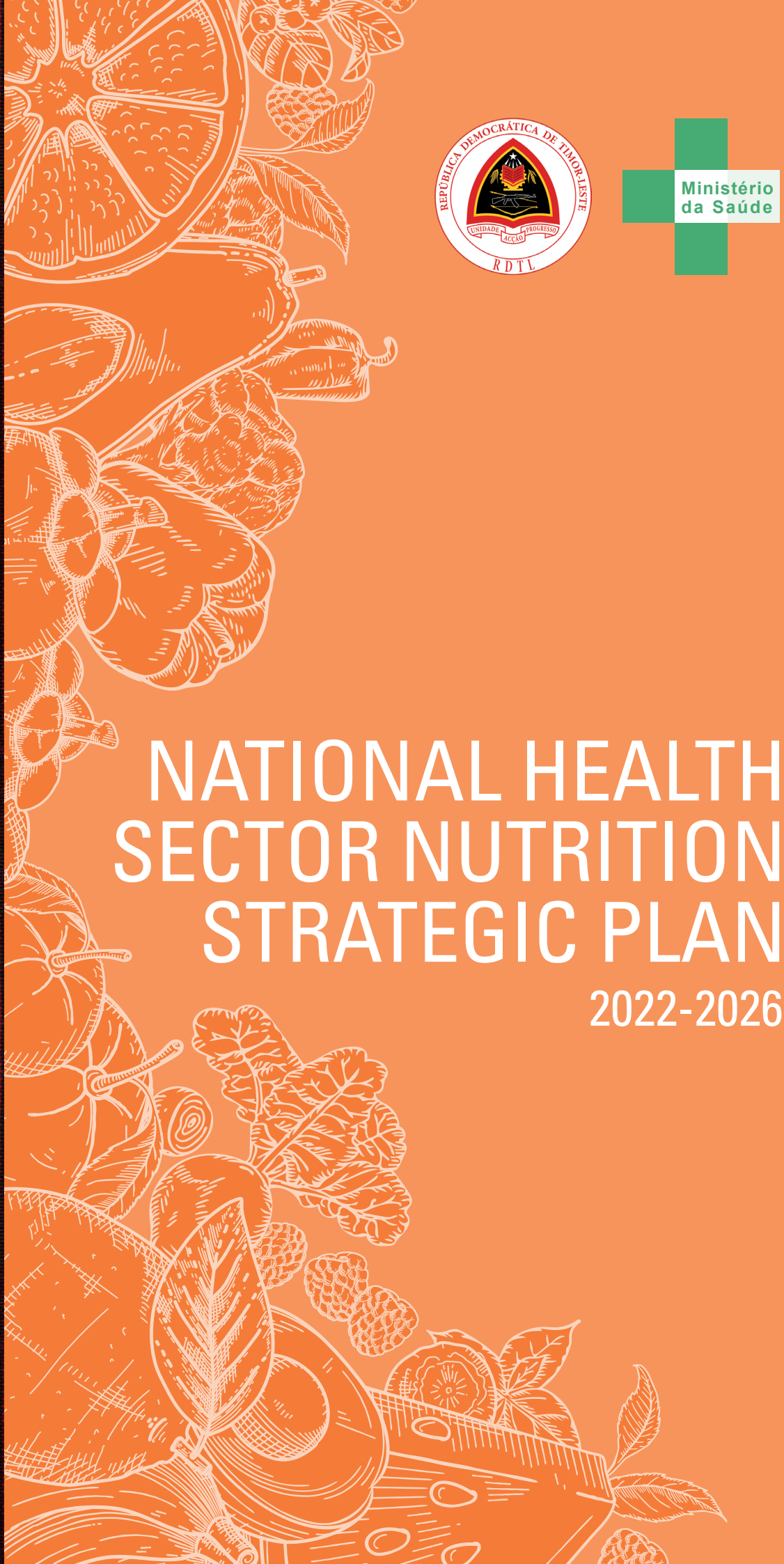

NATIONAL HEALTH SECTOR NUTRITION STRATEGIC PLAN

2022-2026

Table of contents

ACKNOWLEDGEMENTS

The development of the National Health Sector Nutrition Strategic Plan (NHNSP), covering the period 2022-2026 is a result of broader consultations and participation of key stakeholders including senior government officers in key ministries and departments, development partners, representatives of non-government organizations (NGOs), civil society, academia, and the private sector. The Nutrition Department would like to pay special tribute to the following institutions and organizations who actively participated - Ministry of Health (MOH), INS, Ministry of Agriculture and Fisheries; Ministry of Education, Youth and Sports, United Nations Children's Fund (UNICEF), World Food Programme (WFP), World Health Organization (WHO), Partner for Human Development (PHD), TOMAK, Mercy Corps, CARE, MalukTimor, CRS, Catalpa, Fundasaun ALOLA, FAO; and World Vision. The development process of the ensured transparency, consensus building, and integration of multiple strategies and actions leading to a multi-sectoral approach for national scale intervention delivery. A team of dedicated Nutrition Department staff in collaboration with UNICEF nutrition specialists formed the core team that coordinated the whole process with agility and enthusiasm.

The National Nutrition Strategy 2014 – 2019 was revised with the aim of adapting the strategies into the current global, regional and country situation with consideration of emerging evidence and issues in the field of nutrition. The process was compelled by the urgent need to accelerate a health sector response to address malnutrition in the country, particularly the contribution to reducing stunting which has had a slow downward trend over the past decade. The Health Sector Nutrition Strategic Plan (NHSNSP) 2022-2026 has been developed to provide guidance to the health sector workforce in response to improving the nutrition situation in the country in the coming years. It is envisaged that effective implementation of the NHSNSP 2022 - 2026 will enhance nutritional achievements by ensuring that all Timorese children grow into healthy adults to contribute positively to the country's socio-economic development.

The MoH also recognizes and extends appreciation to UNICEF, the European Union (EU) Delegation in Dili, WFP and FAO for providing financial and technical support for the development and formulation of the Strategic Plan. Additional and grateful acknowledgement goes to UNICEF and EU for providing both financial and technical assistance for the costing of the National Health Sector Nutrition Strategic Plan 2022-2026.

The Nutrition Department under the Ministry of Health gratefully acknowledges the valuable contributions and comments of many individuals and workshop participants in the development of the strategy.

Ministry of Health (Nutrition Department)

ABBREVIATIONS

AD	Adolescent Department
ANAS	National Authority for Water and Sanitation Public Institute (ANAS IP.)
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ASEAN	Association of Southeast Asian Nations
BMI	Body Mass Index
BMS	Breast Milk Substitutes
BFHI	Baby Friendly Hospital Initiative
BTL	Bee Timor-Leste Public Company
CHC	Community Health Centre
CVD	Cardiovascular Disease
CMAM	Community Management of Acute Malnutrition
CoP	Community of Practice
COVID-19	Corona Virus Disease -19
CRS	Catholic Relief Service
CSOs	Civil Society Organisations
DBP	Diastolic Blood Pressure
DPHO	District Primary Health Officer
DRNCDs	Diet Related Non-Communicable Diseases
EHD	Environmental Health Department
ENA	Essential Nutrition Actions
EU	European Union
FAO	Food and Agriculture Organisation of the United Nations
FNG	Fill the Nutrient Gap
GBD	Global Burden of Diseases
GMP&A	Growth Monitoring Promotion and Assessment
HIS	Health Information System
HISD	Health Information System Department
HMIS	Health Management Information System
HNGV	Hospital Nacional Guido Valadares
HPD	Health Promotion Department
HR	Human Resource
HSNSP	Health Sector Nutrition Strategic Plan
HSSP	Health Sector Strategic Plan
IDA	Iron Deficiency Anaemia
IEC	Information Education and Communication
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illnesses
IYCN	Infant and Young Child Nutrition
IYCF	Infant and Young Child Feeding
INS	Institute of National Health Sciences
KM	Knowledge Management
KONSSANTIL	The National Council for Food Security, Sovereignty and Nutrition in Timor-Leste
LBW	Low Birth Weight
LISIO	Livriñu Saúde Inan no Oan /Mother and Child Health Booklet
MAD	Minimum Acceptable Diet
MCH	Maternal and Child Health
MCHD	Maternal and Child Health Department
MDD	Minimum Dietary Diversity
MDD-W	Minimum Dietary Diversity for Women
M&E	Monitoring and Evaluation
M&ED	Monitoring and Evaluation Department
MHS	Municipality Health Services

MOH	Ministry of Health
MMF	Minimum Meal Frequency
MSG	Mother Support Groups
MUAC	Mid-Upper Arm Circumference
NGOs	Non-Governmental Organisations
NCDs	Non-Communicable Diseases
ND	Nutrition Department
NDCD	National Directorate of Disease Control /Direção Nacional do Controlo de Doenças
NDHR	National Directorate of Human Resource / DNRH - Direção Nacional dos Rekursos Humanos
NDPH	National Directorate of Public Health
NDPF	
NDPFM	National Directorate of Planning and Financial Management / DNPGF - Direção Nacional do Planeamento e Gestão Finançeira
NDPM	National Directorate of Pharmacy and Medicines / DNFM Direçao Nacional Farmacia e Medicamentos
NDSHS	National Directorate of Support for Hospital Services (DNASH - Direção Nacional do Apoio aos Serviços Hospitalares
NDSnF	National Directorate of Family Health / DNSnF - Direção Nacional de Saude na Familia
NHSNP	National Health Sector Nutrition Strategic Plan
NNS	National Nutrition Strategy
NSBCC	Nutrition Social Behaviour Change
ODF	Open Defecation Free
OPPC	Office of Policy, Planning and Cooperation in Health / Gabinete de Política, Planeamento e Cooperação em Saúde
PAN-HAM-TIL	Zero Hunger Action Plan for a Hunger and Malnutrition Free Timor-Leste 2025
PHC	Primary Health Care
PHD	Partnership for Human Development
PHC	Primary Health Care
RBP	Retinol Binding Protein
RUTF	Ready to Use Therapeutic Foods
SAM	Severe Acute Malnutrition
SAMES	Autonomous Pharmaceutical/ Medical Equipment Service
SBCC	Social and Behaviour Change Communication
SBP	Systolic Blood Pressure
SD	Standard Deviation
SDG	Sustainable Development Goals
SDG2 CNAP-NFS	SDG 2 Consolidate National Action Plan for Nutrition and Food Security
SiSCA	Servisu Intergradu Saude Comunitaria / Integrated Community Health Services
SNIP	Specific Nutrition Intervention Package
STEPS	WHO STEPwise Approach to NCD Risk Factor Surveillance
SUN	Scaling Up Nutrition
TL	Timor-Leste
TLDHS	Timor-Leste Demographic Health Survey
TLFNS	Timor-Leste Food and Nutrition Survey
TOMAK	To'os ba Moris Di'ak / Farming for Prosperity
TWG	Technical Working Group
UHC	Universal Health Coverage
UIE	Urinary Iodine Excretion
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAD	Vitamin A Deficiency
WASH	Water, Sanitation and Hygiene
WFP	The World Food Program
WHA	World Health Assembly
WHO	World Health Organisation
WRA	Women of Reproductive Age

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FOREWORD

The Ministry of Health is committed to addressing the challenges in nutrition in the country by developing and implementing policies and strategies that have high impact, are integrated, sustainable and community-oriented, and target the most vulnerable groups, especially women and children.

This National Health Sector Nutrition Strategic Plan 2022-2026 was made to address nutrition challenges of the country through health sector action, which aligns its targets to the National Development Plan 2011-2030.

Nutrition is one of the priority interventions in the National Basic Package of services, National Health Sector Strategic plan 2011 - 2030, and National Development Plan 2011 - 2030. The Ministry of Health is fully engaged in developing the strategic plan to ensure that the selected nutrition interventions are evidence-based and cost-effective. The strategic plan will help guide nutrition program implementation within the health sector.

The Ministry of Health led this strategy's development with technical support from UNICEF. In addition, the process was informed by literature review and consultation with stakeholders, national organizations and institutions, UN agencies, development partners, national associations, eminent personalities, and community members at all levels. It generated the technical views and opinions from government line ministries linked to existing government strategic documents, including the Food and Nutrition policy 2017 and the SDG 2 National Consolidated Action Plan for Nutrition and Food Security.

The National Health Sector Nutrition Strategic Plan 2022-2026 would not have been possible without the Ministry of Health and the United Nations Children's Fund (UNICEF). We would also like to thank the European Union for the financial support which made this possible.

On behalf of the Government of Timor-Leste, I would like to thank all relevant stakeholders who contributed to the development of this strategy, and I urge all partners within the health sector to align their health nutrition-related actions and resources to this strategy implementation. I have confidence that this strategy will contribute to bringing significant improvement in the nutritional status of children and women of Timor-Leste.

dr. Odete Maria Freitas Belo, MPH
Minister of Health
Democratic Republic of Timor-Leste


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1 BACKGROUND AND CONTEXT

Despite commendable efforts to put in place evidence-based policies, strategies, and interventions, Timor-Leste continues to experience persistently high rates of underweight and obesity in children. There is also a slow upward trend in rates of overnutrition in women, particularly among women of reproductive age. The burden of undernutrition and overweight and obesity threatens the gains made towards human capital development in the past years and achievements towards realising the World Health Assembly (WHA)[1] nutrition targets by 2025. An unacceptably high number of children continue to face the multiple burdens of malnutrition.[2] Malnutrition results from interaction between poor dietary intake; poor-quality health care services; care; environment and behaviours. The multiple burdens of malnutrition persist despite the availability of healthy diets that meet the nutritional needs of individuals by providing sufficient, safe, and diversified foods to maintain an active life and reduce risks of disease throughout the country.

The core drivers of malnutrition are further exacerbated by the overarching factors of poverty and socio-cultural norms and taboos that shape food choices. In addition, gender inequality and the changing climatic conditions expose vulnerable population groups to malnutrition. Together, these overlapping complex interactions are persistently contributing to the malnutrition challenge in Timor-Leste. Accelerating progress towards malnutrition reductions thus deserve serious attention and prioritization within the national agenda.

Since the development of the first National Nutrition Strategy of Timor-Leste in 2004, there have been several emerging global, regional and national initiatives to accelerate improvements in nutritional status. The alignment of this health sector nutrition strategic plan to these initiatives is crucial. Specifically, the global focus to translate the evidence that the first 1000 days of life, between conception and a child's second birthday is a unique period of opportunity to protect, promote and support the foundations of optimum health, growth, and neurodevelopment across the lifespan. There is also growing evidence on the impact of adolescent nutrition in breaking the vicious cycle of intergenerational malnutrition, chronic diseases and poverty. Epidemiological evidence from both developed and developing countries indicates that there is a link between foetal under-nutrition and increased risk of various chronic diseases during adulthood.[3]

1 https://www.who.int/nutrition/global-target-2025/en/

2 Asia & the Pacific Regional Overview of the Food Security and Nutrition. Accelerating Progress Towards SDGs. FAO/UNICEF/WFP/WHO. 2018

3 Adolescent Nutrition: A review of the situation in selected South-East Asian Countries – World Health Organization – Regional Office for South East Asia New Delhi

Rationale for the development of the National Health Sector Nutrition Strategic Plan (2022-2026)

Given the high levels of malnutrition and the contribution of high impact nutrition, specifically interventions to reduce the immediate causes of malnutrition, the MOH decided to develop a health sector nutrition strategic plan. The HSNSP (2022 - 2026) offers an opportunity to guide the health sector in its programmatic efforts to contribute to national and health sector nutrition goals in the next five years. The improvements in nutrition are a critical determinant for building the country's human capital.

Since the National Nutrition Strategy 2014-2019 was completed in 2019, a number of new issues have emerged including:

- **Technical rationale:** The need to address all forms of malnutrition, including obesity, overweight and diet related non-communicable diseases (NCD)s, throughout the life cycle cannot be overemphasized to break the intergenerational cycle. Although, there has been high consideration attached to the 1000 days window of opportunity to improve maternal, newborn, infant and young child nutrition in the National Nutrition Strategy of 2014, the focus was on child nutrition, pregnant and lactating women. In the current strategy, the nutrition gaps along the life course specifically include maternal nutrition and adolescent girls and, vulnerable population groups such as the elderly, sick people, and convalescents.
- **Policy and strategic rationale:** Realignment with nutrition sensitive interventions with proven impacts for improved nutrition outcomes will be promoted and delivered through the health sector. Recognising that stunting cannot be addressed through the health sector alone, attention will be paid to the agriculture and food sector, water, sanitation and hygiene, education as well as social protection both to facilitate access to nutritious food and in the context of gender mainstreaming. Specific attention will be given to institutional and human resource capacity building.
- **Programmatic rationale:** Mainstreaming nutrition interventions into primary health care (PHC) is essential to the successful implementation of this strategy. The collaboration, realignment and coordination with other relevant health departments have been weak in the past. Implementation of high impact nutrition interventions within the health system will be explored. Similarly, targeting hard-to-reach populations including geographically isolated communities, and sub-populations that are not traditionally reached with government programs. It includes ensuring the community health care strategy Saude na Familia incorporates and brings nutrition services closer to the hard-to-reach population.

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2 THE NUTRITION SITUATION

2.1 Nutrition Situation in Timor-Leste:

Children under-five Nutrition Situation

Since 2004, the nutrition status of children and women of reproductive age in Timor-Leste has been improving. However, for most indicators' prevalence remains high and well above acceptable public health cut-offs as per WHO classification with increasing trends of overweight and obesity among women of reproductive age[4].

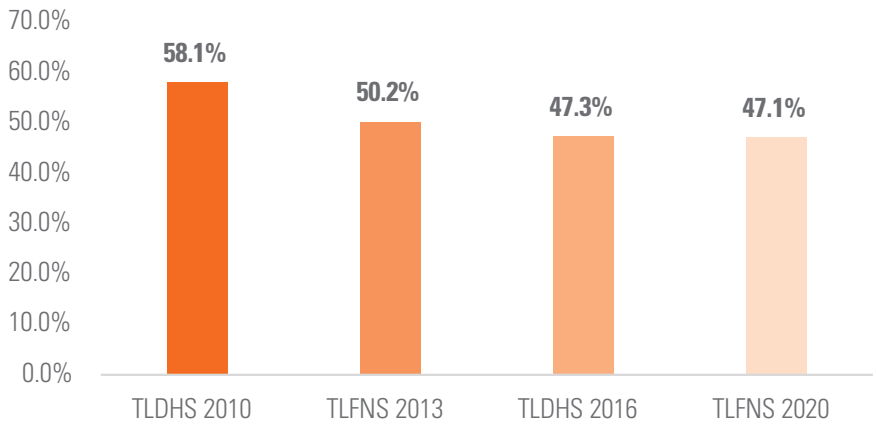
Stunting

The TLFNS 2020 reported that almost half of children under five years are affected by chronic malnutrition with 47.1 % categorised as stunted placing them at risk of morbidity and mortality. Timor-Leste has the highest prevalence of stunting compared to countries in the East Asia Pacific Region and the sixth highest rate globally. The combined moderate and severe stunting rate for children increases from birth to 23 months and stagnates thereafter to five years (0-5 months 13.4%, 6-11 months 20.9%, 12-23 months 51.9%, 24 – 35 months 62.7%, 36 – 47 months 60.4% and 48 – 59 months 55.3%. WHO thresholds for public health significance for stunting are as follows: 'very low' (<2·5 %); 'low' (2·5 - <10 %); 'medium' (10 - 20%); 'high' 20 - 30%) and 'very high' (>30 %), which is above 'very high' threshold. Stunting is a well-established risk marker of poor child development. Stunting before the age of two years predicts poorer cognitive and educational outcomes in later childhood and adolescence[5]. The TLFNS 2020, further reports prevalence to be higher among children in lowest wealth quintile (57.2%) compared to those in highest wealth quintile (34.7%)[4]. Children from mothers with no education have higher prevalence of stunting (52.3%) compared to those from educated mothers (31.2%)[4]. Although there has been a downward trend, it is important to note that stunting prevalence in Timor-Leste is still very high using WHO revised thresholds for public health significance (WHO 2018).

4 Timor-Leste Food and Nutrition Survey (2020)

5 Black RE, Victora CG, Walker SP, Bhutta ZA, Christian P, de Onis M, et al.; the Maternal and Child Nutrition Study Group. Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet 2013;371:243–60. doi:10.1016/S0140-6736(13)60937-X.

Figure 1: Prevalence of stunting among children 0-59 months



Prevalence of low birth weight

Low birth weight (LBW) is defined as less than 2,500 grams (up to and including 2,499 grams). Babies born with LBW are more likely to have poor health and to become stunted during their first two years of life, a stunted adolescent and a malnourished woman who, in turn, will have her own low-birth weight baby[6]. In Timor-Leste, national surveys showed that about 10% of those who reported birth weight of children under-five years of age had LBW (less than 2.5 kg). First-born children (13.8%), those living in rural areas (11.4%) and from lowest quintile (16.7%) are more likely to have low birth weights[7]. The proportion was high in the lowest quintile (10% in 2010[8] and 16.7% in 2016[7]) whereas LBW was higher in women under 20 years (18% in 2010[8] and 8.3% in 2016[7]).

Underweight among children under-five years of age

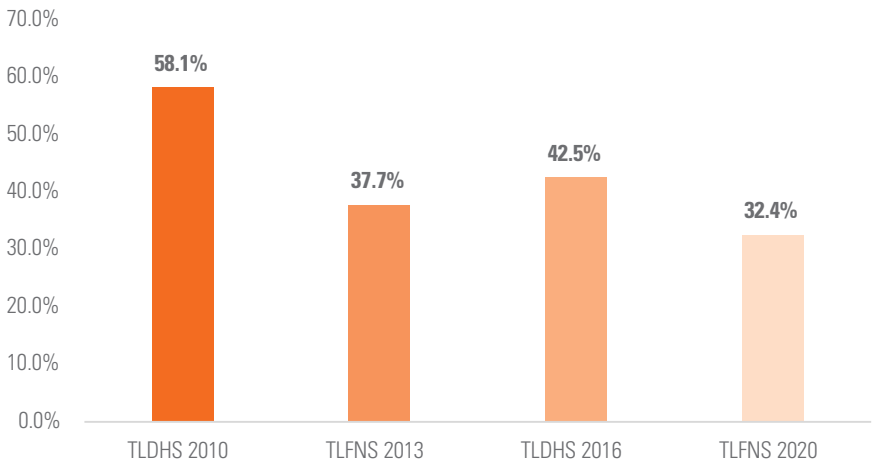
The prevalence of underweight among children under five years of age has decreased from 58.1% in 2010 to 32.4% in 2020. The prevalence is higher among children in the lowest wealth quintile (37.3%) compared to those in the highest wealth quintile (27%). Children from mothers with no education have higher prevalence of underweight (34.6%) compared to those from mothers with education higher than secondary school (21.5%)[4]

6 Low Birthweight – Nutrition policy discussion paper No. 18 https://www.unscn.org/layout/modules/resources/files/Policy_paper_No_18.pdf

7 General Directorate of Statistics (GDS), Ministry of Health and ICF. 2018. Timor-Leste Demographic and Health Survey 2016. Dili, Timor-Leste and Rockville, Maryland, USA, GDS and ICF.

8 National Statistics Directorate - NSD/Timor-Leste, Ministry of Finance/Timor-Leste, and ICF Macro. 2010. Timor-Leste Demographic and Health Survey 2009-10. Dili, Timor-Leste: NSD/Timor-Leste and ICF Macro.

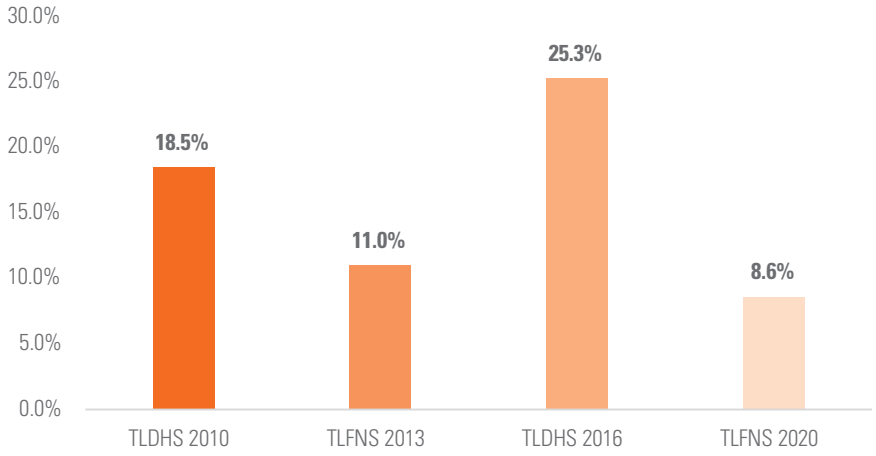
.Figure 2: Prevalence of underweight among children 0-59 months



Wasting among children under-five years of age[9]

Throughout the developing world, 13% of children under five years of age are wasted (low weight for height), and 5% of these children are severely wasted. In Timor-Leste about 8.6%[4] of children under five are wasted and the prevalence starts to peak at age 6-11 months (9.0%) and continues increasing to age 12-23 months (9.8%)[4]. Wasting prevalence in Timor-Leste varies slightly between urban (8.9%) and rural children (7.3%). Also, between lowest quintile (7%) and highest quintile (10%). Children from mothers with no education have higher prevalence of wasting (7.9%) compared to those from educated mothers (6.9%). Table 4 below represents the trends of wasting since 2010, while the rates have fallen by over half, they remain at medium prevalence of WHO thresholds (5 - <10%) for public health problems.

Figure 3: Prevalence of wasting among children 0-59 months

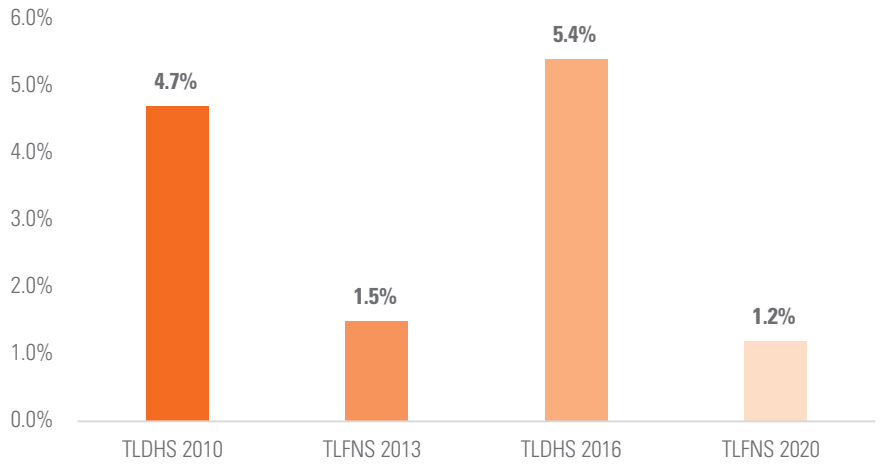


9 WHO 2018 new thresholds for wasting are: 'very low' (<2·5 %); 'low' (2·5 - <5 %); 'medium' (5 - 10%); 'high (10 - 15%) and 'very high' (>15 %).

Overweight among children under-five years of age

1.2% of children (aged 0-59 months) are overweight (>+2SD Weight-for-height).[4]

Figure 4: Prevalence of overweight among children 0-59 months



Situation of maternal nutrition

Data from the 2020 TLFNS indicates that 61.9% of women have a normal BMI, 18.8% are undernourished or thin and 19.3% are overweight/obese. Younger women aged 15-19 years are more likely to be undernourished than women in older age groups. During the period 2013 – 2020 the prevalence of underweight (BMI <18.5) among women of reproductive age (15-49 years) decreased from 24.8%[10] to 18.8%[4]. Low BMI in women is one of the risk factors of LBWs and LBW has been documented as a determinant of stunting[11,12]. In addition, 12.6% of the women had short stature (<145cm) in 2020, increased with age from 10.6% in the 15-19 years age group to 17.2% (in the 40-49 years age group[4]).

The proportion of women who were underweight (<18.5 kg/m^2) decreased from 26.6% in 2016[7] to 18.8% in 2020[4] while the proportion of women who were overweight/obese (BMI >=25kg/m^2) increased from 9.8% in 2016 to 19.3% in 2020.

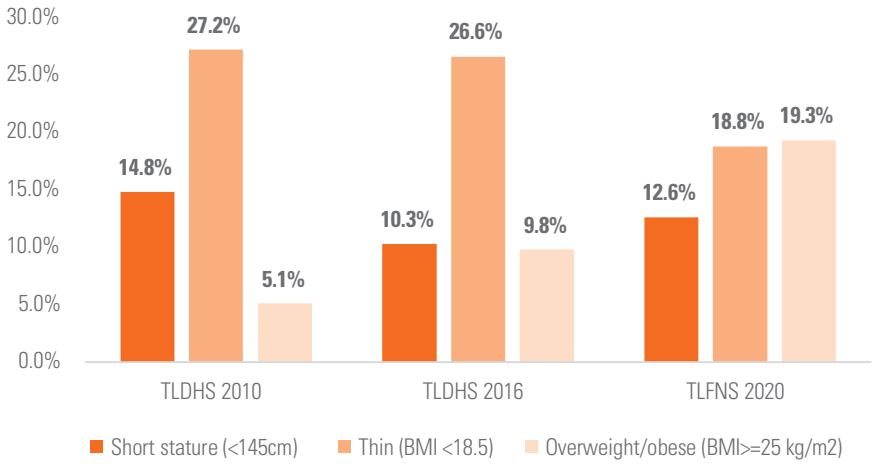
The proportion of women who were thin (MUAC below 21cm) was 9.4%, with 21.9% having a MUAC between 21 and 22.9cm. For pregnant and lactating women, 8.9% were thin (MUAC below 21cm) with 23.2% having MUAC measurements between 21 and 22.9 cm and the proportion was much higher among rural women than urban women and were also lowest in the highest wealth quintile.

10 Timor-Leste Food and Nutrition Survey 2013

11 Aryastami, N.K., Shankar, A., Kusumawardani, N. et al. Low birth weight was the most dominant predictor associated with stunting among children aged 12–23 months in Indonesia. BMC Nutr 3, 16 (2017). https://doi.org/10.1186/s40795-017-0130-x

12 Ntenda, P.A.M. Association of low birth weight with undernutrition in preschool-aged children in Malawi. Nutr J 18, 51 (2019). https://doi.org/10.1186/s12937-019-0477-8

Figure 5: Nutrition status of women 15-49 years



Micronutrient deficiencies

The prevalence of anaemia (Hb concentration <110 g/L) among children (aged 6–59 months) was 63.2% and is classified as a 'severe' public health problem (WHO: prevalence of anaemia >40%). Anaemia was higher in children aged 6–23 months than in those aged 24–59 months of age, in boys than in girls, in children who had suffered from diarrhoea in the last weeks, in children in urban areas and in areas where <50% of aldeias (hamlet) were covered by the open defecation-free (ODF) programme.

The study found low iron stores in 20.5% of children aged 6–59 months and in 23.2% as measured by body iron stores. Functional iron deficiency was reported in 51.7% of children whereas the prevalence of iron deficiency anaemia (IDA; serum ferritin concentration <12 µg/L and Hb <110 g/L) was 18.9% and was higher among boys (22.9%) than girls (14.5%)[10].

The TLFNS 2013 reported 34% of children (aged 6–59 months) with low serum zinc concentrations (<8.7 µmol/L). Serum zinc concentration is a reasonable biomarker of zinc deficiency in a population and when the prevalence is >20%, interventions to improve zinc status are recommended by WHO (2007 The poorest families had the lowest zinc concentration (9.09 poorest vs. 9.81 µmol/L richest), and prevalence of zinc deficiency was higher in rural areas (rural 42.0%, 18.6% urban)[10].

Low serum retinol binding protein (RBP) was reported in 9.7% and low serum retinol concentrations (<0.70 µmol/L) in 8.1% of children aged 6-59 months indicating Vitamin A Deficiency (VAD) is a moderate/mild public health problem (WHO: ≥2% – <10% mild VAD). Children aged 6–23 months had lower serum concentrations of RBP and retinol compared to those 24–59 months, boys had lower concentrations than girls and urban areas had lower concentrations than rural areas[4].

The prevalence of anaemia (Hb <120 g/L) in mothers was 38.9%, classified as a 'moderate' public health problem (WHO: 20 – 39.9%). Functional iron deficiency was found in 29.4% of non-pregnant mothers whereas iron deficiency anaemia was 15.7%. The prevalence of low serum ferritin concentrations was lower in non-pregnant mothers aged 35 years and above[10].

The prevalence of marginal VAD in mothers was 13.5% (retinol) and 4.9% (RBP). The prevalence of iodine deficiency (UIE <100 µg/L) in mothers was 26.7%. Mothers who were aged ≥35 years, with no education and living in rural areas had lower median UIE concentrations than educated mothers aged <35 years living in urban areas. Very low UIE concentrations (<50µg/L) were found in 13.5% of mothers[10].

Nutrition/diet related non-communicable diseases

In 2014 the STEP survey reported raised blood pressure (defined as having SBP ≥140 mmHg and/or DBP ≥90 mmHg) in 39.3% of all adults (45.3% of men and 28% of women). The prevalence of raised blood glucose (fasting glucose level ≥7.0 mmol/L) was 1.5 %. Moreover, the prevalence of raised total cholesterol (defined as having total cholesterol ≥5.0 mmol/L) was 21% in both sexes, with more females having raised blood cholesterol than males (25.5% female and 18.5% male)[13]. WHO estimates indicate that in Timor-Leste, NCDs accounted for 44% of all deaths and that the probability of premature mortality from NCDs was 24%[14]. The Institute of Health Metrics and Evaluation, in its Global Burden of Disease (GBD) report, ranks ischaemic heart disease and stroke as the fifth- and seventh-highest causes of death, respectively, for 2010 in Timor-Leste[15].

Overweight and obese children are at higher risk of developing serious health problems including type 2 diabetes, high blood pressure, asthma and other respiratory problems, sleep disorders and liver disease. They may also suffer from psychological effects, such as low self-esteem, depression and social isolation. Childhood obesity also increases the risk of obesity, NCDs, premature death and disability in adulthood.

13 WHO. 2015. National Survey for Non-communicable Disease Risk Factors and Injuries Using WHO STEPS Approach in Timor-Leste-2014. WHO Regional Office for South-East Asia

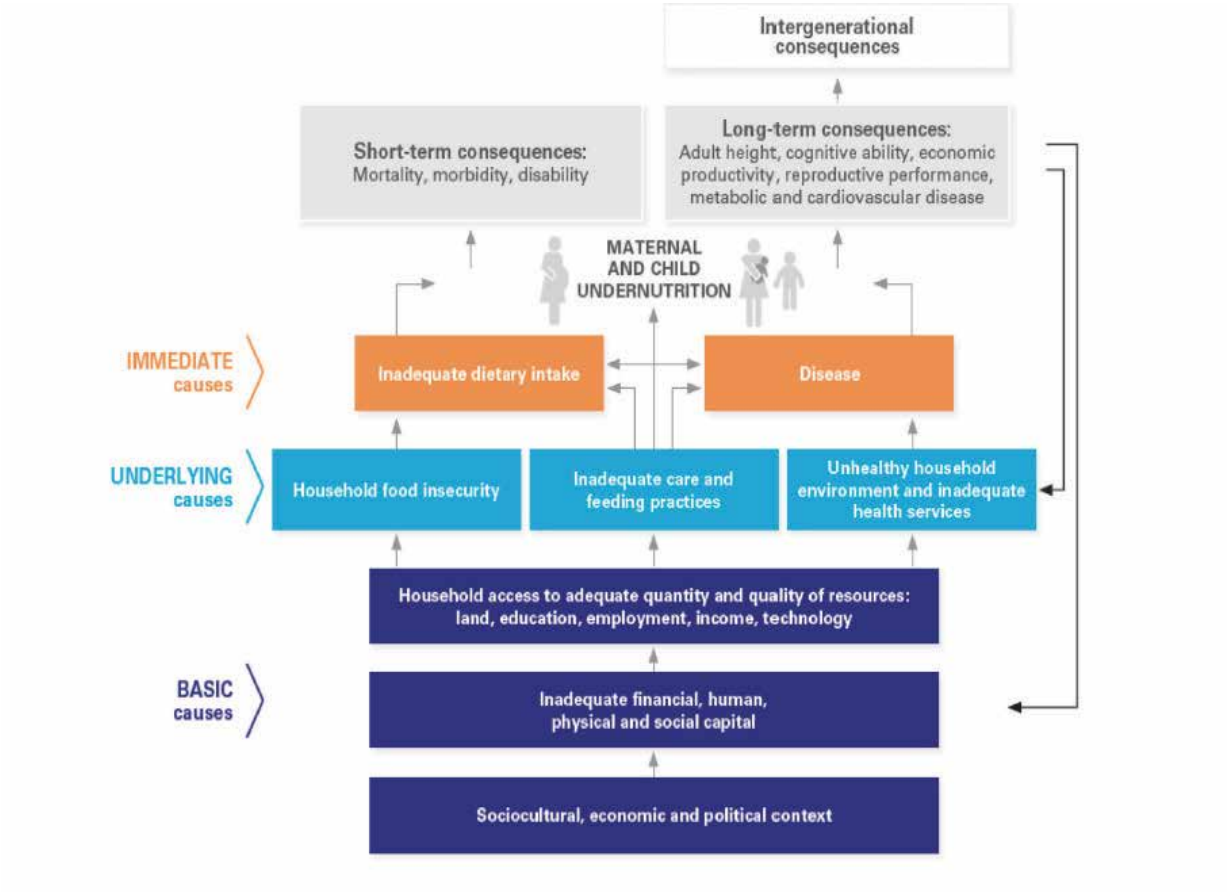
14 Noncommunicable diseases country profiles 2014. Geneva: WHO; 2014

15 GBD profile: Timor-Leste. Seattle: Institute for Health Metrics and Evaluation; 2010

2.2 Summary of Drivers of Malnutrition in Timor-Leste

The causes of malnutrition are multifaceted. The UNICEF framework of malnutrition provides the opportunity to review causes of malnutrition and factors at different levels including immediate, underlying and basic causes (Figure 6).

Figure 6: Conceptual framework of malnutrition

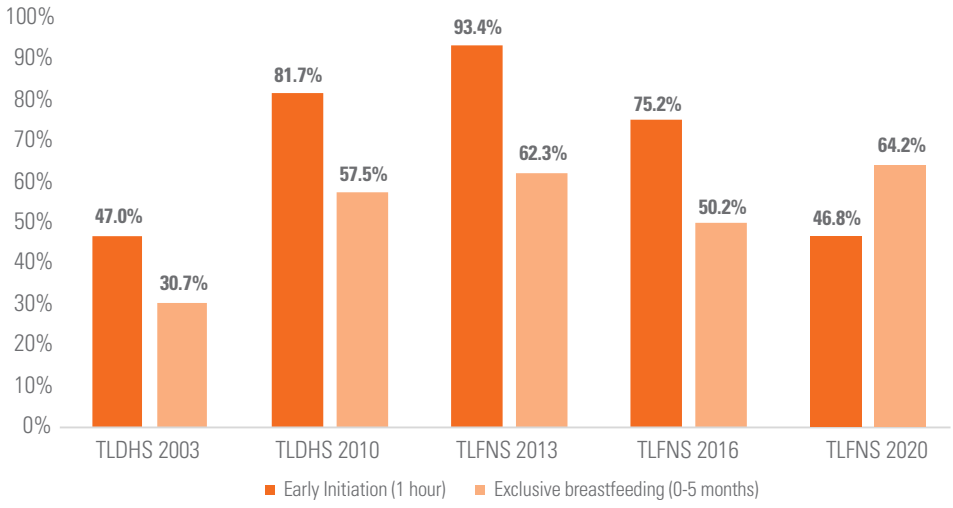


2.2.1 Inadequate Dietary Intake

Children 0-59 months

Optimal infant and young child feeding practices are specifically linked to reduced stunting and improved weight for age[16]. In Timor-Leste, exclusive breastfeeding more than doubled from 2003 to 2020 while early initiation of breastfeeding decreased from 75.2% to 63.5% in 2016[17]. In 2010 the rate was 81.7% and in 2013 it was 93.4%. The proportion of exclusively breastfed infants aged 0-5 months is higher if born from a mother with low education (69%) compared to (57.9%) from an educated mother. The proportion of exclusively breastfed infants is higher for those living in rural areas (70.8%) compared to urban areas (60.8%) and from lower wealth quintile (72.2%) compared to high wealth quintile (56.8%).

Figure 7: Breastfeeding practices



Complementary feeding practices are sub-optimal and for years have remained low. WHO guiding principles for feeding the breastfed child recommend that breastfed infants aged 6–8 months be provided complementary foods 2–3 times per day and breastfed children aged 9–23 months be provided complementary foods 3–4 times per day with additional nutritious snacks offered 1–2 times per day. In Timor-Leste, 52.3% of children 6-23 months received minimum meal frequency (MMF)[18]. The proportion of children fed with MMF has shown a concerning decline since 2013 (79% in 2013, 48% in 2016, and 52.3% in 2020) as MMF is associated with stunting[4]. WHO and UNICEF has recommended that a child should receive the minimum dietary diversity (MDD) of foods and beverages from at least five out of eight defined food groups to maintain proper growth and development during this critical period[19]. In Timor-Leste, 35.3% received minimum dietary diversity (MDD)[4]. On the other hand, the proportion of children 6-23 months receiving MDD has been on the upward rise (28% in 2013 to 35.3% in 2020) although it is still low. Food group diversity is associated with improved linear growth in young children[20]. A diet lacking in diversity can increase the risk of micronutrient deficiencies, which may have a damaging effect on

16 Bhutta Z.A., Das J.K., Rizvi A., Gaffey M.F., Walker N., Horton S. et al. 2013. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? The Lancet 382(9890) 452-477

17 General Directorate of Statistics (GDS), Ministry of Health and ICF. 2018. Timor-Leste Demographic and Health Survey 2016. Dili, Timor-Leste and Rockville, Maryland, USA, GDS and ICF.

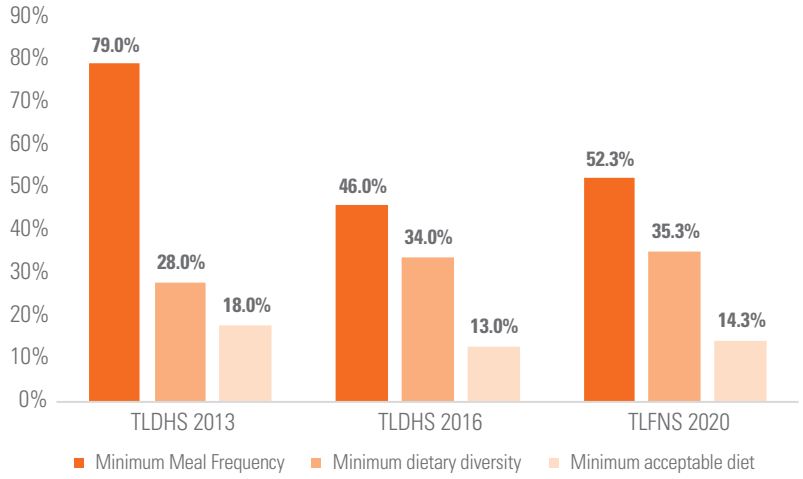
18 Guiding principles for complementary feeding of the breastfed child. Washington: Pan American Health Organization-World Health Organization; 2003 (https://www.who.int/nutrition/publications/guiding_ principles_compfeeding_breastfed.pdf, accessed 31 August 2020).

19 Indicators for assessing infant and young child feeding practices: definitions and measurement methods. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2021. Licence: CC BYNC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo

20 Onyango AW, Borghi E, de Onis M, Casanovas Mdel C, Garza C. Complementary feeding and attained linear growth among 6–23-month-old children. Public Health Nutr. 2014;17(9):1975–83.

children's physical and cognitive development[21]. Consequently, TLFNS 2020 reported that a very high proportion of children 6-23 months had consumed grains, roots, and tubers (97.5%) and breast milk (90.6%), as well as vitamin A-rich fruits and vegetables (71.5%). Consumption of dairy products (0.8%) was low, while consumption of flesh foods (23.1%) and legumes or nuts (31.0%) was also relatively low. The 2020 survey reported that 19.1% of children 6-23 months consumed sugar sweetened beverages, 31.0% consumed sweet or savoury junk foods, while 20.0% did not consume any fruits or vegetables and 35.9% consumed no eggs or flesh foods.

Figure 8: Complementary feeding practices 6-23 months



Inadequate dietary intake among women of reproductive age

Women of reproductive age (WRA) are nutritionally vulnerable and dietary diversity is a key element of diet quality, but diets of women of reproductive age (WRA; aged 15–49 y) in resource-poor settings are often deficient in a range of micronutrients[22,23,24]. Poor nutrition before and during pregnancy and lactation compromises the health of mothers and their infants[25]. The proportion of women who met the minimum dietary diversity (MDD-W) is 65.4%. The proportion did not differ significantly between age groups. The MDD-W is higher among urban women (65.3%) than rural women (57.7%) and was lowest in the lowest wealth quintile (50.1%), increasing to 78.3% in the highest wealth quintile[4].

Nearly 9 in 10 women reported consumption of sugar sweetened beverages (86.3%), with more than 7 in 10 (71.4%) reporting consumption of sweet or savoury junk foods. Only 2.7% consumed no fruits or vegetables, and over 1 in 3 (36.2%) consumed no eggs and/or flesh foods. The proportion of women who consumed sugar sweetened beverages was higher in rural women (87.8%) than urban women (83.5%), and highest in the lowest quintile, and lowest in the highest wealth quintile. The consumption of sweet or savoury junk foods was higher in urban women (75.7%) than rural women (66.8%) and was highest in the highest wealth quintile (77.2%) and lowest in the lowest wealth quintile (64.7%). The proportion who consumed no eggs and/or flesh foods was much higher in rural women (42.5%) than urban women (27.0%) and increased with decreasing wealth quintile from only 16.1% in the highest wealth quintile to 52.4% in the lowest wealth quintile[4].

21 Prado EL, Dewey KG. Nutrition and brain development in early life. Nutr Rev. 2014;72(4):267–84. doi:10.1111/nure.12102.

22 Arimond M, Wiesmann D, Becquey E, Carriquiry A, Daniels MC, Deitchler M, Fanou-Fogny N, Joseph ML, Kennedy G, Martin Prevel Y, et al. . Simple food group diversity indicators predict micronutrient adequacy of women's diets in 5 diverse, resource-poorsettings. J Nutr 2010;140(Suppl):2059S–69S.

23 Lee SE, Talegawkar SA, Merialdi M, Caulfield LE.. Dietary intakes of women during pregnancy in low- and middle-income countries. Public Health Nutr 2013;16:1340–53.

24 Torheim LE, Ferguson EL, Penrose K, Arimond M.. Women in resource-poor settings are at risk of inadequate intakes of multiple micronutrients. J Nutr 2010;140(Suppl):2051S–8S.

25 Black RE, Victora CG, Walker SP, Bhutta ZA, Christian P, de Onis M, Ezzati M, Grantham-McGregor S, Katz J, Martorell R, et al. . Maternal and child under-nutrition and overweight in low-income and middle-income countries. Lancet 2013;382:427–51.

Dietary quality remains poor with overdependence on cereals and starchy roots[26]. Rice constitutes the major source of daily dietary intake although other staples consumed include maize and starchy roots. Rice alone contributes to 45% of cereal intake while maize is 42%. Animal source foods are inadequately and rarely consumed.

A diet that fulfils the nutrient requirements of energy, proteins and micronutrients remains unaffordable to the majority of Timorese households[27]. Fill the Nutrient Gap (FNG) and cost of diet Analysis[28] established that a nutritious diet across the different municipalities would cost between USD32-64 per month for a household of five to meet the energy requirements and on the contrary, USD158-211 to meet the nutrient needs for proteins, energy and micronutrients. This implies that meeting nutrient needs in terms of adequacy, quality, quantity and diversity is a challenge for many households. Furthermore, gaps in nutrient intake are attributable not only to affordability, but equally to availability and access. Nutritious diets may therefore not be accessible to vulnerable population groups, notably pregnant, lactating women, infants and young children all of whom are vulnerable to malnutrition.

2.2.2 Diseases

Acute Respiratory Infections (ARI) and diarrheal diseases remain among the top causes of morbidity and mortality among infants and small children globally[29]

In Timor-Leste, the TLFNS 2020 reported 15.2% of infants and small children having experienced diarrhoea, with 9.9% acute respiratory infection, and 23.5% fever (without cough) two weeks prior to the survey. Diarrhoea and fever two weeks prior to the survey among children 6-59 months was associated with higher rates of stunting and wasting[4]. Anorexia, reduction of intestinal absorption, metabolic damage, disorder metabolism of lipids and carbohydrates, reduction of vitamins, iron, zinc, and copper, weaken the body's ability to fight infection and is a cause of malnutrition[30].

Coverage of child and maternal health services

The health sector has maintained a high coverage of some child and maternal health and nutrition interventions. The coverage of measles vaccination was reported to be 86.3%, with 60.3% confirmed by the card (LISIO). 77.8% of eligible children had received Vitamin A supplementation in the last six months, whereas the coverage of deworming was 71.4%. The proportion of children who received micronutrient powder was 18.1%[4]. Also, TLFNS 2020 reports 64.1% of women participated in 4-7 antenatal care visits in their last pregnancy, with 19.0% having 8 or more visits.

The MOH conducts regular growth monitoring promotion and assessment (GMP&A) monthly at health facilities or SiSCA (Servisu Intergradu Saude Comunitaria / Integrated Community Health Services) with more than 50% of children under-five reached by this service. The GMP&A actions are directly related to the prevention of wasting. If correctly and regularly carried out, early identification of growth faltering can be managed, and cases of acute malnutrition identified.

26 Agriculture Policy and Strategic Framework "Towards Nutrition-Sensitive, Climate Smart Agriculture and Food Systems". June 2017
27 WFP (2019): Fill the Nutrient Gap Timor-Leste
28 WFP (2019): Fill the Nutrient Gap Timor-Leste
29 https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality#:~:text=Top%2010%20countries%20with%20the,children%20under%2D5%20years%2C%202019&text=Globally%2C%20infectious%20diseases%2C%20including%20pneumonia,death%20for%20children%20under%20five
30 Farhadi S, Ovchinnikov RS. The relationship between nutrition and infectious diseases: A review. Biomed Biotechnol Res J 2018;2:168-72.

Diet-related Non-Communicable Diseases (DR-NCD)

The prevalence of overweight and obesity among children under the age of five years is currently 1.2% and prevalence among WRA is 18%[4]. While this is still far below that of neighbouring countries, policy directions must be implemented to dramatically reduce its gradual prevalence before it becomes unmanageable.

Noncommunicable diseases (NCDs) are the world's leading cause of death: they were responsible for an estimated 41 million (73%) of the 56 million deaths in 2017. Many of those deaths were premature (i.e., under the age of 70 years) and occurred in low and middle-income countries. Modifiable risk factors such as unhealthy diet and physical inactivity are some of the most common causes of NCDs, including obesity. Timor-Leste has seen an increasing trend of NCDs and related deaths[31]. Lack of access to integrated healthcare services for people who suffer from cardiovascular diseases (CVD) and other NCDs is also an issue.

Processed foods high in trans fats, saturated fats, sugar and salt, plus sugar-sweetened beverages, are associated with increased risk of hypertension, diabetes, elevated cholesterol and CVD. The TLFNS 2020 revealed an increased consumption of sugary, sweet or savoury junk foods which tend to be highly processed[4]. This corresponds to increased prevalence of overweight and obesity among women. Such nutrition transition is affecting dietary patterns and nutrient intake, thus increasing the risks of diet related non-communicable diseases. Dietary patterns and lifestyles across different socio-economic levels are shifting towards consumption of unhealthy, highly processed foods containing trans fats and sugars[4]. Processed foods such as instant noodles, have increasingly gained popularity over time due to their convenience and taste. These processed foods may contain high salt and fat content which pose health risks and vulnerability to DR-NCD.

Increased urbanisation and use of motorised transport may contribute to sedentary lifestyles, which have detrimental implications for cardiovascular health[32].

2.2.3 Access to Environment Health and Sanitation

In Timor-Leste, access to safe water, hygiene and sanitation has improved only slightly during the past 20 years:

The majority of the population (60%) had no hand washing facilities with soap and most concerningly 28% of rural households still practice open defecation compared to 0% in urban settings. In terms of access to toilet facilities, the TLFNS 2020 reported 31.1% used a flush latrine with septic tank, 31.1% a pit latrine with a slab, 9.9% use a pit latrine without slab, 9.4% use a flush latrine without septic tank and 11.6% without a toilet facility[4]. Safely managed sanitation cannot be traced due to lack of data on human excreta disposal which still lacks public attention compared to access to latrines. This data gap prevents analysing specific implications such as management of children's excreta[33]. Children living in poor sanitary conditions ingest high concentrations of faecal bacteria, which colonise the small intestine and induce tropical enteropathy through a T-cell-mediated process. The hyperpermeable gut facilitates translocation of microbes, which trigger the metabolic changes of the immune response. Growth falters when these changes coincide with reduced nutrient absorption by atrophied villi, marginal dietary intake, and the high growth demands of the first two years of life[34].

31 NCD report
32 World Health Organization. Health in 2015: from MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals. WHO. 2015
33 WHO/UNICEF Joint Monitoring Programme (JMP) on water, hygiene and sanitation, 2019
34 Dr Jean H Humphrey, ScD. Child undernutrition, tropical enteropathy, toilets, and handwashing. The Lancet 2009; 374: 1032–35

2.2.4 Enabling Environment:

The current budgetary allocations for nutrition are not comparable to the scale of the malnutrition problem in the country. On average the nutrition programme spent less than 5% of its health budget on nutrition. To reach targets of stunting, wasting, micronutrient deficiencies of anaemia and exclusive breastfeeding rates, requires increased financial resources for nutrition programming.

Increased investments for nutrition by national government and development partners is critical for a successful nutrition programme. The prevalence of malnutrition remains high, justifying the need for increased resource mobilisation and increased investments for the nutrition programme. In recognition of importance of nutrition, in 2020 the MOH established a harmonized budget line for nutrition, it is a significant step towards scale-up of nutrition interventions and sustainability of the nutrition programme.

Investments in nutrition are critical to saving lives and helping vulnerable population groups to thrive and reach their full potential, yet budget allocations for nutrition as a percentage of the government's expenditure within the health sector remains below the global recommended threshold - 15% of the total budget.

According to the 2019proposal for establishing baseline and targets for increased nutrition budget allocation to MOH and Autonomous Pharmaceutical/Medical Equipment Service (SAMES), over the years, there have been improved financial allocations to medical supplies of relevance to nutrition. Examples include RUTFs, Vitamin A, Iron Folic Acid Supplementation, deworming tablets and albendazole and a nutrition staff member seconded to SAMES to ensure appropriate budget planning and procurement of nutrition supplies.

Direct budget support from the European Union (EU) has funded an integrated nutrition programme and facilitated the MOH to recruit, train and deploy 70 nutrition technicians to health facilities to facilitate the implementation of essential nutrition-specific interventions with both preventive and promotional components. To date, the nutrition technicians are now being financed through MOH budget.

An appropriate regulatory environment is vital to implementation of nutrition interventions and the achievement of improved nutrition outcomes. Regulations that work effectively are those upon which promulgation are enforced and monitored. Political commitment is required to ensure regulatory frameworks are enacted, implemented and monitored. A number of nutrition related laws and regulations await promulgation e.g., the code to regulate the marketing of breast milk substitutes (BMS); mandatory food fortification law which includes salt iodization which mandates all salt (imported and locally produced) should be iodised; and mandatory food fortification law. Promulgation of these need to be accelerated in the next five years.

The Nutrition Policy Context

The Government of Timor-Leste has made enormous political commitments to improve nutrition since independence. The importance of improving nutrition is highlighted as a priority area of intervention in several national strategic documents and policies including Timor-Leste Strategic Development Plan (2011-2030), National Health Sector Strategic Plan (2011-2030) the National Nutrition Strategy (2014-2019); National Food and Nutrition Security Policy (2017); and The Zero Hunger for a Hunger and Malnutrition Free Timor-Leste (PAN-HAM-TL) 2015-2025.

In the national policy space for nutrition and food security, the National Council for Food Security, Sovereignty and Nutrition of Timor-Leste (KONSSANTIL), a government-led body, is vital in coordinating multi-sectoral responses to food security and nutrition. While it offers a unique role in shaping the country's food and nutrition security situation, it faces some operational challenges as the government has not formally endorsed the KONSSTANTIL statute to coordinate cross-sectoral nutrition and food security programs. Also, as an effort to improve multi-sectoral coordination and add footprints to the global nutrition agenda, Timor-Leste, joined the global Scaling Up Nutrition (SUN) movement. The SUN movement secretariate at the Prime Minister's Office has played a significant role in multi-sectoral coordination for food and nutrition security, including elaboration, positioning, and facilitating the endorsement of the statute of KONSSANTIL and the development of the SDG 2 Consolidated Action Plan for Nutrition and Food Security, a common results framework for SUN.

Capacity building

The capacity of health workforce cadres is crucial to deliver quality nutrition services at all levels. Human resource capacity for nutrition is essential and has gradually increased at the national level, however capacity gaps exist in the delivery of quality and quantity at the municipality, administrative post, and Suco levels. One of the successes of NNS 2014-2019 was the development of a specific nutrition intervention package (SNIP) for in-service training. It is essential to acknowledge the contribution of SNIP in strengthening the capacity of the health workforce to deliver quality nutrition services. However, follow-up after training (FUAT) monitoring reports highlighted gaps in translating knowledge provided into practical implementation.

Furthermore, human resources in the community have been documented as effective agents to effect change and improve nutritional status. The MOH developed training packages for other cadres of human resources within the health sector at the community level, such as Family Health Promoters and Mother Support Groups (MSG). However, the rigorous implementation of guidelines and training packages, mentoring, and monitoring needs further strengthening.

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3

THE NATIONAL HEALTH SECTOR NUTRITION STRATEGIC PLAN (2022 - 2026)

3.1 Strategic Plan Development

The foundation of the strategic plan includes the National Nutrition Strategy 2014-2019, progress, challenges, lessons learnt and best practices in achieving the optimal nutrition for the Timor-Leste population through the implementation of nutrition-specific interventions in the health system. It also takes into consideration international priorities to achieve optimal nutrition.

3.2 The Process

The development of the nutrition implementation plan involved a series of interactive steps. The process of development was informed by:

- **Evidence-based analysis of Timor-Leste's nutrition policy landscape** to determine achievements since 2014, gaps, opportunities and lessons learnt, based on available documentary and content analysis and documentation. A literature review of the current global, regional and national policies and developments for nutrition to identify recent strategies and recommended interventions. These informed the desk review on progress, gaps and achievements being made. A report is available documenting these trends and perspectives.
- **Field visits** were conducted to selected municipalities to get an overview of the existing programs and activities implemented to respond to the nutrition situation.

- **Wider stakeholder consultative interviews and meetings** with government line ministries, development partners, UN Agencies, local and international NGOs during all the stages of planning was conducted to further complement desk review. The information generated informed key achievements, gap analysis and opportunities for policy and programmatic actions, and was used to develop the strategic plan.
- The establishment of the technical working group (TWG) was instrumental in guiding the entire process.
- The process of developing the strategic plan also involved the planning and conducting of a national symposium. The information generated complemented the other processes to determine the achievements, gaps and lessons learnt. Feedback from the symposium was instrumental in the development of the draft strategic plan.
- Finally, the draft plan incorporates a monitoring and evaluation framework developed and shared with a wider audience, including the TWG for their feedback prior to incorporating comments for final revision.
- The strategic plan also takes into consideration the outbreak of diseases and
- At a final stage, the draft report will be validated in a consensus workshop prior to approval by Council of Directors.

3.3 Alignment

The Nutrition Department of MOH developed the strategic plan within the context set of strategies highlighted in the Health Sector Strategic Plan (HSSP) to facilitate its implementation for improved nutrition status and well-being of the Timor-Leste population. It aligns with the objectives of the health sector strategic plan anchored under universal health coverage (UHC) principles to achieve equitable improvement in nutritional status. The NHSNSP aligns with the country's efforts to meet the Sustainable Development Goals (SDGs) and the national commitments outlined in the Timor-Leste Strategic Development plan 2011-2030. Special priority is given to the alignment with multi-sector collaboration under KONSSANTIL, Scaling Up Nutrition (SUN) secretariat in Timor-Leste and its contribution to the SGD 2 Consolidated National Action Plan for Nutrition and Food Security (CNAP-NFS) overarching results and national health sector indicators.

To be effectively implemented, the strategic plan has considered a realistic view of the constraints on previous programs, such as insufficient resource allocations, unsuccessful advocacy, and a lack of effective coordination, particularly multisectoral. Inadequate strategic advocacy, inadequate communication support, and irregular and inconsistent monitoring during the 2014-2019 period are also recognized. Some consideration has been given to challenges brought by disease outbreak and pandemic such as COVID-19 in the delivery of services. This has included modification of service delivery mechanisms to adhere to infection prevention and control protocols and protection of both health workers and clients while maintaining coverage and quality.

The use of existing budgetary allocations is considered in the costing, as is the potential tool to mobilize additional funds from international and national sources for new or expanded initiatives. There is also a recognition of the level of human resources required and the capacity building needs for implementing the strategic plan at different management and technical levels. Constraints in funding or human resources will be aligned to the strategic advocacy within the ministry to repurpose the human resources (HR) in line with the Human Resource Strategic Plan of the MOH. A phased approach will be considered in some strategic areas, such as resource mobilization, the orientation of roles and responsibilities of various cadres, planning and training, and scale-up in the subsequent steps through the incorporation of the learning and modification of approaches.

3.4 Scope

The NHSNSP 2022-2026 has adopted a life course approach to nutritional improvements with a focus on addressing the immediate causes of malnutrition. Recognising the importance of 1,000 days, the period between a woman's pregnancy and her child's second birthday which offers a brief but critical window of opportunity to shape a child's development. It is a time of both tremendous potential and enormous vulnerability.

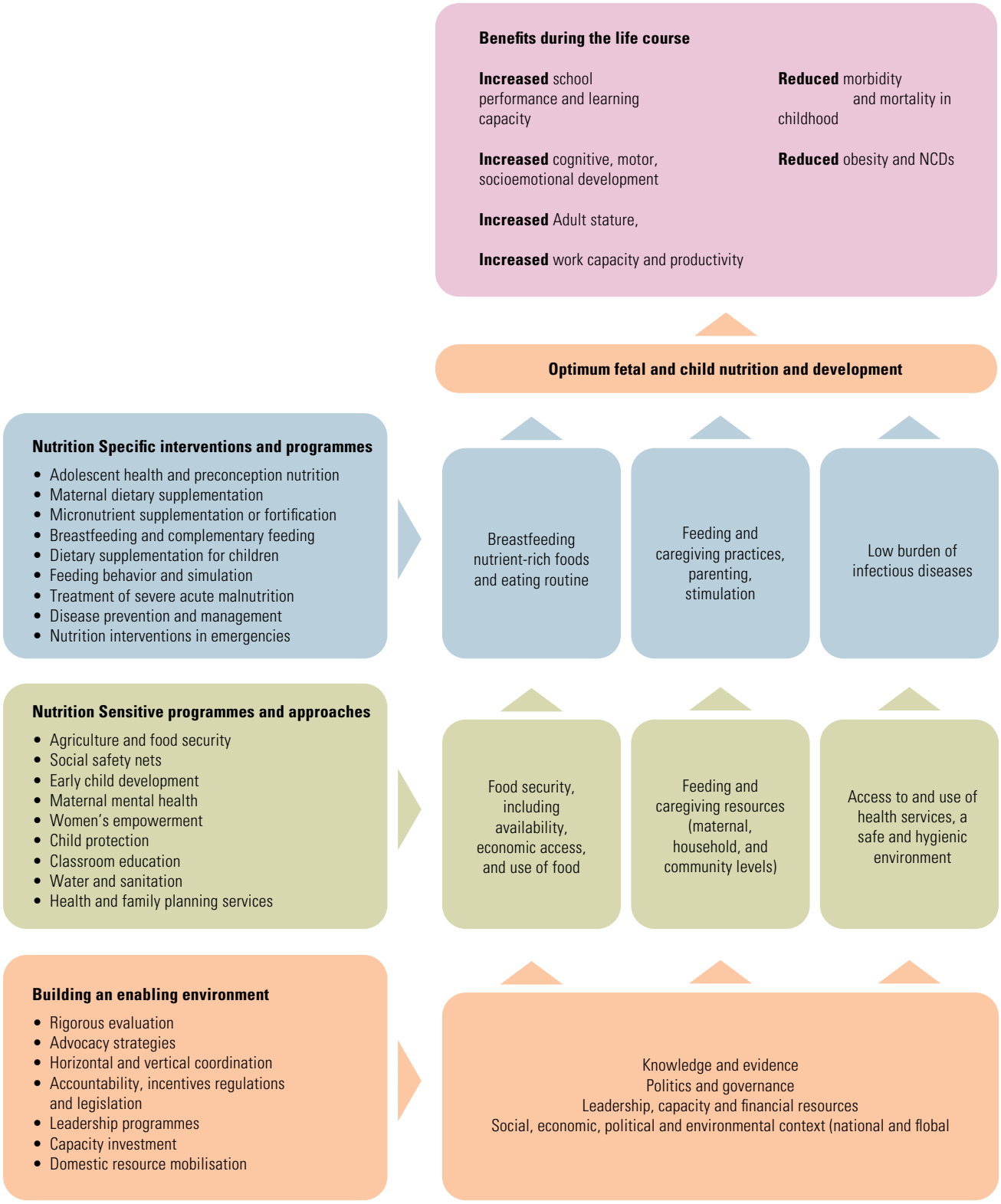
The strategic plan aims to provide guidance to nutrition stakeholders within the health sector including healthcare professionals from the government, civil society and faith-based organisations, the private sector, and development partners to deliver quality nutrition services, that address the immediate and underlying causes of malnutrition, in the short, medium and long-term in Timor-Leste. Although the HSNSP 2022-2026 will be delivered through the Health Sector, it is nonetheless cognisant of the reality that malnutrition is multifaceted requiring broad approaches and coordination to establish linkages and synergies with nutrition sensitive. This will be achieved through fostering and strengthening inter-ministerial coordination and collaboration, through health sector participation in the multisectoral coordination platform KONSSANTIL and SUN movement.

To effectively operationalise identified nutrition actions, the strategic plan provides a framework and context within which sector strategic plan and budget will be coordinated and monitored.

The actions in this strategic plan align with the conceptual framework of malnutrition as detailed in the framework for action to achieve optimum foetal and child nutrition and development (figure 4)[35] with a focus on the interventions implemented within the health sector.

35 Black et al. 2013. 'Maternal and child undernutrition and overweight in low-income and middle-income countries'. The Lancet. Vol. 382, No. 9890, pp. 427–451.

Figure 9: Framework for actions to achieve optimum foetal and child nutrition and development[35]



Source: Black et al. 2013. 'Maternal and child undernutrition and overweight in low-income and middle-income countries'. The Lancet. Vol. 382, No. 9890, pp. 427–451.

3.5 The Vision

The long-term vision of this strategic plan is to ensure that all Timorese population groups are free from all forms of malnutrition, thus enabling them to reach their full potential for improved human capital development well beyond 2030.

3.6 Goal

To ensure quality nutrition and related services are accessible to all Timorese in all health facilities by 2026 with a special focus on children under-five, adolescent girls, pregnant and lactating women.

3.7 Strategic Objectives

The objectives of this strategic plan are to:

i. Prevent all forms of malnutrition through implementation of nutrition specific interventions with an emphasis on pregnant and lactating women, children under-five and adolescents.

ii. Treat and control severe and acute malnutrition among children under-five, adolescent girls, pregnant and lactating women.

iii. Enhance nutritional support to individuals with specific needs in clinic and institutional settings

iv. Prevent and manage overweight and diet related NCDs.

v. Create an enabling environment for effective implementation of nutrition interventions within the health sector.

vi. Enhance evidence-based programming through nutrition monitoring, evaluation research, and surveillance.

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4 THE STRATEGIC FRAMEWORK

4.1 Strategic Priorities

The HSNSP (2022-2026) presents interventions to address malnutrition within the health sector in Timor-Leste, the key focus areas are as follows:

i. **Pregnant and lactating women, new-borns, children under-five years and adolescents** to address all forms of malnutrition with emphasis on the 1000 days critical window of opportunity.

ii. **Scaling up coverage** of high impact nutrition-specific and sensitive interventions delivered through the health sector to ensure access to quality continuum of care for prevention of malnutrition, early detection and treatment of undernutrition and most common childhood diseases.

iii. Community engagement for **social behaviour change** through use of advocacy, social mobilisation and behaviour change communication.

iv. **Health systems strengthening** ensuring nutrition is integrated into the pillars of health system and strengthening the capacity to deliver quality nutrition interventions.

v. **Data generation, utilization & dissemination** for evidence-based planning and programming; **increased investments for nutrition; and innovations and technology** to address malnutrition within the health sector.

vi. **Improved coordination across different programmes within the health sector** as well as with other nutrition-sensitive sectors.

4.2 Strategic Objectives, Key Outputs and Outcomes

This section presents the key strategic action areas linked to outcomes, outputs and key interventions to be achieved in the next five years.

4.2.1 **Strategic Objective 1:** Prevent all forms of malnutrition through implementation of nutrition specific intervention with emphasis on pregnant and lactating women, children under-five years and adolescents.

Rationale:

The first 1000 days of life, between a woman's pregnancy and her child's second birthday, is a unique period of opportunity when the foundations for optimum health and development across the lifespan are established. The importance of adequate foetal nutrition during pregnancy and the first two years of life has been well emphasized for the prevention of undernutrition among children but is also a key determinant of the later development of adult overweight and associated chronic conditions such as diabetes[36].

The WHO essential nutrition action (ENA) recommends a set of interventions considered critical for preventing undernutrition targeting the first 1000 days of life. In Timor-Leste, most ENAs except those related to adolescents are standard protocol in the basic package of essential health services within the health system, although there is a need to improve the coverage and quality of services. The INS supported the MOH to develop the specific nutrition intervention package (SNIP) guideline as a standard package. The importance of adolescent nutritional status in breaking the intergenerational cycle of malnutrition has been documented in various studies globally and cannot be underestimated. For adolescent girls', nutrition is critical for support during the growth spurts in the second window of opportunity and to prepare them for motherhood in the future[37], and reducing the risk of entering pregnancy while they are undernourished.

Emphasis will be on mechanisms to increase coverage of ENA, strengthening the capacity of health workers to deliver quality services, strengthening behaviour change communication activities to influence health-seeking and feeding practices, reviewing the SNIP training package, and strengthening coordination within the ministry directorates, department and programmes. Also, the Nutrition Department will coordinate and advocate with other ministries such as Ministry of Agriculture and Fisheries, Social Solidarity and Inclusion (MSSI), and BTL and ANAS to ensure nutrition sensitive interventions are implemented and scaled-up. The MOH Nutrition Department will link pregnant mothers and mothers of children under-five to social protection (Bolsa da Mae Generesaun Foun) intervention to reduced burden of food prices and improve the quality of diet. New interventions will utilise formative and operational research for evidence programming. Interventions to address adolescent girls will draw on WHO recommendations for adolescent programming and the learnings from Timor-Leste specific projects such as TOMAK-WFP adolescent formative research[38] and small-scale pilot initiatives.

This strategic plan provides recommendations for interventions to improve nutrition outcomes during these critical life stages in line with Essential Nutrition Actions (ENA) recommended by WHO most of which have been included in the specific nutrition intervention package (SNIP) guidelines.

Outcome:

By 2026, nutritional status of children under five, school-going children, adolescents and pregnant and lactating women is improved.

36 Guyon A, Quinn V, Nielsen J, Stone-Jimenez M. Essential nutrition actions and essential hygiene actions framework. Washington (DC): CORE Group; 2015

37 Adolescent Nutrition: A Review of the Situation in Selected South-East Asian Countries, WHO Regional Office for South-East Asia, New Delhi

38 Bonis-Profumo, G. and Meyanathan, S. 2018. Adolescent Nutrition in Timor-Leste: A Formative Research Study. Dili: World Food Programme (WFP) and TOMAK

Outputs:

- Increased proportion of women practicing optimal nutrition before, during and after pregnancy
- Increased proportion of mothers and caregivers of infants 0-6 months practicing optimal nutrition
- Improved feeding practices among children 6-23 months
- Increased proportion of children 6-59 months receiving micronutrient supplementation
- Adolescent girls 10-19 years have access to services for optimal nutrition
- Improved access to maternal newborn and child health services that promote nutrition
- Increased access to hygiene and sanitation services
- Increased access to quality maternal, infant, young children and adolescent health and nutrition services

Key performance indicators:

- >70% of women of reproductive age with acceptable Minimum Dietary Diversity (MDD-W)
- >80% of infants put on the breast within one hour of birth
- >50% of children 6-23 months receiving minimum dietary diversity
- >35% of children 6-23 months receiving minimum acceptable diets

Strategy 1.1: Promote women nutrition before, during and after pregnancy

Activities	Stakeholder
Counselling to improve daily energy and protein intake adherence to micronutrients supplementations and maintain physical activity before, during and after pregnancy.	Maternal and Child Health Department (MCHD), Health Promotion Department (HPD), National Directorate Saude na Familia (NDSnF), Nutrition Department (ND), INS, Municipality Health Services (MHS)
Strengthen referral services and linkages between facility and community for maternal nutrition services.	MCHD, MHS, NDSnF, ND
Control of helminth infections among pregnant women through provision of deworming.	MCHD, MHS, NDSnF, ND
Micronutrient supplementation for pregnant women including introduction and scale-up of multiple micronutrient supplementation[39].	MCHD, MHS, NDSnF, ND
Promote consumption of fortified staple foods and food condiments like rice, wheat flour, oil and salt in their regular diet.	

39 WHO antenatal care recommendations for a positive pregnancy experience Nutritional interventions update: Multiple micronutrient supplements during pregnancy; World Health Organization 2020

Strategy 1.2: Promote optimal breastfeeding practices for infants 0-6 months at facility, community and household levels

Activities	Stakeholder
Nutrition education and breastfeeding counselling for mothers and caregivers of infants 0-6 month at health facilities and in communities	MCHD, MHS, HPD, NDSnF, ND, MHS
Early initiation, establishment and maintenance of breastfeeding, including immediate skin-to-skin contact and kangaroo mother care practices at all levels of health care.	MCHD, MHS, HPD, NDSF, ND, MHS, DNASH
Support optimal feeding for low birth weight(LBW) infants	MCHD, MHS, ND, Hospital
Protect, promote and support breastfeeding and exclusive breastfeeding for the first six months of life	MCHD, MHS, HPD, NDSnF, ND
Assess and certify health facilities for baby-friendly hospital initiative (BFHI)	ND, NDSHS
Monitor adherence to baby-friendly hospital initiative (BFHI)	MCHD, MHS, HPD, NDSnF, ND, MHS
Advocate for environment to support breastfeeding in health facilities/workplace and in communities (including a minimum maternity leave time, mandatory breastfeeding breaks)	MCHD, MHS, HPD, NDSnF, ND
Commemorate national months and world breastfeeding week	HPD, MHS, NDSnF, ND

Strategy 1.3: Promote continued breastfeeding and appropriate complementary feeding practices for children aged 6 to 23 months and beyond and optimal feeding during illness

Activities	Stakeholder
Strengthen and scale-up age-specific, counselling on continued breastfeeding for up to two years or beyond and feeding for infant and young children 6-23 month both facility and community-based.	MHS, HPD, ND
Disseminate recipe book to promote appropriate complementary feeding.	MHS, HPD, ND
Educate on the importance of timely introduction and consumption of nutritionally adequate, diverse and safe complementary food.	MHS, HPD, ND
Promote optimal feeding during illness through education to caregivers, care groups and service providers on the importance of optimal feeding during and after illness.	MCHD, MHS, HPD, ND
Conduct study to understand mechanisms to improve quality and diversity of diet for children 6-23 months.	MHS, HPD, ND

Strategy 1.4: Intensify prevention and control of micronutrient deficiencies

Activities	Stakeholder
Scale up geographic coverage of vitamin A supplementation for children 6-59 months and through routine and child health campaigns and services in all facilities.	MHS, HPD, ND, NDPM, SAMES
	ND
Strengthen and scale up use of multiple micronutrient powders for point-of-use fortification to improve quality of complementary food for children 6-23 month.	MHS, HPD, ND
Control of helminth infections among children 12 – 59 months through provision of deworming.	MCHD, MHS, HPD, ND
Promote consumption of fortified staple foods and food condiments like rice, wheat flour, oil and salt in their regular diet.	

Strategy 1.5: Promote optimal nutrition for adolescent girls

Activities	Stakeholder
Develop adolescent nutrition implementation guidelines based-on evidence and findings from research and studies in Timor-Leste and disseminate to all health workforce.	ND, MCHD
Develop micronutrient supplementation guidelines for school aged children and adolescents.	
Establish and scale-up intermittent micronutrient supplementation and fortified foods and deworming for menstruating non-pregnant adolescent girls in and out of school 10-19 years.	ND, MCHD, MHS, NDSnF
Integrate adolescent nutrition programs in adolescent health and school health programme under health promotion.	ND, MCHD, MHS, NDSnF
Capacity building for the health workforce, mother support groups/PSF and community networks to provide nutrition services for adolescents 10-19 years.	ND, MCHD, HPD, INS
Develop, print and disseminate tools/ guidelines/IEC materials training manuals for adolescent nutrition.	ND, MCHD, HPD
Develop and incorporate standard indicators to report on adolescent nutrition in health management information system (HIMS).	ND, MCHD, HPD, HISD, M&ED

Strategy 1.6: Promote access to maternal, newborn and child health services

Activities	Stakeholder
Improve coverage and quality of antenatal care (ANC) based on National ANC protocols including promotion of safe motherhood and integrate nutrition assessment and management as a minimum package.	ND, MCHD, MHS, NDSnF
Strengthen the delivery of integrated management of childhood illness (IMCI) services especially triage to adequately identify and treat malnutrition.	ND, MCHD, MHS, NDSnF
Strengthen delivery of integrated outreach services (Saude na Familia, SiSCa, etc.) at community levels.	NDSnF, ND MOH, HPD MOH
Strengthen education of the care givers and care groups on importance of early health seeking behaviours and growth monitoring and promotion for children under five years.	ND, MCHD, MHS, NDSnF

Strategy 1.7: Promote hygiene and sanitation practices at the community and household levels

Activities	Stakeholder
Behaviour promotion and demand creation for household level safe water management and empowerment of frontline health workers and establishing stable supply chain system to facilitate household water treatment and safe storage.	Environmental Health Department (EHD), ND, MHS, NDSnF, HPD
Behaviour promotion and demand creation for household level management of improved non-shared sanitation facilities and empowerment of frontline health workers and establishing stable supply chain system preventing contamination of the environment.	EHD, ND, MHS, NDSnF, HPD
Promote the practice of handwashing with soap at critical points in health facilities, households and communities.	EHD, ND, MHS, NDSnF, HPD
Promote adequate Hygiene practices to control helminth infections among <5s, adolescents and pregnant women.	EHD, ND, MHS, NDSnF, HPD

Strategy 1.8: Strengthen the capacity of health care providers to deliver quality of maternal, infant, young children health and nutrition services at health facility and community levels

Activities	Stakeholder
Interpersonal communication training for health care providers on care and feeding practices for infant and young child.	ND, MCHD, INS
Regular review meetings with all cadres of the health workforce and community volunteers to enhance the delivery of maternal, infant, young children nutrition services.	ND, MCHD, INS
Supportive supervision and follow up mechanisms for implementation of quality maternal, infant, and young children nutrition services at health facility and community levels.	ND, MCHD, INS
Disseminate relevant maternal, infant, and young children policies, operational guidelines, tools, IEC, and training materials to all health facilities.	ND, MCHD, INS
Engage health workers to plan and implement maternal, infant, and young children activities during nutrition days; world breastfeeding week and national events.	ND, MCHD, INS
Conduct reviews and training to strengthen capacity to record and report nutrition data.	ND, MCHD, INS
Interpersonal communication (IPC) training for community health workers (PSF/MSG) on counselling and promotion of maternal, infant, and young children feeding practices.	ND, MCHD, INS
Organize consultative events to review and share lessons learned in implementation of maternal, infant, and young children health and nutrition services.	ND, MCHD, INS, MHS

4.2.2 Strategic Objective 2: Treat and control severe and acute malnutrition among children under-five, adolescent girls, pregnant and lactating women.

Rationale:

Management of acute malnutrition and early detection and treatment of the most common childhood diseases:

The strategic objectives address the actions in the roadmap for reduction of child wasting under the global action plan (GAP) on prevention and treatment of child wasting. Early identification through mid-upper arm circumference and monthly growth monitoring promotion and assessment (GMP&A) for children less than five years of age and pregnant women is implemented in the health system. However, there is a need to improve screening coverage at community level and the quality of GMP&A by integrating counselling, campaigns, maternal and child health services. In coordination and collaboration with Ministry of Education Youth and Sports and the Adolescent Health Department in MOH, The ND-MOH will integrate early detection in school to screen for wasting children 6-19 years.

The important aspects that need to be strengthened in the GMP&A programme include ensuring the availability of measuring tools and training of health care providers on effective use of Livru Saude Inan no Oan (LISIO) to plot the outcome of the GMP&A. Emphasis will be on screening, counselling, and case follow-up, especially for children identified to have growth faltering and those admitted for treatment of acute malnutrition to ensure completion of treatment. In addition, the strategic objective will strengthen the capacity of community health workers (PSF/MSG) to conduct community mobilization for active screening and raise awareness of the importance of participation in the monthly GMP&A sessions.

The aspects of the referral system and supply chain for managing acute malnutrition with and without complications within the health system require further strengthening. Therefore, the strategic objective will prioritize strengthening decentralized forecasting, planning, and reporting to effectively procure the therapeutic supplies and logistics to the lowest level health system (the Health Post).

Outcome:

By 2026, children under five, school-going children, adolescent girls, pregnant and lactating women have access to quality early screening and treatment for severe and acute malnutrition at all levels

Outputs:

An increased proportion of children, adolescent girls, pregnant and lactating women suffering from severe and acute malnutrition identified and treated.

Increased capacity of health workers to treat severe and acute malnutrition.

Key Performance Indicators:

- >75% cure rate
- < 15% defaulter rate
- < 10% death rate
- < 4% non-recovered rate
- 50% coverage of treatment services

Strategies and activities:

Strategy 2.1: Early case detection, routine screening, referral, and treatment at all levels is strengthened

Activities	Stakeholder
Identification, referral and follow-up of cases suffering from acute malnutrition at all levels within the health system.	ND, MCHD, NDSnF, HPD, MHS,
Scale-up treatment of acute malnutrition services to ensure geographic coverage in all municipalities including remote areas.	ND, MHS
Revitalize and improve the quality of growth monitoring and assessment, focussing particularly on children with growth faltering, wasting, severe underweight and those with overweight/obesity while integrating nutrition counselling for caretakers.	ND, MCHD, NDSnF, HPD, MHS
Improve referral systems between outpatient and inpatient management.	ND, MCHD, NDSnF, HPD, MHS, NDSHS
Provide treatment for children with active TB, severe and acute malnutrition.	CDC, ND
Introduce, document and scale-up based on evidence approaches to simplify management of acute malnutrition.	ND, MHS, INS
Introduce screening of malnutrition in schools and establish links with health systems for referrals, treatment and follow-up.	ND, Adolescent Health Department
Strengthen supply chain management for treatment of malnutrition.	ND, MCHD, NDSnF, HPD, MHS, SAMES

Strategy 2.2: Capacity of the health workforce and community volunteers to deliver services for treatment of acute malnutrition

Activities	Stakeholder
Train health workers and community-based resource persons on detection, prevention and treatment of acute malnutrition.	ND, MCHD, NDSnF, HPD, MHS, INS
Conduct growth monitoring training for health workers through on-the-job training and supportive supervision.	ND, MCHD, NDSnF, HPD, MHS, INS
Strengthen capacity to estimate supply needs, forecast, plan, report, record and request supply at all levels of implementation to minimize stockout.	ND, MHS, NDPM, SAMES

4.2.3 **Strategic Objective 3:** Enhance nutritional support to individuals with specific nutrition needs at clinic and in institutional settings

The provision of nutrition services for individuals with special needs is currently implemented at small scale only for people admitted in inpatient facility. The nutritional status of people suffering from chronic diseases (TB, HIV/AIDS), those in prisons, older people, veterans and athletes will be prioritised under this strategic objective. This strategic objective will design mechanisms to support individuals with specific nutrition needs including those in institutions.

Outcome:

By 2026, individuals with special needs have access to quality nutrition services for wellbeing

Outputs:

Improved access to services for individuals with special nutrition needs at clinic (inpatient, outpatient) and at institutional settings: F-FDTL, PNTL, orphanages, prisons, sports institutions; people with disabilities, nursing homes; mental health institutions and others.

Capacity to deliver to services for individuals with special nutrition needs increased.

Key performance indicators:

- Operational guidelines for individuals with specific needs in clinic and institutional settings developed and used for implementation
- # of clinics and institutions providing nutrition services for individuals with special nutrition needs

Strategies and activities:

Strategy 3.1: Scale-up services for individuals with special nutrition needs at clinic (outpatient and inpatient) and in institution settings

Activities	Stakeholder
Review and disseminate National Nutrition guidelines inpatient management for individuals with specific needs.	ND, INS, NDDC
Develop monitoring and reporting tools, SOP specifically for nutrition interventions.	ND, INS, M&ED
Update food menus for individuals with specific needs.	ND, M&ED, HPD, MHS NDDC
Improve and strengthen nutrition indicators coverage and quality of services through integrated community interventions, such as: SISCA in its municipality, outreach and mobile clinic, home visits, integrated screening and sweeping with other relevant programs (CDC & Non-CDC).	HPD, ND, MHS, NDSnF,
Strengthen the allocation and participation of the MSG, PSF in the nutrition community services.	HPD, ND, MHS, NDSnF,
Nutrition screening and counselling for individuals suffering from TB and HIV/AIDS	ND, NDSnF, HPD, MHS NDDC
Provision of nutrition services for people in prisons.	ND
Update food menus for individuals with specific needs based on in institutions based on age groups.	ND, NDDC
Regular nutrition review meeting (semestral and annual basis).	ND, M&ED, NDDC
Design, introduce and scale-up provision of nutrition services for the old including veterans and athletes.	ND, NDDC

Strategy 3.2: Strengthen capacity of service providers to deliver quality services for individuals with special nutrition needs at clinic and in institution settings

Activities	Stakeholder
Develop a training package on nutrition services for individuals with special needs.	ND, INS, NDDC
Train the health workforce to deliver nutrition services for individuals with special needs.	INS, ND, NDDC, MHS
Develop a standardised menu for inpatients with special nutrition needs.	ND, NDDC
Develop orientation of health workers and supplier on the standardized menu.	INS, ND, NDDC, MHS

4.2.4 **Strategic Objectives 4:** Prevent and manage overweight and diet related NCDs.

Rationale

Obesity poses a serious public health concern and is associated with poorer health outcomes and reduced quality of life and is a risk factor for diet related non-communicable diseases (DR-NCDs).

Past strategies addressed only undernutrition and there were no strategies to address chronic diseases. This dichotomy has obstructed effective action to curb the advancing problem of chronic diseases. For example, the prevailing approach of measuring child undernutrition based on the underweight indicator (weight-for-age) as well as underweight in women led to gross underestimation of the presence of obesity. Diet is known for many years to play a key role as a risk factor for chronic diseases[40].

It is important for the health sector to integrate the prevention and control of overweight and obesity and DR-NCDs into this new nutrition strategic plan. There is a need to expand the MOH's focus to recognise the threat that obesity and DR-NCDs poses to national well-being.

The strategic plan aims at implementing the following set of actions to prevent and manage overweight, obesity and DR- NCDs.

Outcome:

By 2026, reduce the prevalence of overweight, obesity and DR-NCDs.

40 Diet, nutrition and the prevention of chronic diseases: report of a joint WHO/FAO expert consultation Geneva, 28 January - 1 February 2002 (WHO Technical Report Series 916)

Outputs:

Prevention and early detection of overweight, obesity and DR-NCDs services introduced into health facilities.

Capacity of service providers to provide dietary and lifestyle counselling services and management of overweight, obesity and DR-NCDs strengthened.

Key performance indicators:

- Operational guidelines for individuals with specific needs in clinic and institution settings developed and used for implementation
- # of clinics and institutions providing nutrition services for individuals with special nutrition needs

Strategy 4.1: Introduce and gradually scale-up services for prevention and early detection of overweight, obesity and DR-NCDs

Activities	Stakeholder
Develop and disseminate operational guidelines for prevention and management of obesity, overweight and DR-NCDs in-line with food-based dietary guidelines (FBDG) for Timor-Leste to all health facilities.	ND, HPD, MHS, NDDC
Introduce routine screening for early detection of and referral for overweight, obesity and DR-NCDs among at-risk groups including routine check-up of BMI, blood pressure, blood glucose levels, cholesterol levels.	ND, HPD, MHS NDDC
Disseminate dietary guidelines to promote use across the life stages through education to population on healthy diets, lifestyles and physical activity to reduce prevalence of overweight and obesity and DR-NCDs.	ND, HPD, MHS NDDC
Procure and distribute equipment and supplies for diagnosis, management and treatment of overweight, obesity and DR-NCDs.	ND, NDDC, SAMES
Organise public campaigns to disseminate information on healthy diets.	ND, HPD, MHS NDDC
Promote and educate the importance of food safety.	ND, HPD, MHS NDDC

Strategy 4.2: Strengthen capacity of service providers to provide dietary and lifestyle counselling services and management at facility and community level

Activities	Stakeholder
Develop a training package on dietary and lifestyle counselling in line with FBDG.	ND, HPD, MHS NDDC
Train the health workforce to deliver services for prevention and management of overweight, obesity and DR-NCDs.	ND, INS, MHS NDDC
Advocate for provision of basic structures for physical exercise including physical activity in workplace and schools and inclusion of physical activity into the curriculum.	ND, HPD, MHS NDDC

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5

ENABLING ENVIRONMENT FOR THE IMPLEMENTATION OF THE NATIONAL HEALTH SECTOR NUTRITION STRATEGIC PLAN

Introduction

In the past decade the Government of Timor-Leste has implemented measures to prioritise improved nutrition indicators. Some of these components are the inclusion of nutrition in the development agenda such as Vision 2030, sector policies, establishment of high-level multi-sector and multi-stakeholder coordination committees, and placement of nutrition officers in the MOH. At operational level, District Primary Health Officers (DPHO) - Nutrition have been deployed to each municipality, Nutrition Coordinators are in each Community Health Centre (CHC) and there has been an increase in resources allocated for nutrition.

In addition to increasing coordination, accountability, and resources for nutrition, the Government recognises the need for capable and competent human resources for quality implementation of nutrition-specific interventions. Despite efforts to increase the number of nutritionists trained and deployed by the Government, the quality of nutrition services at service delivery point is unsatisfactory.

The conceptual framework of malnutrition under the basic causes, Black et al 2013 (see figure 4) recommend a set of core components of an enabling environment for effective reduction of malnutrition; these have all been considered in the strategic plan.

In addressing all forms of malnutrition, legal frameworks are required to protect consumers from violations related to food products, unhygienic handling of foods in food outlets; food adulteration and improper food processing; and importation of uncertified food supplements, that deny certain family members access to an adequate diet. The MOH will provide technical support and endorse high impact nutrition specific and sensitive interventions delivered through other line ministries and departments as well as policies developed to standardize and regulate the quality of the nutrition specific or sensitive interventions

The strategic plan aims to implement the following set of actions to create an enabling environment for effective implementation of nutrition services in line with recommendations from Black et al. 2013[41].

Outcomes:

By 2026, an enabling environment effective for the implementation of nutrition interventions within the health sector is established.

Output:

- Resources for nutrition interventions within the health sector increase progressively.
- Legal mechanisms to support implementation and improvement of nutrition status enacted.
- Improved capacity of health care workforce to deliver quality nutrition services.
- Improved capacity of key influencers to promote positive social norms and healthy behaviour practices to achieve optimal nutrition.
- Improved inter-sectoral and intra- sectoral coordination.
- Knowledge management introduced as part of the enabling environment.
- Improved nutrition screening, early detection and treatment services for malnutrition during emergencies.
- Improved nutrition education and counselling during emergencies.
- Improved inter and intra sectoral coordination for nutrition response.

Key performance indicators:

- % of nutrition strategy planned amount allocated to nutrition specific interventions funded through government budget
- # of nutrition related operational research projects
- # of enabling Nutrition Related codes
- # of enabling Nutrition Related decree-laws
- # number of nutrition specific surveys
- Coordination mechanism platform for nutrition

41 Black et al. 2013. 'Maternal and child undernutrition and overweight in low-income and middle-income countries'. The Lancet. Vol. 382, No. 9890, pp. 427–451.

5.1 Strategy 1: Nutrition Financing

Strategy 5.1.1: Advocate for financial resource allocation for nutrition by government and development partners

Activities	Stakeholder
Develop and implement an advocacy and resource mobilization plan for increased domestic and foreign investments for nutrition.	ND, NDPH, NDPPC
Develop and implement mechanisms to track and analyse investment in nutrition within the health sector for accountability.	ND, NDPH, NDPPC, NDPFM
Develop an investment case to guide financing of nutrition specific interventions.	ND, NDPH, NDPPC, NDPFM
Strengthen capacity to budget and track allocation and expenditures on nutrition.	ND, NDPH, NDPPC, NDPFM
Endorse evidence-based nutrition interventions for investment by other departments of the government and donor partners.	

5.2 Strategy 2: Regulatory and Legal Arrangements to Implement Nutrition Programs

Strategy 5.2.2: Enforce legal mechanisms to guide implementation of nutrition services and support improvement in nutrition status.

Activities	Stakeholder
Accelerate promulgation and enactment of the decree-law to regulate the marketing of Breast Milk Substitutes (BMS).	ND MOH, NDPH, DNFM, GAJC
Finalisation and enactment of mandatory food fortification law for targeted foods with priority micronutrient and salt iodization.	ND MOH, NDPH, OPPCH, GIAS, GAJC
Advocate for enactment of a regulatory environment to support breastfeeding practices e.g., provide breastfeeding facilities at workplaces; baby friendly hospitals and communities, maternity and paternity laws.	ND MOH, NDPH, OPPC, GAJC, NDHR
Advocate for the introduction of regulatory mechanisms in the marketing of food and non-alcoholic beverages that expose children and population to consumption of unhealthy foods (high in saturated fats, trans-fats, free sugars or salt/sodium, as well as sugar-sweetened beverages).	ND MOH, NDPH, OPPCH, GIAS, GAJC
Develop and disseminate standards and guidelines for procurement and provision of healthy foods at preschools/ nurseries, primary schools and hospitals, with support from licensing and inspection authorities.	ND MOH, NDPH, OPPCH, GIAS, GAJC
Establish a national level reference laboratory for quality control and quality assurance of various fortified food items.	

5.3 Strategy 3: Capacity Development for Nutrition

Strategy 5.3.3: Strengthen human capacity for effective programming and delivery of nutrition services at all levels

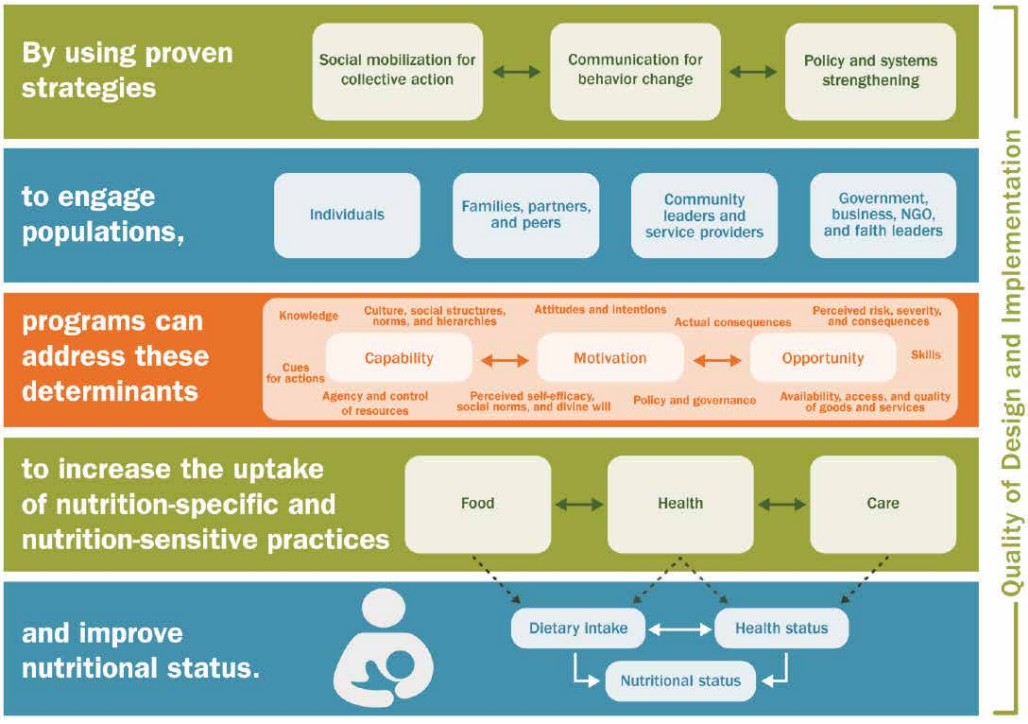
Activities	Stakeholder
Review the effectiveness of Specific Nutrition Intervention Package (SNIP) training package, and develop a needs-based action plan to train all health workers country-wide.	ND, INS, NDPH
Review different health cadres and nutritionist competencies to align with role and responsibilities at all levels of the health system.	ND, NDRH
Strengthen the capacity of the national Institute of Health Sciences (INS) to conduct and deliver need-based in-service nutrition training, with widened geographical scope, supervision and follow up after training.	INS
Strengthen the capacity of national and municipality levels to plan and implement regular supportive supervision visits.	ND, INS, OPPCH
Provide in-service training and continuing education on nutrition to managers and service providers, especially to middle level workers in the health sector.	ND, INS
Integrate nutrition training into medical, midwifery, nursing and public health training curriculums care practices.	ND, MCHD, INS
Capacity development for planning, forecasting, report and request for nutrition supplies.	ND, NDP, INS, SAMES, MHS
Adopt on-the-job training (OJT) mechanism for healthcare providers to facilitate skills acquisition.	ND, MHS
Mobilize resources and implement National Directorate for Human Resources (DNRH) plan including development of appropriate training plan, curricula, job aids and IEC materials.	ND, DNRH

5.4 **Strategy 4:** Nutrition education, community mobilisation and social behaviour change communication, and positive behaviour change.

Rationale:

Human behaviour is at the core of poor nutrition. All the immediate and underlying causes of malnutrition are linked to the behaviours of individuals and their household members[42]. Therefore, improvements in nutrition are not possible without broad, widespread changes in the everyday behaviours of people and population. Carefully designed nutrition social and behaviour change communication (NSBCC)[43] (see figure 10) interventions can change nutrition practices at community and household levels as well as build support for an enabling environment for nutrition. To improve the nutritional status of the population in Timor-Leste, especially nutritionally vulnerable groups, there must be a focus on improving knowledge, attitudes, beliefs, and behaviours related to nutrition. The SNIP training package provides guidance on how to implement interpersonal communication for behaviour change. The training package needs revision to incorporate the evidence-based formative research reports. Individual behaviour is a product of multiple overlapping individuals, social, and environmental influences. For individuals to be able to change their behaviour, key factors affecting the individuals themselves and those directly or indirectly influencing them need to be addressed, including motivation and the ability to act (e.g., self-efficacy and social/gender norms)[44].

Figure 10: Nutrition Social Behaviour Change Framework (SPRING)



From: Moving Nutrition Social and Behavior Change Forward: lessons learned from Nutrition Project (SPRING)

42 USAID. 2017. Multi-Sectoral Nutrition Strategy 2014–2025 Technical Guidance Brief: Effective At-Scale Nutrition Social and Behavior Change Communication. Washington, DC: U.S. Agency for International Development.

43 Nutrition social and behavior change communication (NSBCC) is a set of interventions that combines elements of interpersonal communication, social change and community mobilization activities, mass media, and advocacy to support individuals, families, communities, institutions, and countries to adopt and maintain high-impact nutrition-related practices.

44 C-Change. 2012. CModules: A Learning Package for Social and Behaviour Change Communication (SBCC). Washington, DC: C-Change/FHI 360.

In addition, community mobilisation and sensitisation is important to facilitate early identification and referral, treatment and follow up of individuals suffering from severe and acute malnutrition. The community must be fully involved in the identification and referral of children suffering from acute malnutrition within their communities to health facilities for further management and support for compliance to full recovery. Communities need to be empowered with knowledge and skills in early case identification of acute malnutrition within their communities using the MUAC measuring tape and by screening for bilateral pitting oedema.

This strategy will ensure that the population is provided with adequate information on the risk factors associated with diet related NCDs and provide suggestions that help them change their lifestyle. Fostering existing village structures such as Suco councils as platforms for community mobilisation for nutrition behaviour change will be prioritized.

Strategy 5.4.1: Promote behaviour change for collective action, community ownership and nutrition knowledge, attitude and practices

Activities	Stakeholder
Review existing studies on behaviour change and develop behaviour change communication incorporating findings from studies on culture-specific norms and practices related to dietary choices and food consumption patterns.	HPD, ND
Conduct research on social behaviour, attitude and practices to fill in knowledge gaps and guide development of evidence-based behaviour change communication strategy for nutrition.	HPD, ND, INS
Increase awareness of dietary choices and food consumption related behaviours tied to culturally appropriate nutrition behaviour and social norms.	HPD, ND, NDSnF
Increase involvement of community health workers (MSGs/PSFs) in community mobilisation and awareness raising on nutrition.	HPD, ND, NDSnF, MHS
Training of community workers on screening, referral and counselling for recommended feeding and key care practices.	HPD, ND, NDSnF, MHS
Leverage strong coalition of civil society organizations and social networks to influence community participation to nutrition services.	HPD, ND, NDSnF, CSOs,
Raise awareness on the importance of prevention and treatment of acute malnutrition to overcome beliefs and practices that contribute to malnutrition.	HPD, ND, NDSnF
Review and disseminate IEC materials on recommended practice and optimal feeding of children, adolescents, pregnant and lactating women including incorporation of feeding during and after illness.	HPD, ND, NDSnF
Advocate for the creation of an enabling environment that promotes physical activity in order to address sedentary lifestyle from the early stages of life.	HPD, ND, NDSnF

5.5. **Strategy 5:** Coordination Mechanisms for Nutrition Actions

Mechanisms for inter-ministerial coordination within the health sector for nutrition activities remain weak yet instrumental for the implementation of this health sector nutrition strategic plan.

Coordination mechanisms between the different health departments such as Health Promotion/ Environment Health /Maternal and Child Health and Nutrition needs to be strengthened. Currently, the nutrition linkages within the different Health Ministry Departments and between the MOH and Autonomous Agencies (HNGV, SAMES and INS) are weak.

It is important to note that coherence of interventions implemented by stakeholders is key to effective operationalisation of the nutrition strategic plan. Collaboration and co-ordinated actions across sectors and different levels of government are documented as essential for reduction of nutrition[45]. In Timor-Leste, many NGOs, international organizations and international development agencies implement diverse nutrition interventions at various scales; it is important to conduct mapping, to understand scale and fill coverage gaps for an effective implementation. It is also important that activities are jointly implemented and coordinated. At multisectoral level, the MOH will enhance its participation in joint planning and implementation of priority, evidence-based action. It will also influence budget allocation, disbursement and monitor priority interventions identified in the SD2 CNAP-NFS. In addition, the MOH will conduct advocacy meetings to influence the enactment of legal mechanisms to prevent all forms of malnutrition and encourage the implementation of pro-nutrition interventions with relevant ministries. The following actions will be implemented to enable coordination:

Strategy 5.5.1: Strengthen nutrition coordination

Activities	Stakeholder
Strengthen collaboration and coordination between the different MOH departments for implementation of nutrition activities e.g., health promotion/community health/ maternal and child health and nutrition.	ND, NDPH, OPPCH, NDSHS
Strengthen collaboration and coordination roles between MOH, SAMES, INS and hospitals.	ND, NDPH, OPPCH, NDSHS
Strengthen the coordination role of health sector within KONSSANTIL and SUN.	ND, NDPH, OPPCH,
Develop advocacy guidelines for line ministries to implement pro-nutrition strategies including integration of nutrition into the school curriculum, social safety net for improved nutrition of children under-two years, agriculture and food security to improve dietary diversity etc.	ND
Map and update annually nutrition programmes and partners at all levels.	ND, OPPCH
Coordination with partners in the health sector through quarterly Nutrition Working Group (NWG) meetings.	ND
Conduct annual review and planning meetings.	ND, HIS, M&E, NDPH
Advocate to the Ministry of Education to put in place restrictions on advertising and promotion of unhealthy and highly processed food items to children.	ND, NDPH, OPPCH,

45 Scaling Up Nutrition A Framework For Action Reprint April 2011

5.6 Strategy 6: Knowledge Management & Innovations

Evidence-based data is vital for the decision-making processes, yet data gaps remain a significant impediment to nutrition decision making. Research for nutrition constitutes a basis for evidence-based policies and programming. Data inadequacies further makes it difficult to hold institutions and governments accountable.

The strategic plan will explore the introduction of knowledge management (KM) which aims to understand, articulate and share all knowledge generated from the implementation of the strategic plan. It will encompass making all nutrition information and data from HMIS readily available and user-friendly. The management will include analysis and interpretation of data obtained from regular programmes, research projects and studies and their implication on programme management and adjustment of strategies. Knowledge management will explore innovative approaches and critical thinking on alternative mechanisms to address nutrition problems. The strategic plan will explore the development of simple and easily accessible (searchable in digital KM) portals or dashboards. The Nutrition Department will work with HIS to identify a team of experts to ensure the information is interpreted and disseminated. A lesson learned database will be reacted to actively capture knowledge in the form of metrics, case studies, and shared in discussions and forums to solve problems and provide feasible solutions. The strategic plan will also explore the introduction of community of practice (CoP) as a social learning cluster to assist in the knowledge creation, knowledge transfer, and knowledge management processes.

Activities	Stakeholder
Define the components of knowledge management to be introduce as part of strategic plan.	ND, HISD, M&ED
Analyse and share information to facilitate decision making.	ND, M&ED, DNPH, OPPCH,
Develop lessons learned database and dashboards for information sharing.	ND, HISD, M&ED
Establish the community of practice for different components of nutrition.	ND, M&ED
Integration of nutrition data into the MOH Annual Report and UMPA quarterly reports.	ND, M&ED, NDPH, NDPFM
Introduce innovative approaches to knowledge management.	ND, M&ED
Lead operational research study designs on specific nutrition issues confronting the country as a basis for evidence-based policies and programs.	ND, INS, UNTL
Disseminate research studies on all forms of malnutrition, (stunting, wasting, anaemia, obesity, and DR-NCDs).	ND, NDCDC
Develop nutrition early warning system as an alert to emergencies on natural disasters such as drought, tsunami, earthquake, mudslides or any other emergency situations that may heighten nutrition vulnerability to malnutrition.	ND, M&ED

5.7 Strategy 7: Emergency preparedness

When emergencies such as floods, earthquakes, drought, or disease outbreaks occur, people could be displaced from their homes, lose their livelihoods, or have little access to resources or services. Specific targeted nutritional interventions to vulnerable groups, including children under the age of five, pregnant women, lactating mothers, and other vulnerable groups would help safeguard them from undernutrition. The emergency preparedness and response plan for nutrition needs to be in place to guide interagency humanitarian actions following any type of disaster. The MOH Nutrition Cluster Contingency Plan provides guidance for the management of nutrition interventions during emergencies and will serve as the preparedness and response plan.

The strategic objective aims to implement the following set of actions to improve delivery of nutrition interventions during emergencies and humanitarian situations.

Strategy 5.7.1: Promote timely detection, referral and treatment of malnutrition during emergencies

Activities	Stakeholder
Map partners supporting the emergency response at national and municipality levels.	ND, NDPPC,
Develop and disseminate guidelines on preparedness, response and management of nutrition during emergencies.	ND
Procure and pre-position nutrition supplies in all emergency prone municipalities	ND, NDPM
Conduct routine mass screening for timely detection, referral and treatment of undernutrition in children, adolescents and adults.	ND, HPD, AD
Conduct bi-annual nutrition smart surveys.	ND, INS, M&ED
Train DPHO nutrition and frontline workers on nutrition response during emergencies.	ND, MHS, INS
Conduct routine monitoring of the quality and effectiveness of the emergency nutrition responses.	ND, M&ED

Strategy 5.7.2: Promote nutrition education on maternal and child nutrition during emergencies

Activities	Stakeholder
Develop and disseminate guidelines and messages on IYCF during emergencies.	ND, MCHD
Train service providers and district officers on IYCF during emergencies.	ND, INS
Enforce the code of marketing for breast feeding substitutes during emergencies.	ND,
Develop and disseminate IEC materials on nutrition response during emergencies.	ND, HPD
Disseminate information, communication and campaigns on prevention, mitigation and response to the risk of malnutrition during emergencies.	ND, HPD, MCHD

Strategy 5.7.3: Strengthen inter and intra sectoral coordination for nutrition response during emergencies at all levels

Activities	Stakeholder
Engage and plan for nutrition within a national humanitarian response.	ND, NDPH, NDPPC
Conduct nutrition cluster coordination meetings at national and municipality levels.	ND, NDPH,
Mobilise resources to ensure preparedness for emergency nutrition response.	ND, NDPH, NDPPC
Conduct joint monitoring assessments to the affected areas.	ND
Train managers and partners on nutrition in emergency and cluster management.	ND, INS
Bi-annual review and updating of the contingency plan.	ND

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6

MONITORING, EVALUATION, RESEARCH, SURVEILLANCE, ACCOUNTABILITY AND LEARNING

The aim of nutrition monitoring, evaluation, research, and surveillance is to measure achievements, progress and identify gaps, and to trigger corrective actions for nutrition planning and programming. Nutrition M&E is a continuous process of data collection and knowledge management designed to provide stakeholders with relevant information on the implementation progress of nutrition services, further supporting evidence-based decision making.

In the previous strategy (NNS 2014-2019) several pieces of research were conducted; however, the results were not incorporated into programming. The development of this strategic plan has taken into consideration the evidence from this research as recommended by partners during the review of the NNS 2014-2019[27]. Nutrition surveys are important elements of the implementation cycle as they measure progress and help establish strategic plan targets. While the WHA endorsed 2025 Global Nutrition targets serve as useful references, in this framework, the country has set its own realistic targets that are context specific, albeit using global targets for referencing.

The monitoring and evaluation framework will track progress to deliver nutrition results, valuable lessons will be learnt, the cost effectiveness of prioritised interventions will be established, targets will be realised and the impact of nutrition interventions will be understood. Successful implementation of the Strategic Plan will therefore be dependent on the quality of data collected and reported in a timely manner.

Outcome:

By 2026, evidence-based programming through nutrition monitoring, evaluation, research, and surveillance is enhanced.

Outputs:

- A national nutrition research guideline is developed to ensure collaboration and coordination among researchers in the field of nutrition.
- Increased capacity to conduct research and use country specific generated evidence on nutrition for programming.
- Improved quality of data, analysis, interpretation, and utilization for programming.

Key performance indicators:

- National nutrition research guidelines.
- # of conferences to disseminate nutrition research results conducted.
- Mid-term and end-term evaluation conducted.

Strategy 6.1: Promote and strengthen coordination and collaboration of nutrition researchers and other existing actors in the research institutions

Activities	Stakeholder
Develop and regularly review the national nutrition research guidelines.	ND, M&ED, GPPCS, INS
Engage with INS and academic institutions to coordinate and guide on nutrition research in Timor-Leste.	ND, INS
Map on-going nutrition research projects and researchers in Timor-Leste.	ND, INS, Academic institute

Strategy 6.2: Promote and use the result of nutrition research for advocacy, and evidence-based programming

Activities	Stakeholder
Advocate for local research to generate information for nutrition programming.	ND, NDPH, GPPCS
Conduct nutrition research dissemination conferences every two years.	ND, NDPH, GPPCS, INS
Operational research capacity strengthened for evidence-based decision making.	ND, INS
Conduct nutrition research to fill local and global data gaps.	ND, INS
Conduct operational research to show how evidence-based interventions can be implemented and scaled up in the local context.	ND, INS

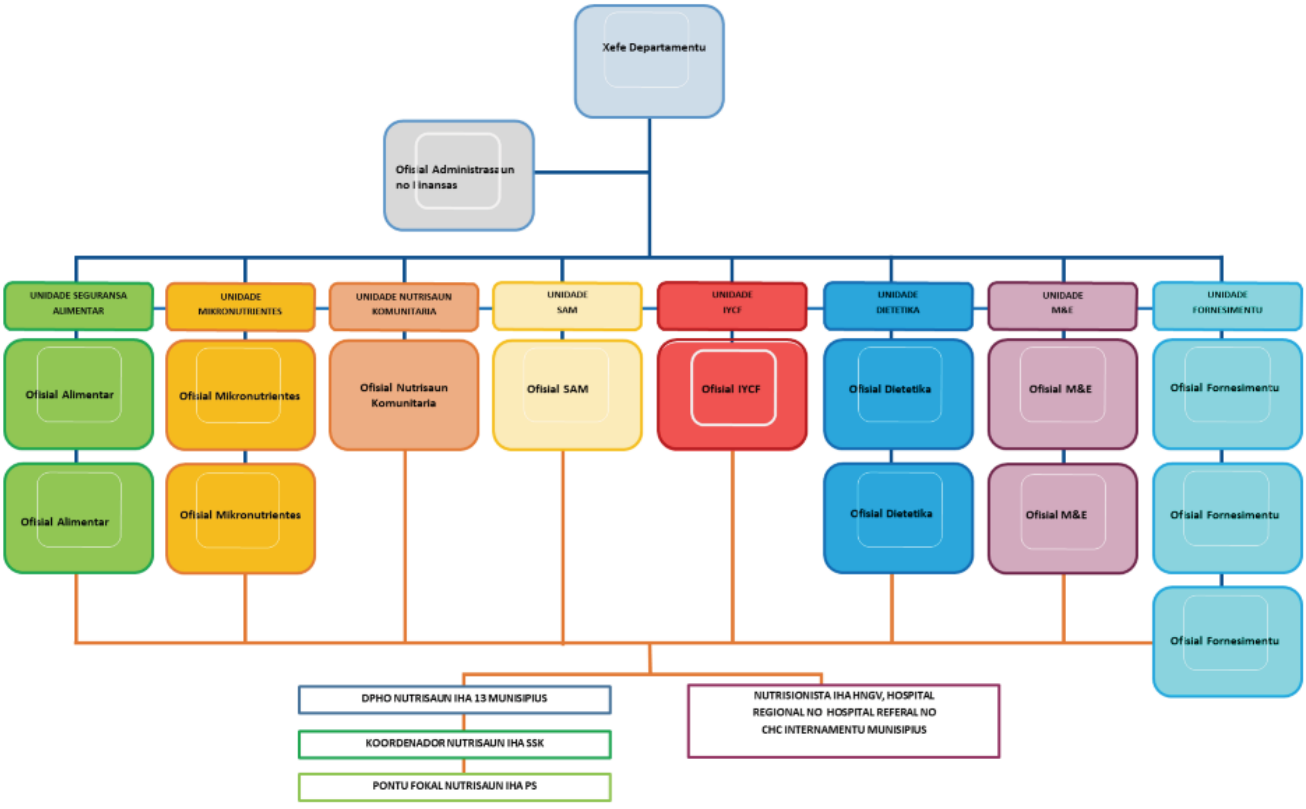
Strategy 6.3: Strengthen monitoring, evaluation and surveillance systems for routine information sharing and data utilization at all levels

Activities	Stakeholder
Conduct bi-annual nutrition M&E coordination meetings.	ND, M&ED, INS
Collaborate with HIS Department (HISD) and M&E Department MOH to conduct routine nutrition data quality assessments and audits (RDQA).	ND, HISD, M&ED, INS
In collaboration with HISD MOH and M&E Department, train M&E officers, DPHO nutrition, nutrition focal points and Municipality Health Services on data management (collection analyses, interpreting and reporting) at all levels.	ND, HISD, M&ED, INS
Develop and disseminate the Nutrition M&E Plan.	ND, M&ED
Strengthen the nutrition information system within the HMIS by integrating key nutrition indicators and databases.	ND, HISD, M&ED
Establish and scale up a nutrition surveillance system for real time monitoring at all levels.	ND, M&ED, INS
Conduct mid-term and end-term evaluation of the nutrition strategic plan.	ND, HISD, M&ED, INS
Conduct a food and nutrition survey every 5 years.	ND, HISD, M&ED, INS
Conduct knowledge attitude and practices (KAP) survey on nutrition.	ND, HISD, M&ED, HPD, INS
Liaise with HMIS to introduce real-time data collection linked to DHIS2.	ND, HISD, M&ED
Periodic publishing of nutrition bulletin/report	ND, HISD, M&ED
Develop and regularly review nutrition indicators monitoring and evaluation guideline.	ND, HMIS, M&ED, INS

7 IMPLEMENTATION ARRANGEMENTS

The National Health Sector Nutrition Strategic Plan 2022-2026 will be implemented within the health sector. the chart below presents the nutrition programme structure.

Figure 11: Nutrition programme structure in health sector



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8

ROLES AND RESPONSIBILITIES OF THE PARTNERS

The MOH recognises the importance of stakeholders and partnership in implementation of this strategic plan. The roles and responsibilities of stakeholders including directorates, autonomous institutions, departments, agencies, development partners, academic and research institutions, the public sector, the private sector, CSOs, NGOs, faith-based organisations, and the communities are as follows:

Ministry of Health (MOH)

The MOH will be responsible for providing leadership and technical direction in programming and delivery of quality and cost-effective clinical and biomedical nutrition services in partnerships with stakeholders.

The Nutrition Department - MOH (DN-MOH)

The Nutrition Department will be responsible for oversight, strategic leadership, policy direction, coordination, resource mobilisation, capacity building, and monitoring and evaluation of the national nutrition response. The department will also be responsible for 1) high level advocacy; 2) spearheading the mainstreaming and integration of nutrition in the national development agenda, sectorial policies, programs, and outreach services; 3) ensuring the implementation of the strategic plan by stakeholders based on the defined mandates; 4) tracking sector performance and ensuring accountability; and 5) resource mobilisation and tracking.

Health Promotion Department

The Health Promotion Department will be responsible for planning, designing, developing and monitoring all interventions and activities for social behaviour change communication to influence and mobilize the community to adapt recommended nutrition behaviours and practices.

Maternal and Child Health (MCH) Department

The MCH Department is responsible for the planning, designing, implementation, monitoring and supportive supervision of MCH interventions in all health facilities in the country. The MCH Department is responsible for ensuring adherence to the IMNCI protocol including triage to identify children suffering from severe and acute malnutrition at health facilities and administration of appropriate treatment services.

Department of Adolescent and Youth Health

The AYH Department will facilitate the incorporation of adolescent nutrition into the health system through the planning and design of adolescent-friendly health and nutrition services.

National Directorate of Pharmacy and Medical (NDPM)

The NDPM is responsible for the execution, monitoring, and evaluation of the national policy for medicines, pharmaceutical, and health laboratories. In addition, the NDPM will support the Nutrition Department to plan needs, forecast, track and collect consumption and stock utilization data for submission to SAMES to request procurement of nutrition supplies and equipment.

National Directorate of Planning Financial Management (NDPFM)

The NDPFM is responsible for ensuring adequate financial resources for nutrition in yearly budgeting and timely disbursement. Also, the NDPFM will provide support to the Nutrition Department in planning, development of budget, monitoring the use of resources and audit where necessary.

National Directorate of Human Resource Management

The NDHRM is responsible for ensuring the right recruitment and placement of nutrition personnel, with appropriate competencies. Also, NDHRM will work with the Nutrition Department in the development of human resources for nutrition.

Office of Policy, Planning and Cooperation in Health

The Office of Policy, Planning and Cooperation in health will support to ensure that policies, strategies and guidelines are within MOH standards. The Office will also support discussion and negotiation with nutrition partners to ensure coverage of nutrition services at municipality level. In addition, the Office will support the Nutrition Department to improve the quality of data and implement monitoring and evaluation, specifically the mid and end-term evaluation of this strategic plan.

INS

INS will be responsible for all in-service training on nutrition to increase capacity of health workers including conducting a training needs assessment and developing needs-based training. Also, INS will ensure quality of nutrition related research in the health sector through its ethics committee.

SAMES

SAMES will be responsible for procurement of all nutrition supplies and equipment in the essential medicine list and distribute them to regional warehouses and municipalities.

Academic and Research Institutions

Academic and research institutions will be responsible for conducting nutrition research in collaboration with INS ethics committee and for disseminating findings to inform policy and programming. Academic and research institutions will leverage resources and expertise from credible national and international research organisations and institutions to conduct the necessary research on nutrition. The academic institutions will also play an important role in integrating and updating nutrition services training into the pre-service inline nutrition policies, interventions, and standards that are relevant to the Timor-Leste context.

Development Partners

Development partners who support nutrition interventions within the health sector and across sectors will be members of nutrition working groups and sub-committees. They will align their support to the MOH for nutrition interventions, programmes and financial support within the National Health Sectors Strategic Plan (2011 – 2030) and National Health Sector Nutrition Strategic Plan 2022-2026. Development partners will continue to undertake high-level advocacy for nutrition among policy and decision makers; provide technical support including policy analysis and implementation; and assist government sectors in mobilising additional resources for nutrition.

Private Sector

The private sector will: continue to ensure that the standards in the production and marketing of high nutritive-value foods are upheld; follow mandatory fortification requirements and recommended fortification levels in all the centrally processed foods; facilitate the provision and access to improved technology for nutrition promotion; meet their social corporate obligation in promoting good nutrition for their employees and the nation.

Civil Society Organisations/ FONGTIL

At national level, CSOs will collaborate with the MOH to advocate for and implement nutrition specific and nutrition-sensitive interventions, ensuring mutual accountability. The CSOs implementing nutrition interventions under the health system will play a crucial role in ensuring that the concerns of various stakeholders in nutrition are heard.

KONSSANTIL

The National Commission for Nutrition, Food Security and Sovereignty (KONSSANTIL) is a multi-sectoral coordination body responsible for bridging sectors to ensure synergies and linkages are created by engaging all nutrition-relevant ministries in nutrition policy formulation, fund raising and budgeting, planning, implementation, monitoring and evaluation. KONSSANTIL will guide the direction for inter-sectoral coordination at all levels.

Municipality Nutrition Coordination Committees

Municipality committees will work closely with all municipality level structures including the Administrative Post and Suco Development Committees. The Committees will be responsible for providing nutrition technical guidance to stakeholders, coordination, monitoring and evaluation of interventions at the municipality level.

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9 IMPLEMENTATION PLAN

This Strategic Plan will guide implementation of nutrition interventions and programmes by the defined directorates under the coordination of Department of Nutrition guided by the strategic interventions contained in Appendices I.

10 MONITORING AND EVALUATION

The monitoring and evaluation will be guided by the Monitoring and Evaluation Framework as presented in Appendices II.

11 APPENDICES

Appendix 1: The M&E Implementation Framework

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Goal	To achieve optimal nutrition for all Timorese by 2026 with special focus on children, adolescent girls, pregnant and lactating women and vulnerable groups	% of newborn with Low Birth Weight (LBW)	10.1% (DHS 2016)	< 7%	9	8	7	6	5	Monthly report, information system in place (EIS). DHS and other survey
		Prevalence of stunting in children 0-59 months	47.1% (TLFNS 2020)	< 30.2%	4	40	37	34	31	Monthly report, information system in place (EIS). DHS and other survey
		Prevalence of wasting in children 0-59 months	8.6% (TLFNS 2020)	< 5%	8	7.4	6.6	6	5.4	Monthly report, information system in place (EIS). DHS and other survey
		% exclusive breastfeeding among children 0-5 months	64.2% (TLFNS 2020)	> 70%	66.2	64.2	66.2	68.2	70	Survey (DHS & TLFNS)
		Anaemia among under five-year-old children (Hb<11g/dL)	40% (TLDHS 2016)	< 30%	40	38	35	32	30	TLDHS
		Anaemia among women of reproductive age (Hb<12g/dL)	23% (TLDHS 2016)	< 20%	22.5	22	21.5	21	20.5	Monthly report, information system in place (EIS). DHS and other survey
		Proportion of households using iodised salt								

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Strategic objective 1: Prevention of all forms of malnutrition in first and second window of opportunity	**OUTCOME 1:** Prevent all forms of malnutrition through implementation of nutrition specific intervention improved nutrients intake with emphasis on first and second window of opportunity									
	Proportion of women of reproductive age with acceptable minimum Dietary Diversity (MDD-W)		65.4% (TLFNS 2020)	> 70%	67.4	69.4	70	72	74	Survey
	% of infants put on the breast within one hour of birth		63.5% (TLFNS 2020)	>80%	67	70	73	75	78	Formato SMI, Survey (TLFNS)
	% of children 6-23 months receiving minimum dietary diversity		35.3% (TLFNS 2020)	> 50%	35.3	40	45	48	50	Survey
	% of children 6-23 months receiving minimum acceptable diets		14.3% (TLFNS 2020)	> 35%	15	20	25	30	35	Survey
Output 1.1	**Strategy 1.1:** Promote women's nutrition before, during and after pregnancy									
	Increased proportion of women practicing optimal nutrition before, during and after pregnancy	% of pregnant women who received iron folic acid supplementation for 90 days	31.7%	>50%	34	38	42	46	50	Monthly report, HMIS, Survey
		% of pregnant women who received two deworming doses after first trimester of pregnancy	(DHS 2016)	>50%	34	38	42	46	50	Monthly report, HMIS, Survey
		% of pregnant mothers who receive multiple micronutrient supplementation	N/A	>80% (HMIS)	30	50	60	70	80	Monthly report, HMIS
Output 1.2	**Strategy 1.2:** Promote optimal breastfeeding practices for infants 0-6 months at facility, community and household levels									
	Increased proportion of mothers and caregivers of infants 0-6 months practicing optimal nutrition	% of children under-five who receive continued breastfeeding until 1 year	29.2% (TLFNS 2020)	60%	30	40	45	50	60	Survey,
		% of mothers of LBW babies receiving optimal feeding support	N/A	80%	20	40	60	70	80	Hospital reports
		% of target health facilities implementing BFHI	None	80% of hospitals and CHC with in patient	20	40	60	70	80	BFHI assessment report, Hospital and CHC self-assessment report
		% of target health facilities accredited and maintain BFHI status	N/A	80% of hospitals and CHC with in patient	20	40	60	70	80	BFHI assessment report, Hospital and CHC self-assessment report

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Output 1.3	**Strategy 1.3:** Promote continued breastfeeding and appropriate complementary feeding of children aged 6 to 23 months and beyond and optimal feeding during illness									
	Improved feeding practices among children 6-23 months	Proportion of children 6-8 months who received semi solid and solid foods	75.8% (TLFNS 2020)	>85%	76	78	80	82	85	Survey
		% of children 6-23 months who received minimum meal frequency	52.3% (TLFNS 2020)	70%	53	57	61	65	70	Survey
		% of children 6-23 months who received minimum dietary diversity	35.3% (TLFNS 2020)	50%	38	41	44	47	50	survey
		Study to understand mechanisms to improve diet of children 6-23 months		Study report available						
		% of children 6-59 months who received appropriate feeding during diarrhoea (continued breast-feeding, continued complementary feeding and increased fluids)	26% (DHS 2016) fed during diarrhoea	60%	33	40	47	53	60	Survey
Output 1.4	**Strategy 1.4:** Intensify prevention and control of micronutrient deficiencies									
	Increased proportion of children 6-59 months receiving micronutrient supplementation	% of children 6-59 months who received 2 doses of vitamin A supplementation annually	77.7% (TLFNS 2020)	>80%	78	79	80	81	82	Monthly report, HIS, survey
		% of children 6-23 months who received multiple micronutrient supplementation	18.8% (TLFNS 2020)	80%	30	42	54	66	78	Monthly report, survey
		% of children 12-59 months who received deworming	71.4% (TLFNS 2020)	>80%	73	75	77	79	81	Monthly report
Output 1.5	**Strategy 1.5:** Promote optimal nutrition for adolescent girls									
	Adolescent girls 10-19 year have access to services for optimal nutrition	% of adolescent girls 10-19 years who received intermittent iron folic/micronutrient supplementation	N/A	80%	20	50	60	70	80	HMIS/EIS reports
		% of adolescent girls 10-19 years who received deworming medicine	N/A							

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Output 1.6	**Strategy 1.6:** Promote access to maternal, newborn and child health services									
	Improved access to maternal, newborn and child health services that promote nutrition	% of births attended by a skilled attendant	49% (DHS 2016)	80%	50	55`	65	75	80	Monthly report, HMIS
		% of pregnant women who received 4 ANC	84% (DHS 2016)	>80%	81	82	83	84	85	Monthly report, HIMS
		% of post-partum mothers and new-borns who receive the recommended postnatal check-up within the first 2 days after birth	35% - mothers (DHS 2016) 31% new-borns (DHS 2016)	>50% >50%	40 36	45 41	50 46	55 51	60 56	Monthly report, HMIS
		% of children suffering from severe and acute malnutrition identified through IMNCI screening services	N/A	60%	20	40	50	60	60	IMCI report
		% of children under-five suffering from diarrhoea who receive ORS+Zinc	29.9%	50%	32	35	38	41	44	Monthly report IMCI
		% of HIV positive pregnant mothers who received nutrition and infant feeding counselling	<1%	5%	1	2	3	4	5	Monthly report, EIS
		% of SiSCa sessions incorporating nutrition services								Reported every trimester
		% of health facilities having plans and implementing growth monitoring and promotion and assessment (GMP&A) services	60	100%	60	80	90	100	100	HMIS report
Output 1.7	**Strategy 1.7:** Promote hygiene and sanitation practises at the community and household levels									
	Increased access to hygiene and sanitation services	% of households practicing household water treatment	4%	70%	50	55	60	65	70	Census, DHS and other surveys
		% of households having access to at least basic sanitation facility	54%	70%	54	60	65	70	70	Census, DHS and other surveys
		% of households with the knowledge of hand washing with soap	TBC	50%						Census, DHS and other surveys
		% of households with the knowledge of solid and liquid waste management	NA	40%	10	20	30	40	40	Census, DHS and other surveys

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Output 1.8	**Strategy 1.8:** Strengthen the capacity of health care providers to deliver quality of maternal, infant, young children and adolescent health and nutrition services at health facility and community levels									
	Increased access to quality maternal, infant, young children and adolescent health and nutrition services.	% of health care providers trained on delivery of maternal, infant, young children and adolescent nutrition services	N/A	>80%	30	50	65	85	90	Capacity Assessment report
		% of health care providers trained on screening and GMP&A		100%	30	50	65	85	100	
		# of conferences held on MIYCN	No data	5	1	1	1	1	1	Nutrition Annual reports
		Proportion of members MSG trained and offering nutrition counselling	No data	100%	30	50	65	85	100	Nutrition Assessment Reports
		% of health care providers trained IYCF counselling, interpersonal communication (IPC), and community mobilisation for nutrition services	50%	100	50	60	70	90	100	Training report
		% of health care providers who received on-the-job training on SNIP services implementation.	N/A	80%	30	50	65	75	80	OJT reports
		% of IPC trained health care providers at all levels conducting nutrition counselling sessions and community mobilisation.	N/A	80%	30	50	65	85	100	Monitoring reports
		% of health facilities with a full set of nutrition related job aids.	50%	100%	50	60	70	90	100	Monitoring reports
Strategic Objective 2: Treatment of severe and acute malnutrition	**4.2.2 Strategic Objective 2:** Treat and control severe and acute malnutrition among children under-five, adolescent girls, pregnant and lactating women									
	% cure rate		75% (HMIS)	> 75%	75	79	83	87	>90	HMIS
	% defaulter rate		10%	<15%	10	8	7	6	<6	HMIS
	% death rate		1% (2019)	< 10% (<2%)	<1	<1	<1	<1	<1	HMIS
	% non-recovered rate		7%	<4	7	6	5	<5	<4	HMIS
	% coverage of treatment services		12% (IMAM review 2018)	> 50%	12	24	36	48	>50	HMIS

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Output 2.1:	**Strategy 2.1:** Early case detection, routine screening, referral and treatment at all levels is strengthened									
	Increased proportion of children suffering from severe and acute malnutrition identified and treated	% of children 6-59 screened for severe and acute malnutrition at facility and community level referred for treatment	N/A	80%	50	56	62	68	>80	Nutrition Assessment Reports
		Proportion of children suffering from severe and acute malnutrition accessing treatment services	N/A	> 80%	0	20	40	60	>80	HMIS
		# of municipalities with severe and acute malnutrition management programs		13		13	13	13	13	HMIS
		Protocol for simplified approach to treat severe and acute malnutrition developed		Protocol available and distributed to all health facilities						MoH report
		Proportion of health facilities implementing treatment services for severe and acute malnutrition		>80%	80	80	80	80	80	HMIS
Output 2.2	**Strategy 2.2:** Capacity of the health workforce and community volunteers to deliver services for treatment of acute malnutrition									
	Increased proportion of children suffering from severe and acute malnutrition identified and treated	% of children 6-59 screened for severe and acute malnutrition at facility and community level referred for treatment	N/A	80%	50	56	62	68	>80	Nutrition Assessment Reports
		Proportion of children suffering from severe and acute malnutrition accessing treatment services	N/A	> 80%	0	20	40	60	>80	HMIS
		# of municipalities with severe and acute malnutrition management programs		13		13	13	13	13	HMIS
		Protocol for simplified approach to treat severe and acute malnutrition developed		Protocol available and distributed to all health facilities						MoH report
		Proportion of health facilities implementing treatment services for severe and acute malnutrition		>80%	80	80	80	80	80	HMIS
Strategic Objective 3: Nutrition Services for people with special needs	**OUTCOME:** Enhance nutritional support to individuals with specific nutrition needs at clinic and in institutional settings									
	Operational guidelines for individuals with specific needs in clinic and institutional settings developed and used for implementation			Operational guidelines developed and actions implemented						Implementation plan and reports
	# of clinics and institutions providing nutrition services for individuals with special nutrition needs			40%	5	10	20	30	40	Monitoring report

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Output 3.1	**Strategy 3.1:** Scale-up services for individual with special nutrition needs at clinic (outpatient and inpatient) and in institution settings									
	Improved access to services for individuals with special nutrition needs at clinic (inpatient, outpatient) and institutional settings	# of health facilities providing nutrition services for individuals with special nutrition needs	11	13	11	12	13	13	13	Hospital report
Output 3.2	**Strategy 3.2:** Strengthen capacity of service providers to deliver quality services for individuals with special nutrition needs at clinic and in institutional settings									
	Capacity to deliver to services for individuals with special nutrition needs increased	A training package on nutrition services for individuals with special needs developed		Training package developed						
		% of health workers trained on identification and delivery of nutrition services for individuals with special nutrition needs		80%	50	60	70	80	80	Training report
Strategic Objective 4: Overweight, Obesity and DR-NCDs	**OUTCOME:** By 2026, preventive services for overweight, obesity and DR-NCDs available in all community health centres									
	Proportion of children under-five years who are overweight		1.2%	<1.2	<1.2	<1.2	<1.2	<1.2	<1.2	Survey report
	Proportion of adults who are overweight/obesity		19.3% (TLFNS 2020)	<12	19.3	17	15	14	<12	Survey report
Output 4.1	**Strategy 4.1:** Introduce and gradually scale-up of services for prevention and early detection of overweight, obesity and DR-NCDs									
	Prevention and early detection of overweight, obesity and DR-NCDs services introduced into health facilities	Operational guidelines for prevention and management of obesity, overweight and DR-NCDs in-line with food-based dietary guidelines (FBDG) developed and disseminated		Operational guidelines available	20	40	60	80	100	Survey Reports
		Proportion facilities conducting routine screening for early detection of and referral for overweight, obesity and DR-NCDs	N/A	75%	5	20	50	60	70	
		% of people with NCD receiving nutrition counselling	N/A	45%						Program report
		% of health facilities with equipment and supplies for diagnosis, management and treatment of overweight, obesity and DR-NCDs	N/A	80%	40	50	70	80	80	Monitoring reports
		# of public campaigns organised to raise awareness on healthy diets for management of overweight and obesity		10	2	2	2	2	2	Campaign monitoring reports

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Output 4.2	**Strategy 4.2:** Strengthen capacity of service providers to provide dietary and lifestyle counselling services and management at the facility and community level									
	Capacity of service providers to provide dietary and lifestyle counselling services and management of overweight, obesity and DR-NCDs strengthened	A training package on dietary and lifestyle counselling for health care workers developed		Training package developed						Training package on counselling for diet and lifestyle
		% of the health workforce trained to deliver services for prevention and management of overweight, obesity and DR-NCDs services		80%	40	50	60	70	80	Training report
Strategic objective 5: Enabling environment	**Outcome 5:** By 2026, an enabling environment effective for the implementation of nutrition interventions within the health sector created									
	% of nutrition strategic planned amount for nutrition- specific interventions funded through government budget			50%	35	45	50	65	75	Gov budget report/ Budget book #2
	# of nutrition related operational research projects		N/A	4	1	3	5	7	10	Ethic approval/INS
	# of enabling Nutrition Related codes		N/A	1	1					Promulgate
	# of enabling Nutrition Related decree-laws		N/A	1			1			Promulgate
	# number of nutrition specific surveys		1	2					1	Survey report
	Coordination mechanism platform for nutrition			Functional	1	5	9	13	17	Minutes of meetings
Output 5.1	**Strategy 5.1.1:** Advocate for financial resource allocation for nutrition by government and development partners									
	Resource for nutrition interventions within the health sector increase progressively	Advocacy and resource mobilisation plan developed	N/A	Advocacy and resource mobilisation plan available						Advocacy plan and report
		# Costed operational plans for nutrition and related strategies developed	Draft	Costed plan available						Costed plan
		Proportion of health budget allocation for nutrition	5%	10%		6	8	9	10	Approved budget MOH
		Yearly annual nutrition plans of municipalities and national level	14	14	14	14	14	14	14	Annual plans

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Output 5.2	**Strategy 5.2.2:** Enforce legal mechanisms to guide implementation of nutrition services and support improvement in nutrition status									
	Legal mechanisms to support implementation and improvement of nutrition status enacted	National decree-law for regulating promotion of breastmilk substitute (BMS) finalized, socialised and implemented	Draft decree-law BMS	Decree-law for BMS enacted						Publication on Journal Republika, monitoring reports
		National infant and young child feeding (IYCF) policy	Draft IYCF policy	IYCF policy finalized						Official approval and annual report
		National mandatory Food Fortification Law finalized and implemented	Draft Mandatory decree-law on food fortification	Mandatory decree-law on food fortification enacted	Approved	Implemented	Implemented	Implemented	Implemented	Mandatory decree-law on food fortification
		SOP to regulate marketing of food and non-alcoholic beverages developed and implemented in collaboration with line ministries	N/A	SOP in place and implemented	SOP developed	SOP implemented	SOP implemented	SOP implemented	SOP implemented	SOP, implementation plan, monitoring report
Output 5.3	**Strategy 5.3.3:** Strengthen human capacity for effective programming and delivery of nutrition services at all levels									
	Improved capacity of health care workforce to deliver quality nutrition services	# of nutrition courses offered by the various educational and training institutes		7	1	2	5	6	7	Nutrition subject incorporated into medicine, midwifery, nursing and public health curriculum
		SNIP training package reviewed	Not reviewed	SNIP Review report		Finalized	Implemented	Implemented	Implemented	Final and implementation report
		Needs-based training action plan for all health workers developed	N/A	Need-based training plan developed		Finalized	Implemented	Implemented	Implemented	Implementation and monitoring report
		# of quarterly supportive supervision per health facility		16 per health facility	1	5	9	13	17	Supportive supervision report
		% of health facilities received quarterly on-the-job training	N/A	100%	0	25	50	75	100	Training report
		% of health facilities with stockout of nutrition supplies	30%	< 20%		15	10	5	0	

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Output 5.4	**Strategy 5.4.1:** Promote behaviour change for collective action, community ownership and nutrition knowledge, attitude and practices									
	Improved capacity of key influencers to promote positive social norms and healthy behaviour practices to achieve optimal nutrition	% of Sucos and aldeais having functional Mother Support Group (MSG)	128 Sucos (28%)		40%	60%	70%	75%	80%	Municipality report
		% of MSG established	316 Suco 70%	100%	70%	80%	85%	95%	100%	Monitoring report
		% of Mother Support Groups receiving training on nutrition components			40%	60%	70%	75%	80%	Training report
Output 5.5	**Strategy 5.5.1:** Strengthen nutrition coordination									
	Increased inter- and intra-sectoral coordination	# of times Nutrition Department MOH participate in KONSSANTIL meeting		20	4	8	12	16	20	KONSSANTIL meeting minutes
		# of times Nutrition Department MOH participate in KONSSANTIL Technical Working Group meeting		20	4	8	12	16	20	
		# of times Nutrition Department MOH participate in SUN and multisectoral task force meetings			20	4	8	12	16	SUN meeting minutes
		# of DPHO Nutrition participating in quarterly Municipality level KONSSANTIL meetings on nutrition and food security	N/A	20	4	8	12	16	20	Municipality NFS meeting minutes
		Annual planning meetings with INS and SAMES	N/A	4		1	1	1	1	Annual plan
		# of nutrition working group (NWG) meetings per year	4	20	4	8	12	16	20	NWG meeting minutes
		# of advocacy meetings with line ministries implementation of pro-nutrition strategies		8		2	2	2	2	Advocacy meeting minutes
		# of nutrition forums		4		1	1	1	1	Nutrition Forum Report
		Mapping of nutrition partners	N/A	Available		1			1	Map of partners by activity and municipality
Output 5.6	Knowledge management introduced as part of enabling environment	Components of knowledge management defined	N/A	5	1	1	1	1	1	Knowledge management definition manual

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Output 5.7.1	**Strategy 5.7.1:** Promote timely detection, referral and treatment of malnutrition during emergencies									
	Improved nutrition screening, early detection and treatment services for malnutrition	% of children 6–59 months screened for acute malnutrition	N/A	>80%	50	65	70	80	80	Nutrition in emergency response report
		% of children 6–59 months identified as SAM	N/A	>80%	45	57	60	70	80	Nutrition in emergency response report
		% of children 6–59 months identified as MAM	N/A	>80%	45	57	60	70	80	Nutrition in emergency response report
		Emergency nutrition supplies procured and pre-positioned		Nutrition Supplies pre-positioned						Nutrition in emergency response report
Output 5.7.2	**Strategy 5.7.2:** Promote nutrition education on maternal and child nutrition									
	Improved nutrition education and counselling services for maternal and children during emergencies	IYCF in emergency guidelines and messages developed		IYCF in emergency guidelines developed						Nutrition in emergency response report
		# of service providers and officers trained								Nutrition in emergency response report
Output 5.7.1	**Strategy 5.7.3:** Strengthen inter and intra sectoral coordination for nutrition response at all levels during emergencies									
	Improved inter and intra sectoral coordination for nutrition response	# of engagement meetings conducted		20	4	4	4	4	4	Nutrition in emergency response meeting minutes
		Annual mapping exercises conducted, and report developed		5	1	1	1	1	1	Nutrition in emergency response mapping report
		# of cluster coordination meetings conducted		60	12	12	12	12	12	Nutrition in emergency response meeting minutes
		# of resource mobilisation meetings conducted		10	2	2	2	2	2	Nutrition in emergency response resource mobilisation report

Output	Expected Results	Indicator/s	Baseline value	Target	Timeline (2022-2026)					Means of verification
			2020	2026	Y1	Y2	Y3	Y4	Y5	
Strategic Objective 6: Monitoring and evaluation	**OUTCOME:** By 2026, evidence-based programming through nutrition monitoring, evaluation, research, and surveillance enhanced									
	National nutrition research guidelines		N/A	1		1				
	# of conference to disseminate nutrition research results conducted		N/A	4	0	1	2	3	4	
	Mid-term and end-term evaluation conducted						1		1	
Output 6.1	**Strategy 6.1:** Promote coordination and collaboration of nutrition researchers and other existing actors in the research institutions									
		Database on nutrition research projects and researchers in Timor-Leste developed	N/A	1			1			Database
Output 6.2	**Strategy 6.2:** Promote research for nutrition for advocacy, solutions and evidence-based programming									
		# of policies developed incorporating evidence/ recommendations from research		2		1		2		
		# of nutrition research projects conducted		3		1	2	3		Research report
		# of operations research projects conducted		2		1		2		Operational research report
Output 6.3	**Strategy 6.3:** Strengthen monitoring, evaluation and surveillance systems for routine information sharing and data utilization at all levels									
	Improved quality of data, analysis and utilization for programming	# of municipalities achieving Nutrition MIS completeness and timeliness benchmarks		13	4	8	10	13	13	MIS report
		# of RDQAs for nutrition indicators conducted each year	1	5	1	2	3	4	5	RDQA report
		# of joint monitoring conducted each year	2	8	0	2	4	6	8	Joint monitoring report
		# of data related OJT and supportive supervision conducted each year		13	0	5	10	13	13	OJT and supportive supervision report
		# of nutrition related studies and research projects		10	2	4	6	8	10	Studies and research reports
		Nutrition Surveillance system		1						

Appendix 2: Summary Costing of strategies

STRATEGIES	Amount 2022 (USD)	Amount 2023 (USD)	Amount 2024 (USD)	Amount 2025 (USD)	Amount 2026 (USD)
Outcome 1: By 2026, nutritional status of children under five, school-going children, adolescents and pregnant women is improved					
Strategy 1.1: Promote women's nutrition before, during and after pregnancy					
Strategy 1.2: Promote optimal breastfeeding practices for infants 0-6 months at facility, community and household levels					
Strategy 1.3: Promote continued breastfeeding and appropriate complementary feeding of children aged 6 to 23 months and beyond and optimal feeding during illness					
Strategy 1.4: Intensify prevention and control of micronutrient deficiencies					
Strategy 1.5: Promote optimal nutrition for adolescent girls					
Strategy 1.6: Promote access to maternal, newborn and child health services					
Strategy 1.7: Promote hygiene and sanitation practices at the community and household levels					
Strategy 1.8: Strengthen the capacity of health care providers to deliver quality of maternal, infant, young children and adolescent health and nutrition services at health facility and community levels					
Outcome 2: By 2026, children under five, school-going children, have access to quality early screening and treatment for severe and acute malnutrition at all levels					
Strategy 2.1: Early case detection, routine screening, referral and treatment at all levels is strengthened					
Strategy 2.2: Capacity of the health workforce and community volunteers to deliver services for treatment of acute malnutrition					
Outcome 3: By 2026, individual with special needs have access to quality nutrition services for wellbeing					
Strategy 3.1: Scale-up services for individuals with special nutrition needs at clinic (outpatient and inpatient) and in institutional settings					
Strategy 3.2: Strengthen capacity of service providers to deliver quality services for individuals with special nutrition needs at clinic and in institutional settings					
Outcome 4: By 2026, reduce prevalence of overweight, obesity and DR-NCDs					
Strategy 4.1: Introduction and gradual scale-up of services for prevention and early detection of overweight, obesity and DR-NCDs					
Strategy 4.2: Strengthen capacity of service providers to provide dietary and lifestyle counselling services and management at the facility and community level					

STRATEGIES	Amount 2022 (USD)	Amount 2023 (USD)	Amount 2024 (USD)	Amount 2025 (USD)	Amount 2026 (USD)
Outcome 5: By 2026, an enabling environment effective for the implementation of nutrition interventions within the health sector created					
Strategy 5.1.1: Advocate for financial resource allocation for nutrition by government and development partners					
Strategy 5.2.2: Enforce legal mechanisms to guide implementation of nutrition services and support improvement in nutrition status					
Strategy 5.3.3: Strengthen human capacity for effective programming and delivery of nutrition services at all levels					
Strategy 5.4.1: Promote behaviour change for collective action, community ownership and nutrition knowledge, attitude and practices					
Strategy 5.5.1: Strengthen nutrition coordination					
Strategy 5.6.1: Knowledge management & innovations					
Strategy 5.7.1: Promote timely detection, referral and treatment of malnutrition during emergencies					
Strategy 5.7.2: Promote nutrition education on maternal and child nutrition during emergencies					
Strategy 5.7.3: Strengthen inter and intra sectoral coordination for nutrition response during emergencies at all levels					
Outcome 6: By 2026, evidence-based programming through nutrition monitoring, evaluation, research, and surveillance enhanced					
Strategy 6.1: Promote coordination and collaboration of nutrition researchers and other existing actors in research institutions					
Strategy 6.2: Promote research for nutrition for advocacy, solutions and evidence-based programming					
Strategy 6.3: Strengthen monitoring, evaluation and surveillance systems for routine information sharing and data utilization at all levels					


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