural. In such a situation proper management of land tenure becomes critically important, but inappropriate land tenure system with many farmers not owning land, and those who own having small parcels not adequate to sustain their families, is recognised by the government and it is working to address it. The other basic causes of malnutrition are a) natural disasters such as droughts, floods, landslides, soil erosion and strong winds affecting crop yield adversely; b) poor road networks, poor public transport system and high cost of transport which limits farmers ability to bring their produce to the markets (market access); c) rain-fed seasonal agriculture

[24] Japan International Cooperation Agency, 2011, Ccountry Gender Profile: Timor-Leste retrieved on 3 May 2013 from http://www.jica.go.jp/english/our_work/thematic_issues/gender/background/pdf/e10timor.pdf
[25] World Food Programme *2006,* Timor Leste - Comprehensive Food Security and Vulnerability Analysis

which leads to seasonality in food availability leaving farmers with inadequate food during the dry spells; and d) rising unemployment that deprives income to families.

## 2.4 Timor-Leste Nutrition Policy Landscape

Good health is enshrined in the Constitution of Timor-Leste. All Timorese citizens are entitled to health care and the state has a duty to promote and protect the health of its citizen. The government of Timor-Leste has committed to addressing malnutrition through a number of policy frameworks, statements and plans. The commitment of the government to translate the constitutional obligation comes out in form of:

- Timor-Leste's commitment to achieve the MDGs targets which are in line with the Seventh National Development Goals (NDGs) of Timor-Leste;
- The 2004 nutrition strategy which is currently being implemented;
- The 2010 Comoro Declaration against hunger and malnutrition. This is a statement of policy commitment to address nutrition through concerted and joint efforts of seven line ministries viz. the Ministry of Agriculture and Fishery (MAF), Ministry of Finance (MoF), Ministry of Health (MoH), Ministry of Commerce, Industry, and Environment (MCIE) - *formerly known as Ministry of Tourism, Commerce and Industry (MTCI)*, Ministry of Economy and Development (MoED)[26], Ministry of Education (MoE), and Ministry of Social Solidarity (MSS);
- The Timor-Leste Strategic Development Plan 2011-2030 which aims to a) accelerate economic growth and b) reduce poverty, both of which are expected to have impact on the basic causes of malnutrition;
- The National Health Sector Strategic Plan (NHSSP, 2011-2030) which emphasizes delivery of basic health services and health promotion. The NHSSP recognizes that tackling the malnutrition will require paying attention to the nutritional needs of women during pregnancy and of their children during the first two years of life. The Ministry of Health (MoH) has placed a high priority on reducing the rate of malnutrition through improved maternal and child nutrition services as part of the six essential service delivery components of the Basic Services Package (BSP). Presently, the Ministry of Health and its partners are implementing strategy to improve community-based service delivery strategy called *Servisu Integradu Saude Communitaria* (*SISCa*) that provide outreach services beyond health facilities. *SISCa* is an integrated approach of service delivery involving all relevant actors in the community and led by the village council;

[26] Under the newly formed government cabinets (5th Constitutional Government of Timor-Leste), the MoED has been abolished

- The Ministry of Social Solidarity (MoSS) provides social protection and assistance to vulnerable groups. It also provides a conditional grant of US$ 5/month per child for poor families on condition of completing immunization and enrolment to school.
- The Ministry of Agriculture's and Forestry (MAF) has been working to improve a) capacity of agriculture extension workers, b) improve the production of crops and aquaculture, and c)capacity of community-based group to promote home gardening and small scale livestock and fish farming. MAF has also established the Food Security Information and Early Warning System to improve the timely information on food security situation in the country.
- Ministry of Education scaling up child friendly schools, implementing school feeding and school WASH interventions to increase enrolment and reduce school drop-out.
- Ministry of Health and MAF have jointly developed a draft Food and Nutrition policy. Ministry of health has developed several draft nutrition related policies and codes.

The plans and other commitments highlighted above show that the government of Timor-Leste is fully aware of its obligation towards ensuring adequate nutrition for all Timorese. However, as stated above, there is no explicit national nutrition policy and these plans and commitment have not comprehensively addressed the challenges of working across sectors.

Sustainable change in nutrition outcomes require favorable changes in underlying causes and root causes, which are beyond the mandate of a single ministry. Addressing them requires inter-sectoral actions at the level of policy, programmes and budgets and existence of enabling political, economic, legal and regulatory environment. Thus this strategy will have to propose a very strong inter-sectoral mechanism to address the basic causes as responsibility of one relevant sectors of the government.

## 2.5 Existing Programmes and Partnerships in Nutrition

Since the development of the 2004 NNS, the Government of Timor-Leste has been implementing a number of nutrition interventions. Implementation of High Impact Nutrition Interventions (HINI) recommended for the first 1000 days window of opportunity for addressing child malnutrition was initiated and efforts are being made to scale up. Most of the nutrition interventions are being implemented by the MoH. Ministry of Agriculture and Fishery (MAF), and Ministry of Commerce, Industry, and Environment (MCIE), the Non-Government Organizations (NGOs) and church-based organizations. Development partners supporting the Government and NGOs in implementing food and nutrition related interventions include bilateral donors (DFAT Government of Australia, EU, GoJ, USAID, Spain), International Financial Institutions such as the World Bank, and global alliances such as

Spanish MDG Achievement Funds (MDG-F) and the UN agencies (FAO, UNICEF, WFP, WHO). ***Annex-4*** shows the current nutrition interventions with their geographical area and supporting partners. ***Annex-5*** of this document show the existing gaps in implementation.

## 2.6 Lessons from 2004 Nutrition Strategy Implementation

There was no formal evaluation of the 2004 Nutrition Strategy implementation but the lack of positive change in nutrition indicators suggest that it did not address malnutrition challenge effectively. The perceived gaps and lessons that can be drawn from the 2004 Nutrition Strategy implementation are:

- The 2004 NNS laid emphasis on two priorities: a) maternal and child nutrition, and b) food security. This made the strategy health sector and food security focused and this does not adequately address under-lying and basic causes of malnutrition;
- The strategy was not followed up with a costed operational plan which could have led to clear articulation of need for actions, budget, agreed implementation time-frames, responsibilities and monitoring process. This made it hard to implement the strategy and judge its effectiveness;
- There was inadequate focus on addressing the socio-cultural issues around malnutrition. The consultative meetings, notably the kick-off process, and the stakeholder workshop identified that a) malnutrition in Timor-Leste is more of a socio-cultural problem b)women tend not to take children to hospital for malnutrition treatment until the malnutrition has advanced and child gets sick; c) the suboptimal infant and young child feeding practices are associated with cultural beliefs and practices; and d)changing behaviours and practices requires going beyond producing poster and leaflets to adapt context relevant approach to engage community in assessment, analysis and action using culturally appropriate messages and models;
- There was insufficient attention to address women's nutritional status. Other than the MoH led SISCa and supplementary feeding supported by WFP, there are no program currently targeting women with nutrition actions. Putting women at the centre of nutrition actions will be an indicator of a successful nutrition programs in the coming years;
- There was insufficient attention to capacity development for nutrition and this is the reason for the persisting capacity gaps at all levels. The bulk of people who are taking charge of nutrition activities in the districts are graduates from high schools and health volunteers who have no nutrition preparation during their schooling years. This calls for continuing education, in-service training and the need to produce adequate numbers of nutritionists, including developing the capacity of educational institutions to produce nutritionists;
- The 2004 NNS laid emphasis on inter-sectoral collaboration but multi-sectoral approaches were not embraced. The only manifestation of coordination that currently exits is the Nutrition Working

Group comprising of key Nutrition related stakeholders who meet every two months. There are practically no linkages between nutrition and agriculture, food security, water and sanitation, education, social protection, and environment related interventions. Consequently, the current structures and programs on nutrition do not adequately address malnutrition. Inter-sectoral collaboration on nutrition will require clarity on roles and responsibilities, including joint planning, joint resource mobilisation, joint monitoring and joint implementation. Recognising that inter-sectoral approach can be challenging due to divergent objectives and capacities, it was recommended during the consultative meetings that an Inter-Ministerial Committee based in the office of the Prime Minister be tasked to facilitate such cross-sectoral collaboration;

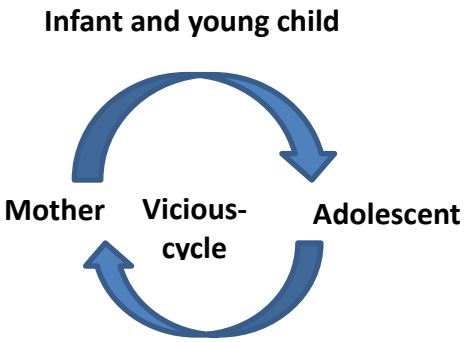
- The Monitoring and Evaluation (M&E) system remains weak. The data derived from the Demographic Health Survey conducted every five year and from Health Management and Information System (HMIS) are insufficient to inform nutrition programming. Indicators to monitor and evaluate food and nutrition security outcomes are inadequate to measure progress being made on any aspect of nutrition programme;
- There is a lack of operational research to identify, among others, effective way of scaling up services coverage and effective way of changing behaviours in the country context;
- There was inadequate attention to strengthen partnerships with the private sector, faith-based organisations and the media. The Catholic Church is one potential partner that was not effectively involved, yet it has the ability to maintain and mobilize unpaid volunteers across the country. Engaging with both the church and private sectors as potential partners need to be pursued in the revised nutrition strategy;
- Equity considerations did not play a significant role in the 2004 strategy. This strategy need to give attention to strengthen social protection systems to provide access to nutritious food to vulnerable households and in areas where the prevalence of stunting is higher.

## 2.7 Other Considerations Informing Formulation of Strategic Response

**Multi-sectoral approaches and coordination**: Good nutrition outcomes require actions across different government sectors and this strategy promotes multi-sectoral approaches involving the Ministries signatory to the Comoro Declaration (local government, health, water, sanitation and hygiene, education, agriculture, social protection, and the environment), the Development Partners (UN agencies, NGOs, and Donors), Civil Society Organizations, Faith-based Organization, Professional Organizations, Media, local communities, and the private sector. The strategy envisages a) these stakeholders having an effective ordination mechanism at the national level and districts level; and b)

each of them mainstreaming nutrition-related interventions in their sectoral plan and implementing them as part of their contribution to the country's development priorities.

**Lifecycle Approach:** This strategy focuses on delivering High Impact Nutrition Intervention (HINI) through the lifecycle approach. The lifecycle approach provides a framework for understanding and addressing vulnerabilities and using opportunities for investing in key stages in the lifecycle, from before birth (from pre-conception and during pregnancy), at birth, infancy and children under five years of age, school-going age, adolescence, women of reproductive age, adulthood and the elderly. Protecting children from risk of being malnourished begins *in utero*, where exposure to maternal infections or nutritional deficiencies increases infant mortality, premature birth, birth defects, and low birth weight. Rapid physical and neurological development takes place in the first months of life. During this stage, various risks accumulate and consequences are likely to be severe and irreversible but this stage also presents extraordinary opportunities for interventions. Appropriate nutrition and care during pregnancy, at birth, and during the first years of life will improve children's physical and cognitive development, and may reduce the incidence of non-communicable diseases later in life. Adolescence is a transition phase when children become adults. During this time, growth in stature accelerates and is faster than at any other time in the individual's postnatal life except the first years and ensuring healthy adolescent girl paves way for healthy motherhood and good birth outcome.




**Good governance:** The strategy will have one plan and one high level monitoring mechanism. It will promote transparency, accountability for budgets, actions and results suggests initiatives for strengthening management, coordination and governance.

**Prioritization for feasibility and impact:** The strategy supports intervention that address immediate, underlying and basic clauses of malnutrition; focuses on the high impact nutrition interventions highlighted in the Lancet Series on Maternal and Child Under-nutrition of 2008 and 2013; and prioritizes interventions at the "1000 days window" of opportunity, a period from conception until end of two years of a child's life where nutrition interventions can have maximum impact.

**Human Resources and Institutional Capacity strengthening:** Development of human resource and institutional capacity is critically important for implementation of nutrition interventions.

**Evidence for policy and actions:** There is a need to improve monitoring and evaluation and to support operational researches that help find solutions to problems.

**Need for a Costed Strategy**: The strategy implementation will need resources and in-order to mobilize resources, there is a need to do realistic costing. The strategy development should be followed by development of a costed operational plan.

**Policy Advocacy and Resource Mobilisation:** Need to give visibility to nutrition problem and nutrition actions placing strategy implementation monitoring at sufficiently high level, generating, and using evidence for advocacy and developing and implementing a resource mobilization plan need to be important areas of this strategy.

# 3 VISION, GOAL, OBJECTIVES AND PRIORITIES

## 3.1 Vision, Goal, and Objectives

**Vision:** The vision of the Timore-Leste National Nutrition Strategy (TL-NNS) 2014-2019 is to contribute to sustainable achievement of national socio-economic and human development goals by improving the quality and productivity of its human capital.

**Goal:** The goal of the TL-NNS 2014-2019 is to improve the nutritional status of Timorese population

**Purpose:** The purpose of the TL-NNS 2014-2019 is to accelerate reduction of maternal and child under nutrition through implementation of nutrition specific and nutrition sensitive interventions

## 3.2 Objectives of the Strategy

The objective of the strategy is to reduce malnutrition and micronutrient deficiency among children and women.

The achievement of the objective will be measured using the indicators, baseline and targets shown in the table-1 below:

**Table 1: Key Timor-Leste nutrition strategic targets**

| Indicators | Value | | WHO cut-offs |
|---|---|---|---|
| | Baseline[27] | 2019 targets | |
| % Underweight among under-five children (WFA <-2SD) | 37.7 | <30 | <10%: low, 10-19%: medium, 20-29%: high and >=30%: very high[28] |
| % Stunting among under-five children (HFA <-2SD) | 50.2 | <40 | <20%: low, 20-29%: medium, 30-39%: high, and >=40%: very high[9] |
| % Wasting among under-five children (WFH <-2SD) | 11.0 | <10 | <5%: low, 5-9%: medium, 10-14%: high and >=15%; very high[9] |
| % Low BMI (18.5kg/m2) among Women of Reproductive Age (WRA) | 24.8 | <20 | 3-5%: Normal, no food insecurity; >5-9%: Warning sign, monitoring required; >10-19%: Poor situation; 20-39%: Serious situation; ≥ 40%: Critical situation[29] |
| % Anemia among under five year old children (Hb<11g/dL) | 62.5 | <40 | 4.9%: No public health problem is, 5.0-19.9%: mild public health problem, 20-39.9%: moderate public health problem, and ≥40%: severe public health problem[30]. |
| % Anemia among women of reproductive age (Hb<12g/dL) | 38.9 | <20 | |
| % Vitamin A deficiency among under-five children (Serum Retinol <0.7mmoL) | TBE | <20% | 2%–<10%: Mild,<br>10%–<20%: Moderate,<br>20%: Severe[31] |
| % Iodine deficiency (urinary iodine excretion among WRA<100µg/L) | 26.6% | <20% (maintain) | Target is <50% for UI<100µg/L and <20% for UI<50 µg/L [32] |
| % Zinc deficiency among underfive children (Zinc level <8.7 mmol/L) | 33.3% | <20% | |
| Low birth weight (Birth weight <2500g) | 12% (TLDHS, 2009/10) | <10% | |

# 4 INTERVENTION TARGETS

Nutrition Specific interventions will prioritize focus on pregnant women and children less than 2 years of age to optimally use the "window of opportunity of 1000 days from Pregnancy to 24 months". In addition, interventions will target children 24-59 months with preventive and promotive nutrition and health interventions and adolescent girls to improve their micronutrient status. The behavior change communication interventions will focus on women and children but will benefit entire family. The nutrition sensitive interventions will engage communities and families and benefit families engaged in the interventions.

# 5 STRATEGIC PRIORITIES (SP)

[27] Baseline data are from Timor-Leste Food and Nutrition Survey 2013, unless otherwise indicated
[28] WHO 2012. Global database on child growth and malnutrition. http://www.who.int/nutgrowthdb/about/introduction/en/index5.html (Accessed on 28th July 2012)
[29] World Health Organization, *Physical status: the use and interpretation of anthropometry. Report of a WHO expert committee.* WHO, Geneva, 1995
[30] WHO 2008. Worldwide prevalence of anaemia 1993–2005 : WHO global database on anaemia. Geneva, World Health Organization. http://whqlibdoc.who.int/publications/2008/9789241596657_eng.pdf (Accessed 28th July 2012)
[31] WHO 2009.Global prevalence of vitamin A deficiency in populations at risk 1995–2005.WHO Global Databaseon Vitamin A Deficiency. Geneva, World Health Organization.http://whqlibdoc.who.int/publications/2009/9789241598019_eng.pdf. (Accessed 28th July 2012)
[32] WHO 2004.Iodine status worldwide.WHO Global Database on Iodine Deficiency.Geneva, World Health Organization. http://ceecis.org/iodine/01_global/01_pl/01_01_who_%20status_worldwide_04.pdf (Accessed 28th July 2012)

To ensure focus of the action of all actors to address malnutrition six Strategic Priorities (SP) are identified. These are described below:

**SP-1: Improved Nutrients Intake by Mothers, Children and Adolescent Girls:** This priority area aims to increase nutrient intake by mothers and children and to improve treatment outcome for malnourished mothers and children. Interventions will promote improved infant and young child feeding and practices by creating conducive environment and by enabling mothers and families with knowledge and skills; promote micronutrient intake through micronutrient supplementation, food fortification and food-based approach; and through therapeutic and supplementary feeding programmes.

**SP- 2: Improved Care for Mothers and Children:** This priority aims to address childhood illnesses and caring practices which are determinants of women's and child's nutritional status. The areas of intervention are: a) promoting safe motherhood, b) promoting community led initiatives to improve home and community care for women and children, c) strengthening local capacity to improve maternal and child nutrition and food security education including health seeking behaviour and addressing food taboos, d) strengthening linkage between maternal and child nutrition with maternal reproductive health (i.e. birth spacing, fertility control, family planning, etc.); f) helminth control, g) malaria prevention and treatment, h) diarrhoea and pneumonia prevention and treatment, i) immunization, j) prevention and management of malnutrition associated to HIV/AIDS, and k) promoting linkage between nutrition and diet related disorders/diseases, and other non-communicable diseases.

**SP-3: Improved Food Security at Household, Community, and National Levels:** This priority area aims to ensure that sufficient quantity of nutritionally adequate food is made available and accessible to all Timorese, especially to the most vulnerable Timorese. The areas of interventions include promoting increase and diversification of domestic food production and improving access to nutritionally adequate foods especially increasing availability and consumption of food from animal source a by adolescent girls, young mothers and young children, increasing opportunity for income earning provided to women, especially young mothers from lowest wealth quintile and increased coverage of social protection scheme for children, adolescent girls and women of lowest quintile.

**SP- 4: Improved Hygiene and Access to Water and Sanitation:** This priority aims to address a major group of underlying causes of malnutrition which are inadequate access to safe water supplies, poor sanitation and food hygiene. The intervention will improve access to safe water and sanitation facilities and promote home and personal hygiene behavior.

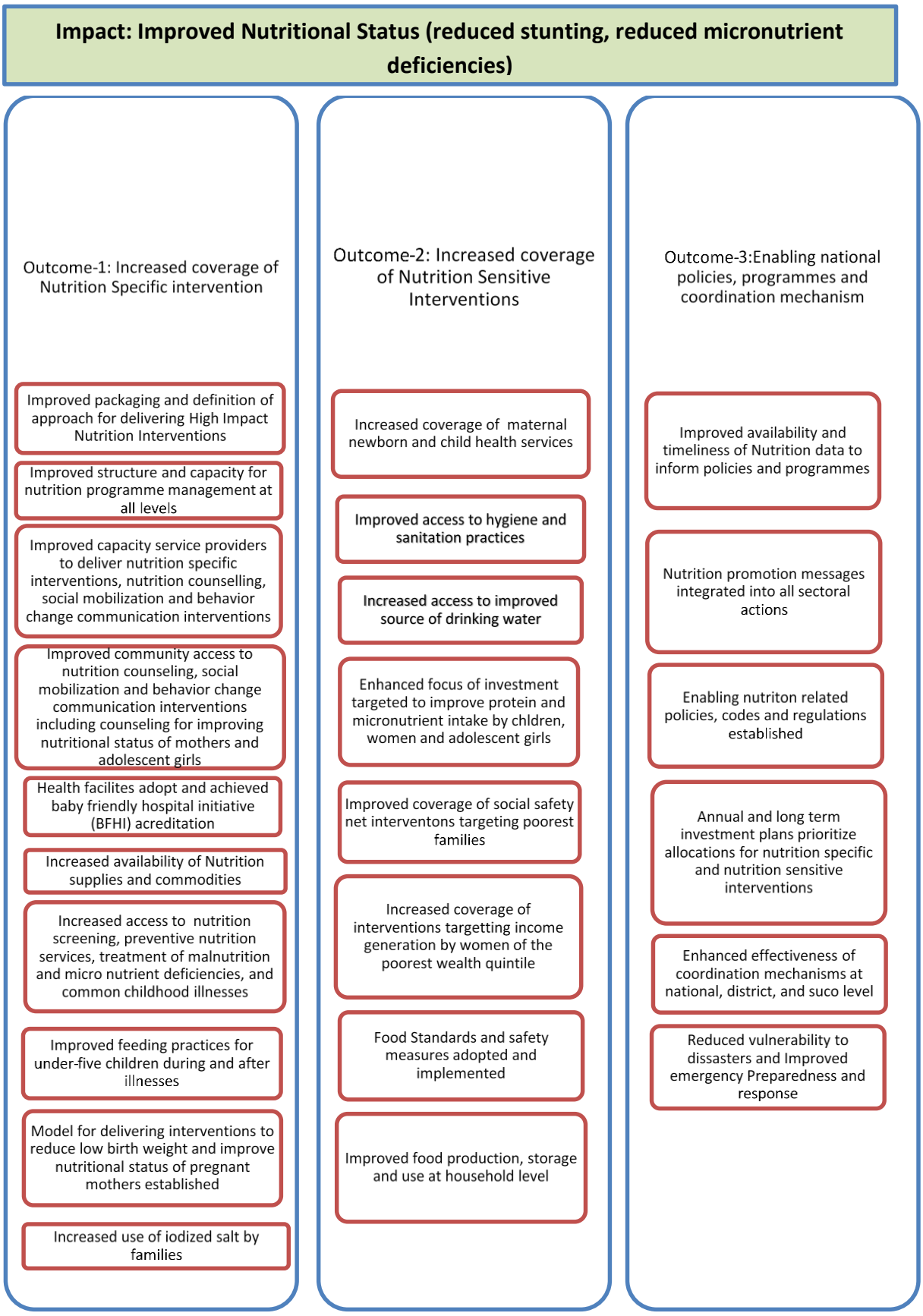
**SP-5: Optimal Nutrition Behaviour and Practices Promoted at All Levels:** This SP will *support all other priority areas* through nutrition related social mobilization and behavior change communication which will be implemented by all sectors involved in this strategy implementation. The areas of intervention are developing national communication strategy for nutrition; influencing community norms for nutrition and health practices; developing and disseminating culturally appropriate nutrition and food security education materials; developing interpersonal and behaviour change communication skills of health workers, community volunteers and extension workers; and integrating nutrition education and messaging in education and other health and agriculture programmes.

**SP-5: Improved Policies and Capacity for Multi-sectoral Nutrition Action:** This priority *will support all other priority areas* by a) establishing effective multi-sector coordination mechanism, and b) putting in place institutional and legal framework, leadership structure, advocacy and coordination systems that will help integrate and mainstream nutrition and food security interventions across all relevant government sectors. Key area of intervention are improving capacity of institution working in nutrition, improving coordination, improving human capacity in nutrition, improving quantity and quality of information on nutrition and increasing investment in nutrition.

# 6 RESULTS CHAIN AND LOGICAL FRAMEWORK

To enable development of a well-informed operational plan for implementing the strategy, a result chain is developed and a logical framework analysis is done. The result chain and log-frame take into account the objectives, strategic priorities and interventions and recognizing that most of the nutrition interventions are being delivered through government systems as packages or part of packages and improving coverage of intervention require improvement of systems functions. Accordingly, the result chain articulates outcomes in three areas, namely, nutrition specific interventions, nutrition sensitive interventions and management and coordination. Nutrition Specific Interventions are “interventions or programmes that address the immediate determinants of fetal and child nutrition and development—adequate food and nutrient intake, feeding, caregiving and parenting practices, and low burden of infectious diseases”. Nutrition Specific Interventions are “interventions or programmes that address the underlying determinants of fetal and child nutrition and development”. These include food security; adequate caregiving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment. The planned outcomes and outputs of the strategy are outlined in the result chain in figure-4 below and the logical framework in ***Annex-1***.

*Figure-4: Results Chain for Nutrition Strategy Implementation Operational plan*



# 7 STRATERY IMPLEMENTATION

## 7.1 Overview of Implementation Approach

The overall approach for implementation and coordination is in Figure-1 in the executive summary. The plan is in ***Annex-3***. The plan in annex-3 will be costed to ensure the needs are well anticipated and funded. Implementation of actions for achieving nutrition outputs, including services delivery, will be through respective line ministries through respective ministries plans and budgets and formal inter-sectoral coordination mechanism will be established at national, district and Suco level. E.G. Nutrition specific interventions such as feeding and care practices and protection from illnesses will be implemented mainly through health sector. Nutrition sensitive interventions such as food availability, affordability and access, quality, utilization by families and communities will be implemented mainly through non-health sectors i.e. Agriculture, Education, Local Development, Social Solidarity, Public Works (WASH sectors).

Currently there are several nutrition service delivery points which provide opportunity to scale-up nutrition services. ***Annex-5*** shows current service delivery points and gaps observed in each of them against the essential nutrition services that need to be scaled up. The operational plan for implementing this strategy will specifically address these gaps.

## 7.2 Roll-out and Scale-up Approach

While the ongoing efforts are expected to continue in all districts, joint working arrangement for improving services and community mobilization will be rolled out and scaled-up in a phased manner taking into account the capacity gaps and attention required in building capacity. First start will be made in three districts selected based on malnutrition rates and hygiene and sanitation coverage. Each district will work initially in two Sucos and expand gradually to cover 50% of Sucos in the first year and all Sucos by middle of second year. All sectors will concentrate efforts in the same districts initially for synergy and to gain experience for scaling up. From middle of year two to end of third year, all Sucos and all districts will be covered.

Once this strategy is endorsed, following steps towards roll-out will start:

- National and district level dissemination of this strategy;
- operationalization of the Nutrition specific functions of Konssantil (details follow);
- Singing a Memorandum of Understanding (MoU) between Ministries engaged in implementing this strategy to re-affirm joint commitment to implement this strategy;

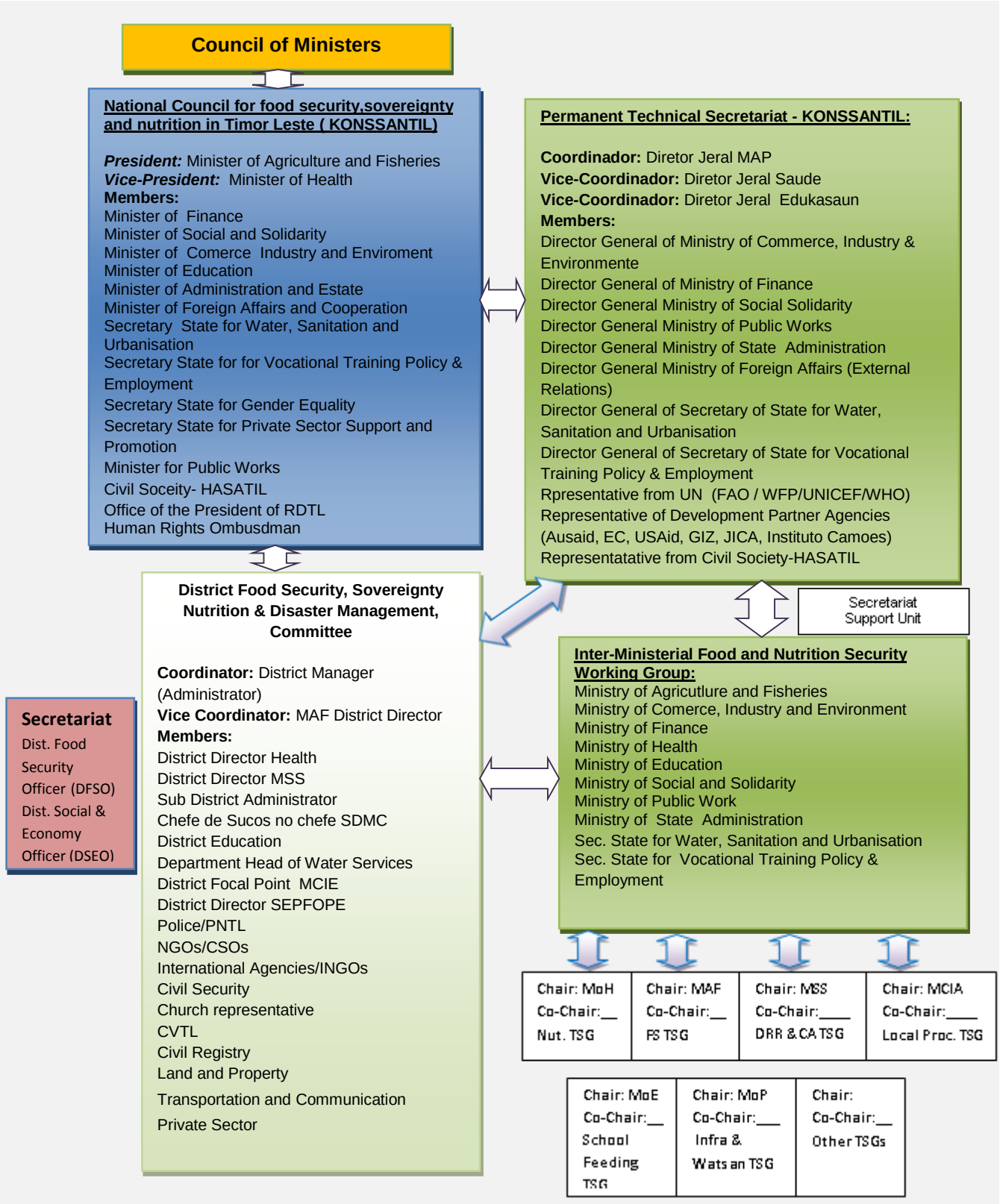
- Reformulation of the current Nutrition Working Group to enable it to take expanded role as an Nutrition Technical Advisory Group (details follow) tasked to provide support to the Inter-Ministerial Council to coordinate and monitor the strategy implementation and to develop necessary guidelines, standards etc.;
- Strengthening of the Directorate of Nutrition in the MoH, and as relevant, other Ministries' departments responsible for nutrition to enable them to take enhanced roles.
- Developing a Costed National Nutrition Strategy Operational Plan (C-NNS-OP) using the strategy's log-frame and the implementation plan.
- Development of a schedule for roll-out and scale-up as part of the process of developing costed operational plan for this strategy implementation;
- Development of and securing of budget by relevant sectors for implementing C-NNS-OP;
- Development of a Nutrition capacity development plan;
- Development of a nutrition communication strategy and plan;
- Provision of technical assistance by relevant partners to the Inter-Ministerial Nutrition Council to oversee progress in implementation of the national strategy and to the Ministry of Health and other Ministries to enable them to fulfill their mandates ;
- Establishment of technical and sub-technical working groups of the NTAG to carry out tasks of developing standards, guidelines etc.;
- Establishment of district level and sub-district level coordination mechanism;
- Implementation of budgetary, institutional capacity development, service delivery, community mobilization and monitoring and evaluation actions based on the costed operation plan by respective sectors;
- Development of National Nutrition Policy to guide and sustain intersectoral actions for nutrition;
- Periodic joint monitoring and joint review;
- Mid-term evaluation of strategy implantation, and course change if needed;
- End-line evaluation and formulation of new strategy.

## 7.3 Strategy Implementation Management and Coordination

### 7.3.1 Inter-Ministerial Committee on Nutrition

This strategy proposes a high level Inter-Ministerial Committee/Council on Nutrition (IMCN) or equivalent chaired by the Vice Prime Minister to oversee National Nutrition Strategy implementation. The government of Timor-Leste has established The National Commission for Nutrition, Food Security and Sovereignty (Konssantil) and the IMCN could be integrated within the Konssantil. Figure 5 below shows the structure of Konssantil.

**Figure 5. Structure of Konssantil**



The anticipated key NUTRITION SPECIFIC functions of the Konssantil are:

- National level nutrition related policy and strategy implementation coordination between various sectors of the government;
- Providing direction for inter-sectroral coordination at all levels;
- Negotiating budget for Nutrition Specific and Nutrition Sensitive interventions;
- Reviewing and endorsing nutrition related policies, strategies and proposed legislations if any; and
- Nutrition strategy implementation monitoring.

The following are expected to be carried out by the Konssantil to carry out its Nutrition Specific functions:

- Prepare a Terms of Reference for with clear deliverables including ensuring multi-sectoral linkage by engaging all nutrition-relevant ministries in nutrition policy formulation, fund raising and budgeting, planning, implementation, monitoring and evaluation.;
- Establish a secretariat with the Director General of the Ministry of Health as the Secretary ;
- Draw on technical expertise from the Nutrition Technical Advisory Group (NTAG) led by Nutrition Department of MoH; and
- Invite contribution/support of UN Agencies, Development Partners, academic institutions, nutrition relevant associations, NGOs and CBOs representation, media and Private Sector representation as and when necessary.

### 7.3.2 Nutrition Technical Advisory Group

This strategy proposes that the current Nutrition Technical Working Group (NTWG) led MoH be tasked to do technical level coordination across all sectors at national level. The NTWG is chaired by the Director-General of Health or his/her representative and the Nutrition Directorate of the Ministry of Health is the secretariat. The members will be the key technical experts from government, Development Partners, the private sector, academia, and CSOs. It is proposed that the NTWG be reformulated as *Nutrition Technical Advisory Group (NTAG)* and have under it working groups working-groups on thematic issues related to IYCF, CMAM, micronutrient programmes, food based approach, food fortification programmes, capacity development, research, information and multi-sectoral approaches and others as necessary. Such working groups will be closed when the given tasks are completed

The NTAG will monitor strategy implementation, provide recommendations to the high-level Inter-Ministerial Commission/Council on Nutrition and Relevant Departments of Government and Implementing Partners. The NTAWG will develop Terms of Reference for itself and in the ToR have roles, including but not limited to, the following:

1. Providing forum for validating nutrition related policies, strategies, plans and guidelines;
2. Technical level monitoring of implementation of the National Nutrition Strategy;
3. Providing technical and operational guidance for implementing the National Nutrition Strategy ensuring linkage and synergy and avoiding duplication;
4. Through sub-groups, develop technical thematic nutrition guidelines customized for use in Timor-Leste:
5. Link up with other sectors including health, agriculture, livestock, water, sanitation and hygiene – WASH, education; and
6. Collect reports from district nutrition working groups, and provide guidance to the sub-national nutrition coordination structures during monthly meetings.

### 7.3.3 Coordination With-in Sectors

Effective implementation of this strategy requires strengthening of coordination between different units within each sector and with respective sector's partners. Each Ministry will identify one of its departments head to lead coordination within the Ministry. At the District level, the district directors of each sector will identify and assign Nutrition Focal Points to lead coordination within the sector. For Example, in the Ministry of Health, the Nutrition Department will lead coordination with the Health Promotion Department, MCH Department and other departments such as planning and finance at national level and the District Nutrition Focal Point will lead coordination between nutrition and related health programme at district level. These coordination leads will be officially notified by respective ministry and district directors. These coordination arrangements will have structured periodic meetings and record and share decisions taken in those meetings. In the initial phase of strategy implementation, frequent meetings are envisaged.

### 7.3.4 Inter-sectoral Coordination at District and Sub-district Level

This strategy proposes establishment of District Nutrition Working Group (DNWG) chaired by the District Administrator with the District Nutrition Coordinator (DNC) located at the District Health Office as the secretariat. The DNWG will coordinate and monitor implementation of district nutrition plans. This strategy also proposes identification and notification of Nutrition Focal Points in all relevant departments at the district level. These Focal Points will engage in DNWG and also coordinate nutrition interventions within respective sectors' district office, with respective sectors partners in the district and with the sub-district stake-holders of respective sector. The DNWG will have representation which will include the officials from Ministries of Health, Agriculture, Education, Infrastructure, Social Solidarity as well as representative other implementing partners at district level (NGOs and CBOs). District nutrition coordination will preferably hold monthly meetings. The Term of Reference for district nutrition coordination will be developed by the NTAG. Envisaged role of the DNWG include:

1. Steering development and implementation of district plans to achieve the Nutrition Strategy targets;
2. Identifying nutrition gaps in respective district and mobilizing partners and resources to fill gaps;
3. Coordination of nutrition activities in the district to ensure synergy and to avoid duplication;
4. Linking up with other sectors in the district to ensure synergy and complementarity; and
5. Reporting to the national level and asking for guidance on the challenges faced.

### 7.3.5 Sub-District Level Coordination

Coordination at Suco level will be done as part of the regular Suco's development coordination mechanism under the chairpersonship of the Suco Chief and coordination at Aldeia level will be done as part of the regular Aldeia's development coordination mechanism under the chairpersonship of the Aldeia Chief. Nutrition focal points will be identified for each health post and these focal points will serve as secretariat for Suco and Aldeha level coordination. Relevant sectors's having presence at Suco Level or Aldeia level are expected to participate in the Suco and Aldheia level coordination meetings. To ensure that Nutrition is given priority, this strategy proposes that Nutrition be placed in the standing agenda of Suco and Aldeia level coordination meetings.

### 7.3.6 Linkages between National and District Coordination Structures

There will be both vertical and horizontal linkages between the national and district coordination mechanisms. The National Level will provide strategic directions, guidance and decisions based on the deliberations of monthly meetings. The district level coordination mechanism will provide information necessary for nutrition gap identification and nutrition action and communicate these issues to the National level for further action.

## 7.4 Advocacy, Social Mobilization and Behavior Change Communication

### 7.4.1 Advocacy

Nutrition advocacy is a critical for mobilizing resources for successful implementation of the strategy. Advocacy efforts will aim to create awareness among key decision makers about impact of malnutrition on the health and human capital and the economic benefits of investing in nutrition. Advocacy efforts will also engage the influential voices in Timor-Leste such as parliamentarians, philanthropic bodies, eminent personalities, church Bishops, media etc. to raise visibility of nutrition and influence political and programming action. Key advocacy actions identified are:

1. Develop nutrition advocacy plan for Timor-Leste to guide advocacy activities in the country:
2. Develop Nutrition policy briefs targeting politicians and other policy makers touching on pertinent areas requiring nutrition policy change;
3. Hold special policy sessions with parliamentarians and other policy makers to advocate them the role of nutrition in national development and future; and
4. Continue messaging on success of interventions and programmatic gaps to key government figures, donors and other development partners. .

### 7.4.2 Social Mobilization

To achieve desirable nutrition results all segments of the society including decision makers, opinion leaders, technocrats, academia, professional groups and associations, religious groups, private partners, communities and individuals need to be engaged. The following actions are identified to trigger and sustain social mobilisation for nutrition:

1. Developing and implementing a comprehensive nutrition communication strategy and plan:
2. Planning, publishing and holding regular national nutrition conference to highlight nutrition and related issues in Timor-Leste:
3. Engaging school children and youth groups as change agents:
4. Establishing community groups to promote appropriate nutrition behaviours:
5. Conducting campaign, road shows etc. to promote good nutrition actions;
6. Empowering and building capacity of local leaders to talk about nutrition issues with communities: and
7. Initiating and observing a National Nutrition Day, Annual World Breastfeeding Week at national and district levels to give publicity to nutrition issues and good practices.

### 7.4.3 Behavior Change Communication

This strategy will ensure a broad-based approach to encourage community participation for nutrition. It will provide them nutrition knowledge and skills and empower them to apply the skills in their real life situations. Community participation will be encouraged through establishing and working with community groups including mother support groups and youth groups in youth-friendly centers, schools and churches. Actions at community will help community do Assessment of their own nutrition problems and challenges, do Analysis of causes and possible solutions and resources, and plan and implement feasible, culturally acceptable Actions to address malnutrition. With this approach communities will take action to address malnutrition stimulated by their own participation. The costed operational plan for implementing this strategy will keep adequate provision in actions and budget for implementing this approach.

## 7.5 Enhancing National Capacity for Nutrition

### 7.5.1 Enhancement of Nutrition Programming Structures

The current Nutrition Program within the Ministry of Health is led by a department under the Directorate of Maternal Child Health. This is perceived to be giving Nutrition less than desired level of visibility, policy attention and structural strengths needed to tackle the complex and huge burden of malnutrition in the country. The strategy aims to raise the Nutrition Department to a level of Directorate under the leadership of National Director of Nutrition Services. The Directorate would also act as the Secretariat for both the Inter-Ministerial Council on Nutrition and the Nutrition Technical Advisory Group, provide leadership for Nutrition in the Country also oversee the District Nutrition Programs.

At the district level, currently each district has a District Nutrition Coordinator who coordinates nutrition interventions. For enhancing nutrition actions at district level, following will be done:

- Establish additional nutrition positions at the district Health Office to meet capacity need for additional coordination work;
- Deploy Sub-District Nutrition Coordinators in each of the 65 Sub-districts. These sub-district coordinators will be responsible for implementation of nutrition programs at Community Health Centre, Health Posts, *SISCa* and other community outreaches;
- Designate the Nutrition Focal Point for Community Health Centers and Health Post and give them clearly defined nutrition tasks, including those for mobilizing community and implementing behavior change interventions.

The Terms of Reference for the proposed Nutrition Directorate, National Director of Nutrition Services, sub-district coordinators and nutrition focal points at will be developed by the NTAG.

### 7.5.2 Nutrition Human Resource Development

Ensuring availability of skilled nutrition managers and services providers including nutritionists, and ensuring adequate performance of human resource will be will be a critical determinant of success. The strategy prioritizes the following to improve human resource capacity:

a. Mapping human resource gaps, especially in health facilities, outreaches and gaps in community volunteers;

b. Undertaking a comprehensive training needs assessment at all levels of programme management and services delivery to identify short and long-term training needs and resources needed to improve nutrition capacity among all relevant ministries, especially the signatories of Comoro Declaration;
c. Development of Nutrition Human Resource Development (NHRD) plan, preferably as part of each sectors Human Resources Development plan where possible;
d. Mobilizing resources and implementing NHRD plan including development of appropriate training plan, curricula, job aids and IEC materials for the different cadres of the health personnel, agriculture extension workers and other community level workers;
e. Providing in-service training and continuing education on nutrition to managers and services providers, especially to the middle level workers in health and related line ministries.
f. Establishing nutrition academy/courses at the universities in Timor-Leste as a long term measure and sponsoring students to universities in the region for higher level nutrition training (diploma, degree and masters level) as an interim measure; and
g. Incorporating nutrition training into the curricula of doctors, nurses, mid-wives, agriculture extension workers, environmental/sanitation engineers, teachers and social workers.

### 7.5.3 Supportive Supervision and Performance and Management

A structured approach for managing performance of nutrition managers and service provider will be introduced, scaled-up and sustained. Key actions that need to be undertaken are:

a. Formally designating nutrition focal points in all level of services delivery in all nutrition related sectors;
b. Revising and updating job description of different level nutrition mangers and services providers;
c. Developing and disseminating job aides to help staff understand and carry out their functions adequately;
d. Investing in establishing and operationalizing structured supportive supervision to ensure that service providers and mid-level managers are performing their functions as desired;
e. Setting performance standards for all level of staff; and
f. Providing performance linked incentives to community level health workers and community volunteers involved in nutrition activities.

## 7.6 Nutrition Commodities and Logistics Management

Effective implementation of this strategy will require a robust nutrition commodities (supplements, therapeutic supplies etc.) and equipment (anthropometry, MUAC etc.) management system to be in place. Key actions that will be implemented towards this are:

- Developing National Standard List (NSL) of nutrition supplies and equipment which shows what items are expected to be available at what level;
- Developing a forecast for these supplies and equipment;
- Securing budget for procuring these supplies and equipment;
- Procuring and distributing timely and in adequate quantity;
- Managing stock and inventory; and
- Reporting on use and stock-outs etc.

The above actions will be implemented by developing and implementing a Nutrition Commodity Management Plan and assigning national and district level focal persons accountable for nutrition commodity management.

## 7.7 Resource Mobilization

Considering the devastating impact of malnutrition on future of the country's human capital, the strategy envisages increase in government investment in Nutrition Specific and Nutrition Sensitive interventions. Technical assistance and support to fill gaps where they exist is expected from multi-lateral agencies and bilateral donors. The following actions will be undertaken to ensure adequate funding for implementing the National Nutrition strategy:

- A Costed National Nutrition Strategy Operational Plan (C-NNS-OP) will be developed for period of five years (2014-2019). The C-NNS-OP will prioritize necessary and sufficient actions to achieve the targets for 2019 and cost for these actions. The costed operational plan will have sections for each of the sectors involved in addressing malnutrition challenge in the country;
- Resource mobilization plan (for the operational plan) will be developed and submitted to the Inter-Ministerial Council/committee on Nutrition (IMCN) for review and endorsement. The IMCN endorsed costed operational plan showing funding needs and gaps will be submitted to appropriate level in the government for review and budget allocation;
- Each of the sectors will establish budget line for nutrition interventions to enable tracking of expenditure on nutrition;
- Each sector will prioritize and allocate additional resources from their respective sectoral budget for the nutrition actions as a demonstration of sectoral commitment, seek increased funding through the government budget, and approach donors/partners to fill the gaps.

- Where gaps remain, each sector will communicate to appropriate authorities within the government and to the donors through the IMCN;
- Results tracking and sharing and generating additional evidence including cost of malnutrition on the country and cost benefit of nutrition interventions will be used to sustain government funding and donor commitment for nutrition; and
- Efforts would be made to join global partnership such as Scaling up Nutrition (SUN) Initiative to learn from global work in nutrition and to leverage technical expertise and resources.

## 7.8 Policy Linkages

Sustained Government's commitment and efforts are needed for sustaining nutrition actions and achieving desirable nutrition outcomes. Policy linkages that identified to sustain efforts are:

1. Recognition and mainstreaming of nutrition into all sectoral policies including, but not limited to, the Policies and Plans of that guide National Development , Health, Agricultural, Commerce, etc;
2. Development and enforcement of food and nutrition security and related policies, codes, regulations etc; and
3. Enhancement of Nutrition in government's structure and operations including having nutrition focal points in all ministries.

## 7.9 Monitoring, Evaluation and Research

### 7.9.1 Nutrition Strategy Implementation Monitoring

The logical framework in Annex-1 has impact, outcomes, outputs with indicators, baselines, targets and sources of information. The indicators in the framework are expected to be measured and reported by responsible government department/ministry. The monitoring and evaluation plan in Annex-2 shows key monitoring, evaluation and research related activities that will be undertaken. The Konssantil is expected to expect to task the Konssantil secretariat or Nutrition Technical Advisory Group (NTAG) to monitor outputs, outcome and impact indicators and report to it.

Possible sources of nutrition data for strategy implementation monitoring are:

- Health Management Information System (HMIS) and other sector information management systems;
- Demographic Health Surveys and nutrition surveys

- Other project based nutrition assessments and evaluations;
- District and National level Nutrition Programme review reports; and
- Field monitoring reports.

The strategy implementation process will accord priority to ensure that these sources of information generate quality and timely data for monitoring.

To complement or to validate information provided by sectoral periodic *joint field monitoring* will be conducted. The joint monitoring will be done in a structured way using a pre-agreed tool that has tracer indicators which help track key process in Nutrition Strategy Implementation.

### 7.9.2 Nutrition Information Management

The routine nutrition information system will need improvement to make it capable of providing information to monitor and inform program implementation, policies and actions. As of now, few nutrition indicators are monitored routinely through Health Management Information System (HMIS) and there are no linkages established between the HMIS and Management Information System (MIS) of other sectors such as Agriculture, Education, Public Works etc. Following approach will be taken to improve Nutrition Information management system:

- Each of the sectors implementing nutrition specific and nutrition sensitive interventions will review existing information management system, and where needed revise, and implement an information management system that enables them to track progress of interventions through routinely reported data from facilities, outreaches and communities (where relevant);
- The national and district level coordination mechanism will put together data from all sectors periodically and publish *nutrition bulletin* showing analysis that could guide inter-sectoral action;
- A suitable Nutrition Management Information System (NMIS) will be developed for health services delivery network and merged with Health Information Management System (HIMS) and implemented as HMIS nation-wide in a phased manner. The validity of the indicators reporting by this system will be improved by training health care workers on Nutrition related HMIS data collection, reporting, analysis and use;
- The capacity of the district nutrition coordinator will be enhanced to enable him/her to collect, analyse, and interpret data and report; and to conduct supportive supervision to enhance the capacity of the health posts, SISCa and CHC focal points who report on nutrition; and

- Mapping of nutrition partners countrywide (Who is doing What, Where) will be done as part of Nutrition MIS to avoid duplication.

### 7.9.3 Nutrition Surveillance, Survey and Research

The MIS of sectors give data from the service outlets and this is not enough to help monitor programme and to inform decisions. The following nutrition surveillance, survey and research related action will be done to improve availability of data and information:

- Conduct researches which a) provide evidence for advocacy and programme design; b) research that help provide local solutions to practical challenges; c) operational research that shows how evidence based interventions can be implemented and scaled up in the local context;
- Establish a sentinel surveillance system which provide robust data periodically and help track nutrition services, behaviors, practices and outcomes.
- Put systems for conducting, validating and disseminating nutrition surveys and research results; and
- Put in place a nutrition early warning system that provides alerts on nutrition and food insecurity which may be precipitated by emergencies such as drought, tsunami, earthquake or man-made disasters.

# 8 ANNEXES

## Annex 1. Logical Framework for Nutrition Strategy Implementation Operational plan

The logical framework analysis below outlines takes the intervention logic from the result chain from section-6 of the strategy, identifies, indicators, baselines, targets, means of verification and *actions that are necessary and sufficient to achieve the targets*.

| Intervention logic | | Indicator | Baseline | Target | Means of verification | Risks and Assumptions |
|---|---|---|---|---|---|---|
| Objective/Impact | Reduced malnutrition and micronutrient deficiency among children and women | a. Underweight among under-five children (WFA <-2SD)<br>b. Stunting among under-five children (HFA <-2SD)<br>c. Wasting among under-five children (WFH <-2SD)<br>d. Low BMI (18.5kg/m2) among WRA<br>e. Anemia among under five year old children (Hb<11g/dL)<br>f. Anemia among women of reproductive age (Hb<12g/dL)<br>g. Iodine deficiency among general population (urinary iodine excretion <100µg/L)<br>h. Vitamin A deficiency among under-five children (Serum Retinol <0.7mmoL)<br>i. Zinc Deficiency among under-five children<br>j. % of newborn with Low Birth Weight (LBW) | a. 37.7%<br>b. 50.2%<br>c. 11.0%<br>d. 24.8%<br>e. 62.5%<br>f. 38.9%<br>g. 26.6%<br>h. 46% (WHO[33] estimate)<br>i. 33.3%<br>j. 12% (DHS 2003) | a. <30%<br>b. <40%<br>c. <10%<br>d. <20%<br>e. <40%<br>f. <20%<br>g. <20%<br>h. <20%<br>i. <20%<br>j. <10% | Timor-Leste Food and Nutrition Survey (TLFNS 2013), DHS and other nationwide surveys | Government continues pro-poor policies and accelerates efforts to increase coverage of nutrition specific and nutrition sensitive interventions |
| Outcome-1 | 1. Increased coverage of Nutrition Specific interventions | a. % of early initiation of breastfeeding (within one hour)<br>b. % exclusive breastfeeding among children <6 months<br>c. % of children 6-23 months receiving minimum dietary diversity | a. 93.4%<br>b. 62.3%<br>c. 27.5%<br>d. 17.6%<br>e. 71%<br>f. 53.2%<br>g. 38.8%<br>h. 31.7% | a. Maintained<br>b. 80%<br>c. 50%<br>d. 50%<br>e. >80%<br>f. 80%<br>g. 80%<br>h. 60% | Timor-Leste Food and Nutrition Survey (TLFNS 2013); TLDHS; MoH Nutrition Department's Annual Report | |

[33] WHO. 2009. Global Prevalence of Vitamin A Deficiency in Populations at Risk 1995-2005. WHO Global Database on Vitamin A Deficiency.

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|---|---|---|---|---|---|---|
| | | d. % children 6-23 met minimum acceptable diet<br>e. % of children under-five continued breastfeeding until 1 year<br>f. % children 6-59 months who received vitamin A supplementation<br>g. % children 12-59 months who received deworming<br>h. % pregnant women who received iron folic acid supplementation for 90 days<br>i. % pregnant women who received two times deworming after first trimester of pregnancy<br>j. % children 6-23 months who received multiple micronutrient supplementation<br>k. % under five children with diarrhea who receive ORS+Zinc<br>l. % underfive children with Pneumonia treated with antibiotics<br>m. Cure rate (%) of moderate malnourished children<br>n. % malnourished pregnant mothers who receive supplementary feeding<br>o. Cure rate (%) of severe acute malnutrition | i. TBE<br>j. 71% (Aileu district)<br>k. 29.9%<br>l. 45% (DHS 2009/10)<br>m. TBE<br>n. TBE<br>o. <50% | i. 60%<br>j. 70%<br>k. 60%<br>l. >90%<br>m. >75%<br>n. >80%<br>o. >75% | | |
| Output 1.1 | 1.1. Improved packaging and definition of approach for delivering High Impact Nutrition Interventions | a. Set of High Impact Nutrition Intervention (HINI) guideline, training materials, job aids, and curriculum endorsed<br>b. # of sets of HINI guideline, training materials, job aids, and curriculum distributed | a. CMAM and IYCF guidelines exist<br>b. To be done | a. Guidelines, training materials, job aids and curriculum for all HINI exit<br>b. 1000 set distributed | National Nutrition programme review reports | |
| Key actions to achieve output-1.1 | 1.1.1. Hire consultant to review and update IYCF and other High Impact Nutrition Intervention (HINI) guidelines, training materials, job aids, facilitator's guide and curriculum in line with relevant global guidelines, national nutrition programme intents and national health service package | | | | | |

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|---|---|---|---|---|---|---|
| | 1.1.2. Translate and present and seek endorsement of IYCF and other High Impact Nutrition Intervention (HINI) guidelines, training materials, job aids, facilitator's guide and curriculum<br>1.1.3. Print 1000 set of documents for dissemination workshop<br>1.1.4. Conduct dissemination workshop to disseminate IYCF and HINI guidelines among stakeholders at all levels | | | | | |
| Output 1.2 | 1.2. Improved structure and capacity for nutrition programme management at all levels | a. # of CHC with sub-district Nutrition coordinators<br>b. Nutrition functions explicitly noted in one of health post care providers (HCP) job descriptions (JD) | a. Nil<br>b. Nutrition functions not explicit in JD of one of health post care providers of HP | a. 90% CHC have nutrition coordinators<br>b. Nutrition functions explicit in JD one of health post care providers of HP | National Nutrition programme annual reports | |
| Key actions to achieve output-1.2 | 1.2.1. Review and update the structure of nutrition programme management and service delivery arrangements at national, district, sub-district and Suco level including job descriptions and performance standards of service providers in line with the MoH service package, delivery arrangements and policies<br>1.2.2. Present and seek endorsement of the updated structure and job description<br>1.2.3. Print and disseminate updated structure, job descriptions and performance standards<br>1.2.4. Hire, train and deploy sub-district Nutrition coordinators<br>1.2.5. Assign Nutrition focal point responsibility to existing staff at Suco/health post level through administrative instruction<br>1.2.6. Conduct Nutrition Capacity Assessment of all relevant ministries (signatories of Comoro Declaration)<br>1.2.7. Conduct nutrition training needs assessment, including mapping nutrition human resource gaps, especially in health facilities, outreaches and gaps in community volunteers;<br>1.2.8. Development of Nutrition Human Resource Development (NHRD) plan (preferably as part of each sectors Human Resources Development plan) | | | | | |
| Output 1.3 | 1.3. Improved capacity of service providers to deliver nutrition specific interventions, nutrition counselling, social mobilization and behavior change communication interventions | a. Number of health care providers trained HINI implementation<br>b. Number of health care providers trained IYCF counseling, Interpersonal communication (IPC), and community mobilization for HINI<br>c. % of IPC trained health care providers conducting nutrition counselling sessions and community mobilization<br>d. % of health facilities having full set of nutrition related job aids | a. Some trained on IYCF and CMAM<br>b. To be done<br>c. To be done<br>d. <20% of health facilities having full set of nutrition related job-aids | a. 950<br>b. 950<br>c. 80%<br>d. 90% | National Nutrition programme review reports | |
| Key actions to achieve output-1.3 | 1.3.1. Train 21 national trainers on training health care providers on IYCF and other High Impact Nutrition Intervention (HINI) using comprehensive national guideline and training materials<br>1.3.2. Train 950 suco-based health care providers and CHC and Hospital Nutrition focal points on HINI implementation (at least 2 per suco, two per CHC and two per Hospital)<br>1.3.3. Incorporate nutrition training into the curricula of doctors, nurses, mid-wives, agriculture extension workers, environmental/sanitation engineers, teachers and social workers. | | | | | |

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|---|---|---|---|---|---|---|
| | 1.3.4. Develop and disseminate at least two sets of job aids to help staff understand and carry out their functions adequately to 300 health facilities (all health posts, CHCs and Hospitals)<br>1.3.5. Establish and operationalizing structured supportive supervision to ensure that service providers and mid-level managers are performing their functions as desired;<br>1.3.6. Introduce, test feasibility and impact of approach on performance linked incentives to community level health workers and community volunteers involved in nutrition activities in three districts (one good, one bad, and one medium in terms of IYCF indicators).<br>1.3.7. Train 21 people as trainers on IYCF counseling, IPC and community mobilization for HINI<br>1.3.8. Train 950 suco-based health care providers and CHC and Hospital Nutrition focal points on IYCF counselling, IPC and community mobilization for HINI implementation (at least 2 per suco, two per CHC and two per Hospital)<br>1.3.9. Conduct supportive supervision of the health care providers counselling and community mobilization work<br>1.3.10. Conduct mid-term assessment of counselling and community mobilization work and based on the findings, revise approach and focus as relevant | | | | | |
| Output 1.4 | 1.4. Improved community access to nutrition counselling, social mobilization and behavior change communication interventions including counselling for improving nutritional status of mothers and adolescent girls | a. % of Sucos having functional Mother Support Group (MSG)<br>b. % of mothers who received maternal nutrition counseling during ANC<br>c. % of mothers received IYCF counselling during ANC | a. 27%<br>b. 88.4%<br>c. 84.9% | a. 90%<br>b. 90%<br>c. 90% | District and National Nutrition programme review reports (data source: HMIS and other district reports), and nutrition surveillance; | |
| Key actions to achieve output-1.4 | 1.4.1. Establish partnerships with CBOs/NGOs/Church-based organization to scale up Mother Support Group (MSG) coverage to 280 additional sucos to promote IYCF, maternal, newborn and child health care and Baby Friendly Community Initiative<br>1.4.2. Establish and train MSG for IYCF counseling in all (442) Sucos<br>1.4.3. Engage Suco-based health care providers and civil society organization to support work of MSG in all (442) Sucos<br>1.4.4. Institutionalize through administrative instruction, supervision and monitoring practice of a) Maternal Nutrition Counselling and b) IYCF Counselling during ANC contacts of all SISCa and health facilities, at least four times during pregnancy | | | | | |
| Output 1.5 | 1.5. Health facilities adopt and achieve baby friendly hospital initiative (BFHI) accreditation | a. # of target health facilities implementing BFHI<br>b. # of target health facilities achieving BHFI accreditation | a. Initiated in two<br>b. Nil | a. 40 targeted facilities<br>b. 32 of targeted facilities | BFHI implementation review report | |
| Key actions to achieve output-1.5 | 1.5.1. Hire consultant to develop/adopt Baby Friendly Initiative (BFHI) guidelines, training materials and job aides<br>1.5.2. Present and seek endorsement of Baby Friendly Initiative guideline<br>1.5.3. Print 100 sets of guideline, training materials, job aids, and audio vision material for implementing BFHI<br>1.5.4. Procure 10-steps successful BF board for 40 health facilities<br>1.5.5. Train of trainers of 12 staff from 6 hospitals on BHFI<br>1.5.6. Establish BFHI committee in 6 hospitals and target 34 CHCs (of the 6 districts having the 6 hospitals)<br>1.5.7. Conduct self-assessment of 6 hospitals and target 34 CHCs using BFHI criteria<br>1.5.8. 40 health facilities BFHI committee implement BFHI standards, including improving IYCF corner and staff skills in IYCF | | | | | |

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|---|---|---|---|---|---|---|
| | 1.5.9. Conduct external accreditation assessment of 40 health facilities (that meet BFHI criteria in self-assessment) | | | | | |
| Output 1.6 | 1.6. Increased availability of Nutrition supplies and commodities | a. Number of health facilities reporting stock out of therapeutic feeding supplies, micronutrients and albendazole<br>b. % of health facilities having a defined set of equipment needed for nutrition screening and treatment of malnutrition in children and mothers<br>c. % of Health Facilities having defined set of Nutrition promotion job aids and communication materials<br>d. % of Health Facilities having full set of nutrition recording and reporting formats | a. Few facilities reported stock out of therapeutic feeding supplies, MN, and Albendazole<br>b. <50%<br>c. <50%<br>d. <50% | a. Nil<br>b. 100%<br>c. 100%<br>d. 100% | District and National Nutrition programme review reports (data source: HMIS and other district reports), and nutrition surveillance; | |
| Key actions to achieve output-1.6 | 1.6.1. Develop National Standard List (NSL) of nutrition supplies and equipment which shows what items are expected to be available at what level and allocate national budget for procuring supplies and equipment<br>1.6.2. Develop National Nutrition Commodity Management Plan<br>1.6.3. Assign through administrative instruction national and district level focal persons accountable for nutrition commodity management including forecasting, procuring, distributing, managing stock and inventory and reporting on use and stock-outs etc.<br>1.6.4. Train national and district level (30 people, at least two from each level and two from INS) on nutrition commodity management including forecasting, procuring, distributing, managing stock and inventory and reporting on use and stock-outs etc.<br>1.6.5. Procure and distribute of nutrition supplies and equipment to all level of serviced delivery **(detail list attached, Annex 1a)**<br>1.6.6. Print and distribute Nutrition Job Aids, communication materials and recording and reporting formats 300 health facilities (all health posts, CHCs and Hospitals) | | | | | |
| Output 1.7 | 1.7. Increased access to nutrition screening, preventive nutrition services, treatment of malnutrition and micro nutrient deficiencies, and common childhood illnesses | a. % estimated moderate malnutrition 6-59 months receiving targeted supplementary feeding<br>b. % of children under-five screened (weight for age and MUAC) at least twice every year<br>c. % of pregnant mothers who have at least four contacts with Nutrition Services (deworming+iron folate)<br>d. % under-five children with ARI are taken to a health facility | a. <50% (TLFNS)<br>b. <30%<br>c. TBE<br>d. 71% (DHS 2009/10)<br>e. 72% (DHS2009/10)<br>f. Only few CHC, nutrition focal points at hospital nor pediatric ward staff trained on CMAM<br>g. Not trained | a. >60%<br>b. 80%<br>c. 80%<br>d. 90%<br>e. 90%<br>f. 91 trained on identification and treatment of SAM<br>g. 442 Suco based doctors trained on CCM | HMIS and national nutrition programme review reports; and nutrition surveillance; | |

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| | | e. % under-five children with diarrhea taken to health facility<br>f. # of nutrition coordinators (CHC) and focal points (hospital) trained on identification and treatment of severe acute malnutrition (SAM)<br>g. # of Suco based doctors trained on community case management (CCM) of diarrhea and ARI | | | | |
| Key actions to achieve output-1.7 | 1.7.1. Review current approach nutrition services delivery to identify opportunities for improving access to nutrition screening and preventive nutrition services for mothers and children<br>1.7.2. Define and institute measures to ensure that under-five children who have completed vaccination are screened for malnutrition at least twice every year either through SISCa or home visits<br>1.7.3. Define and institute measures to ensure that under-five children who have completed vaccination are provided deworming and vitamin A supplementation twice every year either through SISCa or home visits<br>1.7.4. Train midwives and other ANC providers on maternal nutrition interventions (at least iron folate, deworming, diet and rest during pregnancy)<br>1.7.5. Train 91 nutrition focal points (67 CHC nutrition coordinators and 24 hospital staff, one Hospital Nutrition focal points and 3 pediatric ward staff from each hospital) on identification and treatment of acute malnutrition<br>1.7.6. Implement targeted supplementary feeding for moderate acute malnutrition targeting approximately 14,000 under-five children /year nationwide<br>1.7.7. Scale-up multiple micronutrient supplementation targeting 37,000 children 6-24 month in all Sucos<br>1.7.8. Introduce, test feasibility and impact, and scale up preventive zinc supplementation to 26,000 children 24-59 months in three districts (one from east, one from central region and one from west)<br>1.7.9. Introduce, test feasibility and impact and scale up approach to deliver weekly iron folate supplementation and 6-montly deworming targeting 18,000 adolescent girls (in and out of School) in three districts (one from east, one from central region and one from west)<br>1.7.10. Train all (442) suco-based doctors on community case management of diarrhea and ARI<br>1.7.11. Conduct a review of diarrhea and ARI treatment practices and compliance to national IMCI guidelines<br>1.7.12. Procure and distribute ORS and Zinc in adequate quantities for estimated case load of 102,500 diarrhea episodes per year<br>1.7.13. Procure/develop/print and distribute IMCI Job-Aides to all health facilities (300 facilities), including job-aid for use of zinc together with ORS for diarrhea management<br>1.7.14. Institutionalize through administrative instruction, training and supportive supervision practice that focusses on a) Maternal Nutrition Counselling and IYCF Counselling during ANC contacts of all SISCa and health facilities at least four times during pregnancy; b) delivery of nutrition services (vitamin A supplementation, deworming and iron folate supplementation); and treatment of common childhood illnesses | | | | |
| Output 1.8 | 1.8. Improved feeding practices for under-five children during and after illnesses | % children 6-59 months who received appropriate feeding during diarrhea (continued breast-feeding, continued complementary feeding and increased fluids) | 23.8% (TLFNS) | 60% | Survey (TLFNS/DHS) and nutrition surveillance; | |
| Key actions to achieve output-1.8 | 1.8.1. Design and implement nationwide campaign promoting appropriate feeding practices for children during and after episodes of diarrhea and ARI<br>1.8.2. Train at least one staff from each CHC and two from pediatric ward (preferably IMCI focal points) of each hospital on screening sick children for malnutrition and providing counselling for feeding during and after diarrhea and ARI | | | | | |

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| Output 1.9 | 1.9. Model for delivering interventions to reduce low birth weight and improve nutritional status of pregnant mothers established | a. Findings of the new initiative published<br>b. Interventions for reducing LBW integrated into MCH service package<br>c. % Low Birth Weight babies (in intervention areas)<br>d. % of pregnant women with optimal weight gain during pregnancy (in intervention areas) | a. To be conductied<br>b. To be done<br>c. TBE<br>d. TBE | a. Findings of the new initiative published<br>b. Interventions for reducing LBW integrated into MCH service package<br>c. 10% reduction<br>d. 10% improvement | New initiative implementation report and national nutrition programme review report | |
| Key actions to achieve output-1.9 | 1.9.1. Recruit TA and establish NGO partnership to assist INS, National Hospital in Dili and MCH department to design and implement operational pilot delivering interventions targeted to reduce low birth weight<br>1.9.2. Integrate feasible interventions for reducing LBW (based on the new initiative findings) in MCH service package nationwide | | | | | |
| Output 1.10 | 1.10. Increased use of iodized salt by families | a. % households consuming adequate iodized salt (>15ppm)<br>b. % of locally produced salt iodized<br>c. Comprehensive national programme to address Iodine Deficiency Disorder (IDD) | a. 60% (TLSLS 2007)<br>b. <50%<br>c. Salt iodization being promoted | a. 90%<br>b. 80%<br>c. Comprehensive IDD elimination programme exists | Survey (TLDHS/TLFNS/TLSLS) and nutrition surveillance; and national nutrition programme review report | |
| Key actions to achieve output-1.10 | 1.10.1. Hire TA to develop National IDD elimination programme with a five years operational plan<br>1.10.2. In collaboration with relevant line ministries, support salt farmers to establish salt-farmers cooperatives to improve production, quality and marketing of locally produces salt<br>1.10.3. Support salt-farmers cooperatives to establish salt iodization plants and internal quality control measures<br>1.10.4. Monitor salt iodization at production sites and in the markets<br>1.10.5. Conduct a nationwide campaign to highlight the benefits of using iodized salt<br>1.10.6. Conduct household and market monitoring of iodized salt using rapid test kits<br>1.10.7. Conduct IDD elimination status review | | | | | |
| Outcome-2 | 2. Increased coverage of Nutrition Sensitive Interventions | a. % birth attended by a skilled attendant<br>b. % pregnant women who received 4 ANC<br>c. % post-partum mothers and newborns who received PNC visits within first 2 days of delivery<br>d. % pregnant women sleeping under ITN<br>e. % under-five children sleep under ITN | a. 29.9% (DHS 2009/10)<br>b. 81.6%<br>c. 24.9% (DHS 2009/10)<br>d. 40.7%<br>e. 41%<br>f. 86.5%<br>g. <1%<br>h. Unknown local model<br>i. Unknown local model | a. >65%<br>b. 95%<br>c. >65%<br>d. 90%<br>e. 90%<br>f. 95%<br>g. 80%<br>h. Models for social transfers linked to production and consumption of animal source food, other protein sources and dietary diversity targeting | Survey (TLDHS/TLFNS/TLSLS) and nutrition surveillance; and national nutrition programme review report, HMIS, WASH JMP report, FSEWS (Food Security and Early Warning System) | |

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| | | f. % 12-23 months children who received complete immunization<br>g. % HIV positive pregnant mothers who received ART and infant feeding counselling<br>h. Models for social transfers linked to production and consumption of animal source food, other protein sources and dietary diversity targeting poorest households from poorest quintile<br>i. Models for income generation by women of the poorest wealth quintile<br>j. % of household having access to improved drinking water<br>k. % of household having improved latrine<br>l. % mothers with children underfive wash their hands with soaps before feeding the child<br>*m.* % household with acceptable food consumption score (*having adequate dietary diversity, dietary frequency, and relative nutrition importance)*<br>n. Household with coping strategy index (Reduced Coping Strategy Index or RCSI) | j. 69% (WHO/UNICEF JMP 2012)<br>k. 47% (WHO/UNICEF JMP 2012)<br>l. <5%<br>m. 61.3%<br>n. 4.6 (TLFNS 2013) | poorest households from poorest quintile established<br>i. Models for income generation by women of the poorest wealth quintile established<br>j. 80%<br>k. >60% (Sanitation Strategic Plan)<br>l. >50%<br>m. >50% (Draft food and nutrition policy).<br>n. Decreased (Draft Food and Nutrition policy) | | |
| Output 2.1 | 2.1. Increased coverage of maternal newborn and child health services | a. % of health facilities having midwife<br>b. % of health facilities meeting expected level of 80% for staffing, facility, medicines and equipment | a. 57%<br>b. 4.5% (Report of Facility assessment in 3 districts)<br>c. TBE | a. 90%<br>b. 90%<br>c. 100% (RMNCAH Strategy)<br>d. 80%<br>e. 100% (RMNCAH Strategy)<br>f. 80% | | |

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| | | (according to MoH facility assessment check list)<br>c. % health facilities having staff trained on essential newborn care<br>d. % of health facilities implementing post-partum home visits for mothers and newborns<br>e. % health facilities having IMCI trained health care providers<br>f. % sick children screened and treated following IMCI protocol | d. Not established yet<br>e. TBE<br>f. TBE | | | |
| Key actions to achieve output-2. | 2.1.1. Implementation and monitoring of National Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy and MoH defined service package<br>2.1.2. Implementation and monitoring of Immunization strategy, IMCI and community case management strategy, national malaria control strategy, national HIV/AIDS programme strategy and MoH defined service package | | | | | |
| Output 2.2 | 2.2. Improved access to hygiene and sanitation practices | a. # of district declared ODF<br>b. % of suco achieving ODF<br>c. % household having a hand-washing place soap and water<br>d. % health facility with toilet and water supply<br>e. % schools with hygienic toilets<br>f. # of sub districts sanitation facilitators for Sucos | a. Nil<br>b. <10%<br>c. 40.7% (TLFNS 2013)<br>d. TBE<br>e. 80%<br>f. TBE | a. At least 5 districts (Sanitation strategic plan)<br>b. >70% (Sanitation Strategic Plan)<br>c. >60%<br>d. 80%<br>e. >90% (Sanitation Strategic Plan)<br>f. 80 (Timor-Leste strategic development plan) | | |
| Key actions to achieve output-2.2 | 2.2.1. Implementation and monitoring of National Hygiene and Sanitation Strategy and plan with focus on making Suco Open Defecation Free (ODF), hand washing practices promotion and providing schools and health facilities with adequate water and sanitation facilities | | | | | |
| Output 2.3 | 2.3. Increased access to improved source of drinking water | a. # of rural village water systems completed<br>b. # rural households covered by newly installed water systems | a. TBE<br>b. TBE | a. 400 water systems (Timor-Leste strategic development plan)<br>b. 25,000 rural households (Timor-Leste strategic development plan) | MoPWD reports and other publications. National surveys | |
| Key actions to achieve output-2.3 | Implementation and monitoring of National Water supply and sanitation strategy and plan | | | | | |
| Output 2.4 | 2.4. Enhanced focus of investment on interventions targeted to | a. % of women who had taken animal source food in the last 24 hours (in pilot area) | a. 52.8% (TLDHS 2009/10)<br>b. 52.1% (TLDHS 2009/10) | a. 70%<br>b. 70%<br>c. >3 models for improving dietary diversity and | Surveys (DHS or Nutrition survey or living standard surveys), Nutrition programme | |

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| | improve protein and micronutrient intake by children, women and adolescent girls | b. % of children 6-59 months who were given animal source food in the last 24 hours (in targeted area)<br>c. # of models for improving dietary diversity and increasing protein and micronutrient intake<br>d. Food fortification strategy<br>e. % farmers growing micro-nutrient rich local foods | c. TBE<br>d. To be developed<br>e. TBE | increasing protein and micronutrient intake<br>d. Developed<br>e. >50% | annual review reports, Nutrition strategy review report, MoFA published reports and bulletins | |
| Key actions to achieve output-2.4 | 2.4.1. Working in partnership with Ministry of Agriculture and Fishery and NGOs working with communities to establish proof of concept and scale up approaches to promote production and use of protein rich food at household level<br>2.4.2. Working in partnership with Ministry of Agriculture and Forestry and NGOs working with communities, establish proof of concept and scale up approaches to promote production and use of micronutrient rich food at household level<br>2.4.3. Working in partnership with Ministry of Agriculture and Forestry identify, recognize and use model good practices that improve protein and micro-nutrient intake by children, women and adolescent girls in communities to encourage communities to adopt good practices<br>2.4.4. Working in partnership with relevant ministries design and implement incrementally measures to improve availability of fortified food in market (e.g. iodized salt, fortified imported food etc.) | | | | | |
| Output 2.5 | 2.5. Improved coverage of social safety nets targeting the poorest families | a. % of families in the lowest quintile covered by Bolsa da Mae<br>b. Cash transfers are linked to household production and consumption of animal source food, other protein sources and dietary diversity targeting poorest households | a. 0.9%<br>b. Not in place | a. >50%<br>b. In place | Nutrition programme annual report, implementing partners reports, MoSS reports/bulletins | |
| Key actions to achieve output-2.5 | 2.5.1. Re-design and expand Bolsa de Mai conditional cash transfer progamme for children<br>2.5.2. Work in partnership with Ministry of Health, Ministry of Social Solidarity, State Administration, Agriculture and Fishery, Ministry of Health and NGOs, design and implement new initiative models of cash transfers linked to household production and consumption of animal source food, other protein sources and dietary diversity targeting poorest households | | | | | |
| Output 2.6 | 2.6. Increased coverage of interventions promoting income generation by women of the poorest wealth quintile | a. % of women in the lowest quintile covered by income generating scheme<br>b. Proof of concept and models for promoting income generation by women of the poorest wealth quintile | a. TBE<br>b. Not available | a. >50% in the targeted area<br>b. Models for promoting income generation by women of the poorest wealth quintile available | Nutrition programme annual report, implementing partners reports, MoFA reports/bulletins | |
| Key actions to achieve output-2.6 | 2.6.1. Continued implementation of current income generation and related programmes targeting women from poorest quintiles<br>2.6.2. Working in partnership with Ministry of Social Solidarity, State Administration, Agriculture and Fishery, Ministry of Health and NGOs design and implement new initiative models for increasing income earning by women from the poorest wealth quintile | | | | | |

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| Output 2.7 | 2.7. Food standards and safety measures adopted and implemented | a. Guidelines on food safety and hygiene standards for food handlers of government facilities<br>b. % of government facility cooks oriented on food safety<br>c. % of primary school students aware of five key food safety issues | a. No guidelines on Guidelines for food safety and hygiene standards<br>b. TBE<br>c. TBE | a. Guidelines available and implemented<br>b. 80%<br>c. >60% | Nutrition programme annual report, guidelines, training report, post campaign monitoring reports | |
| Key actions to achieve output-2.7 | 2.7.1. Develop and implement guidelines on food safety and hygiene standards for all government facilities preparing food<br>2.7.2. Orientation of 1,500 Schools (2/school) and 6 hospitals and 8 CHC (with bed) cooks on food safety<br>2.7.3. Design and implement public awareness campaign on *five key food safety issues* targeting farmers, commercial food producers, retailers, food vendors, and food processors and school going age children<br>2.7.4. Improve national laboratory facility and capacity on food/water analysis and inspection | | | | | |
| Output 2.8 | 2.8. Improved food production, storage and use at household level | a. Composite staple food production index<br>b. % of households practicing home gardening in both urban and rural areas (Draft Food and Nutrition Policy)<br>c. Number of livestock produced<br>d. % of households consumed egg from own production (animal source food proxy) from household production | a. TBE<br>b. TBE<br>c. TBE<br>d. 43.4% (TLFNS 2013) | a. Decreased (Draft Food and Nutrition Security Policy)<br>b. 30% increased from baseline (Draft Food and Nutrition Policy)<br>c. 20% increased from baseline (Food and Nutrition Security Policy)<br>d. 80% | | |
| Key actions to achieve output-2.8 | 2.8.1. Implementation and monitoring of National Food and Nutrition Policy and related strategies by relevant ministries (with focus on promoting practices that increase protein and micronutrient content of diet) | | | | | |
| Outcome-3 | 3. Enabling national policies, programmes and coordination mechanism | a. # of enabling Nutrition Related policies and strategies<br>b. # of enabling Nutrition related codes<br>c. # of enabling nutrition related laws<br>d. # number of nutrition specific surveys<br>e. # of nutrition related operational researches<br>f. Nutrition budget line in government budget<br>g. % of nutrition strategy planned amount for nutrition | a. One draft policy (food and nutrition) and one strategy (nutrition) exist<br>b. One draft code for BMS exist<br>c. One draft salt law exists<br>d. TLFNS and DHS and other surveys provide data<br>e. To be done | a. One food and nutrition policy and one nutrition strategy endorsed<br>b. Two codes (BMS code and Codex Alimentarius) adopted<br>c. Draft salt law endorsed<br>d. Two surveys (midline nutrition behavior and practices assessment and one end-line food and nutrition survey)<br>e. At least 4 operational researches conducted (to set models for targeting and improving delivery of food and nutrition related interventions) | Documents review; Government's expenditure analysis reports;<br>Annual nutrition programme review reports, survey reports reviews | |

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| | | specific interventions funded through government budget<br>h. System to track allocation and expenditure on targeted interventions to improve protein and micronutrient intake by household in the poorest quintile<br>i. Multi-sector coordination mechanism platform for nutrition | f. To be established<br>g. TBE<br>h. No system to track allocation and expenditure on targeted interventions to improve protein and micronutrient intake by household in the poorest quintile<br>i. Konssantil (National Commission for Food Security, Sovereignty, and Nutrition) functions are being established | f. Nutrition budget line exists in government budget<br>g. >90 planned amount for nutrition specific interventions funded<br>h. System to track allocation and expenditure on targeted interventions to improve protein and micronutrient intake by household in the poorest quintile established<br>i. Konssantil's functions are defined | | |
| Output 3.1 | 3.1. Improved availability and timeliness of Nutrition data to inform policies and programmes | a. Nutrition MIS achieving completeness and timeliness benchmarks<br>b. # of joint monitoring conducted each year<br>c. Nutrition Surveillance system<br>d. # of nutrition related studies and researches | a. Limited<br>b. Irregular<br>c. TBE<br>d. TBE | a. Over 80%<br>b. At least once quarterly joint monitoring conducted<br>c. Established<br>d. Over 6 studies/assessment/evaluation reports published | National nutrition programme review reports; HMIS review reports; nutrition surveillance reports, research reports | |
| Key actions to achieve output-3.1 | 3.1.1. Develop Nutrition strategy implementation monitoring framework and a process for NNS implementation monitoring<br>3.1.2. Review and revise Nutrition Management Information System (NMIS) indicators of the Health Management Information System (HMIS) to tailor them to contribute to Nutrition Strategy implementation monitoring<br>3.1.3. Establish and scale up a surveillance system that uses digital technology to report on key nutrition indicators and provides robust data periodically and help track nutrition services, behaviors, practices and outcomes.<br>3.1.4. Conduct sector-specific periodic joint field monitoring using a pre-agreed tool that has tracer indicators which help track key process in Nutrition Strategy Implementation.<br>3.1.5. Conduct researches which a) provide evidence for advocacy and programme design; b) research that help provide local solutions to practical challenges; c) operational research that shows how evidence based interventions can be implemented and scaled up in the local context (researches are included under relevant outputs);<br>3.1.6. Conduct mid-line and end-line nutrition surveys (or add nutrition modules to other surveys) to assess progress of nutrition indicators<br>3.1.7. Conduct an expenditure analysis on nutrition specific and nutrition sensitive interventions<br>3.1.8. Develop a system to track expenditure on targeted interventions to improve protein and micronutrient intake by household in the poorest quintile established<br>3.1.9. Hire a third party to conduct midline and end-line Nutrition Programme evaluation | | | | | |

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| Output 3.2 | 3.2. Nutrition promotion messages integrated into all sectroal actions | a. Nutrition Advocacy materials promoting multi-sectoral action<br>b. Multi-sectoral national nutrition communication plan<br>c. Multi-sectoral messages and communication material for nutrition promotion<br>d. % of Suco meetings having Nutrition in agenda of the Suco Council meetings<br>e. % women of reproductive age women practicing nationally defined feasible practices for improving nutrient intake of families | a. To be developed<br>b. To be developed<br>c. To be developed<br>d. To be developed<br>e. TBE | a. Developed<br>b. Developed<br>c. Developed<br>d. Nutrition in agenda of the Suco Council meetings<br>e. >50% | Document review; national nutrition programme review ; Suco council meeting agenda/minutes review | |
| Key actions to achieve output-2.10 | 3.2.1. Hire TA to develop a multi-sectoral national nutrition communication plan, policy briefs, advocacy materials and communication material for nutrition promotion through relevant government sectors<br>3.2.2. Conduct high level advocacy meeting to promote multi-sectoral action<br>3.2.3. Working in partnership with a local NGO, design and test a recipe book using local protein and micronutrient rich food for a) complementary feeding for children 6-23 month, b) healthy snack for children 24-59 months, and c) healthy meals and snacks for pregnant mothers.<br>3.2.4. Print and distribute one copy each of recipe book using local protein and micronutrient rich food for a) complementary feeding for children 6-23 month, b) healthy snack for children 24-59 months, and c) healthy meals and snacks for pregnant mothers to all sectors extension workers and suco-level health care providers (approximately 5000 copies)<br>3.2.5. Give administrative instructions and engage field based workers of relevant ministries (agriculture, education, health, social solidarity, state administration etc) to disseminate messages to promoting nationally defined feasible practices for improving nutrient intake of families<br>3.2.6. Hold special policy sessions with parliamentarians and other policy makers to advocate for role of nutrition in national development<br>3.2.7. Conduct annual national nutrition conference to highlight progress, good practices and challenges in addressing under-nutrition messaging and to highlight success of interventions and programmatic gaps to key government figures, donors and other development partners.<br>3.2.8. Establish Nutrition Clubs in all schools to engage children and youth in learning and nutrition promotion in communities<br>3.2.9. Initiate and observe a National Nutrition Day annually during world breast-feeding week and use the occasion for nutrition information dissemination (campaign, road shows etc). | | | | |
| Output 3.3 | 3.3. Enabling nutrition related policies, codes and regulations established | a. National code for marketing of breast milk substitutes (BMS)<br>b. National breastfeeding (BF) Policy,<br>c. Law promoting use of iodized salt<br>d. National Codex Alimentarius<br>e. National Food Bill and Regulations (Draft food and nutrition policy) | a. Draft BMS code<br>b. Draft National breastfeeding Policy,<br>c. Draft salt law decree exist<br>d. Codex does not exist<br>e. National Food Bill and Regulations to be developed | a. BMS code endorsed<br>b. National breastfeeding Policy endorsed<br>c. Salt law decree endorsed<br>d. National Codex exists<br>e. National Food Bill and Regulations approved | Document review, National Nutrition Programme review report, Nutrition Programme annual report | |

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| Key actions to achieve output-3.3 | 3.3.1. Organize consultative workshop to review and finalize the current draft of code for marketing of breast milk substitutes (BMS) and breastfeeding (BF) Policy, translate, present and seek endorsement by the CoD and conduct dissemination workshop to disseminate BMS Code and BF Policy among stakeholders at all levels<br>3.3.2. Organize consultative workshop to review and finalize the current draft of 'salt law decree", seek endorsement by the by council of ministers and parliament and conduct dissemination workshop to disseminate the salt law at all levels<br>3.3.3. Hire TA to adopt the Codex Alimentarius to set food standards, guidelines and codes of practice to protect the health of the consumers and ensure fair practices in the food trade, translate, present and seek endorsement of codex by council of ministers and parliament and conduct dissemination workshop to disseminate codex among stakeholders at all levels<br>3.3.4. Hire TA and conduct consultative workshops to draft National Food Bill and Regulations and to present it for review and endorsement by Konssantil, Council of ministers and parliament<br>3.3.5. Implement relevant provisions of the national salt laws, codes and regulations to ensure their compliance | | | | | |
| Output 3.4 | 3.4. Annual and long term investment plans prioritize allocations for nutrition specific and nutrition sensitive interventions | a. Costed operational plans for nutrition and related strategies<br>b. Annual plans of districts and national level have budget lines for nutrition specific and nutrition sensitive interventions | a. To be developed (TBD)<br>b. TBD | a. Costed operational plans for nutrition strategies<br>b. Annual districts and national plan have nutrition budget lines | Document review, National Nutrition Programme review report, Nutrition Programme annual report | |
| Key actions to achieve output-3.4 | 3.4.1. Develop costed operational plan for relevant nutrition related strategies<br>3.4.2. Develop annual plans for financing activities of the costed operational plan through national budget at national and district level<br>3.4.3. Establish budget lines for Nutrition specific and nutrition sensitive interventions in relevant ministries and track allocation and expenditures<br>3.4.4. Develop Nutrition Resource mobilization plan (for the operational plan) and submit to the Konssantil for review and endorsement<br>3.4.5. Conduct advocacy with Suco Xefe and Ministry of State Administration to consider allocation of some suco budget for nutrition community mobilization actions | | | | | |
| Output 3.5 | 3.5. Enhanced effectiveness of Nutrition coordination mechanisms at national, district and Suco level | a. # of national level Konssantil meetings<br>b. # of Konssantil Technical Working Group meeting<br>c. # Nutrition Working Group meeting<br>d. # of District level intersectoral meetings on nutrition and food security<br>e. # of ministries having district level nutrition focal points | a. National level Konssantil meeting held irregularly<br>b. Konssantil Technical Working group held<br>c. Nutrition working group held<br>d. District inter-sectoral meeting held<br>e. TBE | a. National Konssantil meeting at least held every two months<br>b. Konssantil technical working group at least held every two weeks<br>c. Nutrition Working Group at least held every two months<br>d. District inter-sectoral meeting held at least once a month<br>e. All districts have nutrition focal points from relevant ministries | Document review, National Nutrition Programme review report, Nutrition Programme annual report | |
| Key actions to achieve output-3.5 | 3.5.1. Recruit and deploy Nutrition Specialist to support Konsannntil secretariat to contribute to the work of Konssantil specifically at the level of policy formulation and policies and plans implementation tracking<br>3.5.2. Organize Konssantil meetings to approve and monitor policies, strategies and plan (secretariat, DG level and Ministerial level)<br>3.5.3. Conduct advocacy meeting with relevant sectors and propose establishment of Nutrition Focal Point responsibility in other sectors including health, agriculture, livestock, water, sanitation and hygiene –WASH, education etc. at national and district level<br>3.5.4. Conduct quarterly District Nutrition Working group meeting (of relevant sectors Nutrition Focal Points) to review progress of nutrition plans | | | | | |

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| | 3.5.5. Establishment of Nutrition Technical Advisory Group (NTAG) led by Nutrition Department of MoH with nutrition expertise drawn from selected NWG members to advise on technical matters related to Nutrition to all coordination for a.<br>3.5.6. Functionalize district level Konssantil coordination mechanism and conduct periodic meetings<br>3.5.7. Establish District Working Group (DNWG) consisting of Nutrition Focal Points of different Ministries at District level to prepare inputs for district level Konssantil meetings<br>3.5.8. Develop district nutrition plan and conduct quarterly district level nutrition review meetings with DNWG (to and to monitor progress of the plan implementation and to report to national level)<br>3.5.9. Conduct advocacy meeting with Ministry of State Administration, district administrator and Suco Xefe and provide TA to place nutrition in standing agenda of Suco's development coordination mechanism | | | | | |
| Output 3.6 | 3.6. Reduced vulnerability to disasters and Improved emergency Preparedness and response | a. # Vulnerability maps<br>b. # possible disaster Scenarios updated<br>c. # national DRR plan updated<br>d. Early warning system<br>e. Meeting of national and district DRR and emergency preparedness and response coordination mechanisms<br>f. Nutrition response coordination mechanism during disasters<br>g. Nutrition emergency preparedness and response plan<br>h. Nutrition response during disasters | a. To be developed<br>b. To be updated<br>c. To be updated<br>d. To be established<br>e. Irregular meeting<br>f. Irregular meeting<br>g. To be developed<br>h. No emergency currently | a. Developed<br>b. Updated<br>c. Updated<br>d. Established<br>e. Regular meetings<br>f. Regular meetings<br>g. Developed<br>h. Over 90% of Nutrition EPRP plan targets achieved during emergencies | MSS reports, Document review, National Nutrition Programme review report, Nutrition Programme annual report, Food Security and Early Warning System | |
| Key actions to achieve output-3.6 | 3.6.1. Hire consultancy firm to conduct disaster risk and vulnerability mapping<br>3.6.2. Conduct consultative meeting to update possible disaster scenarios and disaster risk reduction plans updated<br>3.6.3. Conduct consultative workshop to update National disaster response plans<br>3.6.4. Conduct at least 6 monthly and additional needs based meetings of the national and district disaster response coordination mechanism<br>3.6.5. Conduct at least 6 monthly and additional needs based meetings of Nutrition emergency response coordination mechanism<br>3.6.6. Recruit consultant to design early warning system for detection food and nutrition related emergencies and implement the system through existing government network<br>3.6.7. Conduct consultative workshop to develop nutrition emergency preparedness and response plan<br>3.6.8. Provide effective and timely nutrition response during emergencies | | | | | |

## Annex-1a. List of Nutrition Supply and Equipment

| No. | Item |
|---|---|
| **I** | **Supplies for treatment of Acute Malnutrition** |
| 1 | Therapeutic Spread (Ready to Use Therapeutic Food/RUTF) |
| 2 | Therapeutic Milk F75 |
| 3 | Therapeutic Milk F100 |
| 4 | Resomal |
| 5 | Supplementary Food |
| **II** | **Micronutrients supplements** |
| 6 | Vitamin A capsules (100,000 IU and 200,000 IU) |
| 7 | Deworming tablet |
| 8 | Micronutrients powder (MNP) |
| 9 | Iron-folic acid |
| 10 | Zinc tablets |
| **III** | **Equipment for screening for malnutrition** |
| 11 | Mid-upper arm circumference (MUAC) tape |
| 12 | Weighing scale of infants/children |
| 13 | Infant weighing trousers |
| 14 | Weighing scale of women |
| 15 | Height measurement for children and women |

## Annex-2: Monitoring and Evaluation Plan

The table below picks up key monitoring, evaluation, review and research related activities in the logical framework and puts a timeline and responsible entity to make a monitoring and evaluation plan. Cost and costing related data/information will be added to this during the process of costing of the plan.

| Sl. No | Outcome/Intervention | Timeline for implementation | | | | | Responsible Department/Unit |
|---|---|---|---|---|---|---|---|
| | | Year-1 | Year-2 | Year-3 | Year-4 | Year-5 | |
| | **Assessment activities within the operational plan** | | | | | | |
| 1 | Conduct Nutrition Capacity Assessment of all relevant ministries (signatories of Comoro Declaration) | X | | | | | MoH Nut Dept and HR Dept |
| 2 | Conduct nutrition training needs assessment, including mapping nutrition human resource gaps, especially in health facilities, outreaches and gaps in community volunteers; | X | | | | | MoH Nut Dept, HR Dept and INS |
| 3 | Conduct mid-term assessment of counselling and community mobilization work and based on the findings, revise approach and focus as relevant | | | X | | | Nut Dept, and INS |
| 4 | Conduct self-assessment of 6 hospitals and target 34 CHCs using BFHI criteria | | X | | | | BFHI committee of facilities |
| 5 | Conduct external accreditation assessment of 40 health facilities (that meet BFHI criteria in self-assessment | | | X | X | | MoH |
| 6 | Conduct end-line nutrition surveys (or add nutrition modules to other surveys) to assess progress of nutrition indicators | | | | | X | MoH |
| 7 | Hire consultancy firm to conduct disaster risk and vulnerability mapping | | X | | | | MoSS |
| | **Reviews and evaluation activities within the operational plan** | | | | | | |
| 1 | Review current approach nutrition services delivery to identify opportunities for improving access to nutrition screening and preventive nutrition services for mothers and children | X | | | | | Nut Dept, Ethics and standards cabinet, Policy and Planning and INS |
| 2 | Conduct a review of diarrhea and ARI treatment practices and compliance to national IMCI guidelines. | | | X | | | MoH Nut Dept and INS |
| 3 | Conduct IDD elimination status review | | | | | X | MoH |
| 4 | Review and revise Nutrition Management Information System (NMIS) indicators of the Health Management Information System (HMIS) to tailor them to contribute to Nutrition Strategy implementation monitoring | X | | | | | MoH |
| 5 | Conduct an expenditure analysis on nutrition specific and nutrition sensitive interventions | | | | X | | Ministry of Finance |
| | **Operational researches, new initiative/intervention to establish proof of concepts and other researches within the operational plan** | | | | | | |
| 1 | Introduce, test feasibility and impact of preventive zinc supplementation to 26,000 children 24-59 months in three districts (one from east, one from central region and one from west) | | X | X | X | | Nut Dept, District, sub-district and health facility nutrition focal point and 2NGO of intervention d3istricts |
| 2 | Operational study for new initiative to deliver weekly iron folate supplementation and 6-montly deworming targeting 18,000 adolescent girls (in and out of School) in three districts (one from east, one from central region and one from west) | | | X | X | X | Nu4t Dept, District, sub-district and health facility nutrition focal point, NGO, MoE and district and School focal point |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | for Nutrition/school health of intervention districts |
| 3 | Operational study on interventions targeted to reduce low birth weight | | X | X | X | | INS, National Hospital, Nut Dept, District, sub-district and health facility nutrition focal point, NGO, |
| 4 | Introduce a concept and scale up approaches to promote production and use of **protein** rich food at household level | | | X | X | X | MOFA, MOH, NGO |
| 5 | Introduce a concept and scale up approaches to promote production and use of **micronutrient** rich food at household level | | | X | X | X | MOFA, MOH, NGO |
| 7 | Introduce models of cash transfers linked to household production and consumption of animal source food, other protein sources and dietary diversity targeting poorest households | | | X | X | X | MSS, MoFA, MoH, State Administration, NGO |
| 8 | Introduce models for increasing income earning by women from the poorest wealth quintile | | | X | X | X | MSS, MoFA, MoH, State Administration, NGO |
| 9 | Conduct researches which a) provide evidence for advocacy and programme design; b) research that help provide local solutions to practical challenges; c) operational research that shows how evidence based interventions can be implemented and scaled up in the local context (researches are included under relevant outputs); | X | X | X | X | X | MoH, NGOs and Development partners |
| | **Routine Nutrition Programme monitoring activities** | | | | | | |
| 1 | Conduct market and household salt iodine monitoring using rapid test kits | | | X | X | X | MoH, MoCIE |
| 2 | Monitor salt iodization at production sites and in the markets | | | X | | | MoH, MoCIE |
| 3 | Develop Nutrition strategy implementation monitoring framework and a process for NNS implementation monitoring | X | | | | | MoH, Konssantil |
| 5 | Implement IT solutions based system for reporting and nutrition surveillance system to obtain robust data to track nutrition services, behaviors, practices and outcomes. | X | | | | | MoH and Private IT service provider |
| 5 | Conduct sector-specific periodic (6-monthly) joint field monitoring using a pre-agreed tool that has tracer indicators which help track key process in Nutrition Strategy Implementation. | | X | X | X | X | MoH. MOFA. MSS, MOPWD |
| 6 | Organize of Konssantil meetings to approve and monitor policies, strategies and plan (secretariat, DG level and Ministerial level) | X | X | X | X | X | MoH, MOFA and Konssantil |
| 7 | Conduct quarterly District Nutrition Working group meeting (of relevant sectors Nutrition Focal Points) to review progress of nutrition plans | X | X | X | X | X | District Administrator and District Health Director |

## Annex-3: Strategy Implementation Plan

The strategy implementation plan below is made taking the activities under each outputs in the logical framework and putting a timeline and responsibility for implementation. (Costing related data/information will be added to this to make it operational plan).

| Sl. No | Outcome/Intervention | Timeline for implementation | | | | | Responsible Department/Unit |
|---|---|---|---|---|---|---|---|
| | | Year-1 | Year-2 | Year-3 | Year-4 | Year-5 | |
| **1 Outcome** | **Increased coverage of Nutrition Specific interventions** | | | | | | |
| **1.1 Output** | **Improved packaging and definition of approach for delivering High Impact Nutrition Interventions** | | | | | | |
| 1.1.1 | Hire consultant to review and update IYCF and other High Impact Nutrition Intervention (HINI) guidelines, training materials, job aids, facilitator's guide and curriculum in line with relevant global guidelines, national nutrition programme intents and national health service package | X | | | | | MoH Nut Dept |
| 1.1.2 | Translate and present and seek endorsement of IYCF and other High Impact Nutrition Intervention (HINI) guidelines, training materials, job aids, facilitator's guide and curriculum | X | | | | | MoH Nut Dept |
| 1.1.3 | Print 1000 sets of documents for dissemination workshop | X | | | | | MoH Nut Dept |
| 1.1.4 | Conduct dissemination workshop to disseminate IYCF and HINI guidelines among stakeholders at all levels | X | | | | | MoH Nut Dept |
| **1.2 Output** | **Improved structure and capacity for nutrition programme management at all levels** | | | | | | |
| 1.2.1 | Review and update the structure of nutrition programme management and service delivery arrangements at sub-district and Suco level including job descriptions and performance standards of service providers in line with the MoH service package, delivery arrangements and policies | X | | | | | MoH Nut Dept and HR Dept |
| 1.2.2 | Present and seek endorsement of the updated structure and job | X | | | | | MoH Nut Dept and HR Dept |
| 1.2.3 | Print and disseminate updated structure, job descriptions and performance standards | X | | | | | MoH Nut Dept and HR Dept |
| 1.2.4 | Hire, train and deploy sub-district Nutrition focal points | X | | | | | MoH Nut Dept, INS and HR Dept |
| 1.2.5 | Assign Nutrition focal point responsibility to existing staff at Suco/health post level through administrative instruction | X | | | | | MoH Nut Dept and HR Dept |
| 1.2.6 | Conduct Nutrition Capacity Assessment of all relevant ministries (signatories of Comoro Declaration) | X | | | | | MoH Nut Dept and HR Dept |
| 1.2.7 | Conduct nutrition training needs assessment, including mapping nutrition human resource gaps, especially in health facilities, outreaches and gaps in community volunteers; | X | | | | | MoH Nut Dept, HR Dept and INS |
| 1.2.8 | Development of Nutrition Human Resource Development (NHRD) plan (preferably as part of each sectors Human Resources Development plan) | X | | | | | MoH Nut Dept, HR Dept and INS |
| **1.3 Output** | **Improved capacity of service providers to deliver nutrition specific interventions, nutrition counselling, social mobilization and behavior change communication interventions** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1.3.1 | Train 21 national trainers on training health care providers on IYCF and other High Impact Nutrition Intervention (HINI) using comprehensive national guideline and training materials | X | | | | | MoH Nut Dept and INS |
| 1.3.2 | Train 950 suco-based health care providers and CHC and Hospital Nutrition focal points on HINI implementation (at least 2 per suco, two per CHC and two per Hospital) | | X | X | | | MoH Nut Dept and INS |
| 1.3.3 | Incorporate nutrition training into the curricula of doctors, nurses, mid-wives, agriculture extension workers, environmental/sanitation engineers, teachers and social workers. | | | X | | | MoH Nut Dept, INS, UNTL |
| 1.3.4 | Develop and disseminate at least two sets of job aides to help staff understand and carry out their functions adequately to 300 health facilities (all health posts, CHCs and Hospitals) | X | | | | | MoH Nut Dept and INS |
| 1.3.5 | Establish and operationalizing structured supportive supervision to ensure that service providers and mid-level managers are performing their functions as desired | | X | | | | MoH Nut Dept and HR Dept |
| 1.3.6 | Introduce approach on performance linked incentives to community level health workers and community volunteers involved in nutrition activities in three districts (one good one bad and one medium in terms of IYCF indicators). | | | X | | | MoH Nut Dept and HR Dept |
| 1.3.7 | Train 21 people as trainers on IYCF counseling, IPC and community mobilization for HINI | X | | | | | MoH Nut Dept and INS |
| 1.3.8 | Train 950 suco-based health care providers and CHC and Hospital Nutrition focal points on IYCF counselling, IPC and community mobilization for HINI implementation (at least 2 per suco, two per CHC and two per Hospital) | | X | X | | | MoH Nut Dept and INS |
| 1.3.9 | Conduct supportive supervision of the health care providers counselling and community mobilization work | | X | X | X | X | Nut Dept, District, sub-district and health facility nutrition focal point |
| 1.3.10 | Conduct mid-term assessment of counselling and community mobilization work and based on the findings, revise approach and focus as relevant | | | X | | | Nut Dept, and INS |
| 1.4 **Output** | **Improved community access to nutrition counselling, social mobilization and behavior change communication interventions including counselling for improving nutritional status of mothers and adolescent girls** | | | | | | |
| 1.4.1 | Establish partnerships with CBOs/NGOs/Church-based organization to scale up Mother Support Group (MSG) coverage to 280 additional sucos to promote IYCF, maternal, newborn and child health care and Baby Friendly Community Initiative | | X | X | X | X | Nut Dept, District, sub-district and health facility nutrition focal point and NGO |
| 1.4.2 | Establish and train MSG for IYCF counseling in 442 sucos | | X | X | X | X | Nut Dept, District, sub-district and health facility nutrition focal point and NGO |
| 1.4.3 | Engage Suco-based health care providers and civil society organization to support work of MSG in 442 Sucos | | X | X | X | X | Nut Dept, District, sub-district and health facility nutrition focal point |
| 1.4.4 | Institutionalize through administrative instruction, supervision and monitoring practice of a) Maternal Nutrition Counselling and b) IYCF Counselling during ANC contacts of all SISCa and health facilities, at least four times during pregnancy | | X | X | X | X | Nut Dept, District, sub-district nutrition focal point |
| **1.5 Output** | **Health facilities adopt and achieve baby friendly hospital initiative (BFHI) accreditation** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1.5.1 | Hire consultant to develop/adopt Baby Friendly Initiative (BFHI) guidelines, training materials and job aides | X | | | | | Nut Dept and INS |
| 1.5.2 | Present and seek endorsement of Baby Friendly Initiative guideline by CoD | X | | | | | Nut Dept |
| 1.5.3 | Print 100 sets of guideline, training materials, job aids for implementing BHFI | | X | | | | Nut Dept |
| 1.5.4 | Procure 10-steps successful BF board for 40 health facilities | | X | | | | Nut Dept |
| 1.5.5 | Train of trainers of 12 staff from 6 hospitals on BHFI | | X | | | | Nut Dept and INS |
| 1.5.6 | Establish BFHI committee in 6 hospitals and target 34 CHCs (of the 6 districts having the 6 hospitals) | | X | | | | District health director and Nut Dept |
| 1.5.7 | Conduct self-assessment of 6 hospitals and target 34 CHCs using BFHI criteria | | X | | | | BFHI committee of facilities |
| 1.5.8 | 40 health facilities BFHI committee implement BFHI standards, including improving IYCF corner and staff skills in IYCF | | X | X | X | | BFHI committee of facilities |
| 1.5.9 | Conduct external accreditation assessment of 40 health facilities (that meet BFHI criteria in self-assessment | | | X | X | | MoH |
| 1.6 **Output** | **Increased availability of Nutrition supplies and commodities** | | | | | | |
| 1.6.1 | Develop National Standard List (NSL) of nutrition supplies and equipment which shows what items are expected to be available at what level and allocate national budget for procuring supplies and equipment | X | | | | | MoH Nut Dept, Pharmacy Dept and SAME |
| 1.6.2 | Develop National Nutrition Commodity Management Plan | X | | | | | MoH Nut Dept, Pharmacy Dept and SAME |
| 1.6.3 | Assign through administrative instruction national and district level focal persons accountable for nutrition commodity management including forecasting, procuring, distributing, managing stock and inventory and reporting on use and stock-outs etc. | X | | | | | MoH Nut Dept and HR Dept |
| 1.6.4 | Train national and district level (30 people, at least two from each level and two from INS) on nutrition commodity management including forecasting, procuring, distributing, managing stock and inventory and reporting on use and stock-outs etc. | | X | | | | Nut Dept, Pharmacy Dept, SAME and INS |
| 1.6.5 | Procure and distribute of nutrition supplies and equipment to all level of service delivery ***(detail list attached)*** | X | X | X | X | X | Nut Dept, Pharmacy Dept, SAME and INS |
| 1.6.6 | Print and distribute Nutrition Job Aides, communication materials and recording and reporting formats to 300 health facilities (all health posts, CHCs and Hospitals) | X | | X | | X | Nut Dept, |
| **1.7 Output** | **Increased access to nutrition screening, preventive nutrition services, treatment of malnutrition and micro nutrient deficiencies, and common childhood illnesses** | | | | | | |
| 1.7.1 | Review current approach nutrition services delivery to identify opportunities for improving access to nutrition screening and preventive nutrition services for mothers and children | X | | | | | Nut Dept, Ethics and standards cabinet, Policy and Planning and INS |
| 1.7.2 | Define and institutionalize through administrative orders, supervision and job-audits (monitoring) measures to ensure that under-five children who have completed vaccination are screened for malnutrition at least twice every year either through SISCa or home visits | X | | | | | Nut Dept, MoH Ethics and standards cabinet |
| 1.7.3 | Define and institute measures to ensure that under-five children who have completed vaccination are provided deworming and vitamin A supplementation twice every year either through SISCa or home visits | | X | | | | Nut Dept, District, sub-district and health facility nutrition focal point |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1.7.4 | Train midwives and other ANC providers on maternal nutrition interventions (at least iron folate, deworming, diet and rest during pregnancy) | | X | X | X | | Nut Dept, MCH and INS |
| 1.7.5 | Train 91 nutrition focal points (67 CHC nutrition focal points and 24 hospital staff, one Hospital Nutrition focal points and 3 pediatric ward staff from each hospital) on identification and treatment of acute malnutrition | | X | | | | Nut Dept and INS |
| 1.7.6 | Implement targeted supplementary feeding for moderate acute malnutrition countrywide targeting approximately 14,000 under-five children /year nationwide | X | X | X | X | X | Nut Dept, District, sub-district and health facility nutrition focal point |
| 1.7.7 | Incrementally scale-up multiple micronutrient supplementation targeting 37,000 children 6-24 month in all Sucos | X | X | X | X | X | Nut Dept, District, sub-district and health facility nutrition focal point |
| 1.7.8 | Introduce, test feasibility and impact and scale up implementation of preventive zinc supplementation to 26,000 children 24-59 months in three districts (one from east, one from central region and one from west) | | X | X | X | | Nut Dept, District, sub-district and health facility nutrition focal point and NGO of intervention districts |
| 1.7.9 | Implement operational study to deliver weekly iron folate supplementation and 6-montly deworming targeting 18,000 adolescent girls (in and out of School) in three districts (one from east, one from central region and one from west) | | | X | X | X | Nut Dept, District, sub-district and health facility nutrition focal point, NGO, MoE and district and School focal point for Nutrition/school health of intervention districts |
| 1.7.10 | Train all (442) suco-based doctors on community case management of diarrhea and ARI | | X | | | | MoH Nut Dept and INS |
| 1.7.11 | Conduct a review of diarrhea and ARI treatment practices and compliance to national IMCI guidelines | | | X | | | MoH Nut Dept and INS |
| 1.7.12 | Procure and distribute ORS and Zinc in adequate quantities for estimated case load of 102,500 diarrhea episodes per year | X | X | X | X | X | MoH Pharmacy Dept and SAMES |
| 1.7.13 | Procure/develop/print and distribute IMCI Job-Aids to all health facilities (300 facilities), including job-aid for use of zinc together with ORS for diarrhea management | X | | X | | X | MoH Nut Dept |
| 1.7.14 | Institutionalize through administrative instruction, training and supportive supervision practice that focusses on a) Maternal Nutrition Counselling and IYCF Counselling during ANC contacts of all SISCa and health facilities at least four times during pregnancy; b) delivery of nutrition services (vitamin A supplementation, deworming and iron folate supplementation); and treatment of common childhood illnesses | | X | X | X | X | Nut Dept, District, sub-district and health facility nutrition focal point, |
| 1.8 **Output** | **Improved feeding practices for under-five children during and after illnesses** | | | | | | |
| 1.8.1 | Design and implement nationwide campaign promoting appropriate feeding practices for children during and after episodes of diarrhea and ARI | | X | X | X | X | MoH, SECOM, telephone service providers |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1.8.2 | Train at least one staff from each CHC and two from pediatric ward (preferably IMCI focal points) of each hospital on screening sick children for malnutrition and providing counselling for feeding during and after diarrhea and ARI | | X | X | | | MoH MCH and INS |
| 1.9 **Output** | **Model for delivering interventions to reduce low birth weight and improve nutritional status of pregnant mothers established** | | | | | | |
| 1.9.1 | Recruit TA and establish NGO partnership to assist INS, National Hospital in Dili and MCH department to design and implement operational study delivering interventions targeted to reduce low birth weight | | X | X | X | | INS, National Hospital, Nut Dept, District, sub-district and health facility nutrition focal point, NGO, |
| 1.9.2 | Integrate feasible interventions for reducing LBW (based on operational study findings) in MCH service package nationwide | | | | | X | MoH Nut, MCH, planning and policy Dept |
| 1.10 **Output** | **Increased use of iodized salt by families** | | | | | | |
| 1.10.1 | Hire TA to develop National IDD elimination programme with a five years operational plan | | X | | | | MoH Nut, Planning and policy Dept |
| 1.10.2 | In collaboration with relevant line ministries, support salt farmers to establish salt-farmers cooperatives to improve production, quality and marketing of locally produces salt | | X | | | | MoH, MoICE and MoFA |
| 1.10.3 | Support salt-farmers cooperatives to establish salt iodization plants and internal quality control measures | | | X | | | MoH, MoICE and MoFA |
| 1.10.4 | Monitor salt iodization at production sites and in the markets | | | X | | | MoH, MoICE |
| 1.10.5 | Conduct a nationwide campaign to highlight the benefits of using iodized salt | | | X | X | X | MoH, MoE, MSS MoICE and SECOM |
| 1.10.6 | Conduct market and household salt iodine monitoring using rapid test kits | | | X | X | X | MoH, MoICE |
| 1.10.7 | Conduct IDD elimination status review | | | | | X | MoH |
| **2 Outcome** | **Increased coverage of Nutrition Sensitive Interventions** | | | | | | |
| 2.1 **Output** | **Increased accesses to maternal newborn and child health services** | | | | | | |
| 2.1.1 | Implementation and monitoring of National Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy and plan, including IMCI and community case management strategy | X | X | X | X | X | MoH MCH Dept |
| 2.1.2 | Implementation and monitoring of Immunization strategy and plan | X | X | X | X | X | National EPI |
| 2.1.3 | Implementation of national malaria control strategy and plan | X | X | X | X | X | National Malaria Control Programme |
| 2.1.4 | Implementation of national HIV/AIDS programme strategy and plan | X | X | X | X | X | National AIDS control Programme |
| **2.2 Output** | **Improved hygiene and sanitation practices** | | | | | | |
| 2.2.1 | Implementation and monitoring of National Hygiene and Sanitation Strategy and plan with focus on making Suco Open Defecation Free (ODF), hand washing practices promotion and providing schools and health facilities with adequate water and sanitation facilities | X | X | X | X | X | MoPWD, MoH and Suco Xefe |
| 2.3 **Output** | **Increased access to improved source of drinking water** | | | | | | |
| 2.3.1 | Implementation and monitoring of National Water and Sanitation Strategy | X | X | X | X | X | MoPWD |
| **2.4 Output** | **Enhanced focus of investment on interventions targeted to improve protein and micronutrient intake by children, women and adolescent girls** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2.4.1 | Working in partnership with Ministry of Agriculture and Forestry and NGOs working with communities to establish proof of concept and scale up approaches to promote production and use of protein rich food at household level | | | X | X | X | MOFA, MOH, NGO |
| 2.4.2 | Working in partnership with Ministry of Agriculture and Forestry and NGOs working with communities, establish proof of concept and scale up approaches to promote production and use of micronutrient rich food at household level | | | X | X | X | MOFA, MOH, NGO |
| 2.4.3 | Working in partnership with Ministry of Agriculture and Forestry identify, recognize and use model good practices that improve protein and micro-nutrient intake by children, women and adolescent girls in communities to encourage communities to adopt good practices | | | X | X | X | MOFA, MOH, SECOM and NGO |
| 2.4.4 | Working in partnership with relevant ministries design and implement incrementally measures to improve availability of fortified food in market (e.g. iodized salt, fortified imported food etc.) | | | X | X | | MOFA, MOH, NGO, MSS and others |
| **2.5 Output** | **Improved coverage of enhanced social safety nets targeting the poorest families** | | | | | | |
| 2.5.1 | Re-design and expand Bolsa de Mai conditional cash transfer progamme for children | X | X | X | X | X | MSS |
| 2.5.2 | Work in partnership with Ministry of Social Solidarity, State Administration, Agriculture and Forestry, Ministry of Health and NGOs design and implement new initiative/models of cash transfers linked to household production and consumption of animal source food, other protein sources and dietary diversity targeting poorest households | | | X | X | X | MSS, MoFA, MoH, State Administration, NGO |
| **2.6 Output** | **Increased coverage of interventions targeting income generation by women of the poorest wealth quintile** | | | | | | |
| 2.6.1 | Continued implementation of current income generation and related programmes targeting women from the poorest quintiles | X | X | X | X | X | MSS |
| 2.6.2 | Work in partnership with Ministry of Social Solidarity, State Administration, Agriculture and Forestry, Ministry of Health and NGOs design and implement new initiative/ models for increasing income earning by women from the poorest wealth quintile | | | X | X | X | MSS, MoFA, MoH, State Administration, NGO |
| **2.7 Output** | **Food standards and safety measures adopted and implemented** | | | | | | |
| 2.7.1 | Develop and implement guidelines on food preparation and hygiene standards for all government facilities preparing food | | | X | | | MoH, MoE |
| 2.7.2 | Orientation of 1,500 (2 cooks per school) schools and 6 hospital and 8 CHC (with bed) cooks on food safety | | | X | | | MoH, MoE |
| 2.7.3 | Design and implement public awareness campaign on *five key food safety issues* targeting farmers, commercial food producers, retailers, food vendors, and food processors | | | | X | X | MoH. MoFA, MSS, SECOM and NGOS |
| 2.7.4 | Improve national laboratory facility and capacity on food/water analysis and inspection | | | X | | | MoH |
| **2.8 Output** | **Improved food production, storage and use at household level** | | | | | | |
| 2.8.1 | Implementation and monitoring of National Food and Nutrition Policy and related strategies by relevant ministries (with focus on promoting practices that increase protein and micronutrient content of diet) | X | X | X | X | X | MoFA |
| **3 Outcome** | **Enabling national policies, programmes and coordination mechanism** | | | | | | |
| 3.1 **Output** | **Improved availability and timeliness of Nutrition data to inform policies and programmes** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3.1.1 | Develop Nutrition strategy implementation monitoring framework and a process for NNS implementation monitoring | X | | | | | MoH, Konssantil |
| 3.1.2 | Review and revise Nutrition Management Information System (NMIS) indicators of the Health Management Information System (HMIS) to tailor them to contribute to Nutrition Strategy implementation monitoring | X | | | | | MoH |
| 3.1.3 | Establish Public-Private Partnership with Telephone and internet service providers to establish and scale up a surveillance system that uses digital technology to report on key nutrition indicators and provides robust data periodically and help track nutrition services, behaviors, practices and outcomes. | X | | | | | MoH and Private IT service provider |
| 3.1.4 | Conduct sector-specific periodic (6-monthly) joint field monitoring using a pre-agreed tool that has tracer indicators which help track key process in Nutrition Strategy Implementation. | | X | X | X | X | MoH. MOFA. MSS, MOPWD |
| 3.1.5 | Conduct researches which a) provide evidence for advocacy and programme design; b) research that help provide local solutions to practical challenges; c) operational research that shows how evidence based interventions can be implemented and scaled up in the local context (researches are included under relevant outputs); | X | X | X | X | X | MoH |
| 3.1.6 | Put in place a nutrition early warning system that provides alerts on nutrition and food insecurity which may be precipitated by emergencies | | X | | | | MoFA and MoH |
| 3.1.7 | Conduct end-line nutrition surveys (or add nutrition modules to other surveys) to assess progress of nutrition indicators | | | | | X | MoH |
| 3.1.8 | Conduct an expenditure analysis on nutrition specific and nutrition sensitive interventions | | | | | | Ministry of Finance, MOFA and MoH |
| 3.1.9 | Develop a system to track expenditure on targeted interventions to improve protein and micronutrient intake by household in the poorest quintile established | | | | | | Ministry of Finance, MOFA and MoH |
| 3.1.10 | Hire a third party to conduct midline and end-line Nutrition Programme evaluation | | | X | | X | MoH |
| **3.2 Output** | **Nutrition promotion messages integrated into all sectoral actions** | | | | | | |
| 3.2.1 | Hire TA to develop a multi-sectoral national nutrition communication plan, policy briefs, advocacy materials and communication material for nutrition promotion through relevant government sectors | X | | | | | MoH |
| 3.2.2 | Conduct high level advocacy meeting with Ministers, Secretary of State and head of national commissions to promote multi-sectoral action | X | | | | | MoH |
| 3.2.3 | Working in partnership with a local NGO, design and to introduce, test a recipe book using local protein and micronutrient rich food for a) complementary feeding for children 6-23 month, b) healthy snack for children 24-59 months, and c) healthy meals and snacks for pregnant mothers | X | | | | | MOFA, MOH, NGO |
| 3.2.4 | Print and distribute one copy each of recipe book using local protein and micronutrient rich food for a) complementary feeding for children 6-23 month, b) healthy snack for children 24-59 months, and c) healthy meals and snacks for pregnant mothers to all sectors extension workers and suco-level health care providers (approximately 5000 copies for health sector and 1000 copies each for other sectors) | | X | | | | MOH, MOFA, MoSS, MoPWD, SSYS, MoE |
| 3.2.5 | Give administrative instructions and orientation and engage field based workers of relevant ministries (agriculture, education, health, social solidarity, state | | X | | | | MoH, MOFA, MSS, SSY, MOE, State |

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| | administration, secretary of state for youth etc) to disseminate messages to promoting nationally defined feasible practices for improving nutrient intake of families | | | | | | Administrations, SECOM and MoICE |
| 3.2.6 | Hold special policy sessions with parliamentarians and other policy makers to advocate for role of nutrition in national development | | X | | | | MoH |
| 3.2.7 | Conduct annual national nutrition conference to highlight progress, good practices and challenges in addressing under-nutrition and to highlight and reward success of interventions to key government figures, donors and other development partners. | X | X | X | X | X | MoH, INS, SECOM and UNTL |
| 3.2.8 | Establish Nutrition Clubs in all schools to engage children and youth in learning and nutrition promotion in communities | | | X | X | X | MoH, MoE |
| 3.2.9 | Initiate and observe a National Nutrition Day annually during world breast-feeding week and use the occasion for nutrition information dissemination (campaign, road shows etc). | X | X | X | X | X | MoH, UNTL, MOE, State Administration |
| **3.3 Output** | **Enabling nutrition related policies, codes and regulations established** | | | | | | |
| 3.3.1 | Organize consultative workshop to review and finalize the current draft of code for marketing of breast milk substitutes (BMS) and breastfeeding (BF) Policy, translate, present and seek endorsement by the CoD and conduct dissemination workshop to disseminate BMS Code and BF Policy among stakeholders at all levels | X | | | | | MoH, Konssantil |
| 3.3.2 | Organize consultative workshop to review and finalize the current draft of 'salt law decree", seek endorsement by the by council of ministers and parliament and conduct dissemination workshop to disseminate the salt law at all levels | X | | | | | MoH, Konssantil |
| 3.3.3 | Hire TA to adopt the Codex Alimentarius to set food standards, guidelines and codes of practice to protect the health of the consumers and ensure fair practices in the food trade, translate, present and seek endorsement of codex by council of ministers and parliament and conduct dissemination workshop to disseminate codex among stakeholders at all levels | X | | | | | MoH, MoA, MoICE and Konssantil |
| 3.3.4 | Hire TA and conduct consultative workshops to draft National Food Bill and Regulations and to present it for review and endorsement by Konssantil, Council of ministers and parliament | | X | | | | MoFA, MoH, MoICE and Konssantil |
| 3.3.5 | Implement relevant provisions of the national salt laws, codes and regulations to ensure their compliance | X | X | X | X | X | All ministries |
| **3.4 Output** | **Annual and long term investment plans prioritize allocations for nutrition specific and nutrition sensitive interventions** | | | | | | |
| 3.4.1 | Develop costed operational plan for relevant nutrition related strategies | X | | | | | MoH and other relevant ministries |
| 3.4.2 | Develop annual plans for financing activities of the costed operational plan through national budget at national and district level | X | X | X | X | X | MoH and other relevant ministries |
| 3.4.3 | Establish budget lines for Nutrition specific and nutrition sensitive interventions in relevant ministries and track allocation and expenditures | | X | | | | MoF, MoH and Konssantil |
| 3.4.4 | Develop Nutrition Resource mobilization plan (for the operational plan) and submit to the Konssantil for review and endorsement | | X | | | | MoH, MoFA, MoICE and other relevant ministries |
| 3.4.5 | Conduct advocacy with Suco Xefe and Ministry of State Administration to consider allocation of some suco budget for nutrition community mobilization actions | | X | | | | MoH and State Administration |
| 3.4.6 | Conduct an expenditure analysis on nutrition specific and nutrition sensitive interventions | | | X | | | MoF and Konssantil |

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| 3.4.7 | Develop a system to track expenditure on targeted interventions to improve protein and micronutrient intake by household in the poorest quintile established | | | X | | | MoF and Konssantil |
| **3.5 Output** | **Enhanced effectiveness of Nutrition coordination mechanisms at national, district and Suco level** | | | | | | |
| 3.5.1 | Recruit and deploy Nutrition Specialist to support Konssantil secretariat to contribute to the work of Konssantil specifically at the level of policy formulation and policies and plans implementation tracking | X | | | | | MoH, MOFA and Konssantil |
| 3.5.2 | Organize Konssantil meetings to approve and monitor policies, strategies and plan (secretariat, DG level and Ministerial level) | X | X | X | X | X | MoH, MOFA and Konssantil |
| 3.5.3 | Conduct advocacy meeting with relevant sectors and propose establishment of Nutrition Focal Point responsibility in other sectors including health, agriculture, livestock, water, sanitation and hygiene –WASH, education etc. at national and district level | X | | | | | MoH, MOFA and Konssantil |
| 3.5.4 | Conduct quarterly District Nutrition Working group meeting (of relevant sectors Nutrition Focal Points) to review progress of nutrition plans | X | X | X | X | X | District Administrator and District Health Director |
| 3.5.5 | Establish Nutrition Technical Advisory Group (NTAG) led by Nutrition Department of MoH with nutrition expertise drawn from selected NWG members to advise on technical matters related to Nutrition to all coordination fora. | X | | | | | MoH |
| 3.5.6 | Functionalize district level Konssantil coordination mechanism and conduct periodic meetings | | X | | | | District Administrator, State Administration, MoFA and MOH |
| 3.5.7 | Establish District Working Group (DNWG) consisting of Nutrition Focal Points of different Ministries at District level to prepare inputs for district level Konssantil meetings | | X | | | | District Administrator and District Health Director |
| 3.5.8 | Develop district nutrition plan (as part of health sector plan) and conduct quarterly district level nutrition review meetings with DNWG (to and to monitor progress of the plan implementation and to report to national level) | | X | X | X | X | MoH, District Administrator and District Health Director |
| 3.5.9 | Conduct advocacy meeting with Ministry of State Administration, District Administrator and Suco Xefe to promote putting nutrition in standing agenda of Suco Council meetings | | | X | | | MoH, Ministry of State Administration, District Administrator and District Health Director |
| **3.6 Output** | **Reduced vulnerability to disasters and Improved emergency Preparedness and response** | | | | | | |
| 3.6.1 | Hire consultancy firm to conduct disaster risk and vulnerability mapping | | X | | | | MoSS and Konssantil |
| 3.6.2 | Conduct consultative meeting to update possible disaster scenarios and disaster risk reduction plans updated | | X | | | | MoSS and Konssantil |
| 3.6.3 | Conduct consultative workshop to update National disaster response plans | | X | | | | MoSS and Konssantil |
| 3.6.4 | Conduct at least 6 monthly and additional needs based meetings of the national and district disaster response coordination mechanism | | X | X | X | X | MoSS and Konssantil |
| 3.6.5 | Conduct at least 6 monthly and additional needs based meetings of Nutrition emergency response coordination mechanism | X | X | X | X | X | MOH MOH Nut Dept |
| 3.6.6 | Recruit consultant to design early warning system for detection food and nutrition related emergencies and implement the system through existing government network | | X | | | | MoA and MOH |

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| 3.6.7 | Conduct consultative workshop to develop nutrition emergency preparedness and response plan | X | X | X | X | X | MOH Nut Dept |
| 3.6.8 | Provide effective and timely nutrition response during emergencies | X | X | X | X | X | MoH and MoSS |

## Annex-4. Existing Nutrition Programmes, Geographical Area of Coverage, and Supporting Partners

| No | Programme Area | Activity | Geographical Area of Coverage | Supporting Partners |
|---|---|---|---|---|
| 1 | Infant and Young Child Feeding | • Promotion of exclusive breastfeeding<br>• Promotion of timely and appropriate complementary feeding practices, including cooking demonstration for good complementary foods<br>• Advocacy on the enactment of Breast Milk Substitute (BMS Code)<br>• Promotion Baby Friendly Hospital Initiatives (BFHI)<br>• Counseling community by health staff and community volunteers through mother-support groups (MSG) | Nationwide<br>Nationwide<br><br><br>National Level<br><br>National & Regional Hospitals<br>Nationwide | WHO, UNICEF, AusAID, USAID, Spanish MDG-F, ALOLA Foundation, Pastoral de Criansa (PdC), Save the Children, Catholic Relief Services (CRS), World Vision, Medicos do Mundo (MDM), Timor-Leste Red Cross (CVTL) |
| 2 | Micronutrient Supplementation Programme | • Vitamin A capsule supplementation for children 6-59 months old<br>• Case treatment for measles and eye problems related to vitamin A deficiency<br>• Iron-folic acid supplementation for pregnant and lactating women<br>• Deworming programme for children 1-5 year old<br>• Deworming programme for school children (6-11 year old)<br>• Micronutrient Powder (MNP) programme for children 6-23 months old<br>• Provision micronutrient supplementation supplies | Nationwide<br>Nationwide<br><br>Nationwide<br>Nationwide<br>Nationwide<br>Targeted districts (currently only in Aileu district)<br>Nationwide | AusAID, UNICEF, WHO, World Vision, SHARE International, MDM |
| 3 | Universal Salt Iodisation (USI) Programme | • Promotion production of iodized salt through development capacity of salt farmers on how to iodized salt locally<br>• Advocacy on the enactment of Salt Law Decree<br>• Monitoring the quality of iodized salt produced at local farmers | Salt Producer districts<br><br>Central<br>Salt farmers at salt producer sites in salt districts | UNICEF, AusAID |
| 4 | Community-based Management of Acute Malnutrition (CMAM) Programme | • Screening, referral, treatment and follow up of acutely malnourished children<br>• Provision supplementary foods for moderately malnourished children and pregnant and lactating women, including cooking demonstration using CSB<br>• Long-term care for malnourished children and their communities | Nationwide (in-patient at hospitals, and out-patients at 64 CHC)<br>Nationwide<br><br>Selected districts | Spanish MDG-F, UNICEF, WHO, WFP, HIAM Health, World Vision, MDM |
| 5 | Nutrition Education and Campaign | • Promotion nutrition and health activities at SISCa (improve quality of Table 2 and Table 6, Nutrition and health promotion, respectively)<br>• Training for health staff and volunteers (PSF) to support SISCa activities<br>• Training for community on home and kitchen-garden | Nationwide<br><br>Nationwide<br><br>Selected districts | UNICEF, WHO, FAO, ALOLA Foundation, HIAM Health, SHARE International |
| 6 | Food Fortification | • Promotion of locally produced blended food fortified with micronutrients<br>• Promote and facilitate food fortification (including production, quality control, marketing, etc) | AusAID, WFP | |

## Annex-5: Nutrition service gap and support required at different service provision points

| # | Service gaps or challenges in providing existing service | Additional support/interventions required | Services being provided currently (to be continued) |
|---|---|---|---|
| **National, Regional referral, District Community Health Centers, Sub-district Community Health Centre and Health post (level I to III)** | | | |
| 1 | Promotion of good nutrition practices (breastfeeding and complementary feeding and hygiene promotion) | 1. Timor-Leste IYCF guidelines and/or development of clear IYCF messages including for water, sanitation and hygiene<br>2. Incorporation of IYCF messaging in *SISCa* health promotion activities<br>3. Incorporation of water, hygiene and sanitation messaging into the hospital health promotion plan | 1. Management of acute malnutrition<br>2. Vitamin A supplementation,<br>3. Iron-folate supplementation for pregnant and lactating mothers<br>4. Micronutrient Powders (MNP) in selected districts<br>5. Deworming and<br>6. Growth monitoring |
| 2 | Zinc supplementation for children with diarrhea | 1. Incorporate zinc supplementation into diarrhea management procedures<br>2. Zinc supplements supplies<br>3. Provide training to health workers for administration of zinc supplements, integrated with IMCI guidelines | |
| 3 | Management of acute malnutrition | 1. Improve technical capacity of health staff in in-patient and out-patient treatment and referral system<br>2. Recording and reporting system | |
| **Integrated Community Health Services (*SISCa*)** | | | |
| 1 | Promotion of good nutrition practices (breastfeeding and complementary feeding) | 1. Timor-Leste IYCF guidelines and development of clear IYCF messages for IEC materials<br>2. Incorporation of IYCF messaging in *SISca* health promotion activities | 1. Growth monitoring<br>2. Iron-folate supplementation for pregnant and lactating mothers<br>3. Deworming<br>4. Vitamin A supplementation<br>5. MNP in selected districts<br>6. Cooking demonstration |
| 2 | Vitamin A supplementation | 1. Provision of supplies<br>2. Training of health volunteers in provision on vitamin A supplementation | |
| 3 | Zinc supplementation for children with diarrhea | Same as for vitamin A above | |
| 4 | Micronutrient powders supplementation | 1. Supplies provision<br>2. Capacity development of health and community volunteers and logistics support in distribution | |
| 5 | Screening of acute malnourished children and pregnant and lactating women | 1. Capacity development for active case findings, referral, and follow up cases in the community<br>2. Recording and reporting system | |
| **Agricultural extension and support** | | | |
| 1 | Education and support on cropping micronutrient rich crops rather than just the staples | Provide micronutrient rich crops seeds ( side by side with the staples seeds) and promotion for growing in agronomic areas where they can grow | 1. Staple food seeds<br>2. Storage improvement<br>3. Advice to the agricultural communities |
| 2 | Nutrition education on diet diversity and cooking methods to prevent nutrient loss | Nutrition education of diet diversity and cooking integrated in agricultural extension or programs | |

## Annex 6: List of People Consulted During National Nutrition Strategy Development

| No | Name | Ministry /Institution/Organization | Position |
|---|---|---|---|
| 1 | Mr. Luis Guterres | Prime Minister Office | Vice Prime Ministry |
| **2** | Mr. Rui Manuel Hanjam | Ministry of Finance | Vice Minister |
| 3 | Ms. Madalena Hanjam | Ministry of Health | Vice Minister |
| 4 | Sr. Agapito da Silva Soares | Ministry of Health | Director General |
| 5 | Sra. Isabel Maria Gomes | Ministry of Health | Director of National Director of Health communitarian |
| 6 | Dr. Odete M.F. Belo | Ministry of Health | Deputy Director/Office of Cooperation and External Funds |
| 7 | Carlitos Correira Freitas | Ministry of Health | Deputy Director Community of Health Directorate |
| 8 | Sr. Basilio Martins Pinto | Ministry of Health | Head of Policy |
| 9 | Sr. Mateus Cunha | Ministry of Health | Head of Planning |
| 10 | Sra. Dirce Maria Soares Araujo | Ministry of Health | Head of Nutrition Department |
| 11 | Sr. Joao Bosco | Ministry of Health | Acting Head of Nutrition Department |
| 12 | Sr. Duarte Mau-buti | Ministry of Health | CMAM Officer |
| 13 | Sra. Joana Melania Maria Mendonca | Ministry of Health | Head of Health Promotion Department |
| 14 | Sr. Apolonario dos Reis Guterres | Ministry of Health | Communication Research Center Officer, Health Promotion Department |
| 15 | Sr. Florentino de C. | Ministry of Health | MCH Department |
| 16 | Sr. Ivo Guterres | Ministry of Health | Head of Environmental health department |
| 17 | Sra. Isabel Exposto | Ministry of Health | SISCa Coordinator |
| 18 | Sr. Luis Celestino Correia | Ministry of Health | Head of Non Communicable disease control |
| 19 | Dr. Teresa Madeira Soares | Ministry of Health | Technical Supervisor PES |
| 20 | Mr. Setio Edi | Ministry of Health | Health Advisor |
| 21 | Sra. Maria Natalia | Ministry of Health | M&E Officer |
| 22 | Sr. Anacleto Pinto | Ministry of Health | Program Officer HIC/AIDS |
| 23 | Sra. Ana Maria Guterres | Ministry of Health | MCH program Officer |
| 24 | Sra. Rita M. Soares | Ministry of Health | |
| 25 | Sr. Victorino da C. Araujo | Ministry of Health | Program Officer |
| 26 | Sr. Jose Moniz | Ministry of Health | |
| 27 | Sra. Auria Celina da Cruz | Ministry of Health | Program Officer, FP |
| 28 | Sra. Fatima Isabel | Ministry of Health | Program Officer |
| 29 | Sra. Florencia Corte Real | Ministry of Health | Program Officer |
| 30 | Sra. Luisa M. Barros | Ministry of Health | Program Officer |
| 31 | Sr. Jose Luna | Ministry of Health | Program Officer |
| 32 | Sra. Nelinha dos Santos | Ministry of Health | |
| 33 | Sr. Romano A. | Ministry of Health | Program Officer |
| 34 | Sr. Daniel da Costa Pinto | Ministry of Health | Program Officer |
| 35 | Dr. Domingos da Silva | Institute National of Health | Director |
| 36 | Pedro Amaral | Health National Institution | INS Nutrition focal point |
| 37 | Dr. Domingos Alves | SAMES (Central Pharmacy of MoH) | Director General – SAMES |
| 38 | Sr. Manuel Maria Alves | Ministry of Tourism, Commerce, and Industry | Director General of Industry |
| 39 | Sr. Antonio da Costa | Ministry of Tourism, Commerce, and Industry | Director of Industry |
| 40 | Sra. Amelia Sarmento | Ministry of Tourism, Commerce, and Industry | Head of Food Industry Department |
| 41 | Sra. Antonia Carmen da Cruz | Ministry of Social Solidarity | Direcção Nacional de Reinserção Social |

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| 42 | Sr. Helder Alberto Neves | Ministry of Agriculture and Fisheries | Head of National and International Cooperation - Food and Security department |
| 43 | Sr. Rofino S. Gusmao | Ministry of Agriculture and Fisheries | Officer |
| 44 | Sr. Apolinario Magno | Ministry of Education | Director General |
| 45 | Sr. Raimundo Pereira | Ministry of Education | |
| 46 | Sr Carlito Mota | Ministry of Education | Head of School Feeding |
| 47 | Sr. Paulo B. Soares | Ministry of Education | |
| 48 | Sr. Felix Piedade | Ministry of Finance | MDG Secretariat |
| 49 | Sr. Joao Pereira Jeronimo | Ministry of Infrastructure | Director National of Water and Sanitation |
| 50 | Sr. Elias Pereira Moniz | Ministry of Infrastructure | Program Coordinator |
| 51 | Sr. Martinus Nahak | Ministry of Infra Structure | Program Officer Water and Sanitation |
| 52 | Mr Alberto Mendez | World Food Programmer | Representative |
| 53 | Ms Diana Borges | World Food Programme | Nutrition Officer |
| 54 | Sr. José Marçal | World Food Programme | Programme Officer |
| 55 | Sr Elias Sarmento | World Food Programme | Nutrition Officer |
| 56 | Ms Ms. Xinmin Zhao | World Food Programme | Former Deputy Country Director |
| 57 | Mr Ruben Flamarique | FAO | Project Manager |
| 58 | Sr Adelio Lopes | FAO | Technical Support |
| 59 | Dr Jorge Maria Luna | WHO | Representative |
| 60 | Dr Rajesh Pandav | WHO | Health Policy Advisor |
| 61 | Crispin da Costa Araujo | WHO | Nutrition Officer |
| 62 | Dr. Domingas Sarmento | WHO | MNCH Officer |
| 63 | Ms. Mikiko | UNDP | Representative |
| 64 | Dr Domingas Berbardo | UNFPA | Assistant of Representative |
| 65 | Ms Isabelle Amorim | UNDP | Social Protection Consultant |
| 66 | Sr. Jorge Mouzinho | UNDP | MDG Advocacy Officer |
| 67 | Sra. Isabel Lopes Pereira | Alola Foundation | Programme Officer |
| 68 | Sra Teresa Verdial de Araújo | Alola Foundation | CEO |
| 69 | Sra Angelina Fernandes | Alola Foundation | MCH Officer |
| 70 | Sr Marcelo Amaral | Global Fund | Program Coordinator |
| 71 | Ms. Hongwei Gao | UNICEF | Representative |
| 72 | Ms. Riitta Poutiainen | UNICEF | Fmr. Deputy Representative |
| 73 | Dr. Monjur Hossain | UNICEF | Fmr. Chief of Health and Nutrition |
| 74 | Dr. Hemlal Sharma | UNICEF | Chief of Health and Nutrition |
| 75 | Ms. Min Yuan | UNICEF | Head of Programme Monitoring & Evaluation |
| 76 | Ms. Mary-Ann Maglipon | UNICEF | Head of Communication Section |
| 77 | Mr. Ceasar Hall | UNICEF | Fmr. Chief of WASH |
| 78 | Mr. Ramesh Bhusal | UNICEF | Chief of WASH |
| 79 | Ms. Norkham Souphanovoung | UNICEF | Fmr. Education Specialist |
| 80 | Ms. Mayang Sari | UNICEF | Nutrition Specialist |
| 81 | Ms. Wahyu Mahanani | Programme Management Unit – MDG-JP Food Security and Nutrition | M&E Food Security and Nutrition Specialist |
| 82 | Dr. Sherin Varkey | UNICEF | Fmr. Health Specialist |
| 83 | Dr. Carla Quintao | UNICEF | Health Officer |
| 84 | Ms. Aderito da Carmo | UNICEF | EPI Officer |
| 85 | Ms. Umbelina Rodriguez | UNICEF | Fmr. HIV/AIDS Officer |
| 86 | Ms. Teresinha Soares | UNICEF | Nutrition Officer |
| 87 | Ms Precy Vinea Cabrera | World Vision International | MCHN Technical Specialist |
| 88 | Sr Joao Moniz | World Vision International | MCH Coordinator |
| 89 | Sr. Ze Calistro | World Vision International | Nutrition Coordinator |
| 90 | Sra. Alice Passos | World Vision International | Nutrition Coordinator |
| 91 | Ms Rie Ozaki | SHARE | Aileu Project Manager |
| 92 | Mr. Julio Goncalves | Care International | DPM Health |

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| 93 | Sr Mirko Gamez Arias | Care International | Agricultural Program Manager |
| 94 | Sra. Celina Exposto | Care International | Health Project Coordinator |
| 95 | Mr Joydip Ghosh | Save the Children | Health Program Manager |
| 96 | Sr Francisco Viera | Health Net | Program Manager |
| 97 | Sr Leao Pinto | Health Net | |
| 98 | Mr Glenn king | CRS | Health Program Manager |
| 99 | Sr. Paulino da Costa | Child Fund | Project Officer |
| 100 | Mr Wahyu A Nugroho | Mercy Corps | Program Manager – Food Security |
| 101 | Rosaria M. da Cruz | HIAM | HIAM director |
| 102 | Antonio Guterres | HIAM | Manager |
| 103 | Sister Angelina Freitas | Pastoral da Criancas | Health Program Manager |
| 104 | Ms. Sarah Lendon | AusAID | Director of Health and Education Unit |
| 105 | Sr. Cornelio de Deus Gomes | AusAID | Program Coordination for Health |
| 106 | Ms. Marion Kelly | AusAID | Intern Health Specialist |
| 107 | Sr. Emilio H. Tilman | Health Improvement Project (HIP-USAID): | Program Officer |
| 108 | Dr. Reginal Gipson | Health Improvement Project (HIP-USAID): | Chief of Party |
| 109 | Ms Marrianne Viatour | Health Improvement Project (HIP-USAID) | Health Promotion TA |
| 110 | Ms. Laura Soriano | AECID – Spanish | Project Officer |
| 111 | Ms Lucia Fernandes | AECID – Spanish | Agriculturist |
| 112 | Ms Diana Carla Pires Silva | Medicos do Mundo (MDM) | District Coordinator |
| 113 | Mr Alberto Jou Yarandes | Medicos do Mundo (MDM) | Program Coordinator |
| 114 | Mr Martin Caldeyro Stajano | EU | MDG EU Consultant |
| 115 | Sra. Maria Isabel A. Silva | EU | PO |
| 116 | Mr. Fransisco Incerpi Montbrun | Ministry of Finance | Team Leader Servicos do Ordenador Nacional National Directorate of Aid Effectiveness |
| 117 | Ms. Emilia Rand | Oxfam | Health Program Manager |
| 118 | Mr. Fransisco Incerpi Montbrun | Ministry of Finance | Team Leader Servicos do Ordenador Nacional National Directorate of Aid Effectiveness |
| 119 | Ms. Yi-Kyoung Lee | World Bank | Health Senior Specialist |
| 120 | Dr. Virna Gusmao | Timor-Leste Medical Doctor Association | Director |
| 121 | Sra. Lydia Gomes | Timor-Leste Midwives Association | Director |
| 122 | Sra. Gabriela Vaca | BCO | Intern |
| 123 | Sr. Francisco C. Viera | HNTL | Director |
| 124 | Sr. Francisco Pinhero E. Silva | Diocese Baucau | Deputy of Bishop |