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Decentralized Evaluation

End-Term Evaluation of treatment of Moderate Acute Malnutrition in Timor-Leste 2015-2017 Evaluation Report

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It is our collective expectation that this report will be a useful resource that will contribute to strengthen the management of moderate acute malnutrition in Timor-Leste

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Executive Summary

Under the Timor-Leste Development Project Number 200770 (DEV 200770) from January 2015 to December 2017, World Food Programme (WFP) developed and implemented the Targeted Supplementary Feeding Programme (TSFP) that aimed to improve the nutritional status of children under-five years of age and Pregnant and Lactating Women (PLW), and to increase ownership and capacity of the Ministry of Health (MoH) to reduce undernutrition. The project had two main components: the first, capacity development, in which WFP provided technical assistance to enhance the capacity of national counterparts to implement nutrition programmes independently; secondly, a food-based component, characterized by the provision of specialized nutritious food products for treatment of moderate acute malnutrition (MAM) in children 6-59 months and acute malnutrition in PLW. The intervention was approved on the 5th of January 2015 and implemented in six out of the thirteen municipalities of the country. The total expected number of beneficiaries was 78,580 (63% children 6-59 months and 37% PLW). The budget of the programme was \$13.7 million USD, funded 59% by the European Union (EU) and 41% by Korea International Cooperation Agency (KOICA). As the DEV 200770 came to an end in December 2017, WFP Timor-Leste commissioned an end line evaluation with the purpose to provide the MoH, donors and other stakeholders with an independent assessment of its performance and draw lessons from the implementation of the programme, in order to take informed decision on adaptation or scaling up in 2018. The **objectives** of the evaluation were to determine to what extent and how the programme had achieved its goal, to contribute to WFP's organisational learning and accountability for results, and to advocate for the allocation of resources to the implementation of the recommended actions. Expected users of the evaluation include the government of Timor-Leste, the WFP Country Office, the Regional Bureau (RB) in Bangkok, the WFP Head Quarter (HQ), the Office of Evaluation (OEV), UNICEF, WHO, donors such as the EU, KOICA and the World Bank Group, the Private Sector and Non-Governmental Organisations (NGOs) involved in the implementation of the programme in the country. Additional potential users of the evaluation are the beneficiaries, particularly PLW, parents of children under-five years of age and community leaders.

Methodology

The evaluation was designed to assess the food-based component of the programme against the evaluation criteria of *relevance, effectiveness, efficiency, impact and sustainability*. Data collection methodologies included (a) *review of documents and secondary quantitative data*, (b) *individual interview of 43 people selected purposively*, (c) *focus group discussion (28 sessions with 278 participants organised in three categories)* and (d) *direct observation*. Limitations of the evaluation included the absence of disaggregated data and NGO activity targets not set in the programme log-frame to ease comparison with achievements. Therefore, analysis was performed on aggregated data only for PLW, and descriptive analysis of NGO activities were not compared against targets.

Key Findings

Relevance

The TSFP was designed in line with international and national policies and strategies aiming to reduce child morbidity and mortality among vulnerable groups in Timor-Leste. Supplementary foods used to address moderate acute malnutrition (MAM) in children and acute malnutrition in PLW were consistent with international guidelines for management of acute malnutrition. The TSFP was imbedded within the Specific Nutrition Intervention Package (SNIP) developed by the MoH with the support of UNICEF, WFP and the EU. On-the-job training developed by WFP played an important role in improving the skills of health staff for anthropometric measurements, clinical assessment and treatment of MAM children and acutely malnourished PLW. However, the programme did not achieve expected treatment coverage for children. Not all health facilities were delivering MAM services within the six municipalities,

which has limited access to services. Targeting process of health facilities was not harmonised between WFP and UNICEF, which hampered mutualisation of resources and continuum of care in health facilities delivering management of severe acute malnutrition (SAM), but not MAM services. TSFP beneficiaries were not linked to other nutrition specific and nutrition sensitive interventions for prevention and household empowerment.

Effectiveness

Gradual increase of children admitted in TSFP was followed by dramatic increase in admissions of children to services providing supplementation of vitamin A, deworming and immunization. Similarly, gradual increase of PLW in TSFP was followed by increase in admissions of pregnant women to deworming and ante-natal care services, as well as lactating women to post-natal care and family planning services. These linkages were attributed to the availability and distribution of supplementary foods in the health facilities, along with sensitisation messages provided by Family Health Promoters (PSF). Recovery rates and default rates did not meet recommended standards for treatment of MAM in children. Reasons explaining these gaps included irregular screenings, insufficient time dedicated to counsel patients properly, insufficient monitoring and supervision of health staff, systematic sharing of supplementary foods by beneficiaries at home, and irregular follow-up of the beneficiaries by PSF. Although WFP collaborated with the Nutrition department and the Health Management Information System (HMIS) for the integration of the TSFP database into the national health information system, this was not yet effective at the time of the evaluation. Municipalities experienced challenges in delivering the food products to the health facilities because of insufficient staff and limited financial and logistic resources. Coordination mechanisms between different sectors for improving nutritional status of children and PLW were perceived as weak because of limited technical and financial capacity of the government and local authorities to lead them.

Efficiency

The average cost per recovered MAM child in the country was \$52.3 USD, the lowest cost (\$35.9 USD) observed in Bobonaro municipality, while the highest cost (\$79.6 USD) was observed in Dili municipality. For PLW, the average cost per recovered beneficiary was \$ 41.7 USD, the lowest cost (\$41.3 USD) observed in Dili municipality, while the highest cost (\$65.1 USD) was observed in Covalima municipality. The cost per recovered beneficiary in TSFP (\$52.3 USD per child and \$ 41.7 USD per PLW) was higher than that of each child and woman managed through blanket feeding (\$8.01 USD). Lower cost observed in blanket feeding programme was explained by its higher number of beneficiaries implemented before 2015 composed of both healthy and MAM cases, thus requesting to spend less time in the programme and consuming lower quantities of supplementary foods on average. Activities undertaken by NGOs, although limited in terms or geographic coverage, were an added value for community adhesion and participation in the programme. Most children (71%) and PLW (52%) admitted to TSFP lived in the three municipalities supported by NGOs. Average recovery rates in MAM children and acutely malnourished PLW were higher in the three municipalities supported by NGOs. Similarly, the average default rates in NGO supported municipalities were lower than that of non-NGO supported ones.

Impact

At national level, global acute malnutrition (GAM) prevalence increased from 11% to 25% between 2013 and 2016. Similarly, SAM and MAM prevalence increased from 1.9% to 9.8% and from 9.1% to 14.2% respectively during the same period. This increase in wasting prevalence occurred in all 13 municipalities of the country, which was not in line with programme expectations. Paradoxically, there were improvements in stunting prevalence, infant mortality and under-five mortality rates in all municipalities. The general perception of service providers and beneficiaries was that the

implementation of the TSFP improved the nutritional status of children and women in their respective localities.

Sustainability

The TSFP services were delivered routinely by MoH staff in the health facilities of the six targeted municipalities. At national level, the department of nutrition oversaw activities related to TSFP, and at municipality level MoH staff supervised the implementation of the programme in close collaboration with WFP and NGOs. WFP signed an agreement with Timor Global, a private company for local production of supplementary foods used for treating acute malnutrition in PLW. WFP also signed an agreement with the Serviço Autónomo de Medicamentos e Equipamentos de Saúde (SAMES) for storage and delivery of food supplies to the municipalities, aiming to integrate delivery of food commodities into the national supply chain system, thereby enhancing ownership. Despite challenges, these initiatives settled an enabling environment conducive for the continuation of the intervention after the termination of WFP's support. The intervention was fully funded by the EU and KOICA during the period 2015-2017. With active advocacy from WFP and other partners, nutrition had been progressively put high in the political agenda, and the government allocated an estimated \$450,000 USD to nutrition for the next country's project cycle starting in 2018. Although still low compared to the national needs, this government funding engagement was a premise for sustainability.

Overall conclusions

In response to the first evaluation criteria of **relevance**, the evaluation team concluded that the TSFP was designed in line with various related international and national policies and was relevant for improving the skills of government health staff and for improving the nutritional status of the target beneficiaries living in the most vulnerable municipalities. Issues in targeting during programme design and implementation hampered access to services to potential beneficiaries living in remote areas.

Regarding the criteria of **effectiveness**, the evaluation team concluded that due to several challenges experienced by service providers and the beneficiaries, the TSFP did not achieve standards in terms of performance indicators. Weak beneficiary tracking system contributed to bias programme monitoring data. Creating and strengthening mother support groups were necessary for boosting adhesion and participation of the community. Availability of supplementary foods in the health facilities was an important catalyst for the uptake of other health services provided to children and PLW. However, beneficiaries of the TSFP were not linked to nutrition sensitive interventions to promote prevention and household empowerment.

In terms of **efficiency**, the evaluation team concluded that recovering an acutely malnourished PLW was cheaper than recovering a MAM child through the TSFP. It was also cheaper to manage children and PLW through blanket feeding than through the TSFP. The support provided by NGOs was important for increasing admissions to the programme and for achieving better recovery and default rates. Estimating to what extent counselling was successful in addressing MAM in children and acutely malnourished PLW, which option was more cost-efficient between counselling and provision of RUSF until normal recovery, and the cost of supplementary foods used in the TSPF versus other types of Super Cereals were not performed.

Regarding the **impact**, the evaluation team concluded that wasting prevalence did not meet the expectations, while there was an improvement in stunting prevalence in children, infant mortality and under-five mortality across the country. Because of these contradictory outcomes, evidence on impact of the TSFP on wasting was inconclusive.

In terms of **sustainability**, the evaluation team concluded that despite critical issues experienced such as pipeline breaks, supplementary food shortages, irregular supervision and insufficient refresher trainings, the implementation of the TSFP settled an enabling environment for technical continuation of the intervention after WFP's support. However, domestic funding allocation is currently very insufficient for ensuring financial sustainability.

Recommendations

The findings and conclusions of this evaluation led to the evaluation team making the following recommendations (more details on each recommendation can be found in the body of the report):

1. Revise the programme strategy design in collaboration with UNICEF to improve coverage and ensure continuum of care between SAM and MAM interventions.
2. Strengthen the capacity of the MoH for appropriate treatment, follow up and prevention of MAM.
3. Strengthen the national health information system for accuracy of data and real time monitoring.
4. Continue to strengthen the governments supply chain and logistics system for timely delivery of supplies in the health facilities.
5. Strengthen linkages and referral of TSFP beneficiaries to existing nutrition sensitive and safety net interventions delivered in the community to empower households and enhance prevention.
6. Continue the partnership between government, donors and development partners to ensure funding for MAM management.
7. Conduct operational research to assess the (a) Cost-effectiveness of counselling versus supplementary foods for addressing MAM in children and acutely malnourished PLW; (b) Cost per recovered MAM child or acutely PLW using RUSF or Timor Vita versus other types of super cereals; (c) Relevance of using Sphere Standards (designed for emergency response) to assess the performance of TSFP implemented in a more stable context like Timor-Leste, and (d) in-depth assessment of the 2016 DHS database for better understanding of nutrition outcomes of the survey.
8. Develop a detailed gender equality and empowerment approach in the next Country Strategic Plan, along with the related indicators

1 Introduction

1.1 Country Context

Timor-Leste is one of the world's newest countries, being internationally recognized as an independent state in 2002. The population is estimated to be 1.2 million inhabitants with a landmass size of 15,410 km². According to the 2016 Human Development Report, the country ranks 133 out of 188 countries, placing Timor-Leste within the medium human development category. The World Bank reported the poverty rate dropping from 49.9% in 2007 to 41.8% in 2014. The 2011 Timor-Leste Household Income and Expenditure Survey (TLHIES) reported that the median per capita monthly income was \$40 USD, indicating that half of the population lived on less than this amount, more than 40% of the population is still living below the poverty line. Additionally, women have a lower literacy rate, 63.9% as compared to men 70.6%. The Timor-Leste Demographic and Health Survey (TLDHS) 2016, indicated the total fertility rate to be 4.2 children, a decline from 5.7 in 2009-10. Rural women have on average about one child more than urban women 4.6 as compared to 3.5 births, and they are more than twice as likely as urban women to have begun childbearing early. The maternal mortality ratio is estimated to be 195 maternal deaths per 100,000 live births. From 2009/2010 to 2016, a stark decline in pregnancy-related mortality was observed (557 deaths per 1000 live births to 218 deaths per 100,000 live births)¹. In 2010, nearly one quarter of women (24%), aged 20-24 years had given birth by the age of 20, which indicates that one in four Timorese adolescent girls are teenage mothers. Teenage mothers are at a higher risk of maternal mortality, as compared to mothers between the ages of 20 and 24. In 2010, 12.3% of households were led by females.

For many rural households, subsistence production remains a primary source of the family's food consumption². Severe food shortages continue to occur in the country especially during the lean season, a period lasting from November to February. An estimated 62% of farmers experience at least one month of food shortages (unavailability of self-produced food crops for consumption) every year, and malnutrition is a leading cause of infant and child morbidity and mortality. The 2013 Timor-Leste Food and Nutrition Survey (TLFNS)³ indicated the prevalence of stunting, wasting and underweight in children under-five (U5) years of age to be 50.2%, 11% and 37.7% respectively. Anaemia in children aged 6-59 months was estimated to be 62.5% and 38.9% among non-pregnant women aged 14-60 years old. The prevalence of breastfeeding for up to 6 months was 62.3%, yet only 27% of children had minimum dietary diversity during the complementary feeding period. Timor-Leste's rate of malnutrition is among the highest in Asia and is categorised as serious by WHO⁴. It is estimated that 1 to 2% of the country's Gross Development Product (GDP) is lost to malnutrition every year.

Reducing high levels of undernutrition in Timor-Leste is crucial for achieving both the goals and targets set out in the 2030 Agenda for Sustainable Development and the Sustainable Development Goal (SDG). In this regard, the Government of Timor-Leste has put in place a number of policies and initiatives aiming at promoting the right to food. The National Food and Nutrition Security Policy (NFNSP) and the National Nutrition Strategy (NNS) are, respectively, complementary to the policy and strategic framework of the Ministry of Agriculture and Fisheries (MAF), and the health sector development plan of the Ministry of Health (MoH). These policies, strategies and plans are focused on achieving the Millennium Development Goals. Their aim is to guide the government's efforts to eradicate hunger and

1 General Directorate of Statistics, Ministry of Finance/Timor Leste, and ICF. 2018. Timor-Leste Demographic and Health Survey 2016. Dili, Timor-Leste: GDS and ICF. Available at <http://dhsprogram.com/pubs/pdf/FR329/FR329.pdf>.

2 República Democrática de Timor-Leste. National Food and Nutrition Security Policy, January 2017.

3 Timor-Leste Food and Nutrition Survey (2013). Final Report, October 2015.

4 https://docs.wfp.org/api/documents/c6cc32eb093541e48ac31dc4d88c3326/download/?_ga=2.24484346.1558808633.1528691901-1241449627.1514259889

malnutrition in all their forms. As such, they would also contribute to poverty reduction by 2020, which is one of the goals of the Timor-Leste Strategic Development Plan (TLSDP) 2011-2030⁵. The government has also introduced a broad range of social protection programmes, including a conditional cash transfer directed at female headed households of lower socioeconomic statuses, who send their children to school and health clinics. Cash transfers are also provided to households of lower socioeconomic statuses with, elderly people, people with disabilities, vulnerable children and veterans of the resistance and their survivors. School feeding, cash-for-work, rice importation, subsidy programmes, and a civil service pension are also provided. Roughly one-tenth of the population is receiving social services in some form.

The 2014 MDGs progress report showed that Timor-Leste was on track for many of the MDGs. There has been progress in many areas of human development including promoting gender equality, empowerment of women and reduction of infant and child mortality. However, child undernutrition remains the greatest contributor to premature death and disability and presents an important development challenge. With regards to the SDG2 (end hunger, achieve food security and improved nutrition, and promote sustainable agriculture), it was estimated in 2015 that 26.9% of the population was still experiencing hunger, with even more people chronically undernourished during the annual hunger seasons. The country's agricultural system does not produce enough to meet the food needs of the population. The country is also experiencing the effects of climate change including higher temperatures and longer dry seasons, which are expected to increase and influence food security and nutrition. The El Niño cycle contributes to these challenges and has had disastrous effects on hunger and undernutrition⁶.

1.2 Overview of Evaluation Subject

World Food Programme (WFP) has been present in Timor-Leste since 1999. The support provided by the organization was initially planned to come to an end after the 2011-2013 Country Programme. However, the MoH requested WFP to extend its support in the country after the critical findings from the 2013 nutrition survey and following an evaluation of the Country Programme 2011-2013. These evaluations recommended changes in the targeting and distribution modalities, from blanket coverage of children 6 to 23 months of age to a targeted approach. The evaluation also identified a number of challenges, including limitations in coverage and participation, extensive sharing of food, transport issues, poor supervision, and weak community outreach⁷. WFP then elaborated and implemented the Timor-Leste Development Project Number 200770 (DEV 200770) from January 2015 to December 2016, which was composed of two main components: the first, capacity development, in which WFP provides technical assistance to enhance the capacity of national counterparts to implement nutrition programmes independently; secondly, a food-based component, characterized by the provision of specialized nutritious food products for treatment of moderate acute malnutrition (MAM) in children 6-59 months and acute malnutrition in pregnant and lactating women (PLW). Distribution modalities such as cash transfers or vouchers were not part of the initiative (see ToR in annex 1). The intervention was approved on the 5th of January 2015 and implemented in six out of the thirteen municipalities of the country, namely: Ainaro, Bobonaro, Covalima, Dili, Ermera, Oecusse. Annex 2 illustrates the map of Timor-Leste with the six municipalities implementing the TSFP. DEV was established to increase ownership and the capacity of the MoH to reduce undernutrition and to improve the nutritional status

5 National Council for Food Security, Sovereignty and Nutrition in Timor-Leste. Zero Hunger Challenge. National Action Plan for a Hunger and Malnutrition Free Timor-Leste. Dili, 2014.

6 Centre of Studies for Peace and Development (CEPAD) Timor-Leste and Johns Hopkins University. Timor-Leste strategic review: progress and success in achieving the sustainable development goal 2, 2016.

7 WFP Office of Evaluation. Country Portfolio Evaluation. Timor-Leste: An Evaluation of WFP's Portfolio. (2008-2012). OE/2013/001

of targeted children and women⁸. Updated admission criteria have been included in the national guidelines for the Integrated Management of Acute Malnutrition (IMAM). The main activities included treatment of MAM, nutrition education and community mobilization, operationalised by the MoH with technical support from WFP. Both UNICEF and WHO were also technical partners; they focused on developing guidelines and training packages on management of acute malnutrition. A partnership between WFP and the private sector partner Timor Global was established in 2008/09 and supported the processing and fortification of the locally produced super cereal (*Timor Vita*), provided to PLW. The NGOs Alola Foundation and World Vision Timor-Leste were contracted by both WFP and UNICEF to support community level nutrition education and mobilization activities in three out of the six municipalities, Covalima, Dili and Oecusse.

There are both high rates of teenage mothers and pregnancy related mortality, and a loss in GDP that is attributed to malnutrition every year. Due to these factors, the main targets of the intervention were PLW and children under-five years of age. A total of 59,000 beneficiaries were expected, comprised of 23,000 PLW and 36,000 children 6-59 months of age (18,500 boys and 17,500 girls). The initial project period spanned from January 2015 to December 2016. Following a budget revision approved in November 2016, the project timeline was extended to December 31st, 2017, and the total number of beneficiaries for the three-year project period increased to 78,580 (63% children 6-59 months and 37% PLW). The total revised budget was \$13.7 million USD, an increase from the initial budget of \$9.9 million USD. The project was funded 59% by the European Union (EU) and 41% by Korea International Cooperation Agency (KOICA). Following DEV 200770, WFP also implemented an intervention for three months between September 1st to November 30th, 2016 for prevention of moderate acute malnutrition in children 6 to 23 months and PLW in response to the El Niño effects⁹. The intervention targeted 20,600 beneficiaries in the affected areas of the country. Upon request of the authorities of the administrative region of Oecusse, WFP also supported the municipality in school feeding and nutrition through the deployment of a school feeding/nutrition specialist that provided technical assistance for strategic planning of the school meals programme. WFP has also recently signed an agreement with TOMAK, an Australian funded programme entitled, "Farming for Prosperity", to conduct formative research on adolescent health in Timor-Leste.

In 2015, the EU¹⁰ and the World Bank¹¹ made recommendations for evaluating the national guidelines for management of acute malnutrition, particularly with regards to the MAM treatment component and provision of specialized nutritious foods, to determine effectiveness, cost-benefit and appropriate scale of the intervention. Beginning in 2018, the EU intends a shift to direct budget support to the MoH while KOICA will transition to focus on health and education, rather than nutrition. The change in aid modality will have consequences on funding levels to UN Agencies. DEV 200770 came to an end in December 2017 and WFP Timor-Leste intends to continue supporting the government in addressing wasting under the Country Strategic Plan (CSP). Subsequently there was a need to analyse the most effective and feasible transfer modalities and service delivery channels for addressing wasting among children 6-59 months of age and among PLW. The **purpose** of the evaluation was to provide the MoH, donors and other stakeholders with an independent assessment appraising what has worked well, what has not worked and why, and to draw lessons that can enable informed decision-making and be applied to an adaptation or scaling up of the intervention in 2018, when the CSP comes into effect. As

8 WFP. Mother and Child Health and Nutrition – Targeted Supplementary Feeding Programme (MCHN – TSFP). Amended description of the action, 2017.

9The El Niño phenomena in late 2015 has resulted in an estimated 25 percent reduction in locally grown food (FAO report). This had an impact on the nutritional intake of households as their coping mechanisms have resulted in, at most, only one meal a day. The El Niño also resulted in 70,000 animals dying (Ministry of Agriculture report) – this has also impacted on nutrition consumption.

10 EU. Final Report - Mid-Term Evaluation of the Integrated Nutrition Project in Timor-Leste. December, 2015.

11 World Bank. Draft Report: Malnutrition in Timor-Leste: A review of the burden, drivers and potential response. 2016.

dictated in the ToR (annex 1), the **objectives** of the end-line evaluation were to determine to what extent and how the project had achieved its goal, to enable evidence-based decision-making that will inform national policies and future strategies on nutrition-specific interventions in the country. The **specific objectives** were to contribute to WFP's organisational learning and accountability for results, to empower the MoH by generating knowledge and lessons learned on the integrated approach for management of MAM implemented beginning in 2015, and to advocate for resource allocation to fund the implementation of the recommended actions¹².

The main stakeholders of the evaluation included the WFP country office, the WFP Regional Bureau (RB) in Bangkok, the WFP Head Quarters (HQ), the Office of Evaluation (OEV), the WFP Executive Board (EB), the government of Timor-Leste, the beneficiaries of the intervention, United Nations (UN) Agencies involved in the implementation of management of acute malnutrition such as WHO and UNICEF, NGOs such as Alola Foundation and World Vision Timor-Leste, donors including EU, KOICA, the World Bank Group, and the Private Sector mainly represented by Timor Global. The primary users of the evaluation will be the WFP Timor-Leste country office and the MoH. Additionally, the RB will use the evaluation to provide strategic guidance, programme support, and oversight. The WFP HQ will use the evaluation as a means for wider organisational learning and accountability, and the Office of Evaluation for feeding into evaluation syntheses as well as for annual reporting to the Executive Board. This report presents the approach, methodology, main findings, conclusions and recommendations of the evaluation.

1.3 Evaluation Approach, Design and Methodology

1.3.1 Evaluation Approach

With the premise that the evaluation should be judged by its utility and actual use, the evaluation team adopted a participatory approach. Perspectives of different stakeholders (designers, implementers, donors and beneficiaries) were explored through various data collection methods. This ensured that their knowledge was shared, and conclusions were verified through an iterative process between the evaluation team, WFP and the evaluation reference group. The team applied a realist evaluation framework to inform and guide the development and conduct of all stages of work. A realist evaluation is a Theory of Change (ToC) driven approach that goes beyond the simplistic focus of input-output evaluation models by also focusing on the underlying policy, social and economic mechanisms and contextual factors that lead to the success (or not) of a policy, a strategy, or a programme¹³. A realist approach was particularly well suited to the current evaluation given the importance of policy alignment and context for the success of the intervention¹⁴. The evaluation team reviewed the programme logframe developed for the intervention, the underlying hypothesis and assumptions, and developed the programme ToC accordingly. The ToC describes the linkages between programme investment (inputs) to processes and outputs, and to anticipated changes (outcomes) in the target populations. A description and visual representation of the ToC developed by the evaluation team is presented in annex 3, highlighting programme components and the related indicators.

WFP Timor-Leste proposed to conduct an activity evaluation of the MAM treatment component of the DEV 200770. The activity evaluation consisted of assessing one WFP activity, which may be one component of an operation or an activity across operations¹⁵. Therefore, as indicated in the ToR, the

12 WFP Timor-Leste. Evaluation Terms of Reference: End-Term Evaluation of Treatment of Moderate Acute Malnutrition, 2015-2017. May 2017.

13 Westthorp, G. (2014) Realist Impact Evaluation: An Introduction. Accessed at: <http://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9138.pdf>

14 Marchal, B. et al (2012). Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research. *Evaluation*; 18:192

15 WFP Technical Note on Activity Evaluation <http://docustore.wfp.org/stellent/groups/public/documents/reports/wfp277850.pdf>

evaluation focused on the food-based component of the programme. The geographic scope of the evaluation was the six municipalities implementing the intervention in the country. The evaluation team visited five out of these six municipalities (Ainaro, Covalima, Dili, Ermera, and Oecusse). The municipality of Bobonaro was not visited because an EU evaluation was conducted a few weeks prior to the present evaluation and visited that municipality. Two additional municipalities, Manufahi and Liquica, not implementing the TSFP, were visited for comparison purposes.

1.3.2 Evaluation criteria and questions

The evaluation used criteria recommended by the UN evaluation group and the OECD Development Assistance Committee (DAC) for programme evaluations¹⁶, specifically, relevance, effectiveness, efficiency, sustainability and impact. The cross-cutting themes of gender equality, partnership and coordination were also assessed. There was a lack of time to deeply implement the Gender Equality and Empowerment of Women (GEEW) responsive approach. During the assessment of each criterion, facilitating factors and barriers affecting the achievements were assessed. Detailed descriptions of the evaluation criteria and questions are presented in annex 4.

1.3.3 Evaluation Methodology

The evaluation undertook an analytical assessment of the progress achieved in implementing treatment of MAM in children aged 6-59 months and treatment of acute malnutrition in PLW in Timor-Leste within the context of the WFP 2015-2017 country project. It captured details regarding the extent to which the project was able to achieve outputs and outcomes and to contribute to the intended impact. The programme ToC, along with the evaluation criteria and questions guided the development of the evaluation matrix (annexe 5). This matrix was developed to structure the data collection process, setting out the evaluation criteria, questions and sub-questions, data sources, data collection and analysis techniques. It also guided the development of data collection instruments, which were customised according to stakeholder groups.

The evaluation used secondary and primary data collection methods. The collection of secondary data included the review of documents and secondary quantitative data. Primary data collection included, individual interviews, focus group discussion (FGD) and, direct observation. Data collection took place at the national, municipal and village levels. Data collection was carried out by a team composed of Dr Camille Eric Kouam, Nutrition and Health Expert and Team Leader, Ms Corinne Roberts, Gender Specialist and Team Member, and Jose Maubere Henrique, Research Assistant and Team Member. A diagram summarising the overall evaluation process and timeline is presented in annex 6.

1.3.3.1 Secondary Data Review of Documents and Quantitative Data Bases

The evaluation team reviewed documents received from the WFP country office and additional documents collected during field visits that took place between November 13th and December 8th, 2017 in the seven selected municipalities. Documents reviewed included the national health policies and strategies, national guidelines, country strategy plans, project strategy, national nutrition and health surveys, assessments and evaluation reports, quarterly monitoring reports, national guidelines for management of acute malnutrition. Secondary quantitative data (monthly report databases, food distribution, financial expenditures) were provided by the WFP country office to the evaluation team.

¹⁶ Organisation for Economic Cooperation and Development/Development Assistance Committee (OECD-DAC): Guidance for Evaluating Humanitarian Assistance in Complex Emergencies. 1999; and Organisation for Economic Cooperation and Development/Development Assistance Committee (OECD-DAC): Evaluating Humanitarian Action Using the OECD-DAC Criteria; an ALNAP Guide, 2006.

These data were used to analyse trends in the programme's outputs and outcomes for the period lasting between 2015-2017. The list of documents reviewed, and data bases accessed are presented in annexe 7.

1.3.3.2 Primary Data Collection

Among the five municipalities implementing the programme and visited by the evaluation team, three were supported by NGOs (Covalima supported by World Vision, Dili and Oecusse supported by Alola Foundation). A simple random sampling technique was used to select the health facilities to be visited, using the list of all functional health facilities in each municipality provided by WFP. In each of the two municipalities (Manufahi and Liquica) not implementing the programme, one community health centre (CHC) was visited. Overall, 15 sites were sampled and visited, which were distributed as follows: five health facilities (one health facility randomly selected in each municipality among the total number of health facilities delivering SAM and MAM services), five health facilities delivering SAM without MAM services (one health facility randomly selected in each municipality among the total number of health facilities delivering SAM but not MAM services), three community outreach sites (one randomly selected in each municipality supported by NGOs), and two CHC randomly selected in each of the two municipalities not implementing the programme. Characteristics of municipalities and sites sampled for field visits are presented in the annex 8.

Given the realist approach and mostly qualitative nature of the evaluation, three data collection techniques were used to collect primary data, namely: individual interviews, focus group discussions (FGDs) and observations. These three techniques complemented each other in the sense that individual interviews were appropriate for understanding participants' experiences and perspectives with regard to different evaluation questions, while FGDs were appropriate for getting perception of different categories of programme's beneficiaries. Direct observations were useful for understanding the process of activities implemented by NGOs in their supported districts.

Stakeholder Interview

Semi-structured individual interviews were conducted at the national, municipal and village levels. The selection procedure of interviewees was purposive^{17,18}, using a snowball sampling method, a nonprobability technique in which identified key informants recruited future subjects from among their acquaintances. Therefore, the evaluation team interacted at different levels with people involved in TSFP planning and implementation that were available and willing to participate in the evaluation. Interview participants included policy makers (MoH), administrative authorities, MoH health and nutrition managers and officers, donors (EU, KOICA), UN agencies (WFP, UNICEF, WHO), staff from implementing NGOs, and the private sector (Timor Global). Individual interviews were conducted in English or in Tetun when necessary. A total of 43 persons were interviewed during field visits. Characteristics and the number of individuals interviewed and distributed according to municipality are presented in annexes 9 and 10. An interview guide was developed for this purpose and customised according to each interviewee during field visits; this guide can be found in annex 11.

Municipality Focus Group Discussion

In the five municipalities supported by WFP, three FGDs were held with three categories of stakeholders

17 Palinkas, L.A., et al., Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. Adm Policy Ment Health, 2013.

18Tongco, M., Purposive Sampling as a Tool for Informant Selection. Ethnobotany Research& Applications, 2007. 5: p. 147 - 158.

in each sampled health facility delivering SAM and MAM services or SAM without MAM services. Additionally, with those receiving NGO support or not. Participants were distributed into these three categories in order to determine perspectives of beneficiaries and community members facilitating the implementation of programme activities. These three categories were as follows:

- *First category:* care givers of children under-five years of age. This group was mainly composed of parents (men and women) of children admitted to the programme in health facilities delivering SAM and MAM services. In health facilities that were not delivering the MAM services, these were caregivers of children that had graduated from SAM status and were following the growth monitoring and promotion (GMP) programme.
- *Second category:* PLW of different age groups admitted to the programme. In line with the ToR, the evaluation team emphasised the importance of having those aged 14-19 years, as well as adolescent girls and boys among the participants to get their specific opinion on accessing the programme.
- *Third category:* health workers (HW), volunteers (mother support groups - MSG), Promotor Saude Familia or Family Health Promoter (PSF) and community representatives (chiefs of villages and sub-villages, youth and church leaders).

Conducting FGDs in these three categories provided insights on gender roles in the programme. The evaluation team assessed how women, men and adolescents were reached or affected by the programme. Facilitators encouraged the participation of all members, rather than relying on answers of the most vocal participants, which created a trust-inspiring environment for discussions. FGD sessions were held in the national language (Tetun) or local dialects. All the discussions were audio recorded with corresponding notes taken by the team leader and research assistant. A total of 28 FGD sessions were conducted. Nine to ten persons attended each session, with a total of 278 participants (78% women and 22% men). Each session was arranged prior by the evaluation team in collaboration with the WFP field staff and health workers in charge of MAM sites. Characteristics of FGD participants and their numbers can be found in annex 12. A FGD guide was developed and customised according to the group category; this guide is presented in annex 13.

Observation of NGO Activities

Direct observations were performed by the evaluation team, focusing on nutrition education and cooking demonstrations using local foods, and performed by the NGO World Vision in the Covalima municipality, and the NGO Alola Foundation in Dili and Oecusse municipalities.

1.3.3.2 Data Analysis and Reporting

Secondary quantitative data obtained from WFP was analysed. Output indicators such as coverage, recovery rate, death rate, default rate and non-response rate were computed and assessed against national and international standards. Additional output indicators that were computed included the proportion of caregivers and PLW receiving counselling on improved child feeding and care practices. Cost per child and PLW recovered was computed and compared according to the type of nutritious food received and according to the implementation modality (blanket feeding versus TSFP). The trends of outcomes indicators such as wasting prevalence, infant mortality rate and under-five mortality rate were analysed to assess the changes occurred in child and PLW nutritional status during programme implementation.

The analysis of qualitative data was inductive¹⁹ and thematic²⁰, relevant sections of documents, interviews and FGDs notes were summarised under evaluation questions and criteria. Throughout the report, the 'reference period' encompassed January 2015 to December 2017. Gender equality was assessed through looking to what extent malnourished boys and girls, as well as pregnant and lactating women were identified and treated, and the efforts put into place to look for those that are not being identified. During the assessment of each criterion, facilitating factors and barriers affecting the project achievements were identified.

Secondary data were obtained from WFP, NGOs and national official sources such as the MoH. Triangulation was employed, data obtained from document reviews, interviews, FGDs and observations compared to ensure coherence and reliability. A half day workshop was organised on December 20th, to present preliminary findings. Comments made during the meeting aided the evaluators to deepen the analysis. The report also underwent a critical iterative process between the evaluation team, WFP and the evaluation reference group, which contributed to the validation of findings, conclusions, and recommendations.

1.3.4 Ethical Considerations

The evaluation methodology and tools were developed in line with the UNEG Ethical Guidelines for Evaluation²¹. Informed verbal consent was obtained from all participants prior to conducting interviews and FGDs. The participants were made aware of the voluntary nature of their participation. The evaluation team pledged confidentiality to interviewees and FGD participants and did not quote them directly in the report.

1.3.5 Limitations and Mitigations

A theory of change was not developed during the programme design by the CO. The evaluation team used the programme framework elaborated by the CO while developing the intervention in order to inform the development of the ToC (annex 3) and the evaluation matrix (annex 5). In terms of gender equality, the project document mainly emphasized the involvement of men, as well as children of both sexes in the programme. However, the document was not clear on the content of empowerment, and no indicator was set to measure it. There were missing indicators in the framework to assess outputs and outcomes so as to address all evaluation questions properly; the evaluation team explored other national health and nutrition strategic documents to extract indicators that could ease the assessment of the achievements. Adolescent girls were not specifically identified as a target group from the start of the programme. Data was not available to determine the percentage of adolescent girls among the PLWs. For this reason, the team performed the analysis with aggregated data only.

To date, there are no standards for treatment coverage and performance indicators in PLW. The analysis of these indicators was limited to describing the achievements, without assessing them against standards. Similarly, NGO activity targets were not set in the programme's logframe. The evaluation team mainly described the achievements of NGO activities without assessing them against targets.

The capacity development component of the programme was not within the scope of the evaluation

19 Thomas, D.R., A General Inductive Approach for Analysing Qualitative Evaluation Data. *American Journal of Evaluation*, 2006. 27(2): p. 237-246.

20 Boyatzis, R.E., *Transforming qualitative information: Thematic analysis and code development*. 1998, Thousand Oaks, CA, US: Sage Publications, Inc. xvi, 184.

21 UNEG Ethical Guidelines for Evaluation, UNEG, March 2008. P5-8.

as described in the ToR; however, given their important influence on programmatic outputs and outcomes and to better understand the reasons explaining programmatic achievements, some elements of these components (such as monitoring and evaluation, procurement and delivery of supplies) were assessed.

Data was not available to assess to what extent children not getting MAM services were slating back to SAM status in areas with and without both services. Quantitative data was not available to assess to what extent counselling was successful in addressing MAM in children and acutely malnourished PLW, or which option was more cost-efficient. Moreover, data was not available to compare the RUSF used in the programme with supplementary food alternatives available at international level.

Regarding the assessment of impact criteria, evidence was not strong enough to conclude the impact of the programme on wasting prevalence, given anthropometric data quality issues experienced while conducting the 2016 DHS survey, along with contradictory trends observed between wasting, stunting, child mortality and under-five mortality rates.

There was not enough time to conduct detail verbatim transcription of interviews and FGDs audio recorded. Consequently, quotations were not used in the report, the analysis relied mainly on summary notes taken during interview and FGD sessions.

2. Evaluation Findings

The following section of the report has structured the findings in accordance with five evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability. It is important to note that there is frequent overlapping between these criteria. The achievements versus the targets are presented, as well as contributing factors to the achievements, mainly originating from review of documents, individual interviews, FGDs and observations. For each evaluation criteria, the findings are presented with respect to the corresponding evaluation questions described in annex 4. Additional findings (tables and figures) are presented in annex 14.

2.1 Relevance

2.1.1 Appropriateness of the TSFP Design and Contribution in the Overall Nutrition Response

The TSFP was part of the Maternal and Child Health and Nutrition (MCHN) Programme implemented by the MoH, the project's goal, was to contribute to strengthen MoH capacity in planning and management of the entire cycle of the TSFP, and to contribute to the reduction of child and maternal undernutrition. This intervention goal was in line with different national policies and strategies, including the Timor-Leste Strategic Development Plan (SDP) 2011-2030, the Timor-Leste National Health Sector Strategic Plan (2011-2030) which aims to reduce the incidence and prevalence of macro and micronutrient deficiencies and associated malnutrition among vulnerable groups. The NNS 2014-2019, which aims to improve the nutritional status of the Timorese population; the Zero Hunger Challenge Action Plan for a Hunger and Malnutrition Free in Timor-Leste (2014-2025) which encompasses a multisectoral approach to tackle both direct and indirect causes of undernutrition; the National Food and Nutrition Security Policy 2017-2020 (NFNSP) aiming to tackle undernutrition through a multisectoral approach as well. The intervention was also in line with the World Health Assembly's targets of reducing childhood wasting and reducing anaemia in women of reproductive age; the Sustainable Development Goal 2.2 which recommends the end of all forms of malnutrition by 2030; Millennium Development Goal 1 (MDG1) to eradicate extreme poverty and hunger, MDG4 to reduce child mortality, and the United Nations Development Assistance Framework (UNDAF) for Timor-Leste.

To illustrate these alignments, activities implemented under the two main components of the intervention included developing the MoH monitoring and evaluation system for TSFP, strengthening the national supply chain system, distributing supplementary food in sufficient quantities and quality to targeted children under 5 years and PLW, and promoting nutrition education. Therefore, main beneficiaries (children under-five and PLWs) were the most vulnerable of the population as stated in the policies. In addition, although mainly composed of nutrition specific interventions, the approach also attempted to address nutrition sensitive issues through community sensitisation, nutrition education and cooking demonstration activities. Implementation of these activities necessitated interaction between sectors such as health, nutrition and education.

As per the UN convention made at the international level, WFP addresses MAM while UNICEF addresses SAM. In this regard, WFP Timor-Leste supported the MoH in the development and implementation of the TSFP with respect to this convention. With the support of the EU and UNICEF a Specific Nutrition Intervention Package (SNIP) was developed in 2016, embedding a package of 10 modules/interventions defined as the most effective and cost-effective for reducing the burden of undernutrition in the country. The TSFP, although designed and implemented prior to the initiation of the SNIP, was imbedded within the SNIP package as one of the four key components of the Integrated Management of Acute Malnutrition (IMAM). On-the-job training was provided by WFP and played an important role in improving the skills of health facility staff for anthropometric measurements, clinical assessment and treatment of MAM children and acutely malnourished PLW. WHO and WFP further collaborated to develop the forms for inpatient treatment of acute malnutrition. In 2017, UNICEF also developed new forms and registration books for nutrition indicators to be used for Timor-Leste Health Information System (TLHIS), with active contribution of WFP during the process.

2.1.2 Reaching the Intended Target Groups and Meeting the Needs of the most Vulnerable

The intervention was designed to be implemented in the six municipalities with the highest levels of stunting and wasting, which was assessed through the 2013 TLFNS. These municipalities were Ainaro, Bobonaro, Covalima, Dili, Ermera, and Oecusse²². The managers interviewed stated, six out of the thirteen municipalities were covered by WFP, and it was intended that the MoH would cover the remaining seven municipalities from their domestic budget. Within the six municipalities, the project was designed to reach the most vulnerable groups of the population including, children under-five years of age and PLW. Additional programme targets included service providers such as doctors, midwives, nurses, CHC managers, Nutrition Focal Points (NFP) and nutrition coordinators/assistants, mother support groups and community members that were equipped with adequate skills for delivering or facilitating the delivery of services. Table 2.1 and table 2.2 below present the admission of beneficiaries in both groups. This is described as “treatment coverage”, which represents the number of cases admitted to the programme compared to the expected caseloads. The NNS stipulates that by 2019, the percentage of children with moderate acute malnutrition receiving supplementary food should increase from <50% to >60%. The yearly expected MAM caseload for children under-five years of age was 17,077, with a total of 51,231 expected cases for the following three years. For PLW, 10,713 were expected every year in the programme, with a total 32,139 cases expected for the following three years. Within the health facilities delivering MAM services, an average of 40% of the expected children were admitted. The admissions were 18% in 2015, 61% in 2016, and 40% in 2017 (table 2.1). Except in 2016, treatment coverage for children under-five years of age did not achieve national nutrition strategy targets of >60% and international recommendations of ≥50%. For PLW, the admissions increased from 12% in 2015 to 158% in 2016 and 139% in 2017. The average treatment coverage was 103% for PLW for the three years (table 2.2). Overall, 20,453 children and 33,085 PLW were admitted in

22 WFP: Mother and child health and nutrition – targeted supplementary feeding programme (MCHN – TSFP), p5-18.

the programme for the three years of implementation.

Table 2.1: Treatment coverage of U5 children in the six municipalities as of December 2017

	2015	2016	2017	Total
Target numbers	17,077	17,077	17,077	51,231
Admitted	3,205	10,364	6,884	20,453
% admissions	18%	61%	40%	40%
National targets	-	-	-	> 60%
International targets	-	-	-	≥ 50%

Table 2.2: Treatment coverage of PLW in the six municipalities as of December 2017

	2015	2016	2017	Total
Target numbers	10,713	10,713	10,713	32,139
Admitted	1,281	16,885	14,919	33,085
% admissions	12%	158%	139%	103%
National targets	-	-	-	None
International targets	-	-	-	None

The health workers and managers interviewed stated, deployment of WFP support staff and nutrition coordinators at the municipality level, active involvement of DPHOs, training of health workers, procurement of necessary materials for identification of malnourished children and PLW, and delivery of food commodities (RUSF and Timor Vita) to the health facilities were contributing factors to the number of admissions. The intervention targeting children 6-59 months of age started in February 2015 and the intervention targeting PLW started in November 2015. As the two interventions started only in three out of the six municipalities, this explains the lower treatment coverage from that year. In February 2016 the intervention was scaled-up to all six municipalities, which explains the higher coverage observed that year. Admission decreased in 2017, due to pipeline breaks and consecutive shortages of supplementary foods in the first quarter of 2017, which also derived from the poor quality of Timor Vita rejected by WFP. Moreover, shortages were experienced by Nutriset, the global supplier of RUSF, which led to delayed arrival of RUSF in the country (ordered in November, initially expected to arrive in January, but later came in April).

There are no national or international recommended targets or standards for treatment coverage in PLW but, compared to children under-five years of age, more PLW were admitted. This can be explained by higher sensitivity to PLW situation in the communities, as reported by PLW, HW, volunteers and community members during FGDs; the expected baby during pregnancy is considered as a divine gift, thus deserving more attention, while MAM in children was not perceived as a problem in the community.

While considering the percentage of admissions in accordance to municipalities, table 2.3 shows that a higher proportion of admission for children under-five years of age was observed in the municipalities of Ainaro (78%) and Covalima (48%). Similar observations were conducted for PLW with 177% of admission in the municipality of Covalima, 154% in Ainaro and 122% in Dili (table 2.4). Thus, for both target groups, the municipalities of Ainaro and Covalima admitted most cases.

Table 2.3: Total admissions by municipality of U5 children in the TSFP for the three years of implementation

	Total admitted	Total planned	% Admissions
Ainaro	2,332	3,006	78%
Bobonaro	2,351	7,986	29%
Covalima	3,844	5,628	68%
Dili	7,604	18,393	41%
Ermera	1,657	6,990	24%
Oecusse	2,665	9,225	29%
Total	20,453	51,231	40%

Table 2.4: Total admissions by municipality of PLW in the TSFP for the three years of implementation

	Total admitted	Total planned	% Admissions
Ainaro	4,958	3,216	154%
Bobonaro	3,948	5,409	73%
Covalima	4,090	2,307	177%
Dili	9,928	8,115	122%
Ermera	7,095	8,880	80%
Oecusse	3,066	4,212	73%
Total	33,085	32,139	103%

The TSFP was implemented in six municipalities; however, according to managers interviewed, the other seven municipalities would have been also considered as they have a high prevalence of acute malnutrition. These municipalities were implementing management of SAM interventions, and all children graduating from SAM status and became MAM were then missed by the TSFP. In addition, not all health facilities were delivering MAM services within the six selected municipalities, which also hampered access to services. To illustrate this finding, table 2.5 below presents the geographical coverage of the programme, which represents the number of health facilities providing MAM treatment as compared to the total number of existing health facilities. The WFP country office used criteria to determine the ability of a functional health facility to deliver supplementary services. These criteria included the presence of at least one health worker, easy access by road for delivery of food commodities by car or by trucks, and the presence of an adequate storage facility. The ideal scenario was to cover all health facilities. At the time of the evaluation (December 2017), 125 functioning health facilities out of 142 fulfilled the WFP criteria, representing a programme geographic coverage of 88%. Full geographic coverages were observed in the municipalities of Bobonaro (100%), Covalima (100%), Dili (100%) and Oecusse (100%). The least covered municipality was Ermera (54%) due to the mountainous nature of the area (health posts located in the mountains), poor road conditions making it difficult to access the health facilities (particularly during rainy seasons), some health posts are closed or not functioning, and there are inadequate rooms for food storage.

Table 2.5: Geographic coverage of the TSFP in the six municipalities as of December 2017

	Health Facility (HF) implementing TSFP			Total HFs implementing TSFP	Functioning HFs in the municipality	TSFP geographic Coverage
	RH	CHC	HP			
Ainaro	0	4	11	15	19	79%
Bobonaro	0	7	22	29	29	100%
Covalima	0	7	13	20	20	100%
Dili	0	6	18	24	24	100%
Ermera	0	6	9	15	28	54%
Oecusse	1	4	17	22	22	100%
Total	1	34	90	125	142	88%

Referral Hospital (RH); Community Health Center (CHC); Health Post (HP); Health Facilities (HF)
Functioning HF: open with at least one health staff in situ.

PLW and community members stated that there were no major issues in reaching younger PLW aged 15-19 years, although they felt shy to come alone to the health facility because of their early age pregnancy. As opposed to coming alone the young PLW were accompanied to the health facility by their mothers or grandmothers to get the services. Local leaders, health workers and mother support group members sensitised young PLW to go to the health facility regularly to get the services. According to interviewees, it would have been relevant to also include non-pregnant adolescent for prevention purpose, as well as elderly and individuals leaving with disabilities as beneficiaries.

2.1.3 Gender-sensitivity of the Project Design and Implementation

The project targeted MAM boys and girls among children under-five years of age. Although adult men were not primary targets, they were involved in different community mobilisation and sensitisation activities. In fact, both men and women participated in Mother Support Groups, and some of them acted as volunteers for the implementation of project's activities at community level. Men and women community leaders, especially chiefs of sub-villages, also facilitated the implementation of project's activities and some of them participated as family health promoters actively involved in SISCa activities. During FGDs conducted with PLW and MSG, women noted they are receiving more support from their husbands in their households during pregnancy and lactation periods, consecutive to their involvement into sensitisation messages delivered during village meetings. More details on men involvement are provided in the effectiveness section, under the subsection addressing cross-cutting issues.

2.1.4 Consistency of TSFP with National and International Guidelines

Activities included treatment of moderate acute malnutrition, nutrition education, as well as community mobilisation. Although there was an agreement between WFP, UNICEF, WHO, the MoH and NGOs on admission criteria for children and PLW in the programme, or in using similar entry-points in the villages (MSG, PSF), at health facilities (health workers, nutrition focal points, nutrition coordinators) and at municipalities (DPHO, DHS) for the implementation of their respective activities, there was no consultation between WFP, UNICEF, WHO while developing their respective projects for addressing acute malnutrition. Each organisation defined its own criteria for targeting municipalities and for selecting health facilities delivering the services within municipalities. Moreover, there was no agreement among the different stakeholders on activities to be delivered in the community, on incentives to be provided to PSF, and on the best approach to support municipality health offices. This gap in joint planning hampered mutualisation of resources and continuum of care in areas delivering SAM, but not MAM services.

International guideline for the management of acute malnutrition recommend the use of supplementary foods for addressing MAM in children and PLW. In the context of Timor-Leste, WFP used RUSF for MAM children and a fortified blended food produced locally and called “*Timor Vita*” to treat acute malnutrition in PLW. Currently, the RUSF used in the country is Supplementary Plumpy, manufactured by the company Nutriset (based in France), thus consistent with International Guidelines. It comes in as one-day sachets and can be eaten directly from its container. It is designed to be eaten in small quantities, as a supplement to the regular diet. In terms of ingredients, Supplementary Plumpy is composed of peanut paste, vegetable fat, soy protein isolates, whey, maltodextrines, sugar and cocoa. The micronutrients content is composed of vitamin A, E, B1, B2, Niacin, Pantothenic acid, vitamin C, B6, B12, D, K, Biotin, Calcium, Magnesium, Selenium, Zinc, Iron, iodine, Copper, Phosphorus, Potassium, Manganese, Folic acid. The nutritional value per 100g is 545Kcal for Energy, 13.6g of Protein and 35.7g of Fat²³. Although the provision of Timor Vita was more an injunction of the MoH than international recommendations, the production, safety, ingredient composition and energy content were in line with international standards for treatment of acute malnutrition in PLW. The matrix below summarises the consistency between supplementary foods used in Timor-Leste and the International Guidelines/recommendations.

Programme	Treating MAM in children 6-59 months		Treating acute malnutrition in PLW	
	Timor-Leste standards	International standards	Timor-Leste standards	International standards
Product	Supplementary Plumpy®	Idem	Fortified Blended Foods/Super Cereal called “Timor Vita”	Fortified Blended Foods/Super Cereal
Key Ingredients	Peanuts, sugar, whey, vegetable oil, milk, soy protein, cocoa, vitamins and minerals	Idem	Corn/vitamins and minerals requirements in human nutrition	Corn/wheat/rice soya, vitamins and minerals
Daily ration	92g sachet	92-100g sachet	200g	200-250g (includes provision for sharing)
Nutrient profile	500 kcal, 13g protein (10%), 31g fat (55%)	Idem	390 kcal for 100g, Protein (51%), Fat (43%)	752-939 kcal, 31-38g protein (16%), 16-20g fat (19%)
Average duration of intervention	60 days	60-90 days	180 days	Variable based on target group

WHO’s technical note suggests that management of MAM in children 6–59 months of age should include essential nutrition actions such as breastfeeding promotion and support, education and nutrition counselling for families, and other activities that identify and prevent the underlying causes of malnutrition²⁴. Although breastfeeding promotion and nutrition counseling were part of community outreach activities of the TSFP, beneficiaries were not linked/transferred to nutrition sensitive interventions such as conditional/non-conditional cash transfers, household food fortification, agriculture support or crop diversification, small livestock, WASH or education, which would have empowered their households and enhanced prevention.

2.2 Effectiveness

To facilitate understanding of findings presented in this subsection, the first and second evaluation question under the effectiveness criteria were merged, describing the achievements and the contributing factors to these achievements. For each question, outputs and outcomes were extracted

23 <http://www.wfp.org/nutrition/special-nutritional-products>

24 WHO. Technical note: supplementary foods for the management of moderate acute malnutrition in infants and children 6–59 months of age. Geneva, World Health Organization, 2012; p7.

from programme data base to illustrate the findings, assessed against national and international standards whenever possible.

2.2.1 Achievements of outputs and outcomes and contributing factors

As per the programme's logframe and the ToC, the main outputs deriving from the implementation of the programme's activities included the following; MAM children and acutely malnourished PLW admitted to the programme are treated; supplementary food distributed in sufficient quantities and quality to targeted PLW and Children U5; nutrition education promoted under management of MAM linked to IYCF practices and provided to targeted communities by health workers and by contracted NGOs, a MoH M&E System for TSFP is established, a supply chain operational guidelines developed, approved and implemented. The outcomes included an increased coverage rate of the TSFP, an improved nutritional status of targeted women and children, and a strengthened MoH capacity to reduce undernutrition through the planning and management of the entire cycle of the MCHN-TSFP (see annex 2).

2.2.1.1 Performance of the TSFP

All health facilities that were delivering TSFP and were visited by the evaluation team in five municipalities had space for nutrition activities, clean water points and latrines, except three HPs that did not have adequate space for storing of food supplements. Height boards, weight scales, MUAC tapes, and materials for clinical examination were in good working condition. Registration forms and formats were also present. The sites were well organised. Weight, height, MUAC and the grade of oedema (if present) were measured properly, and data were recorded in the registers. MAM services were integrated within other child health and nutrition services provided through the basic health package. MAM beneficiaries received medication and supplementary foods, and they were informed that the ration was intended to supplement their usual diet at home. Caretakers of MAM children benefited from counselling on good health, nutrition and hygiene practices. Services were offered free of charge to children under-five years of age and PLW. Health staff mainly complained about their heavy workload due to their insufficient number in the health facility. Consequently, they could not dedicate sufficient time to counselling.

The second outcome of the WFP project document²⁵ is entitled "improved nutritional status of targeted women and children". The second outcome should be appraised through performance indicators defined by sphere standards. These indicators relate to discharged individuals ending treatment and are made up of all who have recovered, died, defaulted or are non-recovered (non-response)²⁶. For children under-five years of age, these indicators are recovery rate >75%, default rate <15%, non-response rate <15%, and mortality rate <3%. The specific target of the NNS related to treatment of MAM was an increased cure rate of moderate and severe acute malnutrition to >75% by 2019. The Timor-Leste Strategic Development Plan 2011-2030 had set a more ambitious target of more than 78% for treatment of acute malnutrition by 2017. Similar performance indicators were also used to assess project's outcomes in PLW.

Table 2.6 indicates that the recovery rates in MAM children were 60%, 62% and 66% for 2015, 2016 and 2017 respectively. Default rates were 33%, 31% and 28% for the three years respectively. There were ≤ 8% non-response rates and 0.31%, 0.04% and 0% deaths for the three years. Recovery rates and default rates did not achieve the targets in children under-five years of age.

²⁵WFP: Mother and child health and nutrition – targeted supplementary feeding programme (MCHN – TSFP), p28.

²⁶ <http://spherehandbook.org/en/management-of-acute-malnutrition-and-micronutrient-deficiencies-standard-1-moderate-acute-malnutrition/>

For PLW, recovery rates were 50% and 57% in 2016 and 2017 respectively, and 0.01% death for the two years. Default rates were 36% and 27% for 2016 and 2017 respectively, and non-response rates were 14% and 16% for the two years (table 2.7).

Table 2.6: Performance in U5 children in 2015, 2016, 2017

	2015	2016	2017	Targets
Recovery	60%	62%	66%	>75%
Mortality	0.31%	0.04%	0%	<3%
Default	33%	31%	28%	<15%
Non-response	7%	8%	5%	<15%

Table 2.7: Performance in PLW in 2016 and 2017

	2016	2017	Targets
Recovery	50%	57%	None
Mortality	0.01%	0.01%	None
Default	36%	27%	None
Non-response	14%	16%	None

Regarding performance according to municipality, table 2.8 shows that the municipality of Covalima achieved the sphere standards for recovery rate in 2015 (76%) for children, but it dropped to 62% in 2016, a year during which none of the municipalities achieved recommended standards. In 2017, the municipalities of Bobonaro and Oecusse achieved recommended standards. For default rates, the municipality of Covalima achieved the standards in 2015. In 2016, none of the municipalities achieved the standards. In 2017, the municipalities of Bobonaro and Oecusse achieved the standards, with default rates of 6% and 7% respectively. Regarding non-response rates in children, all municipalities achieved the standards for the three years.

Table 2.8: Recovery, default and non-response rates in U5 children according to municipality in 2015, 2016, 2017

	Recovery			Default			Non-response		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Ainaro		62%	71%		30%	17%		8%	12%
Bobonaro	51%	55%	88%	45%	41%	6%	4%	4%	6%
Covalima	76%	62%	71%	13%	30%	19%	10%	8%	9%
Dili		67%	47%		26%	37%		8%	2%
Ermera		56%	71%		37%	27%		7%	2%

Oecusse	47%	52%	91%	47%	38%	7%	6%	10%	2%
Targets	> 75%			< 15%			< 15%		

For PLW, table 2.9 shows that higher recovery rates were observed in 2016 in Covalima (60%), Dili (58%) and Oecusse (49%). In 2017, Oecusse (78%) and Covalima (58%) registered higher recovery rates. Higher default rates were observed in Ainaro (59%), Covalima (38%) and Dili (38%) in 2017. During field visits, interviewees and FGD participants could not explain these slight differences between municipalities in terms of project's performance.

Table 2.9: Recovery, default and non-response rates in PLW according to municipality in 2016, 2017

	Recovery		Default		Non-response	
	2016	2017	2016	2017	2016	2017
Ainaro	46%	28%	40%	59%	14%	13%
Bobonaro	33%	48%	50%	31%	17%	21%
Covalima	60%	58%	30%	38%	10%	4%
Dili	58%	41%	29%	38%	13%	21%
Ermera	48%	53%	36%	16%	16%	31%
Oecusse	49%	78%	37%	6%	14%	16%
Targets	None		None		None	

Overall, more than half of the admitted children and PLW successfully recovered, which was an important achievement. Health workers and managers interviewed reported that the main contributing factors for delivery of MAM services in the health facilities were procurement of medicines and food commodities. Reasons explaining low recovery rates included insufficient time dedicated to counsel patients on the relevance of consuming the diet appropriately at home, insufficient monitoring and supervision of health staff, no rigorous implementation at home of nutrition advice received by caregivers and PLW, and systematic sharing of RUSF and Timor Vita by beneficiaries with other household members at home, although, food sharing in the households decreased from 62% in 2016 to 24% in 2017 after active counselling and sensitisation.

High default rates were explained by a low awareness of the beneficiaries on the importance of returning frequently to the health facility for clinical and anthropometric check ups and for collecting additional supplementary foods, long distance to get to the health facility by beneficiaries, insufficient follow up of beneficiaries at home by PSF, shortages of food commodities (RUSF and Timor Vita) at health facilities and the length of stay in the programme perceived as long by the beneficiaries. Regarding this last point, the national guidelines recommend a maximum length of stay of four months in the programme. As beneficiaries travelled for long periods to attend different family events, they were frequently recorded as defaulters when they did not return to the health facility for follow up after two consecutive months, or they were discharged as non-responders if they have not recovered before four months.

Additional reason raised by HWs and health managers interviewed to explain why most performance indicators did not achieve targets was that the target setting was too high. As sphere indicators used by WFP were designed to assess performance of MAM intervention implemented in contexts of humanitarian response, the expectations were higher for a more stable context such as Timor-Leste.

2.2.1.2 Monitoring and Supervision

As indicated in the project's logframe, the MoH monitoring and evaluation system for TSFP should be established during the implementation of the intervention. The national IMAM guidelines state that the health facility in charge should conduct day to day monitoring to ensure that activities are delivered in line with the protocols. At the end of the month, the health facility in charge should prepare the monthly report and submit it to the municipality health office. After compiling all health facility reports the municipality health office submit its reports to the MoH at the national level²⁷. WFP supported the establishment of the MoH's information system for TSFP through the development of monitoring check-lists and establishment of database at municipality and national levels. The MoH's nutrition department staff at the national level, health workers and managers of the information system at the municipality levels were trained on MAM data collection, analysis and reporting. Some of the TSFP indicators were not yet integrated in either the HMIS or the new online Timor-Leste Health Information System (TLHIS) being rolled out in seven pilot municipalities at the time of the evaluation (December 2017). It was expected to be rolled out in all 13 municipalities by early 2018. WFP still mainly relied on its monitoring and database rather than on the HMIS/TLHIS for reporting, as the reporting rate on nutrition from municipalities was perceived as weak, only three municipalities inserting some nutrition data into TLHIS. Separate forms were used for reporting to the HMIS and on TSFP beneficiaries. Health workers did not experience any issue filling out these TSFP monthly reporting forms. WFP shared its data with the MoH and it was their responsibility to enter them in the TLHIS. Reports were paper-based at health facility level and data were entered in the HIS at municipality level by DPHOs. The Timor-Leste Health Information System (TLHIS) was accessible at national level to any stakeholder provided with an appropriate user name and password. Aside this monthly reporting system, WFP support staff in each municipality used tablets/eWin for post distribution monitoring, consisting of questionnaires dedicated to health staff and beneficiaries for assessing the service delivery and any behaviour change as a result of nutrition education provided. DPHO and WFP support staff were satisfied with the establishment of the MoH M&E system for TSFP because MAM data was available on time as compared to previous years (before 2015). This data was used to follow up project progresses, to take appropriate decisions and to make recommendations for improvements. The main issues reported by health managers included the non-availability of TLHIS in all municipalities, as well as frequent discrepancies between the very low rates of nutrition indicators/data reported by MoH through the TLHIS system and those submitted by WFP field support staff. Double-checking of data at municipality level for coherence prior transfer to national level was not performed.

Duplicated data was an additional issue reported by health workers, which occurred for two main reasons: the first, many beneficiaries were not permanent residents of the locality they were first admitted in the programme. When they returned to their home town or village and they did not show up after two consecutive months they were recorded as defaulters. Meanwhile, they were registered as new admissions when they went to their local health facility to get similar services once back to their home town. Thus, there were two admissions and one default recorded for a single beneficiary; the second being, many beneficiaries usually forgot their admission cards at home when they returned to the health facility next month for follow up. As they were afraid to be blamed by the health workers for their negligence, they usually declared they were coming to the health facility for the first time. They were then registered as new admissions while they were not. Meanwhile they were also recorded as defaults after two months of not showing in the previous register. The weak system of tracking beneficiaries favoured duplicated admissions and increased default rates figures observed in the

²⁷ Ministry of Health Timor-Leste. Specific Nutrition Intervention Package (SNIP) Guidelines. MODULE 8: Implementing Integrated Management of Acute Malnutrition (IMAM), 2016, p183-184.

project. However, it was difficult for the evaluation team to ascertain to what extent this issue contributed to bias the programme performance figures.

The national IMAM guidelines recommend that the DPHO should visit the health facilities and the Integrated Community Health Care (SISCa) at least once a month to monitor and supervise the activities. One output reported in the projects' logframe is to conduct monthly joint (MoH and WFP) monitoring to health facilities as well as regular reporting and evaluation of activities (see annex 2). On-site monitoring should be followed by on-the-job training if the protocols are not followed properly²⁸. Supervisions were not performed regularly as planned at national level because of insufficient staff and limited financial and logistic resources. The nutrition division team composed of only two permanent staff could not visit the six municipalities implementing TSFP within a year. Only two cars available at national level were dedicated to nutrition supervisions activities (including TSFP) across the 13 municipalities. At the municipality level, joint supervisions were not taking place for similar reasons. The organization of monitoring activities mostly relied on the logistic and financial support provided by partners (WFP, UNICEF or NGOs).

During field visits, newly appointed nutrition focal points and health workers also reported not undergoing regular supervision and they did not benefit from up-to-date trainings on recent IMAM guidelines. Consequently, they were confused on the use of appropriate rations for addressing MAM and SAM in children. Many of them provided RUTF to SAM children until they reached normal status while there should be a switch from RUTF to RUSF once the situation of the child has improved from SAM to MAM status. Other health workers provided RUSF to SAM and MAM children until recovery, while national and international guidelines recommend the use of RUSF for MAM children only.

2.2.1.3 Procurement and Delivery of Supplies

The second output of WFP project document stipulates that supplementary food is distributed in sufficient quantities and quality to targeted PLW and children under 5 years²⁹. Since 2010, the WFP country office contracted Timor Global, a private sector company established in March 2005 in Timor-Leste, for the production and procurement of Timor Vita. The role of Timor Global in the TSFP has been the production of Timor Vita, a fortified blended food made of local ingredients for PLW. WFP also signed an agreement in 2015 with the Autonomous Service of Health Equipment and Medicines (SAMÉS) for storage, transport and delivery of food commodities from Dili to the six targeted municipalities. Once produced by Timor Global, Timor Vita was stocked in SAMÉS' warehouses in Dili. RUSF was imported by WFP and stored in SAMÉS' warehouses in Dili as well. SAMÉS has the responsibility to dispatch Timor Vita and RUSF to different municipalities, and the later oversee the delivery of these food commodities to the health facilities. For the three years of project implementation, 65% of RUSF and 74% of Timor Vita planned were delivered to the six municipalities (figure 2.1). Fewer quantities were delivered in 2015, as compared to 2016 and 2017, consecutive to fewer admissions in 2015 (the intervention started in three out of the six municipalities, the one targeting children 6-59 months of age starting in February 2015 while the one targeting PLW starting in November 2015). The distribution trends for both food commodities further increased in 2016 (77% for RUSF and 95% for Timor Vita) and 2017 (97% for RUSF and 99% for Timor Vita).

28 Ministry of Health Timor-Leste. Specific Nutrition Intervention Package (SNIP) Guidelines. MODULE 8: Implementing Integrated Management of Acute Malnutrition (IMAM), 2016, p138.

29 WFP: Mother and child health and nutrition – targeted supplementary feeding programme (MCHN – TSFP), p28.

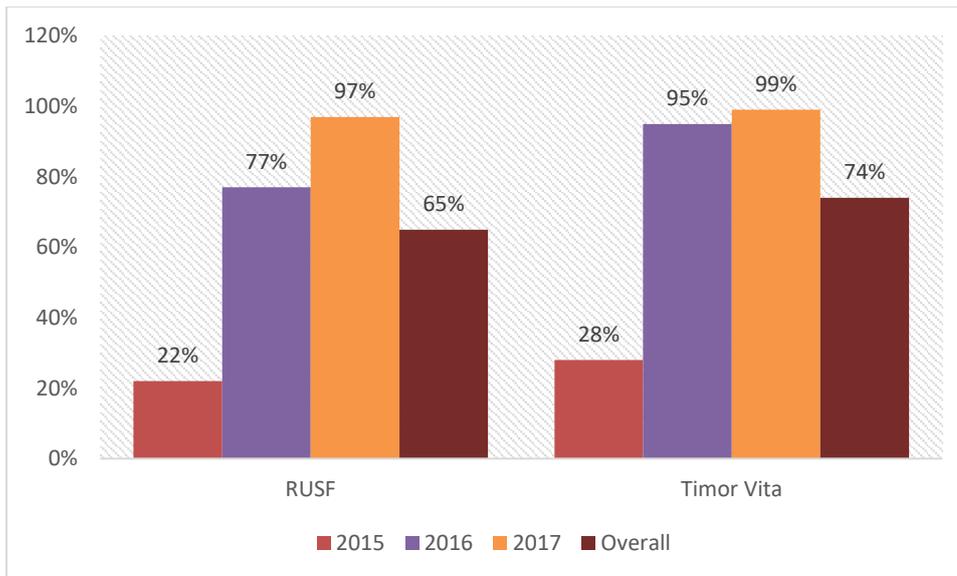


Figure 2.1: Proportion of RUSF and Timor Vita distributed in 2015, 2016, and 2017

Although the WFP-SAMES agreement was satisfactory in terms of timely delivery of Timor Vita and RUSF to the municipalities, these municipalities experienced challenges in delivering the products to the health facilities. While enough quantities of Timor Vita and RUSF were stored in municipality storage rooms, health facilities were experiencing shortages. Managers interviewed at the national level reported that municipalities were financially capable to support the delivery of food commodities to the health facilities, but the technical capacity to forecast properly and to manage the supply chain system was limited. The MoH staff at municipality level reported that the municipality offices were not autonomous enough to take on delivery of food commodities to the health facilities because of insufficient financial and logistics resources. The MoH staff usually used one multifunction vehicle (ambulance or truck) to deliver medicines and food commodities to the health facilities, but not on a regular basis. Most of cars, ambulances or trucks belonging to municipal health offices were broken, and it was up to health facilities to use their own means (often ambulance if available) to collect food commodities from the municipal warehouse.

At the national level, pipeline breaks occurred in the first quarter of 2017, leading to Timor Vita shortages in all six municipalities. The Timor Global managerial board attributed this issue to delays in getting clearance from the MoH for importing raw materials, delays in getting clearance from laboratories testing product samples prior delivery to the warehouses, and WFP's rejection of quantities produced in the first quarter of 2017 because laboratory analysis showed sub-quality product. To anticipate these issues in the future, the company planned to conclude their partnership with foreign companies for expanding its production capacity from the current 2,500 to 7,500 metric tonnes per year and for speeding up laboratory clearances. They wished WFP and MoH would also share their expected level of purchase with Timor Global over a period of 12-24 months for the company to forecast properly.

2.2.1.4 Achievements in Community Mobilisation Component

International guidelines for the management of acute malnutrition structure community outreach into three main subcomponents; active case identification and referral; household follow up; and mobilisation and sensitisation. According to the Timor-Leste national guidelines for Integrated Management of Acute Malnutrition (IMAM), the community outreach refers to a series of participatory

activities aiming to raise awareness about the programme, to facilitate its understanding and to minimise barriers to accessing treatment. It also aims to identify malnourished children as early as possible, maximizing programme coverage and uptake, and minimise default rates³⁰. The 2015-2017 TSFP designed outreach activities around five main objectives: (1) to enhance community and informal leaders engagement to reduce under-nutrition in the targeted villages (*sucos*); (2) to strengthen the capacity of households to prevent malnutrition through good feeding practices and improved hygiene for child and pregnant women; (3) to strengthen the knowledge of communities on healthy behaviours and signs of danger for common sickness; (4) to reinforce the existing or establish communities support groups which can promote healthy behaviours; and (5) to organise case finding of acute malnutrition and referral for treatment. These objectives were translated into several activities³¹. This sub-section describes findings extracted from different programme activities to inform the achievements.

Case identification consists of using a MUAC tape to screen for acute malnutrition and assessing for bilateral pitting oedema. Children and PLW can be screened by health workers and PSF during household visits, at SISCa, CHC, health posts, community meetings or during health campaigns in the community³². Those identified as malnourished are provided with referral slips and referred to the nearest health facility for case confirmation and admission. In all six municipalities, health workers, volunteers and beneficiaries reported that screening was mainly performed during SISCa activities and household visits. A total of 3,205 children under-five years of age were admitted in 2015. Admission increased to 10,364 in 2016 then 6,884 in 2017. Regarding PLW, the admissions increased from 1,281 in 2015 to 16,885 in 2016, then 14,919 in 2017. Higher admission in 2016 was associated to higher achievements in community outreach activities, particularly active case identification and referral, as well as community mobilisation.

According to the national IMAM guidelines, follow up involves visiting certain patients admitted to TSFP in their homes to investigate the reasons for their absence or their poor recovery, to determine any need for special attention and to encourage them to return to the programme. The volunteer (PSF) also used this opportunity to give appropriate health education on children and PLW's condition at home. Community mobilisation and sensitisation consists of getting information on community structure and its key stakeholders, understanding the local perception of malnutrition, and involving key community members from the outset of the intervention³³. The number of recommended household visits were not specified in the national guidelines. WFP supported health staff for the implementation of activities such as nutrition education, cooking demonstrations (teaching how to prepare Timor Vita and other nutritious foods using locally available ingredients at home), behaviour change communication (BCC) and TV promotion as part of the MoH monthly activity planning the six municipalities. These activities were supported and organised by WFP with MoH staff, in addition to BCC activities undertaken by NGOs in the municipalities of Covalima, Dili and Oecusse.

Information gathered from interviews and FGDs showed that the implementation of these activities made people aware of the existence of the intervention. Both men and women attended different mobilisation sessions. Table 2.10 shows that in 2017, most of the community mobilisation sessions were held in the municipalities of Covalima (29%), Bobonaro (21%), Oecusse (19%) and Ermera (16%). Nutrition education (66%) and cooking demonstrations (32%) were mostly implemented during these

30 Ministry of Health Timor-Leste. Specific Nutrition Intervention Package (SNIP) Guidelines. MODULE 8: Implementing Integrated Management of Acute Malnutrition (IMAM), 2016, p127-129.

31 WFP: Mother and child health and nutrition – targeted supplementary feeding programme (MCHN – TSFP).

32 Ministry of Health Timor-Leste. Specific Nutrition Intervention Package (SNIP) Guidelines. MODULE 8: Implementing Integrated Management of Acute Malnutrition (IMAM), 2016, p131.

33 Ministry of Health Timor-Leste. Specific Nutrition Intervention Package (SNIP) Guidelines. MODULE 8: Implementing Integrated Management of Acute Malnutrition (IMAM), 2016, p132-134.

sessions. According to health staff interviewed, these two activities were more convivial for reaching most of the expected participants.

Table 2.10: Different community mobilisation sessions supported by WFP in the six municipalities in 2017

	Ainaro	Bobobaro	Covalima	Dili	Ermera	Oecusse	Total	%
Nutrition education	8	39	47	4	20	30	148	66%
Cooking demonstrations	4	8	17	15	16	12	72	32%
BCC training	1	0	1	2	0	1	5	2%
TV promotion	0	1	0	0	0	0	1	0%
Total sessions	13	48	65	21	36	43	226	100%
Percentage (%)	6%	21%	29%	9%	16%	19%	100%	

Adolescent boys and girls as well as women and men attended several sessions of different activities implemented in the community. Table 2.11 shows that 43% of boys and 57% of girls attended the four main activities implemented in the community, while these proportions were 28% and 72% for men and women respectively (table 2.12). In terms of location of activities, table 2.13 shows that they mostly took place at SISCa (60%) and health facility (20%) levels.

Table 2.11: Boys and girls attending mobilisation and sensitisation activities undertaken by WFP

	Boys	Girls	Total boys and girls
Nutrition education	352	490	842
Cooking demonstrations	395	506	901
BCC training	0	0	0
TV promotion	0	0	0
Total participants	747	996	1743
Percentage	43%	57%	100%

Table 2.12: Men and women attending community mobilisation activities undertaken by WFP

	Men	Women	Total men and women
Nutrition education	2003	4434	6437
Cooking demonstrations	872	3123	3995
BCC training	39	65	104
TV promotion	5	15	20
Total participants	2919	7637	10556
Percentage	28%	72%	100%

Table 2.13: Location of community mobilisation activities implemented by WFP and MoH staff

	Boys	Girls	Men	Women	Overall Total	Percentage
SISCa	425	516	1388	4726	7055	60%
HF's waiting room	181	224	540	1521	2466	20%
Household visit	0	1	58	106	165	2%
DHS training venue	0	0	31	60	91	1%
School	0	0	387	508	895	9%
Other venue	141	255	208	620	1224	8%

The main issues mentioned by PSF and health workers during FGDs were irregular screenings and follow ups, remoteness of some villages (Ainaro, Ermera, Oecusse), and sending away malnourished patients referred to the health facility when there was stock-out of supplementary foods. Additional follow up challenges included absence of incentives and transportation means for volunteers, frequent absence of beneficiaries at home because they were attending 2-3 weeks traditional ceremonies far away from their houses, insufficient number of available volunteers during coffee harvesting period (2-3 months) as people were busy working in coffee farms, and difficulties to find the houses of beneficiaries, particularly in urban context of Dili where there is no formal system of home addresses/identifications. Therefore, volunteers mainly relied on SISCa sessions to perform follow ups. Exceptionally, some health workers phoned beneficiaries to remind them about their next visit at the health facility, but this was not done on a regular basis because there was no budget dedicated to phone calls.

2.2.2 Children Progressing from MAM to SAM in Areas with and without SAM and MAM Components

Within the six municipalities implementing TSFP, all health facilities provided SAM services but only some provided MAM services. Joint planning between different stakeholders addressing acute malnutrition did not take place, hampering the continuum of care and mutualisation of resources. Quantitative data was not available to assess to what extent children not getting MAM services were progressing to SAM status in areas with and without MAM services. In such contexts, some health workers reported providing RUTF (dedicated to SAM only) to the beneficiaries until they fully retrieved normal nutritional status. Others reported counselling caregivers on appropriate infant feeding practices using local foods. Counselling was also used in the two visited municipalities (Manufahi and Liquica) not implementing the TSFP, and according to health workers interviewed, it was successful in addressing MAM in children and PLW when local foods were available, accessible, and the population and caretakers applied nutrition advices properly. However, data were not available for assessing the effectiveness of using RUTF or counselling to address MAM.

2.2.3 Effects of Activities Implemented by NGOs

WFP contracted NGOs (Alola Foundation and World Vision) for delivering community mobilisation and sensitisation in three municipalities (Covalima, Dili and Oecusse). In the other three municipalities (Ainaro, Bobonaro, Ermera), UNICEF also contracted NGOs to support MSG. Activities delivered included among others screening and referral of children and PLW, community mobilisation meetings, nutrition education and counselling, and cooking demonstrations. MSG were created and trained by these NGOs and PSF identified within these groups were provided with materials, incentives, visual aids and transport allowances for delivering services during SISCa, household visits and at health facilities.

Outputs derived from the implementation of these activities showed that most children and PLW were screened during growth monitoring and promotion (GMP) and SISCa. Table 2.14 shows that out of the total screened, a proportion of 14.7% children and 23.8% PLW were referred to the nearest health facilities for case confirmation and admission. Table 2.15 shows that mobilisation activities reached 1,122 community leaders, 1,688 women support group participants, 483 youth representatives, 326 church representatives, 4,697 caregivers (73.5% women and 26.5% men), 1,169 pregnant women and 1,723 lactating women. These activities stimulated community adhesion and participation to the programme.

Table 2.14: Number of children and PLW screened and referred during different screening sessions organised by NGOs

	Alola Foundation		World Vision	Total
	Dili	Oecusse	Covalima	
U5 Children screened during GMP and SISCa	17405	1546	693	19644
U5 with AM referred to the health facility	2143	722	25	2890
% U5 children referred	12.3%	46.7%	3.6%	14.7%
PLW screened during GMP at HF or SISCa	4625	2893	864	8382
PLW with AM referred to the health facility	1361	601	32	1994
% PLW referred	29.4%	20.7%	3.7%	23.8%

Table 2.15: Participants to different community mobilisation meetings facilitated by NGOs

	Alola Foundation		World Vision	Total
	Dili	Oecusse	Covalima	
Community leaders/Suco representatives	627	143	352	1122
Women Support Groups members	452	250	986	1688
Youth representatives	234	122	127	483
Church representatives	239	87	0	326
Care givers Female	1751	914	789	3454
Care givers Male	524	522	197	1243
Pregnant women	285	338	546	1169

Lactating women	695	633	395	1723
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Since 2016, additional opportunities such as the World Food Day and the World Breastfeeding Week, organised by the MoH in collaboration with partners, were used by NGOs to raise the communities' awareness on the importance of preventing malnutrition through appropriate infant and young child feeding (IYCF) practices. During these events, MSG facilitated the implementation of cooking competition among caregivers and PLW, promoting dietary diversity using local foods. Food taboos such as preventing women from eating fish, chicken, or eggs during pregnancy were also discussed during these sessions, and communities were informed on alternatives to these sources of proteins if they were not willing to change their food beliefs.

As shown in table 2.16 (in annex 14), additional NGO achievements included:

- Mobilisation through household visits to attend SISCa and health facility (2,208 PLW attending)
- Nutrition education and counselling during health promotion activities, reaching 7,105 PLW and 6,096 caregivers (69% women and 31% men).
- FGD with caregivers on health issues reaching 2,026 PLW and 3,735 caregivers (64% women, 36% men).
- Teaching community groups the signs of acute illness reaching 15,459 PLW and 20,795 participants (56% women, 54% men).
- Cooking demonstrations reaching 1,926 PLW and 4,156 caregivers (76% women, 24% men).

During FGDs, women (both caregivers and PLW) declared they were now able to cook nutritious dishes using local ingredients after exposure to different sensitisation activities in their villages, and they have taken steps to improve their household eating practices. The main challenges they experienced (also confirmed by men during FGDs) were limited household financial resources to afford all local foods recommended during counselling sessions as well as insufficient space and water for initiating home garden to produce vegetables. Another issue raised by NGOs managers, volunteers and community members was the low coverage of community activities. Mobilisation and sensitisation activities did not take place in all villages and sub-villages within the municipalities supported by NGOs because of insufficient financial resources and low number of motivated volunteers who could reach all villages, particularly the remote ones.

2.2.4 Influence of the Availability of Food at Health Facilities on other Health and Nutrition Services

Aside from targeted supplementary feeding services, health facilities also delivered immunization, micronutrient supplementation (vitamin A), multi-micronutrient supplementation (MNP) to children 6-23 months, Iron and Folic Acid supplementation (IFA) to pregnant women, ante- and post-natal care, infant and young child feeding, family planning, and health promotion services. Figure 2.2 (in annex 14) shows that from 2015 to 2017, gradual increase of children under-five in MAM admissions was followed by dramatic increase in admissions of children to vitamin A, de-worming and immunization services. Similarly, a gradual increase of PLW to services addressing acute malnutrition was followed by an increase in admissions of pregnant women to de-worming and antenatal care services, as well as lactating women to post-natal care and family planning services (figure 2.3 in annex 14)). According to health workers and managers interviewed, these linkages were attributed to the availability and distribution of supplementary foods in the health facilities (beneficiaries of these services also expected to get the foods), along with sensitisation messages provided by PSF. Thus, the availability of supplementary foods in the health facilities attracted beneficiaries and boosted the uptake of other services delivered for children and PLW.

2.2.5 Cross-cutting Issues

Gender Equality

There was no significant difference between boys and girls admitted to the TSFP. Slightly more girls (52%) than boys (48%) were admitted during the three years of implementation (figures 2.4 in annex 14). The majority of children admitted belonged to the age group of 6-23 months (figure 2.5 in annex 14)), which represents the period of the introduction of complementary foods in the child's diet. There were slightly more pregnant than lactating women admitted in the programme (54% versus 46%), regardless of the age groups (figure 2.6 in annex 14). Interviewees and FGDs participants did not mention any community-based discrimination between young boys and girls, or between pregnant and lactating women during screening, referral, admission, and follow up. Similarly, there was no significant difference between boys and girls in recovery rates during the three years of implementation (figure 2.7 in annex 14). More children aged 6-23 months than those aged 24-59 months recovered (figure 2.8 in annex 14), which was coherent with admission patterns (most children admitted aged 6-23 months). Overall, 18,645 (35.2%) men participated to mobilisation and sensitisation activities undertaken by WFP and NGOs, although fewer than the 34,200 (64.8%) women, which influenced the level of support they provided to women in the households. Interviewees and FGD participants reported that sensitisation messages delivered to men during village meetings convinced them to increase their support to women at households, especially during the pregnancy and lactation periods. This support mainly consisted of giving more money to their wives for purchasing food, collecting firewood and water, taking care of children while the mother was preparing family meals or assisting her in cooking, and attending parent's clubs and mother support group activities whenever possible. Men also shared information learned during these sessions with their counterparts in the village. However, it was reported that the level of support provided generally dropped after the woman's pregnancy and lactation. The time during pregnancy is culturally considered as the window period during which women need more assistance at home.

In terms of equity, as previously mentioned, implementing the TSFP in six out of the 13 municipalities of the country and not delivering MAM services to all (100%) health facilities within the six municipalities has hampered access to services to potential vulnerable beneficiaries, thus explaining low treatment coverage observed.

Women Empowerment

During FDGs with caretakers, PLWs and community leaders, respondents reported that cooking demonstrations improved the capacity of women to prepare nutritious dishes using local foods or combining local ingredients with Timor Vita. As Timor Vita was shared in the households (although not supposed to be shared), PLW were considered as a source of food for these households. One important issue that hampered women's empowerment was raised during FDGs with health workers and volunteer women. The national guideline for establishment of mother support groups³⁴ recommend the provision of \$5 USD per month as a means of incentive to PSF, but this was not applied in the municipalities because the government had not yet funded the initiative. The lack of incentives for PSF in areas not supported by NGOs and in non-WFP supported municipalities was a source of frustration. As they spent whole days outside the households delivering community mobilisation activities and returning home with "empty hands", their husbands/partners or family members did not appreciate their involvement, especially given that PSF received \$2.5 USD per day from World Vision or \$60 USD

34 Ministry of Health Timor-Leste. Guideline for establishment and operation of Mother Support Groups. Nutrition and maternal newborn and child health practices in the context of primary health care. Guideline developed with financial and technical support from European Union and UNICEF, 2017.

per month from Alola Foundation in NGO supported areas.

Partnership and Coordination

Managers interviewed indicated that, coordination mechanisms between different sectors for improving nutritional status of children and PLW was weak. Coordination meetings were not held on a regular basis at both the national and municipality levels, and decisions taken during these meetings were not often followed by concrete actions. Coordination councils established at the village/Suco levels were not operational. Interviewees noted limited technical and funding capacity were reasons explaining weak coordination leadership from the government and local authorities, along with conflicting priorities between donors and development partners. This has fragmented coordination initiatives between beneficiary agencies/organisations implementing the interventions in the field. This weak coordination also translated into incoherence in targeting (municipalities and health facilities within municipalities) observed among agencies during programme planning. According to interviewees, the KONSSANTIL³⁵, a national council in charge of facilitating collaboration between different line ministries, partners and donors for nutrition multi-sectoral design and implementation did not have sufficient funds and technical capacity to lead the coordination mechanism.

2.3 Efficiency

2.3.1 Cost-efficiency of MAM Addressed with or without Specialised Nutritious Foods

The evaluation team explored treatment modalities used in the two municipalities (Liquica and Manufahi) not implementing the TSFP, and in health facilities not delivering MAM services within the six municipalities. As mentioned above, two options were used by health workers in such circumstances; the first, by providing RUTF to SAM and MAM children until recovering normal status; or the second, by providing counselling on optimal good feeding practices for infants and children. Health workers noted, these two options worked well, but quantitative data was not available to assess to what extent counselling was successful in addressing MAM in children and acutely malnourished PLW, or which option was more cost-efficient.

2.3.2 Cost per Beneficiary Recovered and per Type of Specialised Nutritious Foods Provided

The analysis of TSFP costs relied on project disbursements from the beginning of the intervention in 2015. The total programme budget was \$13.7 million USD, funded 59% by the EU (\$8.083 million USD) and to 41% by KOICA (\$5.617 million USD). The comparison of cost per beneficiary (PLW and children under-five years of age) recovered according to the type of nutritious food received (Timor Vita versus RUSF) was computed. These two analyses were bounded. Table 2.17 shows that the average cost per recovered MAM child in the country was \$52.3 USD, the lowest cost (\$35.9 USD) was observed in Bobonaro municipality. The highest cost (\$79.6 USD) was observed in Dili municipality (table 2.18).

Table 2.17: Cost per recovered MAM child treated with RUSF

	2015	2016	2017	Total
Amount spent for RUSF	\$ 67,002 USD	\$389,132 USD	\$75,639 USD	\$531,773 USD

35 The KONSSANTIL (National Council for Food Security, Sovereignty, and Nutrition in Timor-Leste) is a high-level coordinating body established in 2012 to guide the national multisectoral response to food insecurity and malnutrition, outlining activities required across sectors to end malnutrition in Timor-Leste. It functions under the Council of Ministers, lead by the Ministry of Agriculture and Fisheries. It operates at three levels: (a) the Inter-Ministerial Food and Nutrition Security Working Group; (b) the Permanent Technical Secretariat with membership from Directors General and (c) the municipality Food Security, Sovereignty Nutrition & Disaster Management Committee.

Number of recovered children	1,533	5,912	2,722	10,167
Cost per recovered³⁶ U5	\$ 43.7 USD	\$65.9 USD	\$27.7 USD	\$52.3 USD

Note: this calculation does not consider transportation and handling costs.

Table 2.18: Cost per recovered MAM child according to municipality

	Total cost of RUSF distributed (in USD)	Number of recovered U5	Cost per recovered U5 (in USD)
Ainaro	\$37,648	842	\$44.7
Bobonaro	\$44,101	1,229	\$35.9
Covalima	\$77,732	1,917	\$40.5
Dili	\$262,912	3,303	\$79.6
Ermera	\$30,232	606	\$49.9
Oecusse	\$80,148	1,238	\$64.7
Total	\$-531,773	10,167	\$52.3

Note: this calculation does not consider transportation and handling costs; U5: children under-five years of age

For PLW, the average cost per recovered beneficiary for the three years of implementation was \$41.7 USD (table 2.19). The lowest cost (\$41.3 USD) was observed in Dili municipality, while the highest cost (\$65.1 USD) was observed in Covalima municipality (table 2.20).

Table 2.19: Cost per recovered acutely malnourished PLW using Timor Vita

	2015	2016	2017	Total
Amount spent for Timor Vita	\$10,782 USD	\$345,739 USD	\$105,583 USD	\$462,104 USD
Number of recovered PLW	0	6,623	4,446	11,069
	\$ 0 USD	\$ 52.2 USD	\$23.7 USD	\$41.7 USD

³⁶ Recovered children are those admitted and followed up until clinical and anthropometric recovery. Defaulters and non-responses were not included in this computation.

Cost per recovered PLW

Note: this calculation does not consider transportation and handling costs

Table 2.20: Cost per acutely malnourished PLW recovered according to municipality

	Overall cost of Timor Vita distributed (in USD)	Number of recovered PLW	Cost per recovered PLW (in USD)
Ainaro	\$64,349.6	1,201	\$53.6
Bobonaro	\$42,497.5	941	\$45.2
Covalima	\$70,432.5	1,082	\$65.1
Dili	\$136,107	3,296	\$41.3
Ermera	\$110,606.3	1,866	\$59.3
Oecusse	\$37,843.3	789	\$48.0
Total	\$462,104.3	11,069	\$41.7

Note: this calculation does not consider transportation and handling costs

2.3.3 Cost of Targeted Approach Versus Previous Blanket Supplementary Feeding Programme

Before the TSFP, there was a Blanket Supplementary Feeding Programme implemented by WFP, targeting children less than two years of age and PLW. For both groups, well-nourished and acutely malnourished were admitted. Target beneficiaries were therefore different for these two programmes. Analysis showed that the cost per recovered beneficiary in TSFP was higher than that of blanket feeding (table 2.21), that is \$ 52.3 USD and \$ 41.7 USD in TSFP versus \$8.01 USD in blanket feeding. Lower cost observed in blanket feeding can be explained by higher number of beneficiaries, particularly many children consuming lower quantities of Timor Vita as compared to PLW. In addition, both healthy and MAM cases were admitted into blanket feeding programme while only MAM children aged less than five years and acutely malnourished PLW were admitted to TSFP. Well-nourished children and PLW might have spent less time in the programme, consuming lower quantities of Timor Vita, resulting in lower cost per beneficiary.

Table 2.21: Comparison of cost per beneficiary recovered through TSFP versus beneficiaries admitted to blanket feeding

	Total amount spent for commodities distributed (in USD)	Number of beneficiaries	Cost per beneficiary (in USD)
TSFP for U5 children (RUSF)	\$531,773	10,167 ^{&}	\$52.3
TSFP for PLW (Timor Vita)	\$462,104.3	11,069	\$41.7
Blanket feeding (Timor Vita)	\$414,778	51,750	\$8.01

Note: this computation does not consider transportation and handling costs. For blanket feeding, Timor Vita was distributed to both U5 children and PLW.

[&]: Number of beneficiaries that have recovered for TSFP, and number of beneficiaries admitted to blanket feeding. Blanket feeding is not considered treatment, and there was no monitoring of progress of nutritional status in the blanket approach.

Few studies have estimated the cost per MAM child recovered through targeted supplementary feeding in low- and middle-income countries. An evaluation conducted in Kenya³⁷ in 2012 estimated the cost per recovered MAM child at \$56.5 USD, which is almost similar to the figure estimated in Timor-Leste (\$52.3 USD). Another evaluation conducted the same year in Pakistan³⁸ estimated the cost per recovered MAM child at \$21 USD, far lower than that observed in Timor-Leste. In Pakistan the RUSF used was produced locally and cheaper than the imported RUSF in Timor-Leste. No data were available to compare cost per recovered acutely malnourished PLW in Timor-Leste with other low- and middle-income countries.

2.3.4 Efficiency of the Implementation of TSFP Compared to Alternatives

The TSFP used RUSF, an imported food supplement to address MAM in children, and Timor Vita, a locally produced supplementary food (a super cereal) for PLW. As mentioned above, the average cost per recovered MAM child receiving RUSF (imported food) was \$52.3 USD, which is higher than the cost per recovered acutely malnourished PLW receiving Timor Vita (\$41.7 USD). The lower cost for Timor Vita can be explained by the fact that it was locally produced. Data was not available for comparing the cost of foods used in TSPF with other types of blended fortified foods.

2.3.5 Performance in Areas with and without NGO Support

A comparison of performance was made between municipalities supported by NGOs for community-based activities and areas not supported by NGOs. Table 2.22 shows that children admitted to TSFP in the three municipalities supported by NGOs represented 71% of the total admissions for the three years of implementation. This proportion was 72%, 68% and 76% in 2015, 2016, and 2017 respectively.

Table 2.22: Admissions of children 6-59 months of age in NGO supported versus non-NGO supported municipalities

		2015	2016	2017	Total
NGO supported municipalities	Covalima	1,267	1,239	1,338	3,844
	Dili	75	4,685	2,844	7,604
	Oecusse	975	1,090	600	2,665
	Sub total NGOs	2,317 (72%)	7,014 (68%)	4,782 (70%)	14,113 (71%)
Non-NGO supported municipalities	Ainaro	70	1,398	864	2,006
	Bobonaro	757	924	670	2,167
	Ermera	61	1,028	568	1,482

37 UNICEF. Evaluation of Community Management of Acute Malnutrition: Kenya Country Case Study. Evaluation report. New York: UNICEF Evaluation Office, December 2012. http://www.unicef.org/evaldatabase/files/Kenya_CMAM_formatted.pdf

38 UNICEF. Evaluation of Community Management of Acute Malnutrition: Pakistan Country Case Study. Evaluation report. New York: UNICEF Evaluation Office, September 2012. http://www.unicef.org/evaldatabase/files/Pakistan_CMAM_final_report_11oct2012%281%29.pdf

Sub total non-NGOs	888 (28%)	3,350 (32%)	2,102 (30%)	5,655 (29%)
Total admissions U5	3,205 (100%)	10,364 (100%)	6,884 (100%)	19,768 (100%)

For PLW, table 2.23 shows that 52% of admissions were registered in the three municipalities supported by NGOs. These proportions were 49.5%, 51% and 53% for the year 2015, 2016 and 2017 respectively.

Table 2.23: Admissions of PLW in NGO supported versus non-NGO supported municipalities

		2015	2016	2017	Total
NGO supported municipalities	Covalima	164	2,112	1,814	4,090
	Dili	468	4,726	4,734	9,928
	Oecusse	0	1,761	1,305	3,066
	Sub total NGOs	632 (49.5%)	8,599 (51%)	7,853 (53%)	17,084 (52%)
	Total admissions PLW	1,281 (100%)	16,885 (100%)	14,919 (100%)	33,085 (100%)
Non-NGO supported municipalities	Ainaro	323	2,473	2,162	4,958
	Bobonaro	0	2,149	1,799	3,948
	Ermera	326	3,664	3,105	7,095
	Sub total non-NGOs	649 (50.5%)	8,286 (49%)	7,066 (47%)	16,001 (48%)
	Total admissions PLW	1,281 (100%)	16,885 (100%)	14,919 (100%)	33,085 (100%)

Compared to PLW, higher proportions of children were then admitted in NGO supported municipalities. Community mobilisation and sensitisation implemented by NGOs boosted admission of more children while this was not the case for PLW. This could be explained by the fact that the community was more culturally conscious about pregnancy and lactation status than MAM in children (as already mentioned in the effectiveness chapter). Another explanation could be the fact that Timor Vita provided to PLW was more attractive (because sharable at households) than RUSF provided to MAM children.

In terms of performance indicators, table 2.24 shows that except in 2017, the average recovery rates in children was slightly higher in the three municipalities supported by NGOs than in those not getting such support. Recovery rates in children achieved sphere standards in 2017 in Oecusse. Similarly, Bobonaro, a non-NGO supported municipality achieved sphere standard in 2017. Sphere standards were not achieved in 2016 in the three NGO supported municipalities, but the achievements were slightly higher than that of non-supported municipalities.

Table 2.24: Recovery rates in children in NGO supported versus non-NGO supported municipalities

	2015	2016	2017	Average
Covalima	76%	62%	71%	69.6%

NGO supported municipalities	Dili	-	67%	47%	57%
	Oecusse	47%	52%	91%	63.3%
	Average	61.5%	60.3%	69.6%	63.3%
Non-NGO supported municipalities	Ainaro	-	62%	71%	66.5%
	Bobonaro	51%	55%	88%	64.6%
	Ermera	-	56%	71%	63.5%
	Average	51%	57.6%	76.6%	64.8%
Target			> 75%		

For PLWs, table 2.25 shows that average recovery rates were higher in NGO-supported municipalities than in non-supported ones.

Table 2.25: Recovery rates in PLW in NGO supported versus non-NGO supported municipalities

		2016	2017	Average
NGO supported municipalities	Covalima	60%	58%	59%
	Dili	58%	41%	49.5%
	Oecusse	49%	78%	63.5%
	Average	55.6%	59%	57.3%
Non-NGO supported municipalities	Ainaro	46%	28%	37%
	Bobonaro	33%	48%	40.5%
	Ermera	48%	53%	50.5%
	Average	42.3%	43%	42.6%

One of the community mobilisation objectives in management of acute malnutrition is to reduce defaulters. Table 2.26 shows that for children, except in 2017, average default rates in NGO supported municipalities were lower than that of non-NGO supported ones for 2015 and 2016. The municipalities of Oecusse (NGO-supported) and Bobonaro (non-supported NGO) achieved sphere standards in 2017. This can be explained by the fact that in 2017, NGOs recruited by UNICEF were also active in the non-WFP and non-NGO supported municipalities, thereby influencing their performance.

Table 2.26: Default rates in children in NGO supported versus non-NGO supported municipalities

		2015	2016	2017	Average
NGO supported municipalities	Covalima	13%	30%	19%	20.6%
	Dili	-	26%	37%	31.5%
	Oecusse	47%	38%	7%	30.6%
	Average	30%	31.3%	21%	27.5%
Non-NGO supported municipalities	Ainaro	-	30%	17%	23.5%
	Bobonaro	45%	41%	6%	30.6%
	Ermera	-	37%	27%	32%
	Average	45%	36%	16.6%	28.7%
Target			< 15%		

For average default rates in PLWs, they were lower in NGO supported versus non-NGO supported municipalities in 2016 and 2017 (table 2.27).

Table 2.27: Default rates in PLW in NGO supported versus non-NGO supported municipalities

		2016	2017	Average
NGO supported municipalities	Covalima	30%	38%	34%
	Dili	29%	38%	33.5%
	Oecusse	37%	6%	21.5%
	Average	32%	27.3%	29.6%
Not-NGO supported municipalities	Ainaro	40%	59%	49.5%
	Bobonaro	50%	31%	40.5%
	Ermera	36%	16%	26%
	Average	42%	35.5%	38.6%

Overall, community mobilisation and sensitisation, nutrition education and cooking demonstrations delivered by NGOs achieved higher admissions and slightly better performance. NGO support was therefore an added value for the intervention in NGO-supported municipalities.

2.4 Impact

According to the national IMAM guidelines, the impact of rehabilitating MAM children should be to prevent them from developing SAM, prevent mortality and morbidity associated with MAM, and prevent deterioration of maternal nutritional status and subsequent poor birth outcomes. The TOR suggested the assessment of two questions for impact. The first, what was the contribution of the intervention in reducing wasting prevalence among boys and girls between 2013 and 2016 in geographic target areas? The second, to what extent the project promoted equity in access in reducing wasting in disadvantaged, marginalised and less reached areas/districts? Based on the programme's log-frame and the consecutive ToC developed, stunting prevalence, infant mortality rate and under-five mortality were also analysed to further assess the impact of TSFP.

2.4.1 Contribution of the Intervention in Reducing Wasting Prevalence among Boys and Girls

As per the programme's theory of change, the implementation of the TSFP should lead to a reduction in wasting prevalence, which in turn should contribute to the reduction of infant and under-five mortality. It is also considered in the project theory that the provision of Timor Vita to PLW will contribute to the national target of stunting reduction. The impact of TSFP on wasting and stunting prevalence among children between 2013 and 2016 was assessed through secondary data analysis of the 2013 TLFNS and 2016 DHS. Figure 2.9 shows that at the national level, GAM prevalence increased from 11% to 25% between 2013 and 2016. Moreover, SAM prevalence increased from 1.9% to 9.8% while MAM prevalence increased from 9.1% to 14.2% during the same period. The dramatic increase of GAM, MAM, and SAM prevalence was observed in both, the six WFP intervention municipalities and the seven non-intervention municipalities as well (figure 2.10, figure 2.11, and figure 2.12 in annex 14). Thus, wasting prevalence increased across the country rather than decreasing as expected. Paradoxically, there were improvements in stunting prevalence. Figure 2.9 shows that at the national level the prevalence of stunting decreased from 50.2% in 2013 to 45.6% in 2016. Except for the municipalities of Dili and Viqueque, the decrease in stunting prevalence occurred in 11 municipalities (figure 2.13 in annex 14). Similarly, improvements were observed in infant mortality and under-five mortality in all 13 municipalities across the country. Figure 2.14 shows that from 2010 to 2016, infant

mortality decreased from 45 to 30 live births, and under-five mortality decreased from 64 to 41 live births.

Findings on the project’s impact showed contradictory figures in children, although the span of surveys used for comparing the outcomes were different (2013 to 2016 for wasting and stunting, and 2010 to 2016 for infant mortality/under-five mortality)³⁹. The perception of health workers, beneficiaries and community members was that the implementation of the project positively contributed to reducing the number of children and PLW suffering from acute malnutrition in their respective municipalities. Different reasons can explain these negative wasting outcomes, including frequent shortages of food supplements in health facilities, inadequate child feeding practices at home, high incidence of diseases such as malaria or anaemia in the country during the implementation period of TSFP, recurrent food insecurity issues (such as El Niño effects in 2016) experienced by the country, low treatment coverage of TSFP implemented within a short period of time, weak linkages between TSFP and other IMAM components, weak linkages between TSFP and nutrition sensitive interventions, and probably poor quality of anthropometric measurements taken during the 2016 Demographic and Health Survey (DHS). It should also be noted that at the time of data collection for the DHS 2016 (which took place between September-November), TSFP had only been fully implemented in all six municipalities for less than a year (starting in early 2016), which is a limited timeframe for significant impact on wasting prevalence. Therefore, evidence on impact of the TSFP on wasting is inconclusive.

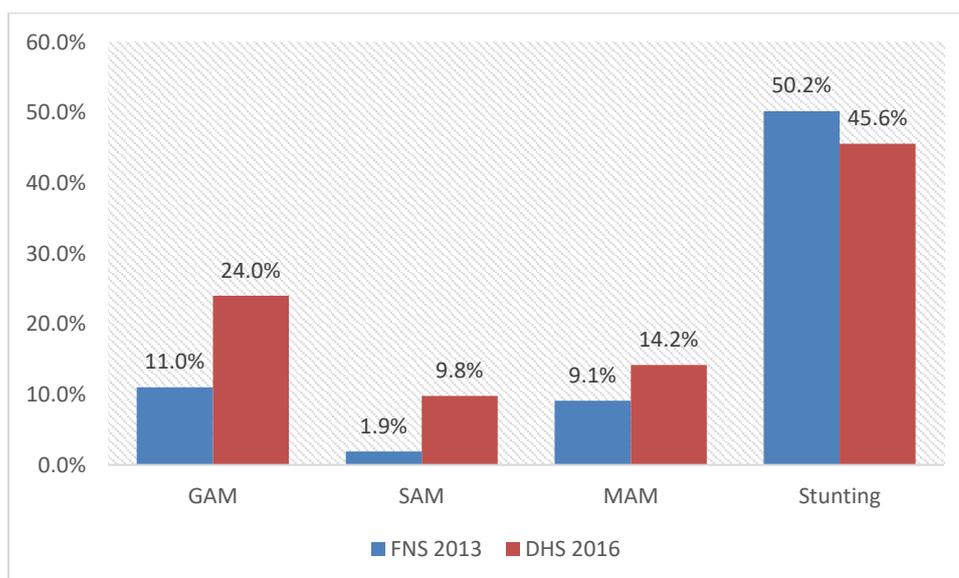


Figure 2.9: Trends of GAM, SAM, MAM and stunting prevalence at national level for the period 2013-2016

³⁹ Infant mortality and under-five mortality are not considered in nutrition surveys (e.g. the food and nutrition survey conducted in 2013). Only the comprehensive DHS survey considers these indicators. At the time of the evaluation, the final report of the 2016 DHS was not yet published. Preliminary findings reported infant mortality and under-five mortality rates at national level only. Municipality-based figures on these two indicators were not yet available.

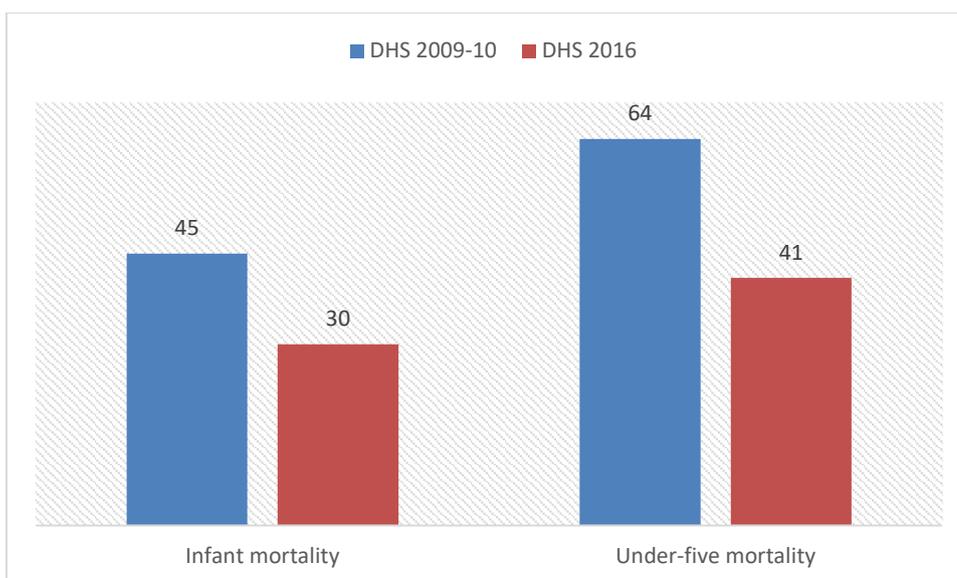


Figure 2.14: Trends of infant mortality and under-five mortality in Timor-Leste, 2010-2016

2.4.2 Impact on Reducing the Equity Gaps

As previously mentioned, the six TSFP municipalities were selected due to their high vulnerability to nutrition and food security outcomes. The fact that only six out of 13 municipalities could be covered with the given budget limited access to services to potential beneficiaries living in the other non-intervention seven municipalities. Services should be available to all vulnerable groups across the country, similar for SAM treatment. Within the six target municipalities, selection criteria were used by WFP to identify health facilities that can deliver MAM services. These criteria included the presence of at least one health worker, easy access by road for the delivery of food commodities and the presence of an adequate storage facility. Potential beneficiaries living in the catchment areas of health facilities not meeting the selection criteria might have been missed. Moreover, as access points for service delivery were mostly the health facilities than communities, the equity in accessing services by beneficiaries depended on the distribution of health facilities across the municipality. Despite important achievement in geographic coverage, treatment coverage did not achieve targets. In health facilities delivering SAM services but not MAM services, vulnerable children once graduated from SAM to MAM status were not managed and followed properly. NGOs delivering community mobilisation activities in three out of the six municipalities did not cover all villages and sub-villages. Many villages were not reached because of their remoteness. Therefore, there may have been areas with pockets of high malnutrition prevalence that were not covered by the intervention. Given that the nutrition survey considered overall population of children, including those living in areas not reached by the TSFP, these pockets of malnutrition might have influenced survey results with high wasting prevalence.

2.5 Sustainability

2.5.1 Likelihood that the Benefits of the Intervention Will Continue after WFP's Support

In Timor-Leste, the TSFP was designed in line with different national policies and strategies on nutrition. The services were delivered routinely within health facilities in the six municipalities, and the intervention was supervised by MoH staff whenever possible. At the national level, the department of nutrition at the MoH oversaw activities related to nutrition interventions across the country, including the TSFP. At the municipality level, there were DPHO appointed in charge of supervising nutrition interventions, in close collaboration with WFP and NGOs in regard to TSFP. At the health facility level, nutrition coordinators/focal points were appointed to supervise the delivery of nutrition services

(including TSFP) in the health centres and at the community level. Health staff were trained for the management of MAM in children and PLW. According to health workers interviewed, on-the-job training delivered by WFP staff played an important role in improving the performance of health facility personnel in anthropometric and clinical assessment, treatment protocols and counselling on appropriate feeding practices using local foods. In 2010, WFP signed an agreement with Timor Global to produce Timor Vita locally. Despite having to import key ingredients such as maize and vitamin premix (mainly from Indonesia) to bridge the national production gaps, the company delivered the quantity necessary for project implementation. Additionally, WFP signed an agreement with SAMES for the storage and delivery of food supplies to the municipalities, aiming to integrate delivery of food commodities into the national supply chain, thereby enhancing ownership. Despite challenges, these initiatives settled an enabling environment for the continuation of the intervention after the end of WFP's support.

2.5.2 Incorporation of Cost for Treatment of MAM into National Budgets, Plans and Policies

Most national policies and strategies were developed in Timor-Leste, but insufficient domestic financial resources were allocated to nutrition. Through the agreement signed by WFP and SAMES it was expected that the government of Timor-Leste would fund the delivery of supplies from municipalities to the health facilities, along with monitoring and supervision. However, the allocation of funds to these activities was challenging in the six municipalities. The EU and KOICA were the main donors for the TSFP during the project period, between 2015-2017. WFP actively contributed to the advocacy of nutrition, it was then progressively put high on the political agenda, and the government allocated an estimated \$450,000 USD to nutrition for the country's next project cycle, due to start in 2018. It was planned that some amount of this budget would be used to import RUSF and super cereals for MAM interventions in children and acute malnutrition in PLW. This government funding allocated to nutrition was very low compared to the demand. Government authorities reported not being able to allocate more funds to nutrition, due to the current national top priorities including; country wide road construction and infrastructure development. Therefore, sustaining TSFP will still depend on donor funding for the years to come unless there is a drastic shift of gear on national budget allocation for nutrition.

The Scaling up Nutrition (SUN) initiative, adopted by international technical partners and donors (including the EU and KOICA), promotes the development of multi-sectoral strategies for nutrition that have the potential to promote long-term funding and mutualisation of resources^{40,41,42}. In Timor-Leste, the collaboration between the MoH and UN partners enabled the development of the SNIP in 2016, imbedding TSFP within the IMAM approach⁴³. Diverse nutrition sensitive interventions were implemented across the country by different organisations, but they were not linked to the TSFP.

2.5.3 Project's Potential to Positively Influence Gender Relations and Increase Involvement of Men

Although the project was specifically designed to target PLW and children between the ages of 6 to 59 months the implementation of community activities involved both men and women in the municipalities. Following the project's implementation, men were more aware of the importance of dedicating sufficient time and resources to the care of children and PLW, in turn they supported them

40 Nutrition at the World Food Programme. Programming for Nutrition-Specific Interventions, December 2012.

41 Addressing Undernutrition in Emergencies. Accompanying the document: Enhancing maternal and child nutrition in external assistance: an EU policy framework, 2013.

42 United Nations Children's Fund. UNICEF's approach to scaling up nutrition for mothers and their children. Discussion paper. Programme Division, UNICEF, New York, June 2015.

43 Ministry of Health Timor-Leste. Specific Nutrition Intervention Package (SNIP) Guidelines, 2016.

in attending the services. Additionally, they were more supportive at the household level during the pregnancy and lactating periods. During FGDs, they claimed for expansion of current community nutrition activities to all villages, along with support in initiating kitchen gardens for vegetable and crop production and small livestock. These were opportunities to attract and involve them in future activities.

2.5.4 Practical and Feasible Recommendations for the Continuation and Sustainability of the Intervention

Practical and feasible recommendations for the continuation and sustainability of the intervention would be to improve the targeting process and strengthening of linkages with other IMAM components and with nutrition sensitive interventions. Further details can be found in the recommendation section.

3 Conclusions and Recommendations

3.1 Conclusions

The following, section presents the key evaluation conclusions according to evaluation criteria. It is important to note, as previously mentioned, it is possible that there is overlap between the criteria.

Relevance

The TSFP was designed in line with various international and national policies and was relevant for improving the nutritional status of the target beneficiaries living in the most vulnerable municipalities. Issues in targeting during programme design and implementation hampered access to services to potential beneficiaries living in remote areas. The TSFP did not achieve standards in terms of treatment coverage. For reasons of equity, the intervention should be extended to more municipalities and to non-pregnant adolescents, elderly and disable populations. Adjustments should be made accordingly to maximise the chance of reaching more vulnerable beneficiaries (Recommendation #1).

Effectiveness

The intervention did not achieve standards in terms of performance due to several challenges experienced by service providers and beneficiaries. Weak result tracking mechanism contributed to bias programme data monitoring. Addressing these challenges would be necessary for improving programme outputs (Recommendation #3). Creating and strengthening mother support groups was important in boosting adhesion and participation of the community and such an initiative should be continued (Recommendation #1, #2). Availability of supplementary foods was an important catalyst for the uptake of other health services provided to children and PLW. Their permanent availability in the health facilities should be ensured (Recommendation #4). Programme design did not explicitly link beneficiaries of TSFP to nutrition sensitive interventions to promote empowerment and prevention. This gap should be bridged in the next project cycle, and collaboration between partners should be strengthened in this regard for optimal results (Recommendation #5). Moreover, gender equality and empowerment approach was not clearly defined in the project document. This should be addressed properly in the next Country Strategic Plan, along with the related indicators (Recommendation #8).

Efficiency

Recovering an acutely malnourished PLW was more cost effective, as opposed to recovering a MAM child. The cost per beneficiary treated through blanket feeding (implemented before 2015) was also lower than that of children and PLW who recovered through the TSFP. The support of NGOs was relevant in boosting admissions and achieving reasonable performance (recovery rates and default rates) in MAM children and acutely malnourished PLW. Such support should be maintained and replicated (Recommendation #1, #2). In-depth studies should be conducted to assess to what extend

counselling was successful in addressing MAM in children and acutely malnourished PLW, and analyze which option between counselling and provision of RUTF until normal recovery was more cost-efficient, along with comparing the cost of supplementary foods used in the TSFP with other types of Super Cereals (Recommendation #7).

Impact

Wasting prevalence did not meet the expectations, while improvements were seen in stunting prevalence in children, infant mortality and under-five mortality across the country. Because of these contradictory outcomes, evidence on impact of the TSFP on wasting was inconclusive. An in-depth analysis of the recent DHS database should be performed to mitigate these contradictions (Recommendation #7).

Sustainability

The implementation of the TSFP settled an enabling environment for the continuation of the intervention after WFP's support. However, critical issues such as pipeline breaks, supplementary food shortages, irregular supervision and insufficient refresher trainings should be addressed to enhance technical sustainability. Active advocacy for allocation of more domestic funding to nutrition by the government should continue (Recommendation #6). Improving targeting process, along with strengthening linkages between the TSFP and other nutrition specific and nutrition sensitive interventions are best approaches for the continuation of the intervention (Recommendation #1, #5).

3.2 Main Lessons

The evaluation has drawn some lessons from the implementation of TSFP in Timor-Leste during the reference period 2015-2017. These lessons are described below:

1. The intervention was designed in line with different national policies and strategies but did not include adolescents as direct beneficiaries. This might have limited the achievements of the country's targets around the first 1000 days of a child's life cycle. The next country programme cycle should consider this category of beneficiaries.
2. High geographic coverage does not necessary induce high treatment coverage. The intervention was not implemented in all health facilities within the municipalities, hampering the continuum of care between SAM and MAM services. Moreover, NGO activities did not take place in all expected villages and sub villages, limiting access to potential beneficiaries. Issues of coverage and targeting should be properly considered in the next programme design,
3. Better anticipation of issues such as irregular monitoring and supervision, non respect of established ration for addressing SAM and MAM in children, sharing of supplementary foods and poor application of nutrition counselling messages at home, irregular screening and follow up of beneficiaries and shortages of food commodities are necessary for ensuring adequate programme's outputs and outcomes.
4. Continuous availability of supplementary food in the health facilities, especially Timor Vita, is an important catalyst for maternal and child service attendance, as it attracted beneficiaries and boosted the uptake of other services provided for children and PLW.
5. Integrating TSFP supplies into the national supply chain does not preclude timely delivery of supplementary foods to the health facilities. Until full technical and financial capacity of the

government is achieved, this essential element of the TSFP should function in parallel to the MoH system for better efficiency and effectiveness.

6. Community mobilisation and sensitisation implemented by NGOs contributed to better achievements in terms of admissions, recovery and defaults rates in children. In the context of Timor-Leste, NGO support for community activities remains of great importance for achieving key programme's targets.
7. The participation of men into parent's groups and community activities positively influenced the level of support they provided to children and women in the households. They claimed for expansion of community nutrition interventions empowering their households, which would be opportunities to increase their involvement in future activities.
8. One important outcome of the TSFP was to improve the nutritional status of targeted children and women in the community. From design to implementation stages, weak linkages between the TSFP, nutrition sensitive and other safety nets interventions did not promote optimal impact and prevention of undernutrition in the community.
9. Leading the process of developing policies, strategies, guidelines and training packages for nutrition interventions does not systematically preclude adequate domestic funding allocation. There is still need to explore means for securing sustainable funding for MAM management and other nutrition interventions by the government of Timor-Leste.

3.3 Recommendations

The evaluation has determined that the TSFP is a relevant approach for addressing MAM in children and acute malnutrition in PLW in Timor-Leste. The following eight recommendations were identified as priority areas (structured according to their priority) to be addressed by the Government of Timor-Leste, WFP and other partners to improve the next phases of TSFP implementation in the country.

DETAILED RECOMMENDATIONS	PROPOSED MANAGEMENT RESPONSIBILITY
<p>1. Revise the programme strategy design to improve coverage.</p> <ul style="list-style-type: none"> • Expand the TSFP to all health facilities in the six municipalities. This should be planned in collaboration with UNICEF and WHO to ensure continuum of care. • Harmonise the targeting criteria between WFP and UNICEF for the identification of health facilities that deliver services addressing acute malnutrition. • Expand NGO activities within all villages, in the six municipalities, in order to access more beneficiaries. • Include non-pregnant adolescent girls, and adolescent boys as direct programme beneficiaries. • Set up mobile clinics as a strategy for identifying and following up with more beneficiaries. • Conduct coverage surveys to appraise the distribution of health facilities delivering the TSFP versus the actual pockets of acute malnutrition in each targeted municipality. 	<p><i>The Government of Timor-Leste should take the lead, with technical support from WFP and implementing partners.</i></p>

<p>2. Strengthen the capacity of the MoH for appropriate treatment, follow up and prevention of MAM.</p> <ul style="list-style-type: none"> • Undertake refresher trainings for health staff at all levels to improve the quality of service. • Include pre-service training on the management of acute malnutrition for medical students, nurses and other health staff in the curricula of health schools to ensure sustainability. • Institutionalise joint monitoring and supervision and dedicate specific fund to it. • Initiate a stronger engagement of local leaders and community volunteers to ensure children and PLW do not default from treatment once enrolled. • Support the MoH in budgeting monitoring activities and dedicating the necessary human, material and financial resources. 	<p><i>The Government of Timor-Leste should take the lead, with support from donors, WFP, WHO, UNICEF, implementing partners.</i></p>
<p>3. Strengthen the national health information system for accuracy of data and real time monitoring</p> <ul style="list-style-type: none"> • Harmonise the reporting mechanism (using tablets) with TLHIS and systematise double checking of data. • Build the capacity of the MoH staff in the management and analysis of data reported in the harmonised reporting system. 	<p><i>WFP should take the lead, in collaboration with WHO and UNICEF.</i></p>
<p>4. Continue to strengthen the government supply chain and logistics system for timely delivery of supplies in the health facilities.</p> <ul style="list-style-type: none"> • Plan ahead on total supplies all municipalities would need annually, including the extra needs for household sharing. • Support the MoH in transport and delivery of supplies from municipalities to the health facilities. • Support the municipalities in exploring options of delegating delivery of supplies to a third-party for efficiency. • Share the annual quantification of supplies with local supplementary food producer. • Provide the government’s approval to WFP to use super cereal as a back-up to mitigate the risks of a pipeline break with Timor Vita. 	<p><i>WFP should take the lead in collaboration with the MoH, donors and technical partners.</i></p>
<p>5. Strengthen linkages and referral of TSFP beneficiaries to exiting nutrition sensitive and safety net interventions delivered in the community.</p> <ul style="list-style-type: none"> • Integrate NGO community activities within a broader multi-sectoral approach for prevention of undernutrition. • Expand the existing IMAM guidelines by including a job description of mother support groups and PSF and allocating the necessary incentives and transport means. • Harmonise permanent means of incentives for PSF/volunteers in charge of managing community mobilisation activities. 	<p><i>The Government of Timor-Leste should take the lead, with support from donors, WFP, WHO, UNICEF, implementing partners.</i></p>

<ul style="list-style-type: none"> • Strengthen the coordination mechanism (through harmonisation of priorities) from the national to municipality level to enhance joint planning and implementation between partners. • Strengthen the technical, managerial, financial and logistic capacity of The KONSSANTIL to adequately lead the design and implementation of the multi-sectoral approach at national, municipality and community levels. • Define clear linkage mechanisms between TSFP beneficiaries and existing nutrition sensitive and safety net interventions. 	
<p>6. Continue the partnership between government, donors and development partners to ensure funding for MAM management.</p> <ul style="list-style-type: none"> • Actively advocate with the government for allocating sufficient, consistent and long-term funding to MAM management, and for the relevance of a comprehensive and long-term funding source from donors for MAM management in the country. • Strengthen community capacity during community mobilisation and sensitisation to advocate for increased government engagement/responsibility regarding food delivery to the health facilities. 	<p><i>WFP should lead the process in collaboration with the Government of Timor-Leste.</i></p>
<p>7. Conduct operational research to assess the following areas:</p> <ul style="list-style-type: none"> • Cost-effectiveness of counselling versus supplementary foods for addressing MAM children and acutely malnourished PLW. • Cost per recovered MAM child or acutely PLW using RUSF or Timor Vita versus other types of super cereals. • Relevance of using sphere standards (designed for emergency response) to assess the performance of TSFP implemented in a more stable context like Timor-Leste. • In-depth assessment of the 2016 DHS database for better understanding of nutrition outcomes of the survey. 	<p><i>Academics should take the lead in collaboration with the MoH and technical support from WFP, UNICEF, WHO and implementing partners.</i></p>
<p>8. Develop a detailed gender equality and empowerment approach in the next Country Strategic Plan, along with the related indicators</p>	

Annexes

Annex 1: Terms of Reference - End-Term Evaluation of Treatment of Moderate Acute Malnutrition 2015-2017. WFP Timor-Leste

Introduction

These Terms of Reference (TOR) are for the end-term evaluation of the activity Treatment of Moderate Acute Malnutrition (MAM) implemented in six municipalities of Timor-Leste (Ainaro, Bobonaro, Covalima, Dili, Ermera, and Oecusse) under the World Food Programme (WFP) Development Project 200770 (DEV). This evaluation is commissioned by the WFP Timor-Leste Country Office (CO) and will cover the project period of the Development Project during which the activity was implemented, i.e. 2015 to 2017. The expected evaluation duration is from May to October 2017.

These TOR were prepared by the WFP Timor-Leste CO based upon an initial document review and following a standard template. TORs will be consulted through the external reference group after quality assurance. The purpose of the TOR is twofold. Firstly, it provides key information to the evaluation team and helps guide them throughout the evaluation process; and secondly, it provides key information to stakeholders about the proposed evaluation.

As the Timor-Leste DEV 200770 comes to an end in December 2017, this will be considered an end-term evaluation. An evaluation of the project's achievements with respect to its targets, overall performance and impact was initially planned to take place in late December 2016, as part of the DEV 200770 monitoring and evaluation plan⁴⁴. Following a Budget Revision in 2016, the timeline of the project has been extended to 31 December 2017.

The evaluation of the previous Country Programme (2011-2013)⁴⁵ found a number of challenges compromising the effectiveness of the nutrition programme, including limitations in coverage and participation, extensive sharing of food, transport issues, poor supervision, and weak community outreach. The DEV 200770 has seen notable improvements in the performance indicators of the activity, in particular in the recovery rate of children admitted for treatment of MAM. However, several of the listed challenges still remain and continue to affect effectiveness of the intervention, as noted by continued high defaulter rates in 2016 (31% compared to the target of <15%).

As nutrition will be a key component of the forthcoming Country Strategic Plan (CSP), the CO has opted for an in-depth evaluation focusing on the nutrition-specific activities of the DEV 200770 rather than the operation as a whole. Other focus areas of the DEV 200770, such as capacity building activities on monitoring and supply chain management, are not included in the scope of the evaluation.

Reasons for the Evaluation

The reasons for the evaluation being commissioned are presented below.

Rationale

The evaluation is being commissioned to assess strengths and challenges of the ongoing programme and to identify advocacy points for programme adjustment to adequately deliver quality supplementary feeding gaps. Some contextual justification for the evaluation include the following:

There is a need to inform key stakeholders of the effectiveness and quality aspects of interventions for management of acute malnutrition and related supplies, and to appropriately guide and advocate for specific strategic recommendations, including on capacity development needs, products, etc. This evaluation will document experiences in management of acute malnutrition and therefore inform advocacy.

Though the donor, European Union, plans to conduct an end-term evaluation of the activity, this is likely to place at the end of the project period which is December 2017. At the same time, there is an

⁴⁴ WFP Timor-Leste Development Project 200770 (January 2015 – December 2016), approved 5 January 2015.

⁴⁵ WFP Office of Evaluation. Country Portfolio Evaluation. Timor-Leste: An Evaluation of WFP's Portfolio. (2008-2012). OE/2013/001

increased and urgent need for detailed investigation on the ongoing intervention's relevance, effectiveness, efficiency, sustainability and impact in order to make evidence-based decisions on adjusting the design or implementation to achieve the desired impact. Conducting an independent activity evaluation ensures specific and timely feedback which will be based on comprehensive evidence.

A detailed evaluation of the activity will further inform the CSP and provide evidence that can be used to solicit financial support from the donors.

Reducing the high levels of wasting, or acute malnutrition, in Timor-Leste is crucial for achieving the goals and targets set out in the 2030 Agenda for Sustainable Development and the Sustainable Development Goal (SDG) target 2.2. WFP Timor-Leste intends to continue supporting the Government in addressing wasting under the CSP, with the aim of reaching national targets for reducing undernutrition in children under five years of age.

Under the Timor-Leste DEV 200770 (January 2015 - December 2017), WFP implements the following activities: i) treatment of moderate acute malnutrition in boys and girls 6-59 months; and ii) treatment of acute malnutrition in pregnant and lactating women. The expected outcome of the activity is to improve the nutritional status of targeted women and children and increase coverage of the intervention. Performance is measured by monitoring of key indicators for management of moderate acute malnutrition (MAM), which include coverage, recovery, defaulter and death rate⁴⁶.

By building the knowledge base on nutrition programmes, the activity evaluation will contribute to the objectives of the DEV 200770, which include strengthening the Government's capacity to design, implement and manage policies and systems for reducing undernutrition, and to hand-over sustainable food-based nutrition programmes to the Government in a responsible manner.

WFP, as a technical partner to the Government of Timor-Leste, provides recommendations based on evidence. There is however insufficient evidence and guidance globally to determine the most effective strategy for addressing MAM in population settings. The Lancet Series on Maternal and Child Nutrition highlight the importance of assessing outcomes for future learning and improved design of effective nutrition interventions that support long-term actions to address underlying causes of undernutrition⁴⁷. The gap in consensus and programmatic guidance for community-based management of MAM is a constraint that has been recognized internationally⁴⁸ as well as in the national context.

The European Union (EU)⁴⁹ and the World Bank⁵⁰ have made recommendations for evaluating the national guidelines for management of acute malnutrition, in particular with regards to the MAM treatment component and provision of specialized nutritious foods, to determine effectiveness, cost-benefit and appropriate scale of the intervention. In addition, the on-going Strategic Review of SDG 2 in Timor-Leste highlights the need for early case detection and treatment of acute malnutrition as a preliminary finding from national consultations⁵¹.

Hence, there is a stated need to assess what has worked well, what has not and why, including looking at effectiveness, efficiency and sustainability of this particular activity of the Development Project, implemented in parts of the country since 2015. As the DEV 200770 will come to an end in December 2017, it is essential to provide the Ministry of Health, donors and other stakeholders with an independent assessment of the performance and lessons from the implementation of the activity that

⁴⁶ The Sphere Project. Humanitarian Charter and Minimum Standards in Humanitarian Response. <http://www.spherehandbook.org/en/management-of-acute-malnutrition-and-micronutrient-deficiencies-standard-1-moderate-acute-malnutrition/>

⁴⁷ Bhutta, Zulfiqar A. et. al. (2013). Evidence-based Interventions for Improvement of Maternal and Child Nutrition: What can be done and what will it cost? *The Lancet* 382:452-77.

⁴⁸ Annan et al. Management of Moderate Acute Malnutrition: Current Knowledge and Practice *CMAM Forum Technical Brief* (2014)

⁴⁹ EU. Final Report - Mid-Term Evaluation of the Integrated Nutrition Project in Timor-Leste. December, 2015.

⁵⁰ World Bank. Draft Report: Malnutrition in Timor-Leste: A review of the burden, drivers and potential response. 2016.

⁵¹ John Hopkins University, CEPAD. Achieving SDG2: Building On the Achievements of Timor Leste. Advisory Board Meeting for the SDG2 Strategic Review, March 2017.

can enable informed decision-making and be applied to an adaptation or scaling up of the intervention in 2018, when the CSP comes into effect. Thus, the Timor-Leste CO proposes to conduct an activity evaluation⁵² of the MAM treatment component of the DEV 200770.

The evaluation will have the following uses for the WFP Timor-Leste CO:

Apply learning in order to improve performance of management of acute malnutrition programmes in the next programme phase (2018) and generate recommendations for refining programme design and treatment activities, make adjustments to implementation arrangements and/or for scaling up of the intervention;

To inform the Ministry of Health, donors and stakeholders of the performance of the activity from 2015-2017, including relevance, cost-benefit, effectiveness, efficiency and sustainability;

To inform national decision-making on programmatic choices as to the most cost-effective approach to addressing MAM in the Timor-Leste development context, feeding into the Ministry of Health's budget planning process for 2018 and development of the next National Nutrition Strategy;

To generate secondary data analysis of preliminary Demographic Health Survey (DHS) 2016 results, assess impact of the activity on wasting, and mitigate questions raised about quality of data and evidences produced around effectiveness of the programme;

To contribute to WFP's corporate commitment to enhancing accountability for results and generate evidence to stakeholders, including government, donors and beneficiaries, on progress made towards the national targets for treatment of acute malnutrition identified in national plans and strategies⁵³. This will also support the Ministry of Health's aim of good governance and accountability of budget, actions and results, as indicated in the National Nutrition Strategy (NNS)⁵⁴.

Objectives

Evaluations in WFP serve the dual and mutually reinforcing objectives of accountability and learning.

Accountability – The evaluation will assess and report on the performance and results of the activities related to treatment of MAM in children 6-59 months of age and acutely malnourished pregnant and lactating women, implemented under the DEV 200770.

Learning – The evaluation will determine the reasons why certain results occurred or not to draw lessons, derive good practices and pointers for learning. It will build evidence to inform policy and future strategies and programming on nutrition-specific interventions to achieve national targets for reduction of wasting. The implementation of the activity in accordance with national guidelines will explore in details the reality of continuum of care for the achievement of the intended results and impact of the intervention. This will also serve as an end-line evaluation of the joint WFP/Ministry of Health programme, given the closure of funding from EU and the Korean International Cooperation Agency (KOICA) in 2017.

As there is insufficient concrete evidence as to the cost-effectiveness of the provision of specialized nutritious foods for the management of MAM in Timor-Leste, the focus of the evaluation will be on generating learning and findings that can address some of the concerns raised by stakeholders and donors. The national plans for increasing coverage of treatment should be based on clear evidence and analysis of the most appropriate channels and systems for service delivery. Furthermore, recommendations will be used to advocate for leveraging resources for future nutrition-specific interventions in the CSP. For example, the CO envisions using the recommendations of the evaluation

⁵² Activity evaluation: Assesses one WFP activity, which may be one component of an operation or an activity across operations. Activity evaluations are distinct from other types of WFP evaluations in their consideration of a specific, bounded component of an operation(s) to understand if, what, how, and why it is contributing to development results. WFP Technical Note on Activity Evaluation <http://docustore.wfp.org/stellent/groups/public/documents/reports/wfp277850.pdf>

⁵³ Government of Timor-Leste. Strategic Development Plan 2011-2030. Target 2.6.2.3, DPCM Code S-14.

⁵⁴ Ministry of Health Timor-Leste. National Nutrition Strategy 2014-2019.

to conduct joint formative research under the CSP on the Integrated Management of Acute Malnutrition (IMAM), to address specific evidence gaps and contribute to the global research agenda currently being established by e.g. the Council of Research and Technical Advice on SAM (CORTASAM) and the No Wasted Lives (NWL) initiative⁵⁵. CORTASAM intends to produce a list of research priorities in 2017, which will form a basis for donor contributions to research on wasting⁵⁶.

Stakeholders and Users

A number of stakeholders both inside and outside of WFP have interests in the results of the evaluation and some of these will be asked to play a role in the evaluation process. Annex 1 provides a preliminary stakeholder analysis, which should be deepened by the evaluation team as part of the Inception phase. Accountability to affected populations is tied to WFP's commitments to include beneficiaries as key stakeholders in WFP's work. As such, WFP is committed to ensuring gender equality and women's empowerment in the evaluation process, with participation and consultation in the evaluation by women, men, boys and girls from different groups. Feedback on the evaluation results will be provided to beneficiaries and other stakeholders at the implementation level.

The primary users of this evaluation will be:

The WFP Timor-Leste CO and the Ministry of Health in decision-making, notably related to design, implementation and scale of nutrition-specific interventions for addressing wasting. Recommendations and lessons will contribute to the refining of activities planned in the WFP Country Strategy (with start date January 2018), which aim to support the Government of Timor-Leste in achieving SDG 2 and 17. Recommendations will contribute to WFP's organizational learning and accountability for results, and beyond the organization will also empower the Ministry of Health by generating knowledge and lessons learned on the integrated approach for management of MAM implemented from 2015. Furthermore, the recommendations can be used to inform national policies and strategies related to nutrition, including the development of the next National Nutrition Strategy, and to advocate for resources to be allocated to nutrition for the implementing the recommended actions.

The Regional Bureau (RB) is expected to use the evaluation findings to provide strategic guidance, programme support, and oversight.

WFP HQ may use evaluations for wider organizational learning and accountability.

OEV may use the evaluation findings, as appropriate, to feed into evaluation syntheses as well as for annual reporting to the Executive Board.

Context and subject of the Evaluation

Context

Timor-Leste is a State party to seven of the nine core UN human rights treaties, including the: International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR); Convention on the Elimination of all forms of Racial Discrimination (CERD); and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). While progress has been made in some areas of human development, including promoting gender equality and empowerment of women, and reduction of infant and child mortality, malnutrition - particularly maternal and child undernutrition - is the single greatest contributor to premature death and disability in the country and presents an important development challenge.

According to the Timor-Leste DHS 2009-10 on mother's age at first birth, nearly one quarter of women (24%), aged 20-24 years had given birth by age 20. This means that one in four Timorese adolescent girls is a teenage mother. Furthermore, rural women are more than twice as likely as urban women to

⁵⁵ <http://www.nowastedlives.org/>

⁵⁶ CORTASAM meeting, Brussels, October 2016.

have begun childbearing early Furthermore, teenage mothers in Timor-Leste are at increased risk of maternal mortality as mothers aged 20-24 years.

In 2013, a national nutrition survey found that the prevalence of wasting⁵⁷ in Timor-Leste – an indicator of acute malnutrition and a prominent risk factor for child mortality – was 11%, with emergency levels of wasting experienced in Covalima (17%) and Oecusse (20%) municipalities (districts). The prevalence of wasting was significantly higher among boys than girls, among older children and among rural children.

Based on the results of the 2013 nutrition survey, the Ministry of Health requested WFP to extend its support in the country, which was initially planned to come to an end after the 2011-2013 Country Programme. Hence, the DEV was established to contribute to the reduction of undernutrition among children under five and pregnant and lactating women targeted through the national Mother and Child Health and Nutrition Programme. Activities under the DEV 200770 capture two main components: i) capacity-development, in which WFP provides technical assistance to enhance the capacity of national counterparts to implement nutrition programmes independently; and ii) food-based component, with the provision of specialized nutritious food products – locally produced Super Cereal for pregnant and lactating women, and ready-to-use supplementary foods for children.

The capacity development component focuses on three areas: i) nutrition, including nutrition education and behaviour change communication for improved infant and young child feeding practices; ii) developing the monitoring and evaluation system for nutrition programmes; and iii) developing and implementing operational guidelines for supply chain management.

The Timor-Leste National Nutrition Strategy (NNS) 2014-2019 is the most relevant strategy for WFP's support to the Government's nutrition interventions. Its goal is to improve the nutritional status of the Timorese population, and the objective is to reduce malnutrition and micronutrient deficiency among children and women. Specific targets of the NNS related to the activity Treatment of MAM are: by 2019, increase the cure rate of moderate and severe acute malnutrition to >75%; by 2019, increase the % of children with moderate acute malnutrition receiving supplementary food, from <50% to >60%. The Timor-Leste Strategic Development Plan 2011-2030 has set a more ambitious target for treatment of acute malnutrition, of increasing the recovery rate to more than 78% by 2017.

Reducing the high levels of wasting, or acute malnutrition, in Timor-Leste is crucial for achieving the goals and targets set out in the 2030 Agenda for Sustainable Development, in particular SDG target 2.2. WFP provides technical support to governments to develop and scale up sustainable nutrition solutions that contribute towards achieving SDGs 2 and 17 and supports the development and delivery of national plans and policies to end malnutrition in all its forms.

The 2013 Lancet Maternal and Child Nutrition Series identifies MAM as well as SAM treatment as evidence-based interventions with sufficient evidence to warrant action at scale⁵⁸. However, while community-based treatment of SAM has grown rapidly globally, this does not apply to management of MAM, most likely due to the inconsistent evidence for effective strategies in population settings. The lack of attention, research and consensus on programmatic guidance community-based management of MAM continues to be a key constraint for scaling up access to treatment⁵⁹.

In Timor-Leste, the EU is currently the main donor for the community-based treatment of acute malnutrition, with a total budget allocation of €9,240,000 to UNICEF and WFP during the project period 2015-2017. From 2018, EU will shift to direct budget support to the Ministry of Health. The change in

⁵⁷ Wasting refers to a child who is too thin for his or her height. Wasting, or acute malnutrition, is the result of recent rapid weight loss or the failure to gain weight. The definition of wasting is weight-for-height of less than -2 standard deviations (SD) from the median weight-for-height or a reference population. A child can be 'moderately' wasted (between -2 and -3 SD, or <80% of the median), or 'severely' wasted (<-3 SD, or <70% of median). Edema in both feet and/or other clinical signs also classify a child as severely wasted (WHO 2005).

⁵⁸ Maternal and Child Nutrition Study Group. Executive Summary of the Lancet Maternal and Child Nutrition Series. Lancet 2013; published online June 6, [http://dx.doi.org/10.1016/S0140-6736\(13\)60996-4](http://dx.doi.org/10.1016/S0140-6736(13)60996-4)

⁵⁹ Annan et al. Management of Moderate Acute Malnutrition: Current Knowledge and Practice CMAM Forum Technical Brief (2014)

aid modality will have consequences on the levels of funding to UN Agencies. Within the health sector, the key donors are Australian Aid and USAID, providing institutional support to the Ministry of Health. KOICA has funded the activity, however as of 2018 they will transition to focus on health and education, rather than on nutrition. WHO, UNICEF and other UN Agencies provide technical support in planning and technical issues to the Ministry of Health. The EU and WHO are the co-chairs of the donor coordination for the Health Sector. There is also a Working Group on Nutrition, which meets to discuss and share information on specific issues.

Timor-Leste is still in transition from a conflict and is a member of the g7+ group of fragile states, in which it has led discussions related to the 2030 Agenda and the recognition that countries affected by conflict face unique challenges that require special attention. In this context, there are a number of external factors and events affecting the implementation of the activity, mainly: i) social instability, as underlying conflict factors and drivers persist and have the potential to escalate, in particular during the Parliamentary election scheduled in July 2017; ii) the appointment of a new Government in 2017 may lead to changing priorities and slow down the implementation of the programme; iii) high turnover of staff, lack of skilled human resources and difficulties in maintaining staff with specialised training in nutrition is a challenge, however this is partly being addressed by the Ministry of Health through the recruitment of Nutrition Coordinators/Focal Points in March 2017; iv) lack of coordination among stakeholders – including between Government entities - working on nutrition affecting the efficiency and effectiveness of service delivery.

In Annex - Key resources related to the nutrition and food security situation in Timor-Leste.

Subject of the evaluation

The proposed evaluation will focus on the activity Treatment of Moderate Acute Malnutrition in Timor-Leste, implemented under DEV 200770. The geographic scope of the activity evaluation will be the following six municipalities (see map in Annex 1): Ainaro, Bobonaro, Covalima, Dili, Ermera, Oecusse. Considering that a new Country Strategy will come into effect in January 2018, the evaluation is expected to be completed within the current project period, ending on 31st December 2017. Pending approval of the application, expected in April 2017, the evaluation will commence in May, and is expected to be finalized in August 2017. The dissemination of management responses and inclusion of recommendations into the planning of next Country Strategy will continue until the end of 2017.

The focus of WFP's Development Project is to build capacity of existing Government structures with a view to operating a sustainable Government led nutrition programme. Specific objectives are to: strengthen the Government's capacity to design, implement and manage tools, policies and systems for reducing undernutrition; hand-over sustainable food-based nutrition programmes; and to ensure that all analysis, policies, activities and monitoring respect principles of gender equality. The main activities are: treatment of MAM in boys and girls 6-59 months; and treatment of acute malnutrition in pregnant and lactating women. Through these activities, WFP aims to increase the ownership and capacity of the Ministry of Health to reduce undernutrition, improve nutritional status of targeted women, girls and boys from 6-59 months of age, and increase the coverage of the treatment programme.

The need for improvements in the quality of monitoring and evaluation of the activities was recommended in the Country Portfolio Evaluation in 201360. The DEV collects key performance indicators (coverage, recovery, defaulter, non-response and mortality rate) on a monthly basis from health facilities, based on the project Logical Framework. The indicators for the activity follow the Strategic Results Framework (2014-2017) and forms the basis for regular assessment of the activity's performance against internationally agreed upon targets and standards for management of acute malnutrition, endorsed by WHO, UNICEF and WFP. It is essential that the data quality, analysis, and use

60 WFP Office of Evaluation. Country Portfolio Evaluation. Timor-Leste: An Evaluation of WFP's Portfolio. (2008-2012). OE/2013/001

of the information collected is ensured for improved programming, and monitoring data from 2015-2017 will be one of the main sources of information for the evaluation.

The initial planned food requirement for the activity was 1,167 MT for the project period of January 2015 to December 2016, for an estimated 59,000 beneficiaries composed of: 23,000 pregnant and lactating women; 18,500 boys 6-59 months of age; and 17,500 girls 6-59 months of age. Following a second budget revision of the project approved in November 2016, the project timeline was extended to December 2017, and planned outputs revised accordingly. The planned food requirements have now increased to 1,568 MT, and the total number of beneficiaries for the three-year project period are expected to be 78,580. Out of these, 63% are children 6-59 months of age and 37% are pregnant and lactating women. Women and girls represent 69% of the total number of beneficiaries, and the remaining 31% are boys in the age group 6-59 months of age.

The total revised budget value is US\$13.7 million, an increase from the planned budget of US\$9.9 million. The project is funded to 59% by EU (US\$4.4 million) and KOICA (US\$3.6 million). The DEV 200770 allocated US\$50,000 for assessments and evaluations in the original budget.

The Ministry of Health is the main partner for the activity. UNICEF and WHO are technical partners for nutrition, including for developing guidelines and training packages on management of acute malnutrition. NGOs Alola Foundation and World Vision Timor-Leste are contracted by both WFP and UNICEF to support community level nutrition education and mobilization activities in three municipalities. A partnership between WFP and the private sector partner Timor Global was established in 2008/09 and supports the local production of Super Cereal provided to pregnant and lactating women.

The current approach to treating MAM in children under five years of age, with specific admission criteria for accessing treatment⁶¹, came into effect in 2015, following an evaluation of the Country Programme 2011-2013⁶² which recommended changes in targeting and distribution modalities, from blanket coverage of children 6 to 23 months of age to a targeted approach. The new admission criteria have been included in national guidelines for Integrated Management of Acute Malnutrition (IMAM), revised in 2016. The integrated programme includes both treatment of moderate and severe acute malnutrition (SAM) as well as nutrition education and community mobilization.

The Ministry of Health's operationalization of the IMAM guidelines is currently supported only by WFP and UNICEF, with funding from EU and KOICA. EU's mid-term evaluation of the project made the following observations with regards to the treatment of MAM and provision of supplementary foods⁶³: "In conclusion, the evaluation feels that, from a nutritional point of view and considering the current country context, an intervention to treat children suffering from moderate acute undernutrition and women is currently justified. Whether this can best be achieved by a targeted supplementary feeding programme such as currently implemented, or by another type of intervention such as, for instance, cash-transfers as mentioned above by the WHO, would require further study."

WFP Timor-Leste recognizes the need for further analysis of the most effective and feasible transfer modalities and service delivery channels for addressing wasting among children 6-59 months of age in a non-emergency context. The CSP can provide a key opportunity to initiate new strategies, based on lessons from the DEV 200770. Future strategies and priorities will also be dependent of the findings of the Demographic Health Survey (DHS) 2016, with preliminary results expected to be released at the end of March 2017.

The Timor-Leste Strategic Review of SDG 2 will be finalized in May, and results from national and community consultations on nutrition have so far highlighted the need to identify and treat wasting

61 The National Protocol on Management of Acute Malnutrition uses the following admission criteria for community based management: all children 6-59 months of age with mid-upper arm circumference (MUAC) 11.5 to 12.5 cm; and pregnant and lactating women with MUAC below 23 cm.

62 WFP Office of Evaluation. Country Portfolio Evaluation. Timor-Leste: An Evaluation of WFP's Portfolio. (2008-2012). OE/2013/001

63 EU. Final Report - Mid-Term Evaluation of the Integrated Nutrition Project in Timor-Leste. December, 2015.

early to prevent further deterioration, to target adolescent girls with nutrition-specific interventions, and to bring men into the conversation on nutrition.

In Annex: map of geographic target areas for the evaluation; DEV 200770 Logical Framework.

Evaluation Approach

Scope

The expected time frame of the activity evaluation will be from May to August 2017, taking into consideration the end date of the DEV 200770 of 31st December 2017 and start date of the next Country Strategy in January 2018.

The evaluation will focus on transfer-based activities for treatment of MAM rather than on the capacity development components of the DEV 200770. Therefore, activities related to augmentation of Ministry of Health's capacity for monitoring and evaluation and supply chain management are not within the scope of this evaluation.

Geographically, six out of 13 municipalities are currently implementing treatment of MAM with provision of specialized nutritious foods and monitoring data from these municipalities will be used to assess performance of the programme. Community consultations may take place in additional selected municipalities, where specialized foods are not provided as part of treatment, to assess the level of participation in nutrition services of women, men, boys and girls in areas with and without provision of food.

As described under sections 2.1 and 2.2, the evaluation will focus on the effectiveness, efficiency and sustainability of the MAM treatment activity implemented under DEV 200770, including analysing the cost-effectiveness of the targeted approach and transfer modalities. Furthermore, it will seek to verify the quality of the data supporting the performance measurement of the treatment programme including accuracy and reliability of key nutrition indicators. Pending the availability of preliminary results from DHS 2016, this data will be used as a source for secondary data analysis on the prevalence of wasting in targeted municipalities and associated factors.

The evaluation will seek to assess the effects of access to treatment on the targeted population groups (children 6 – 59 months of age, pregnant and lactating women and adolescent girls), including assessment of barriers and bottlenecks influencing implementation of the response, and opportunities that may contribute to improved coverage and reduced defaulter rates.

Gender aspects will be considered in all aspects of the evaluation, including assessing the level of participation of nutritionally at-risk adolescent girls in the treatment programme and barriers to accessing nutrition services for this population group. As pregnant and lactating girls in the age group 15-19 have been identified as a particularly vulnerable group in the context of Timor-Leste, the participation of this population group in the evaluation will be particularly important, also considering that the CSP will include specific activities for adolescent girls. The level of participation of men and adolescent boys in community mobilization and nutrition education activities is also a subject for the evaluation, as the preliminary results of the on-going Country Strategic Review has identified this to be a gap. Further analysis of gender considerations to be addressed by the evaluation, including specific gender-related questions, will be further established by the gender specialist to be recruited for the evaluation.

Evaluation Criteria and Questions

Evaluation Criteria The evaluation will apply the international evaluation criteria of relevance, effectiveness, efficiency, and sustainability⁶⁴. Impact will be assessed pending DHS 2016 data, to allow for analysis of changes in prevalence of wasting as compared to the baseline. The evaluation criteria

⁶⁴ For more detail see: <http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm> and <http://www.alnap.org/what-we-do/evaluation/eha>

are based on utility and need to for timely information that will enable decision-making processes in preparation for the CSP and contribute to ensuring optimum cost-effectiveness of the activity. Gender equality will be mainstreamed and incorporated into evaluation questions to reflect the participation and inclusion of pregnant and lactating women, adolescent girls, boys and girls under five years of age in the programme. Community consultations will include both women and men, to reflect different perspectives, priorities, needs and awareness of nutrition.

Evaluation Questions Allied to the evaluation criteria, the evaluation will address the following key questions, which will be further developed by the evaluation team during the inception phase. Collectively, the questions aim at highlighting the key lessons and performance of the treatment of MAM, which could inform future strategic and operational decisions.

Table 1: Criteria and evaluation questions

Criteria	Evaluation Questions
Relevance	<p>To what extent was the design of the treatment of MAM intervention relevant to the development context of Timor-Leste? Clearly identify strengths and limitations of its current form and implementation and areas of improvement, if considered relevant. Views of the activity's contribution in the overall nutrition response should be reflected.</p> <p>To what extent did the intervention reach the intended target groups, and is the intervention in line with the needs of the most vulnerable groups (boys and girls under five years of age, pregnant and lactating women and adolescent girls);</p> <p>To what extent was the design and implementation of the intervention gender-sensitive, addressing the diverse needs of children under five and pregnant and lactating women/adolescent girls;</p> <p>To what extent was the design and implementation of the intervention, including ration, consistent with national and international guidelines for management of acute malnutrition.</p>
Effectiveness	<p>To what extent were corporate outputs and outcomes for MAM treatment of girls and boys 6-59 months achieved, and what were the main results including positive, negative, intended and unintended outcomes;</p> <p>What were the major constraints and facilitating factors leading to achievements;</p> <p>What was the number or percentage of children progressing from MAM to SAM in areas with and without SAM and MAM components implemented;</p> <p>To what extent did community mobilization and nutrition education activities, implemented by NGOs, lead to creating awareness and demand of the nutrition services and what was the level of participation of women and men;</p> <p>To what extent did the availability of food at health facilities positively or negatively influence participation and uptake of other health and nutrition services;</p> <p>To what extent were cross-cutting issues and standards for assistance, in particular related to gender equity and women's empowerment, and in other areas such as partnership and coordination; protection and accountability?</p>
Efficiency	<p>Was the implemented modality for MAM treatment cost-efficient, compared to other parts of the country where specialized nutritious foods for MAM treatment were not provided;</p> <p>Cost per beneficiary treated and per type of specialized nutritious foods provided (Timor Vita and Ready-to-Use Supplementary Food), and analysis of nutrient density of the foods provided. This could also include an analysis of affordability of locally</p>

	<p>available foods and guidance on options for alternatives or areas of improvement needed to enhance impact of MAM management.</p> <p>Did the targeted approach, as compared to the previous blanket supplementary feeding programme, with provision of Timor Vita for both children and PLW, result in improved cost-efficiency;</p> <p>Was the intervention implemented in the most efficient way compared to alternatives, e.g. considering different transfer modalities (locally produced vs imported foods) and compared to using alternative transfers (based on WHO's guidance on the dietary management of children with MAM65);</p> <p>Comparison of performance in areas with different institutional arrangements, i.e. where NGOs have supported the community-based activities with areas with no presence of local partners/NGOs, and in areas with and without active community outreach (SISCa).</p>
Sustainability	<p>To what extent is it likely that the benefits of the intervention will continue after WFP's support under the DEV 200770 ends in December 2017;</p> <p>To what extent has the cost for treatment of MAM been incorporated into national budgets, plans and policies;</p> <p>Does the intervention have potential to positively influence gender relations, and what would be sustainable approaches to increase the involvement of men in future activities;</p> <p>What are practical and feasible recommendations for the continuation and sustainability of the intervention (adapting, scaling up or phasing out)?</p>
Impact	<p>Contribution of intervention on wasting prevalence on boys and girls between 2013 and 2016 in geographic target areas, based on secondary data analysis of DHS results (2009/10 and 2016) and Food and Nutrition Survey (2013).</p>

Data Availability

Aside of Standard Project Reports (SPR) from 2015 and 2016, the main source of information in the CO on performance of the MAM treatment intervention during the project period includes: quarterly monitoring/progress reports (2015 - 2016); Capacity Assessment Report (2014 & 2015); baseline report of nutrition screening results (2016); monthly national key facts (2016); questionnaires based on interviews at health facilities and households; monthly reports database (MPR); supportive supervision report/field visit reports (2016); notes for the record and reports from NGO partners. In addition, qualitative information from focus group discussions conducted with community groups in three municipalities where NGO partners support community mobilization activities is available.

External key data sources include the Health Management Information System (HMIS) and Timor-Leste Health Information System (TLHIS), which collects data from all 13 municipalities on the number of children screened and prevalence of MAM. The quality and timeliness of this data is however considered weak. Documented challenges include: insufficient capacity of HMIS staff in reporting, recording, and analysis; substandard documentation practices; low coverage for vital registration, inadequate compliance to international best practice guidelines in clinical documentation; and overburdening of health workers with excessive data and reporting demands from multiple subsystems⁶⁶.

Additional sources include national surveys, such as the Population and Housing Census (2015), the Timor-Leste Demographic Health Survey (2009-10), the Timor-Leste Food and Nutrition Survey (2013);

65 WHO (2013) Essential nutrition actions: improving maternal, newborn, infant and young child health and nutrition. WHO, Geneva.

66 Ministry of Health Timor-Leste. Health Management Information Systems Strategic Plan 2016 – 2020.

and the Living Standards Survey (2014). The Economic Burden of Undernutrition in Timor-Leste (2014) report provides evidence-based estimates of the consequences of undernutrition on the national economy and a basis for prioritizing actions to address undernutrition. It is anticipated that preliminary results of the DHS 2016 will be available at the time of the evaluation, which will be a key source of data for population level comparisons of changes in prevalence of wasting in targeted geographic areas and among different population groups (rural/urban, by age group and sex, and by wealth index).

With regards to gaps – data quality is the main issue encountered during the implementation of the programme (e.g. food stocks not matching with total food distributed; admission of beneficiaries that do not fulfil the criteria). This is partly a result of high staff turnover, lack of ownership of the programme by Ministry of Health staff, and staff capacity on data recording and reporting. To address these gaps and potential data quality issues, the evaluation team should:

assess data availability and reliability as part of the inception phase expanding on the information provided in section 4.3, to verify the quality of the data used for performance tracking;

check accuracy, consistency and validity of collected data and information and acknowledge any limitations/caveats in drawing conclusions using the data.

Methodology

The methodology will be designed by the evaluation team during the inception phase and described in an Evaluation Matrix. It should:

Employ the relevant evaluation criteria stated in Table 2 above (relevance, effectiveness, efficiency, sustainability, impact).

Demonstrate impartiality and lack of biases by relying on a cross-section of information sources. The selection of field visit sites will also need to demonstrate impartiality.

Use mixed methods (quantitative, qualitative, participatory etc.) to ensure triangulation of information through a variety of means.

Apply an evaluation matrix geared towards addressing the key evaluation questions taking into account the data availability challenges, the budget and timing constraints;

Ensure through the use of mixed methods that women, girls, men and boys from different stakeholders groups participate and that their different voices are heard and used, and present evaluation data is gender-disaggregated;

Ensure that adolescent girls that are pregnant or lactating are appropriately and proportionally represented in the selection of interviewees;

Mainstream gender equality and women's empowerment (GEEW), as above, and apply GEEW dimensions in line the UN SWAP evaluation criteria;

Apply ethical principles for evaluation design, conduct and management in order to ensure overall credibility and reliability.

The anticipated methods for the evaluation, to be further developed by the Evaluation Team during the Inception Phase of the evaluation, include: desk review, national stakeholder interviews, and community consultations composed of both municipality Focus Group Discussion (FGD) and Key Informant Interviews (KII). The proposed methodology and interview questions will reflect a gender analysis, to be conducted by a gender specialist.

The following mechanisms for independence and impartiality will be employed: internal review of methodology by the Evaluation Committee (EC), external review through consultations with the Evaluation Reference Group (ERG) to enhance the relevance, quality and validity of the Evaluation Matrix.

This evaluation will not be subject to an ethical review committee approval, however the Evaluation Committee will seek the approval of relevant government entities prior to data collection. Each individual to be interviewed will be asked to provide verbal consent to participating in interviews and

discussions. The interviewee's confidentiality will be warranted, in line with the UN Evaluation Group Norms and Standards for Evaluation norm on ethics (#6) and Ethical Guidelines for Evaluation.

The following potential risks to the methodology have been identified: potential bias in the selection of data collection sites and selection of interviewees; availability of respondents at health facility and community level; accessibility to implementation locations; security risks including Parliamentary elections impacting on security and travel to municipalities. These risks can be mitigated by: anticipating bias in the evaluation design and planning of field work, limiting the involvement of WFP staff in the participation in data collection and reassuring contributors of confidentiality; allowing sufficient time for preparation of field work, informing community leaders and Ministry of Health staff in advance of the schedule for data collection, and ensuring community mobilization through WFP field staff. Security risks will be assessed prior to field travel through UN Security channels. Accessibility will be taken into consideration during planning of field work, identifying alternative routes and data collection sites.

Quality Assurance and Quality Assessment

WFP's Decentralized Evaluation Quality Assurance System (DEQAS) defines the quality standards expected from this evaluation and sets out processes with in-built steps for Quality Assurance, Templates for evaluation products and Checklists for their review. DEQAS is closely aligned to the WFP's evaluation quality assurance system (EQAS) and is based on the UNEG norms and standards and good practice of the international evaluation community and aims to ensure that the evaluation process and products conform to best practice.

DEQAS will be systematically applied to this evaluation. The WFP Evaluation Manager will be responsible for ensuring that the evaluation progresses as per the DEQAS Process Guide and for conducting a rigorous quality control of the evaluation products ahead of their finalization.

WFP has developed a set of Quality Assurance Checklists for its decentralized evaluations. This includes Checklists for feedback on quality for each of the evaluation products. The relevant Checklist will be applied at each stage, to ensure the quality of the evaluation process and outputs.

To enhance the quality and credibility of this evaluation, an outsourced quality support (QS) service directly managed by WFP's Office of Evaluation in Headquarter provides review of the draft inception and evaluation report (in addition to the same provided on draft TOR), and provide: systematic feedback from an evaluation perspective, on the quality of the draft inception and evaluation report; recommendations on how to improve the quality of reports, including to what extent the findings include a gender analysis.

The evaluation manager will review the feedback and recommendations from QS and share with the team leader, who is expected to use them to finalise the inception/ evaluation report. To ensure transparency and credibility of the process in line with the UNEG norms and standards [1], a rationale should be provided for any recommendations that the team does not take into account when finalising the report.

This quality assurance process as outline above does not interfere with the views and independence of the evaluation team, but ensures the report provides the necessary evidence in a clear and convincing way and draws its conclusions on that basis.

The evaluation team will be required to ensure the quality of data (validity, consistency and accuracy) throughout the analytical and reporting phases. The evaluation team should be assured of the accessibility of all relevant documentation within the provisions of the directive on disclosure of information. This is available in WFP's Directive (#CP2010/001) on Information Disclosure.

[1] UNEG 2016 Norms and Standards states Norm #7 states "that transparency is an essential element that establishes trust and builds confidence, enhances stakeholder ownership and increases public accountability"

The ERG will further support the relevance, utility and independence of the evaluation and review recommendations made to ensure feasibility, acceptability and ownership. Deliverables will be shared with the Regional Monitoring and Evaluation Advisor (RMEA)/Regional Evaluation Officer (REO) for technical review. The Evaluation Manager will maintain an audit trail, using a Comments Matrix, to keep records of stakeholder’s inputs and how these have been addressed.

All final evaluation reports will be subjected to a post hoc quality assessment by an independent entity through a process that is managed by OEV. The overall rating category of the reports will be made public alongside the evaluation reports.

Phases and Deliverables

The evaluation will proceed through the following phases. The deliverables and deadlines for each phase are as follows:

Figure 1: Summary Process Map



Planning (March) – identifying evaluation type and scope, establishing Evaluation Committee, external consultations.

Preparation (April – May) - TOR, selection of the evaluation team, and contracting of the evaluation company. Deliverable: TOR, budget, Communication and Learning Plan

Inception (June) – gender analysis, evaluation matrix, inception report and detailed planning of field work. Deliverable: Inception Report, Evaluation Matrix

Data collection and analysis (July - August) - field work to selected locations. Deliverable: aide-memoire or debriefing PPT

Reporting (August - September) - the evaluation team will analyse the data collected during the desk review and field work, conduct additional consultations with stakeholders as required. Deliverable: Evaluation Report

Dissemination and follow-up (September - October) - The evaluation report is shared with relevant stakeholders and users of the evaluation. The WFP Timor-Leste management respond to the evaluation recommendations by providing actions that will be taken to address each recommendation and estimated timelines for taking those actions.

Responsibilities for deliverables are as follows:

TOR, budget, Communication and Learning Plan – Evaluation Manager

Inception Report, Evaluation Matrix – Evaluation Team Leader

Aide-memoire or debriefing PPT - Evaluation Team Leader

Evaluation Report – Evaluation Team Leader

Dissemination and follow-up – WFP Timor-Leste CO

The preliminary evaluation schedule is outlined in Annex 3.

Organization of the Evaluation

Evaluation Conduct

The evaluation team will conduct the evaluation under the direction of its team leader and in close communication with the WFP Evaluation Manager. The team will be hired following agreement with WFP on its composition.

The evaluation team will not have been involved in the design or implementation of the subject of evaluation or have any other conflicts of interest. Further, they will act impartially and respect the code of conduct of the evaluation profession.

The key stakeholders that will be involved in the different phases of the evaluation are outlined in the preliminary evaluation schedule in Annex 2.

Team composition and competencies

Independent researchers with experience in nutrition and/or public health and knowledge of the Timor-Leste context will be appointed to carry out the activity evaluation through a consultative and inclusive process involving relevant stakeholders at national, municipal and community levels. The evaluation team is expected to include three members, including the team leader and a mix of national and international evaluators. To the extent possible, the evaluation will be conducted by a gender-balanced, geographically and culturally diverse team with appropriate skills to assess gender dimensions of the subject as specified in the scope, approach and methodology sections of the TOR.

The team will be multi-disciplinary and include members who together include an appropriate balance of technical expertise and practical knowledge in the following areas:

- Public Health or Nutrition
- Monitoring and Evaluation
- Gender expertise

All team members should have strong analytical and communication skills, evaluation experience and familiarity with Timor-Leste or Asia region.

At least one team members should have prior knowledge of WFP.

English will be the main required language for the team leader, while the national evaluator will require local language skills (Tetun). The evaluation report is expected to be in English and will be translated to Tetun by use of translation services.

The Team leader will have technical expertise in one of the technical areas listed above as well as expertise in designing methodology and data collection tools and demonstrated experience in leading similar evaluations. She/he will also have leadership, analytical and communication skills, including a track record of excellent English writing and presentation skills.

Her/his primary responsibilities will be: i) defining the evaluation approach and methodology; ii) guiding and managing the team; iii) leading the evaluation mission and representing the evaluation team; iv) drafting and revising, as required, the inception report, the end of field work (i.e. exit) debriefing presentation and evaluation report in line with DEQAS.

The team members will bring together a complementary combination of the technical expertise required and have a track record of written work on similar assignments. Team members will: i) contribute to the methodology in their area of expertise based on a document review; ii) conduct field work; iii) participate in team meetings and meetings with stakeholders; iv) contribute to the drafting and revision of the evaluation products in their technical area(s).

Security Considerations

Security clearance where required is to be obtained from Timor-Leste.

As an 'independent supplier' of evaluation services to WFP, the evaluation company is responsible for ensuring the security of all persons contracted, including adequate arrangements for evacuation for medical or situational reasons. The consultants contracted by the evaluation company do not fall under the UN Department of Safety & Security (UNDSS) system for UN personnel.

Consultants hired independently are covered by the UN Department of Safety & Security (UNDSS) system for UN personnel which cover WFP staff and consultants contracted directly by WFP. Independent consultants must obtain UNDSS security clearance for travelling to be obtained from designated duty station and complete the UN system's Basic and Advance Security in the Field courses in advance, print out their certificates and take them with them.⁶⁷

However, to avoid any security incidents, the Evaluation Manager is requested to ensure that: The WFP CO registers the team members with the Security Officer on arrival in country and arranges a security briefing for them to gain an understanding of the security situation on the ground.

The team members observe applicable UN security rules and regulations – e.g. curfews etc.

Parliamentary elections will be held in July, which may impact security in the country. Field work will take into consideration the security situation and take place either before or after the elections.

Roles and Responsibilities of Stakeholders

The WFP Timor-Leste Country Office

The WFP Timor-Leste Country Director (CD) will take responsibility to:

Assign an Evaluation Manager for the evaluation, compose the internal evaluation committee and the evaluation reference group.

Approve the final TOR, inception and evaluation reports.

Ensure the independence and impartiality of the evaluation at all stages, including establishment of an Evaluation Committee and of a Reference Group.

Participate in discussions with the evaluation team on the evaluation design and the evaluation subject, its performance and results.

Organise and participate in internal and external debriefings.

Oversee dissemination and follow-up processes, including the preparation of a Management Response to the evaluation recommendations.

The Evaluation Manager (EM), as Head of M&E Unit, accesses all the relevant monitoring data while not directly involved in the implementation of the activity. He will:

Manage the evaluation process through all phases including drafting this TOR.

Ensure quality assurance mechanisms are operational.

Consolidate and share comments on deliverables with the evaluation team.

Ensure use of quality assurance mechanisms.

Ensure that the team has access to all documentation and information necessary to the evaluation; facilitate the team's contacts with local stakeholders; set up meetings, field visits; provide logistic support during the fieldwork; and arrange for interpretation, if required.

Organise security briefings for the evaluation team and provide relevant materials.

An internal Evaluation Committee (EC) consisting of key WFP staff members ensures the independence and impartiality of the evaluation. The chair of the EC is the CD and members are as follows: Evaluation Manager (Programme Officer/Head of M&E Unit); Deputy Country Director/Head of Programme (DCD); the Communications/Public Information Officer; one international and one national Programme Officer for Nutrition.

An external Evaluation Reference Group (ERG) has been formed, with representation from WFP Timor-Leste and Regional Bureau for Asia, Government partners, UN Agencies involved in the area of evaluation, donor representatives, and NGO partners. The reference group members (listed in Annex 3) will review the evaluation products as further safeguard against bias and influence.

The Regional Bureau (RB) management will take responsibility to:

Assign a focal point for the evaluation. Caterina Kireeva, Regional Monitoring and Evaluation Officer (RMEO) will be the focal point for this evaluation

⁶⁷ Field Courses: Basic <https://dss.un.org/bsitf/>; Advanced <http://dss.un.org/asitf>

Participate in discussions with the evaluation team on the evaluation design and on the evaluation subject as relevant.

Provide comments on the draft TOR, Inception and Evaluation reports

Support the Management Response to the evaluation and track the implementation of the recommendations.

Relevant WFP Headquarters divisions will take responsibility to:

Discuss WFP strategies, policies or systems in their area of responsibility and subject of evaluation.

Comment on the evaluation TOR and draft report.

The Office of Evaluation (OEV) will advise the Evaluation Manager and provide support to the evaluation process where appropriate. It is responsible to provide access to independent quality support mechanisms reviewing draft inception and evaluation reports from an evaluation perspective. Upon request, OEV also ensures a help desk function.

Other Stakeholders (Government, NGOs, UN agencies, beneficiaries) will provide the Evaluation Team with information and participate in consultations where relevant. The private sector partner, Timor Global, may be consulted if there is a need for additional information not available at WFP CO. All stakeholders interested in the results of the evaluation will be invited to participate in the dissemination of final results and recommendations, including representatives from community groups and municipality level health staff. Feedback on the evaluation results will primarily be provided to beneficiaries at the implementation level through the community representatives or municipal level health staff present at the debriefing sessions.

Communication and budget

Communication

To ensure a smooth and efficient process and enhance the learning from this evaluation, the evaluation team should place emphasis on transparent and open communication with key stakeholders. Channels and frequency of communication between key stakeholders will be agreed upon between the evaluation team, the Evaluation Committee (EC) and the Evaluation Reference Group (ERG). The EM will bear the overall responsibility for communicating with the EC and ERG, notifying members of meetings, sharing materials for review and be the focal point for receiving and consolidating feedback for forwarding to the evaluation team. Distinct stages such as the data collection and analysis debrief can be communicated internally within WFP. The WFP CO management/chair of EC will communicate the management responses to evaluation recommendations to relevant HQ units.

Communication with external stakeholders will primarily be under the responsibility of the Communications/Public Information Officer and CO management. Progress and learnings will be shared with the Ministry of Health (Departments of Nutrition, Public Health, and Health Promotion), the multi-sectoral coordinating body for the Zero Hunger Challenge, the Ministry of Agriculture, donors, NGOs and local health partners (Alola Foundation, World Vision, CARE international, Catholic Relief Services, HIAM Health), and relevant programmes related to nutrition and food security. The key stages of the communication to external stakeholders are listed in the External Communications Plan, in Annex 6.

In line with international standards for evaluation, following the approval of the final evaluation report, there will be a dissemination workshop to stakeholders and the report will be distributed to the audience. The key deliverables and power point presentations will be translated into the local language, Tetun, after which it can be made available on WFP Timor-Leste's website, and promoted via local Facebook pages, including local donor and UN Facebook pages, as well as linking to local Twitter accounts, such as the UN's and donors. The final simplified presentation could also be presented to Public Health students and staff at the University of Timor-Leste, as part of their learnings on nutrition.

Given high rates of illiteracy in Timor-Leste, it is not envisaged that the evaluation report will be communicated directly to beneficiaries. However, a simplified version of the results, in Tetun, can be presented to Municipal Health Services and District Administrators, in order to inform their planning, as well as increasing accountability of the Ministry of Health and WFP. The WFP CO would also use results of the evaluation to modify the current Social Behaviour Change Communications Strategy and produce a video or other interactive learning tools using the findings of the evaluation for further dissemination and discussion with beneficiaries at community level.

Budget

Budget: For the purpose of this evaluation, the budget will:

Hire individual consultants through Human Resources (HR) action

Honorarium for contracted consultants will be determined by HR regulations on consultancy rates

Daily Subsistence Allowance (DSA) for consultants will be based on WFP regulations and standard rates established by the International Civil Service Commission (ICSC).

Includes provisions for two dissemination workshops, translation services (Tetun-English), and printing of the final evaluation report for dissemination to stakeholders.

Please send any queries to Anastacio Soriano, at Anastacio.Soriano@wfp.org +67077270252
(with cc to alternate: Marina Kalisky, Marina.Kalisky@wfp.org +67077231315)

Annex 2: Map of Timor-Leste showing the six municipalities implementing the TSFP



Annex 3: Programme's Theory of Change developed by the evaluation team to guide the evaluation process

The evaluation team reviewed the programme logframe developed for the TSFP, the underlying hypothesis or assumptions in order to develop the ToC, a model linking programme investment (inputs) to processes and outputs, and to anticipated changes (outcomes) in the target populations.

The **inputs** are composed of different international and national policies and strategies aiming to fight against undernutrition among children and PLWs. At international level, it includes the World Health Assembly targets of reducing childhood wasting and reduction of anaemia in women of reproductive age, the Sustainable Development Goal 2.2, the Millennium Development Goal 1 and the MDG4 to reduce child mortality. At national level it includes the Timor-Leste Strategic Development Plan (2011-2030), the Timor-Leste National Health Sector Strategic Plan (2011-2030), the National Food and Nutrition Security Policy (2017-2020), the Zero Hunger Challenge Action Plan for a Hunger and Malnutrition Free in Timor-Leste (2014-2025), the Maternal and Child Health and Nutrition Programme and the National Nutrition programme. The TSFP was developed in line with all these international and national initiatives. Additional inputs include funding ensured by the EU and KOICA, as well as available human resources, infrastructures and equipment.

Different **activities/processes** were developed under the two-main project intervention components, (1) the Technical Assistance and Capacity Development and (2) the Food Component (Targeted Supplementary Feeding Programme - TSFP). Main activities implemented under these two components included treatment of MAM in boys and girls 6-59 months, treatment of acute malnutrition in pregnant and lactating women.

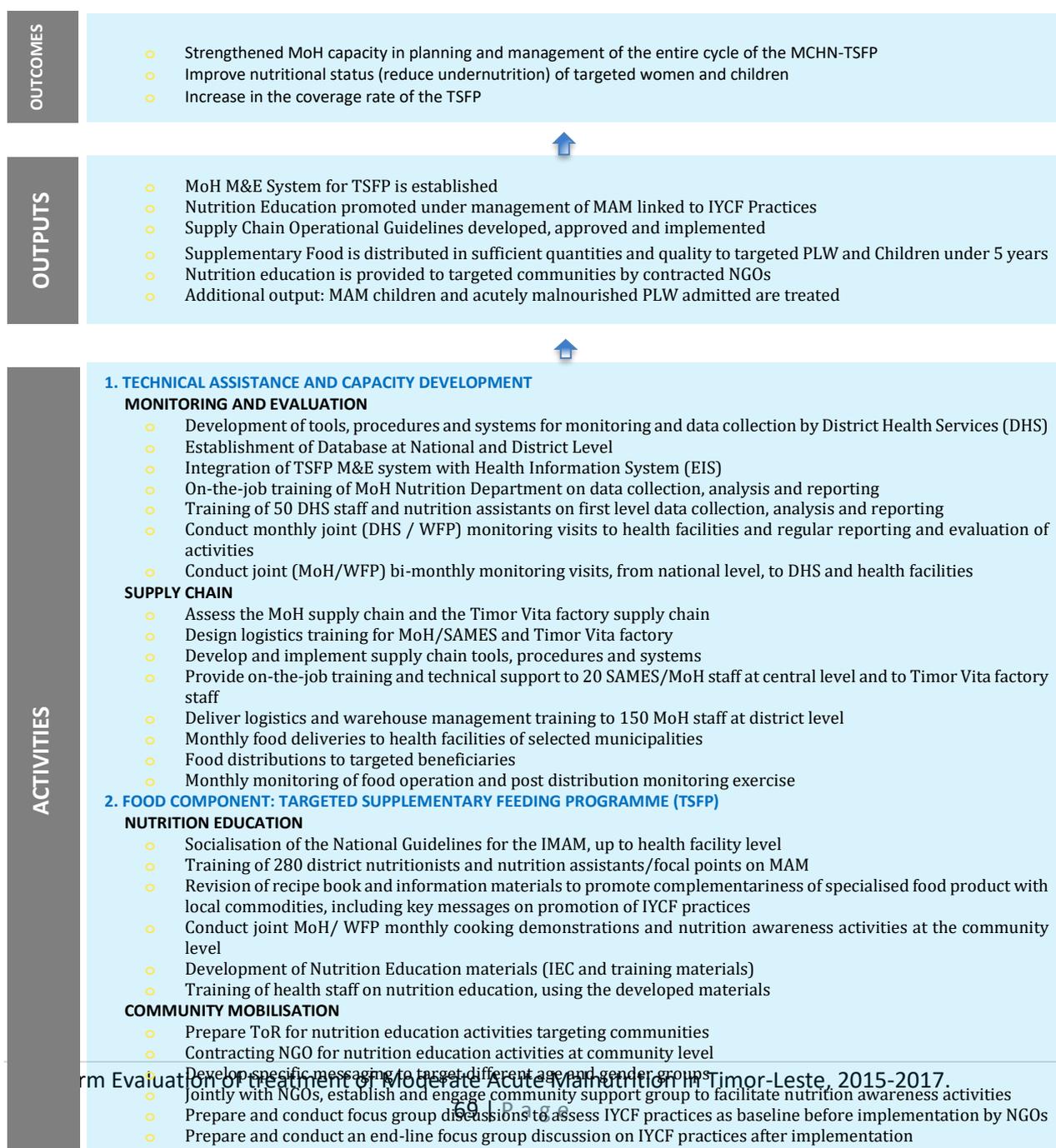
Main **outputs** deriving from the implementation of these activities included an established MoH M&E System for TSFP, the Nutrition Education promoted under management of MAM is linked to IYCF Practices, a Supply Chain Operational Guidelines is developed, approved and implemented, Supplementary Food is distributed in sufficient quantities and quality to targeted PLW and Children under 5 years, Nutrition education is provided to targeted communities by contracted NGOs and MAM children and acutely malnourished PLW admitted are treated. Indicators for assessing the treatment of beneficiaries admitted include the recovery rate, the default rate, the mortality rate and the non-response rate.

The **outcomes** included a (1) Strengthened MoH capacity to reduce undernutrition through the planning and management of the entire cycle of the MCHN-TSFP, (2) an improved nutritional status of targeted women and children, translated into reduction of the prevalence of acute and chronic malnutrition in children and reduced prevalence of acute malnutrition in women, as well as reduced infant mortality and under-five mortality rate. An additional outcome included (3) an increased coverage rate of the TSFP translated into acceptable geographic and treatment coverage.

The program is being implemented within the socio-demographic, political, economic, geographical, cultural and programmatic context of the country and the targeted municipalities that may influence the expected outputs and outcomes. These external factors, specific to the context of Timor-Leste

include, among others, social instability, high turnover of staff, lack of skilled human resources and difficulties in maintaining staff with specialised training in nutrition, lack of coordination among stakeholders – including between Government entities - working on nutrition affecting the efficiency and effectiveness of service delivery.

Overall, the investment (inputs) produces changes at the level of children and PLWs (improved nutritional status), the community (awareness and involvement), as well as the national authorities (improved management capacity and ownership). Different indicators, extracted from the programme’s log-frame, were identified to measure the changes occurred in terms of outputs and outcomes.



Environmental and Programmatic Context
Socio-demographic, political, economic, geographical, cultural



Annex 4: Description criteria and questions used in the evaluation

Relevance: The TOR posed four questions under relevance: (1) appropriateness of the MAM intervention design and contribution to the overall nutrition response in the context of Timor-Leste, (2) reaching the intended target groups and meeting the needs of the most vulnerable among them, (3) gender-sensitivity of the project design and implementation in addressing the diverse needs of children under five and pregnant and lactating women/adolescent girls, and (4) consistency of project design and implementation, including ration, with national and international guidelines for management of acute malnutrition. It was important to delve into how well the national approach has considered gender dynamics among communities. The development of the MAM intervention should be tailored to meet the national needs, and it was compared to recommendations for strategy development at national and international levels.

Effectiveness: The TOR posed six questions for effectiveness which concerned (1) achievements of outputs and outcomes of MAM treatment, including unintended outcomes, (2) major facilitating factors and constraints leading to achievements, (3) proposition of children progressing from MAM to SAM in areas with and without SAM and MAM components, and/or with and without community outreach activities implemented by NGOs, (4) level of awareness and demand created by community mobilisation activities implemented by NGOs, (5) influence of the availability of food at health facilities on participation and uptake of other health and nutrition services, and (6) level of consideration of gender equality, women’s empowerment, partnership and coordination during project implementation.

Efficiency: The TOR posed five questions for efficiency, including (1) to what extent the various activities transformed the available resources into the intended outputs and outcomes, (2) what has worked the best and how well the gaps have been identified and addressed, (3) cost-efficiency of the implemented modality for MAM treatment, compared to other parts of the country where specialised nutritious foods for MAM treatment were not provided, (4) the cost per beneficiary treated and per type of specialised nutritious foods provided, and (5) cost-efficiency of the current targeted approach versus

previous blanket supplementary feeding programme examining options and seeking means to achieve the lowest cost.

Impact: The TOR suggested the assessment of two elements for impact: (1) contribution of the intervention on wasting prevalence among children under five years of age between 2013 and 2016 in geographic targeted areas, (2) promotion of equity in access in reducing wasting in disadvantaged, marginalised and less reached areas/municipalities.

Sustainability: The TOR-posed four questions on sustainability: (1) to what extent it is likely that the benefits of the intervention will continue after WFP's support under the DEV 200770 ends, (2) to what extent has the cost for treatment of MAM been incorporated into national budgets, plans and policies, (3) the intervention potential to positively influence gender relations and sustainable approaches to increase the involvement of men in future activities, and (4) practical and feasible recommendations for the continuation and sustainability of the intervention (adapting, scaling up or phasing out).

Annex 5: Evaluation matrix

The evaluation team broke some evaluation questions into sub-questions to prepare data collection and analysis, and to clarify needed background information. Detailed descriptions of the five key evaluation criteria, questions and respective sub-questions, indicators and data sources are presented in the evaluation matrix below.

TOR Criteria and Questions	Sub-questions/Inquiries	Evaluation Indicators	Data Sources	Data Collection & Analysis Techniques
Relevance				
To what extent was the design of the treatment of MAM intervention relevant to the development context of Timor-Leste?	<p>Was the design of the project consistent with the national priorities and strategies?</p> <p>What are areas that need improvements?</p>	Extent to which the intervention was coherent with national priorities	<ul style="list-style-type: none"> - National Health and Nutrition policies, strategies and action plans - Informant interviews 	Content analysis of documents, interview and FGD notes
To what extent did the intervention reach the intended target groups, and is the intervention in line with the needs of the most vulnerable groups (boys and girls under five years of age, pregnant and lactating women and adolescent girls)?	<p>How have Equity and gender equality issues been factored into project design and implementation? Does the intervention follow the protocol for treating MAM in Timor-Leste and/or follow global best practices?</p> <p>What challenges did the implementing partners face on reaching the most vulnerable (PLW 15-19-year old) and how was the communication and support from the WFP in response to these challenges?</p> <p>Did community education and mobilization initiatives target both men and women?</p> <p>What was the geographic coverage of isolated rural areas for community education and mobilisation initiatives? And in isolated rural areas were adolescent women, youth and families a priority for nutrition education and gender-specific messaging?</p>	<ul style="list-style-type: none"> - Extent to which the project used Equity and Gender Equality principles throughout the project - Guidance provided to implementing partners and their application. - Extent to which the programme reached the most vulnerable. 	<ul style="list-style-type: none"> -WFP/MoH National health and nutrition policies, strategies and action plans -National guidelines of management of acute malnutrition 	Content analysis of documents, interview and FGD notes
To what extent was the design and implementation of the intervention gender-sensitive, addressing the diverse needs of children under five and pregnant and lactating women/adolescent girls?	<p>Was any gender-specific research or evaluation done by WFP or partners to ensure that programming was gender-sensitive and that barriers for accessing care for PLW and their children were considered?</p> <p>Is sex-disaggregated data available on programme entries, exits, and programme performance indicators?</p> <p>Were community consultations held to examine gender-specific perspectives on malnutrition e.g.</p>	- Extent to which the gender equality was mainstreamed into project activities and implementation	<ul style="list-style-type: none"> Project progress reports (quarterly reports, mid-term reviews, evaluations, etc.) Interviews with key informants FGD with beneficiaries and community members 	<ul style="list-style-type: none"> Analysis of available project' quantitative data on Gender Equality Content analysis of documents, interview and FGD notes

	<p>discussing women's and men's role in decision-making on household nutrition, gender-specific cultural taboos and practices to ensure the programme was gender-responsive?</p> <p>Were the key messages used in community and mobilization activities addressing cultural and/or social obstacles that may be having a negative impact on nutrition status?</p> <p>Were partner agencies such as UNICEF, UNFPA and UN Women consulted on key messages promoting gender equality and prevention of Sexual and Gender-based violence in community initiatives and mobilisation?</p>			
To what extent was the design and implementation of the intervention, including ration, consistent with national and international guidelines for management of acute malnutrition?	Was the selection of rations used for the intervention consistent with national and international guidelines?	- Consistency of the rations with national and international guidelines	-National IMAM guidelines -Dietary content/recipes of rations used -International guidelines for management of MAM -Project reports -Interviews with key informants	Content analysis of documents and interview notes Comparison of project design and implementation with national/international guidelines requirements and recommendations
TOR Criteria and Questions	Sub-questions/Inquiries	Evaluation Indicators	Data Sources	Data Collection & Analysis Techniques
Effectiveness				
To what extent were corporate outputs and outcomes for MAM treatment of girls and boys 6-59 months achieved, and what were the main results including positive, negative, intended and unintended outcomes?	What are the achievements and shortfalls as per the results planning matrices?	- Admission trends versus targets - Performance indicators versus targets (coverage, recovery rate, death rate, default rate), distributed according to municipality and gender	-Project data base -Interviews with key informants -FGD with health workers, beneficiaries, volunteers and other community members	Descriptive analysis of quantitative data: comparison of achievements versus targets Content analysis of reports, interviews and FGD notes
What were the major facilitating factors and constraints leading to achievements?	For each aspect of service delivery, how well were standards met? What were the facilitating factors, in order of importance? What were the reasons for the shortfalls?	-Facilitating factors -Shortfalls	-Project reports and evaluations -Interviews with key informants -FGD	Content analysis of qualitative data (reports, interview and FDG notes)
What was the number or percentage of children progressing from MAM to SAM in areas with and without SAM and MAM components implemented?	What is the added value of implementing MAM interventions in areas with SAM intervention?	Percentage of children progressing from MAM to SAM	-Project data bases -National nutrition data base of areas with and	Quantitative and qualitative analysis comparing areas with and

			without SAM and MAM interventions	without SAM and MAM interventions implemented
To what extent did community mobilization and nutrition education activities, implemented by NGOs, lead to creating awareness and demand of the nutrition services and what was the level of participation of women and men?	What is the effect value of community mobilisation and nutrition education implemented by NGOs on raising community awareness, stimulating community adhesion and participation?	<ul style="list-style-type: none"> -Number of mobilisation sessions -Number of males and female participants to mobilisation sessions -Number of screened beneficiaries as compared to targets -Number of admitted beneficiaries as compared to targets -Degree of awareness of the project created by mobilisation activities 	<ul style="list-style-type: none"> -Project data base -Interviews with key informants -FGD with health workers, beneficiaries, volunteers and other community members 	Quantitative and qualitative analysis comparing areas with and without community mobilisation implemented by NGOs
To what extent did the availability of food at health facilities positively or negatively influence participation and uptake of other health and nutrition services?	What were the effects of the availability/presence of supplementary foods at health facilities on participation of the community to other health and nutrition services such as immunization, ante- and post-natal care, general consultation and health promotion?	-Number of admissions to health and nutrition services prior and after the beginning of the treatment of MAM	<ul style="list-style-type: none"> -Project data base -Interviews with key informants -FGD with health workers, beneficiaries, volunteers and other community members 	<p>Descriptive analysis of quantitative data</p> <p>Content analysis of qualitative data</p>
To what extent were cross-cutting issues and standards for assistance, in particular related to gender, equity and women's empowerment, and in other areas such as partnership and coordination; protection and accountability?	<p>Have women taken steps to change their household eating practices and have they seen results from their actions?</p> <p>How did the programme's mother support groups support & empower women to raise awareness among men, women, seniors and youth on the importance of family nutrition?</p> <p>How were the community initiatives designed to minimize any risk of violence against women for example in participating in activities outside of the home?</p> <p>Do women, men and community members consider PLW 15-19-year old as having specific nutrition needs?</p> <p>How do men support women's nutrition during pre- and post-natal periods?</p> <p>How do men support women in their household attending mother support groups outside of the home?</p> <p>-What are the coordination mechanisms at the national, district and community levels for addressing MAM issues?</p> <p>-What is the level of MoH participation in the coordination mechanism? WFP and other partners' participation?</p>	<p>Empowerment of women to make changes after their admission to the project.</p> <p>Protection of women in implementation of project.</p> <p>Men's support of household changes on nutrition.</p>	<ul style="list-style-type: none"> -Project reports and evaluations -Interviews with key informants -FGD with health workers, beneficiaries, volunteers and other community members 	Content analysis of reports, interview and FGD notes

TOR Criteria and Questions	Sub-questions/Inquiries	Evaluation Indicators	Data Sources	Data Collection & Analysis Techniques
Efficiency				
Was the implemented modality for MAM treatment cost-efficient, compared to other parts of the country where specialized nutritious foods for MAM treatment were not provided?	How was MAM treatment implemented in the areas not receiving specialised nutritious foods and what was the cost of treating MAM children, PLW in these areas? What is the affordability of locally available foods?	Cost per recovered child Cost per recovered PLW	-Project data base -Project's finance data -Interviews with relevant staff and logistics	Comparison of cost per beneficiary treated in areas with and without provision of specialised nutritious foods
Cost per beneficiary treated and per type of specialized nutritious foods provided (Timor Vita and Ready-to-Use Supplementary Food), and analysis of nutrient density of the foods provided	What is the cost of using Timor Vita versus Ready-to-Use Supplementary Food? What is the nutrient density of Timor Vita versus Ready-to-Use Supplementary Food?	Cost per recovered child Cost per recovered PLW Nutrient density of Timor Vista Nutrient density of Ready-to-Use Supplementary Food (RUSF)	- Project data base -Project's finance data -Recipes of Timor Vista and RUSF -Interviews with relevant staff and logistics	Comparison of cost per beneficiary treated according to the type of nutritious food received Comparison of nutrition density of nutritious foods according to the category of beneficiaries (children U5 and PLW)
Did the targeted approach, as compared to the previous blanket supplementary feeding programme, with provision of Timor Vita for both children and PLW, result in improved cost-efficiency?	What is the cost of blanket supplementary feeding versus targeted feeding?	Cost per beneficiary	- Data base for both blanket feeding and supplementary feeding project -Finance data for both blanket feeding and supplementary feeding project -Interviews with relevant staff and logistics	Comparison of cost per beneficiary treated through blanket feeding versus targeted feeding
Was the intervention implemented in the most efficient way compared to alternatives, e.g. considering different transfer modalities (locally produced vs imported foods) and compared to using alternative transfers (based on WHO's guidance on the dietary management of children with MAM)?	What is the cost of locally produced versus imported foods? What is the cost of locally produced versus alternative WHO ingredients? What is the cost of imported foods versus alternative WHO ingredients?	Cost per beneficiary	- Project data base -Project's finance data -Recipes of Timor Vista, RUSF and WHO alternatives -Interviews with relevant staff and logistics	Comparison of cost per beneficiary treated through locally produced versus imported foods and/or other dietary supplements
Comparison of performance in areas with different institutional arrangements, i.e. where NGOs have supported the community-based activities with areas with no presence of local partners/NGOs, and in areas with and without active community outreach (SISCa)	What is the performance in areas with and without NGO support? What is the performance in areas with and without active community outreach?	Project performance indicators (admission trends, recovery rate, coverage, death rate, default rate)	- Project and other MoH data base	-Comparative analysis of performance data according to areas with and without NGO support, and according to areas with and without active community outreach
TOR Criteria and Questions	Sub-questions/Inquiries	Evaluation Indicators	Data Sources	Data Collection & Analysis Techniques

Sustainability				
To what extent is it likely that the benefits of the intervention will continue after WFP's support under the DEV 200770 ends in December 2017?	What is the government policy toward sustainability of MAM intervention and other nutrition support programmes?	Sustainable government policy and actions taken	-Project strategies -Interviews with key informants	Content analysis of documents and interview notes
To what extent has the cost for treatment of MAM been incorporated into national budgets, plans and policies?	-What provisions are made in MoUs and agreements for phasing out the project?	-Steps that the government has taken to sustain the achievements of MAM project	-Project documents -Interviews with key informants	Document review Content analysis of interview notes
Does the intervention have potential to positively influence gender relations, and what would be sustainable approaches to increase the involvement of men in future activities?	Was the retention and knowledge of nutrition messaging among men and women tracked in M&E? What was the result? Are men involved in decisions around food since receiving nutrition counselling and nutrition messaging?	Involvement of husbands in decisions around food	-Interviews with key informants -FGD with beneficiaries, volunteers and other community members	Content analysis of interview and FGD data
What are practical and feasible recommendations for the continuation and sustainability of the intervention (adapting, scaling up or phasing out)?		Continuation modality of the project	-Cost-efficiency analysis -Interviews -FGD with beneficiaries, volunteers and other community members	Content analysis
Impact				
What is the contribution of the intervention in reducing wasting prevalence among boys and girls between 2013 and 2016 in geographic target areas? To what extent the project promoted Equity in access in reducing wasting in disadvantaged, marginalized and less reached areas/districts?	What was the prevalence of wasting among U5 children before and after the beginning of the intervention, and in intervention versus non-intervention areas	Wasting prevalence among children under-five years of age	-DHS results (2009/10 and 2016) -Food and Nutrition Survey (2013)	Comparison of changes in wasting prevalence in geographic intervention areas versus non-intervention areas, and among different population groups (rural/urban, age group and sex, and by wealth index)

Annex 6: Evaluation process and timeline

Date	Activity	Location
<i>Inception phase</i>		
02-30 Oct 2017	Review of documents and development of the draft inception report	Home base
01 Nov 2017	Arrival of the Evaluation Team leader in Dili	Timor-Leste
02-03 Nov 2017	Briefing at WFP and submission of the draft inception report	
03-07 Nov 2017	Review of additional documents and in-country consultation with stakeholders	
08 Nov 2017	Presentation of the evaluation methodology to the Evaluation Reference Group (ERG)	
09-28 Nov 2017	Receipt of feedback and finalisation of the inception report	
29 Nov 2017	Submission of the final inception report	
13 Nov-08 Dec 2017	Field visit to seven municipalities for Key Informant Interviews, FGDs and Observations	
<i>Field visit phase</i>		
09-19 Dec 2017	Field work debriefing and preliminary analysis	Timor-Leste
20 Dec 2017	Presentation of preliminary findings and conclusions to the ERG	
21-28 Dec 2017	Further analysis of data	
29 Dec 2017	The Evaluation Team leader leaves Dili	
<i>Reporting phase</i>		
05 Jan-05 Feb 2018	Development and submission of first draft Evaluation Report	Home base
13 Feb-07 Mar 2018	Receipt of feedback, development and submission of second draft	
14 Mar-24 Apr 2017	Receipt of feedback, development and submission of third draft	
14-24 May 2018	Receipt of feedback, development and submission of Final Report	

Annex 7: Documents and databases reviewed

1. World Food Programme in Timor-Leste. Capacity Development for Health and Nutrition. Standard Project Report 2016
2. World Food Programme in Timor-Leste. Timor-Leste development project (jan 2015-Dec 2016) number 200770. Approved project.
3. World Food Programme in Timor-Leste. Full Logframe 0.1 for the project 200770: Development Project -Timor Leste
4. World Food Programme in Timor-Leste. KOICA and EU logframes
5. World Food Programme in Timor-Leste. Moderate acute malnutrition intervention in drought affected areas, Standard Project Report 2016.
6. World Food Programme in Timor-Leste. Country Strategic Plan, Year 2018-2020
7. WFP Office of Evaluation. Country portfolio evaluation Timor Leste: An evaluation of WFP's Portfolio (2008 - 2012). Prepared by Mokoro Limited Stephen Lister, Jane Keylock, Trish Silkin, May 2013.
8. World Food Programme in Timor-Leste. Timor-Leste. Nutrition Sub-Analysis for Children, ppt presentation for the SUN.
9. World Food Programme in Timor-Leste. M&E Quarterly Reports for 2015, 2016, 2017. Targeted Supplementary Feeding Programme.
10. WFP. Mother and Child Health and Nutrition – Targeted Supplementary Feeding Programme (MCHN – TSFP). Amended description of the action, 2017.
11. WFP Timor-Leste. Evaluation Terms of Reference: End-Term Evaluation of Treatment of Moderate Acute Malnutrition, 2015-2017. May 2017.
12. World Food Programme in Timor-Leste. Food fortification. Mission Debrief, by Rizwan Yusufali. Dili, 10-14 October 2016.
13. WFP Technical Note on Activity Evaluation
<http://docustore.wfp.org/stellent/groups/public/documents/reports/wfp277850.pdf>
14. WFP. Nutrition at the World Food Programme. Programming for Nutrition-Specific Interventions, December 2012.
15. <http://www.wfp.org/nutrition/special-nutritional-products>
16. European Commission. Mid-Term Evaluation of the Integrated Nutrition Project in Timor-Leste, Final Report. Prepared by Frans de Koning, 31 December 2015.
17. Final evaluation of the “Integrated Nutrition project in Timor-Leste”, Documentation Activities, October 2017.
18. EU, WFP, MoH. Mother and Child Health and Nutrition – Targeted Supplementary Feeding Programme (MCHN – TSFP). Progress Report, January to June 2017.
19. EU. Addressing Undernutrition in Emergencies. Accompanying the document: Enhancing maternal and child nutrition in external assistance: an EU policy framework, 2013.
20. WHO, Regional Office for South-East Asia. Health in the sustainable development goals: where

- are we now in the South-East Region? What next? 2016.
21. WHO. Technical note: supplementary foods for the management of moderate acute malnutrition in infants and children 6–59 months of age. Geneva, World Health Organization, 2012; p7.
 22. World Bank. Draft Report: Malnutrition in Timor-Leste: A review of the burden, drivers and potential response. 2016.
 23. UNICEF. Evaluation of Community Management of Acute Malnutrition: Kenya Country Case Study. Evaluation report. New York: UNICEF Evaluation Office, December 2012.
http://www.unicef.org/evaldatabase/files/Kenya_CMAM_formatted.pdf
 24. UNICEF. Evaluation of Community Management of Acute Malnutrition: Pakistan Country Case Study. Evaluation report. New York: UNICEF Evaluation Office, September 2012.
http://www.unicef.org/evaldatabase/files/Pakistan_CMAM_final_report_11oct2012%281%29.pdf
 25. UNICEF. UNICEF's approach to scaling up nutrition for mothers and their children. Discussion paper. Programme Division, UNICEF, New York, June 2015.
 26. National Council for Food Security, Sovereignty and Nutrition in Timor-Leste. Zero Hunger Challenge. National Action Plan for a Hunger and Malnutrition Free Timor-Leste. Dili, 2014.
 27. República Democrática de Timor-Leste. National Food and Nutrition Security Policy, January 2017.
 28. Ministry of Health Timor Leste. National food safety strategy: 2016-2020. Final draft, November 2016.
 29. Ministry of Health Timor Leste. Strategic Plan of the National Institute of Health 2015-2019. 2015.
 30. Australian Department of Foreign Affairs and Trade, The World Bank Group. Malnutrition in Timor-Leste: A review of the burden, drivers, and potential response. Prepared by Anne Provo, Steve Atwood, Eileen Brainne Sullivan, Nkosinathi Mbuya, 2016.
 31. Ministry of Health Timor Leste. National Nutrition Strategy 2014-2019.
 32. Ministry of Health Timor Leste. Food-based dietary guidelines (FBDGs) for the whole population, and also for groups with special needs: Pregnant women; Breast-feeding mothers; Infants and children; Adolescent boys and girls; Elderly men and women. Dili, 2015.
 33. Ministry of Health Timor-Leste. Specific Nutrition Intervention Package (SNIP) Guidelines. MODULE 8: Implementing Integrated Management of Acute Malnutrition (IMAM), 2016.
 34. Ministry of Health Timor-Leste. Guideline for establishment and operation of Mother Support Groups. Nutrition and maternal new-born and child health practices in the context of primary health care. Guideline developed with financial and technical support from European Union and UNICEF, 2017.
 35. General Directorate of Statistics, Ministry of Finance/Timor Leste, and ICF. 2018. Timor-Leste Demographic and Health Survey 2016. Dili, Timor-Leste: GDS and ICF. Available at <http://dhsprogram.com/pubs/pdf/FR329/FR329.pdf>.
 36. Centre of Studies for Peace and Development (CEPAD) Timor-Leste and Johns Hopkins University. Timor-Leste strategic review: progress and success in achieving the sustainable development goal 2, 2016.
 37. <http://spherehandbook.org/en/management-of-acute-malnutrition-and-micronutrient-deficiencies-standard-1-moderate-acute-malnutrition/>
 38. National guidelines of management of acute malnutrition
 39. Demographic Health Survey 2009-2010
 40. Timor-Leste Food and Nutrition Survey (2013)
 41. Strategic Development Plan 2011-2030
 42. National Health Sector Strategic Plan 2011-2030
 43. The Economic Consequences of Undernutrition in Timor-Leste (2014)
 44. Measuring Undernutrition among Young Children in Timor-Leste (2016)

45. Baseline report of nutrition screening results (2016)
46. Monthly national key facts (2016)
47. Reports from NGO partners
48. Timor-Leste Health Information System (TLHIS)
49. UNEG Ethical Guidelines for Evaluation, UNEG, March 2008
50. Westthorp, G. (2014) Realist Impact Evaluation: An Introduction. Accessed at: <http://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9138.pdf>
51. Marchal, B. et al (2012). Is realistevaluationkeepingits promise? A review of publishedempiricalstudies in the field of healthsystemsresearch. Evaluation; 18:192
52. Palinkas, L.A., et al., Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. Adm Policy Ment Health, 2013.
53. Tongco, M., Purposive Sampling as a Tool for Informant Selection. Ethnobotany Research& Applications, 2007. 5: p. 147 - 158.
54. Thomas, D.R., A General Inductive Approach for Analysing Qualitative Evaluation Data. American Journal of Evaluation, 2006. 27(2): p. 237-246.
55. Boyatzis, R.E., Transforming qualitative information: Thematic analysis and code development. 1998, Thousand Oaks, CA, US: Sage Publications, Inc. xvi, 184.

Data bases examined

56. WFP nutrition data base of the six municipalities, for 2015, 2016 and 2017
57. Project's finance data for 2014, 2015, 2016, 201

Annex 8: Characteristics of municipalities, the sampled sites and the timeline for field visits

Simple random sampling technique was used to select the health facility to be visited, using the list of all functional health facilities in each municipality provided by WFP. Overall, 15 sites were sampled and visited, distributed as follow: five health facilities (one health facility randomly selected in each municipality among the total number of health facilities delivering SAM and MAM services), five health facilities delivering SAM without MAM services (one health facility randomly selected in each municipality among the total number of health facilities delivering SAM but not MAM services), three community outreach sites (one randomly selected in each municipality supported by NGOs (activities implemented by World Vision in Covalima, and Alola Foundation in Dili and Oecusse), and two CHC randomly selected in each of the two municipalities not implementing the TSFP.

Municipalities implementing TSFP with NGO support			Municipalities implementing TSFP without NGO support		Municipalities not implementing TSFP		Total
Covalima	Dili	Oecusse	Ermera	Ainaro	Manufahi	Liquica	

Stunting -2013	50.4%	39.7%	57.7%	65%	60.9%	49.4%	50.7%	-
Wasting - 2013	17.4%	14.2%	19.8%	8.6%	8.2%	7.3%	9.6%	-
SAM & MAM services	CHC Zumalai	CHC Comoro	HP Oenuo Nitibe	CHC Railako	HP Mauchiga	-	-	5
SAM but no MAM services	HP Sanfuk	HP Campo Alor	HP Suniufe Cabana	HP Goulolo	HP Aimerleu	CHC Same Vila	CHC	7
NGO activities	1	Ailok laran	1	-	-	-	-	3
Total sites	3	3	3	2	2	1	1	15

Note: Prevalence of stunting and wasting in the seven municipalities visited are presented just for information. They were not considered as criteria for sampling or selecting the sites.

Annex 9: Individual interviews undertaken during field visits, November - December 2017

	Municipalities								Total
	National	Ainaro	Covalima	Dili	Ermera	Oecusse	Liquica	Manufahi	
MoH	2								2
Donors	3								3
WFP staff	6								6
UN Agencies	3								3
NGO manager	3								3
Private sector	1								1
SAMES	2								2
Director Health		1	1	1	1	1			5
DPHO		1	1	1	1	1	1	1	7
WFP field staff		1	1	1	1	1			5
NGO staff			1	1		1			3
CHC Manager							1	1	2
President of ZEEMS						1			1
Total	20	3	4	4	3	5	2	2	43

Annex 10: List of people interviewed

Name	Designation	Organisation
Stephen Kearney	Representative & Country Director	WFP
Patrick Teixeira	Deputy Country Director	WFP
Marina Kalisky	Nutritionist	WFP
Anastacio Soriano	Monitoring & Evaluation	WFP

Sebastião da Costa Henrique		WFP
Jose Almeida	Logistics Associate	WFP
Jose Gusmão Freitas	FSU Ainaro	WFP
Angelo N. Martins	FSU Ermera	WFP
Agostinho Soares	FSU Covalima	WFP
Louis Colo	FSU Oecusse	WFP
Ejilo Ulan	Program Assistant Oecusse	WFP
Inacio Jose Dos Santos	FSU Dili	WFP
Dongbao Yu		WHO
Crispin da Costa Araujo		WHO
Maria Paulina Goncalves	Program Officer, Nutrition	UNICEF
Paolo Barduagni	Attaché - Health and Nutrition	EU Delegation, Timor-Leste
Johanes Don Bosco Mau	Programme Officer, Operation Section	EU Delegation, Timor-Leste
Osia R. Da C. Salu	Program Coordinator for development Assistance	KOICA, Timor-Leste
Jennel Barrot	Program Assistant Manager for Development Assistance	KOICA, Timor-Leste
Heather Grieve		DFAT, Timor-Leste
Teresinha Soares		DFAT, Timor-Leste
Evangelita Pereira	MCHN Technical Specialist	World Vision, Dili
Nuno Alves Maria da Costa	Baseline and Evaluation Officer	World Vision, Dili
João Moniz	Project Coordinator	World Vision, Covalima
Macu	MCH Specialist	Alola Foundation, Dili
Pasquela Jasmi Handayani	Program Officer	Alola Foundation, Oecusse
Mario Moreira dos Reis	Food Security Officer	Department of Nutrition, Dili
Dulce Corte Real Tilman	DPHO SMI and Nutrition	SAME, Manufahi
Julio de Corte Xavier	Chief CHC of SAME Villa	SAME, Manufahi
Agostinho Bianco	DPHO Nutrition	SSM, Ainaro
Agostinho da Costa	Director Saude	SSM, Ainaro
Eusebio de Aroujo	DPHO Nutrition	SSM, Covalima
Graciano da Costa Cruz	Interim Director DHS	SSM, Ermera
Mateus Soares Gomes	DPHO Nutrition	SSM, Ermera
Hermina B. Sedo	DPHO SMI and Nutrition	MOH, Oecusse
Lusia Taeki	Regional Secretary of Health	MOH, Oecusse
Arsenio Paixão Bano	President of ZEEMS	Oecusse
Dirce Maria Soares	Director of training	INS
Francisco da Silva	DPHO Nutrition	SSM, Dili
Agostinha da Costa Saldanha Segurcedo	Director	SSM, Dili
Mateus dos Santos	DPHO Nutrition	SSM, Liquica
Luis M. Albino	Chief CHC	SSM, Liquica
Bobby Lay	Director	Timor Global LDA
		SAMES, Dili

Annex 11: Interview protocol

Interview Guide for group of stakeholders: Policy Makers (Ministry of Health), Donors (EU, KOICA), WFP, Other UN Agencies, Implementing NGOs, private sector (Timor Global).

Name _____ Interview Date: _____

Organisation and position in the organisation _____

Introduction, Confidentiality and Access to Information

This interview is being conducted as part of the End-term evaluation of treatment of moderate acute malnutrition in Timor Leste, 2015-2017 implemented by WFP and financed by the EU and KOICA. The purpose of this evaluation is to determine to what extent and how the project has achieved its goal and to build evidence-based decision-making that will inform policy, future strategies and programming on nutrition-specific interventions to achieve national targets for reduction of wasting.

One essential component to the evaluation process is conducting interviews with key informants involved in the intervention, and we wish to thank you for agreeing to participate in this interview.

Please let us know when a question does not apply to you or you feel that you do not have an informed opinion, and we will focus on those questions that are more pertinent. Be assured that your responses will be strictly confidential. Although you may be quoted in the evaluation report, the source of the quote will not be identified by name, position title or specific institutional affiliation.

The Evaluation Team

PART I – Relevance

1. According to you, to what extent the intervention is in line with the Government of Timor-Leste's nutrition strategies?
2. How was the project designed to reach the target groups and how was this implemented?
 - For children under five years of age?
 - PLW
3. How were men involved in the intervention? Did they pass on the information to their counterparts?
4. What about the involvement of adolescent boys?

5. What support did WFP provided to implementing NGOs and other organisations (e.g MoH)?
6. What challenges did you face on reaching the target groups?
 - Children under five years of age?
 - PLW
7. How did you address these challenges?
8. What strategies were used to bring down barriers for reaching PLW 15-19 years old specifically? For example, was outreach planned at times convenient for women, not making expectations on women to travel when pregnant, reaching them in their homes, consider family reluctance to share information on PLW 15-19 years old due to stigma?
9. Was the selection of rations used for the intervention consistent with national and international guidelines?
10. What are the strengths and limitations of the current design and its implementation?
11. What are areas that need improvements?

PART II – Effectiveness

12. What are the major achievements of the intervention?
13. What were the major facilitating factors influencing the achievements?
14. What are the main shortfalls?
15. What were the reasons for these shortfalls?
16. What were the achievements that were unexpected?
17. What was the added value of implementing MAM and SAM interventions concomitantly, versus implementing treatment of MAM only?
18. What were the effects of community mobilisation and nutrition education implemented by NGOs on
 - Raising community awareness?
 - Stimulating community adhesion and participation?
 - Involvement of women?

- Involvement of men?
19. What were the effects of non-implementing community mobilisation and nutrition education in other municipalities?
 20. What were the effects of the availability/presence of supplementary foods at health facilities on participation of the community to other health and nutrition services such as immunization, ante- and post-natal care, general consultation, health promotion, etc?
 21. What were the main issues with the identification of beneficiaries?
 - Children under five years of age?
 - PLW
 22. What was the effects of the intervention on women's household eating practices and actions?
 23. What are the existing coordination mechanisms at the national, municipality/district and community levels for addressing MAM issues?
 24. What is the level of MoH participation in the coordination mechanism at each level?
 - National
 - Municipality/district
 - Community

PART III – Efficiency

25. How are children under five, PLW and adolescent girls with MAM managed in municipalities/areas not receiving specialised nutritious foods?
26. Do you think it is more cost-efficient of treating MAM children, PLW and adolescent girls with MAM these municipalities/areas?
27. What is the affordability of locally available foods to the population for addressing MAM?
28. According to you, what is the most cost-efficient approach when comparing the current targeted approach to the previous blanket supplementary feeding approach (with provision of Timor Vita to both children and PLW)?
29. Tell us about your perception on the cost of locally produced versus imported nutritious foods for MAM children and PLW?
30. Broadly, how do you think cost-efficiency of the intervention can be improved? How can funds be saved with the same results?

31. What is the potential for prevention programmes to reduce the MAM cost?

PART IV – Sustainability

32. What provisions are made in MoUs and agreements for phasing out the project? Are they realistic?

33. What is the government's policy toward sustainability of MAM intervention and other nutrition support programmes?

34. Will the results achieved from this project have a lasting benefit over time for the country partners and beneficiaries? What are the risks if not?

35. To what extent do you think the government can own the intervention without donor contribution?

36. What do you think should be done by the communities to ensure that they take more of the responsibility of sustaining the treatment of MAM?

37. What would be sustainable approaches to increase the involvement of men in future activities?

PART V – Impact

38. How successful the intervention has been to date in achieving the long-term results (impact on wasting prevalence)?

Overall,

39. What are the good practices of the intervention?

40. What lessons would you like to share?

What are your recommendations for improving the intervention?

Annex 12: Focus group discussion sessions conducted during the evaluation and number of participants the sessions

	Parents of children under-five years of age			PLWs, adolescent boys and girls			HWs, volunteers, community leaders			Total		
	Sessions	Women	Men	Sessions	Women	Men	Sessions	Women	Men	Sessions	Women	Men
Airnaro	2	12	2	2	11	3	2	7	10	6	30	15
Covalima	2	13	3	2	20	2	2	5	4	6	38	9
Dili	2	11	2	2	6	0	2	12	6	6	29	8
Ermera	2	48	10	1	6	0	2	7	9	5	61	19
Oecusse	2	31	0	1	17	0	2	13	8	5	61	8
Total	10	115	17	8	60	6	10	44	37	28	219	59
%	-	87%	13%	-	91%	9%	-	54%	46%	-	78.7%	21.3%

Annex 13: Focus group guide

FGD Guide for health workers, volunteers, mothers and fathers of under five children, PLW, PLW 15-19 years old, adolescent girls, adolescent boys, women support groups, community leaders, etc.

Participants

Names, gender and Positions: _____

PART I – Relevance

1. What is the major difference the treatment of MAM made in your community as compared to before?
2. Does the treatment of MAM programme meet the needs in the municipality/locality/village?
3. Do you think the project is successful in reaching
 - Children under five years of age?
 - PLW?
 - Adolescent girls?

Please, explain.

4. What are the difficulties in reaching these target groups?
 - Children under five years of age?
 - PLW?
 - Adolescent girls?
5. How are men involved in the intervention?
6. What about the involvement of adolescent boys?
7. What about the barriers for reaching PLW 15-19 years old?
8. Was the selection of rations used for the intervention consistent with your eating habits?

PART II – Effectiveness

9. Please tell us about your satisfaction of the intervention?
10. What are the major achievements of the intervention?
11. What are the main difficulties and the reasons?
12. What were the main issues with the identification of beneficiaries?
 - Children under five years of age?
 - PLW
 - Adolescent girls?
13. What were the main effects of the intervention of each of these target groups?

- Children under five years of age?
- PLW
- Adolescent girls?

14. What are the effects of the presence of NGOs implementing the intervention in your municipality/locality?

15. What is the effect of the availability/presence of supplementary foods at health facilities on participation of the community to other health and nutrition services?

16. How did the intervention influenced women's households eating practices and actions?

PART III – Efficiency

17. How are children under five, PLW and adolescent girls with MAM managed in your locality/municipality?

18. What is the affordability of locally available foods to the population for addressing MAM?

PART IV – Sustainability

19. Will the results achieved from this project have a lasting benefit over time for the beneficiaries? What are the risks if not?

20. What do you think should be done by you, the community, to ensure that you more of the responsibility of sustaining the treatment of MAM?

21. Are husbands more involved in decision making around food since they received nutrition counselling/messaging? Please, explain.

22. Tell us about husbands' support in attending mother support groups outside of the home?

23. What kind of support do you get from your partners during pre- and post-natal periods?

24. What can be done to increase the involvement of men in future activities?

Overall,

What are your recommendations for improving the intervention?

Annex 14: Additional tables and figures of Findings' Chapter

Table 2.16: Participants attending different community activities undertaken by NGOs in 2015, 2016 and 2017

	Alola		World Vision	
	Dili	Oecusse	Covalima	Total
Mobilisation through HH Visits to attend SISCa and HF activities				
Pregnant women	654	202	98	954
Lactating women	930	256	68	1254
Total	1584	458	166	2208
Nutrition education and counselling during health promotion activities				
Care givers Female	20	2877	1315	4212
Care givers Male	10	1295	579	1884
Pregnant women	1921	634	546	3101
Lactating women	2802	807	395	4004
Total	4753	5613	2835	13201
FGD with caregivers on health issues				
Care givers Female	745	487	1159	2391
Care givers Male	241	538	565	1344
Pregnant women	325	279	336	940
Lactating women	368	324	394	1086
Total	1679	1628	2454	5761
Teaching community groups on the signs of acute illness				
Participants Female	5974	3222	2454	11650
Participants Male	5650	2267	1228	9145
Pregnant women	5501	887	202	6590
Lactating women	6752	1807	310	8869
Total	23877	8183	4194	36254
Cooking demonstrations				
Care givers Female	1886	682	600	3168
Care givers Male	501	166	321	988
Pregnant women	194	160	202	556
Lactating women	376	684	310	1370
Total	2957	1692	1433	6082
Overall total	34860	17574	11082	63506

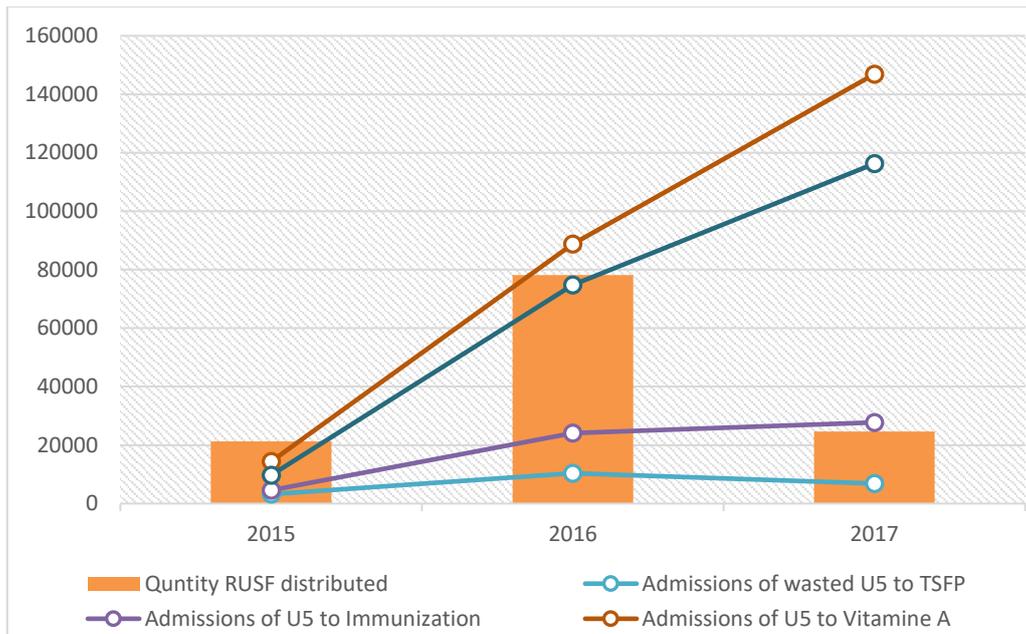


Figure 2.2: Relationship between availability of RUSF and admissions of children U5 to other health services

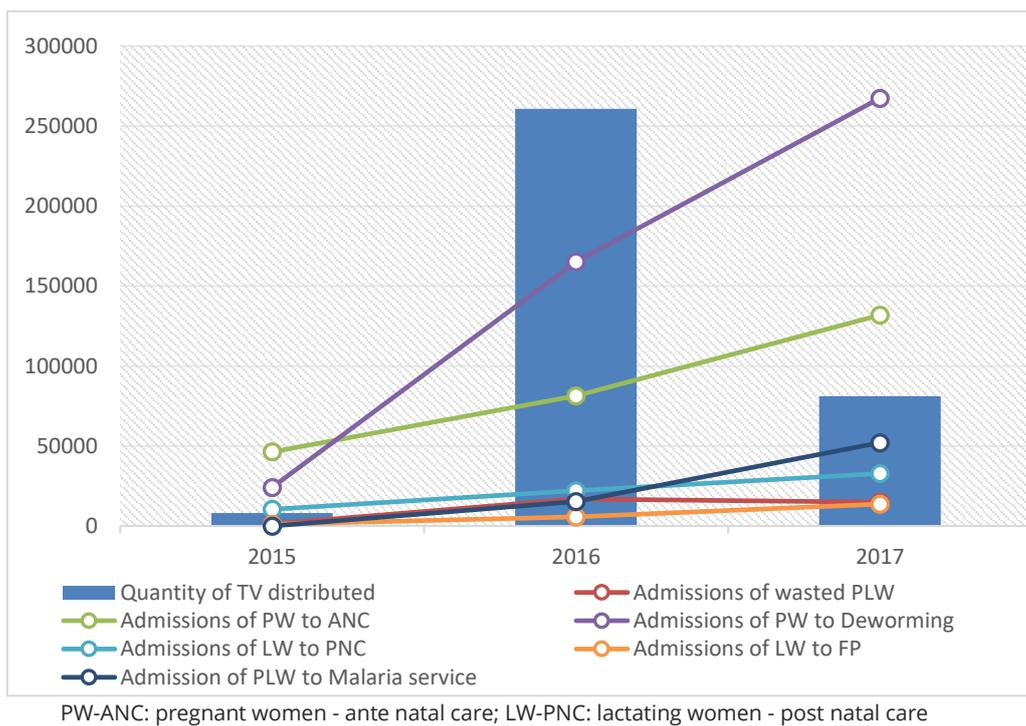


Figure 2.3: Relationship between availability of Timor Vita and admissions of PLW to other health services

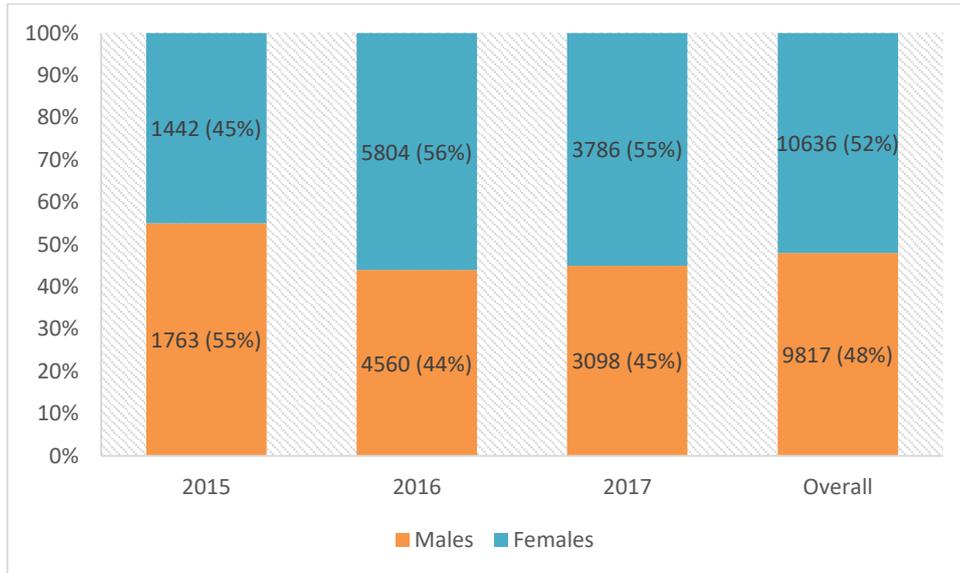


Figure 2.4: Total admissions of U5 children according to gender in 2015, 2016, 2017

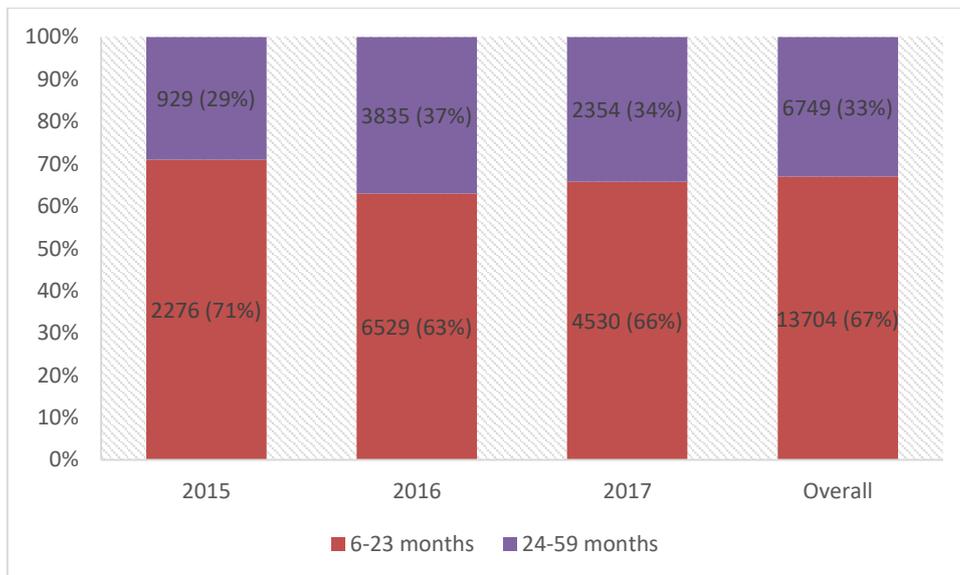


Figure 2.5: Total admissions of U5 children according to age groups in 2015, 2016, 2017.

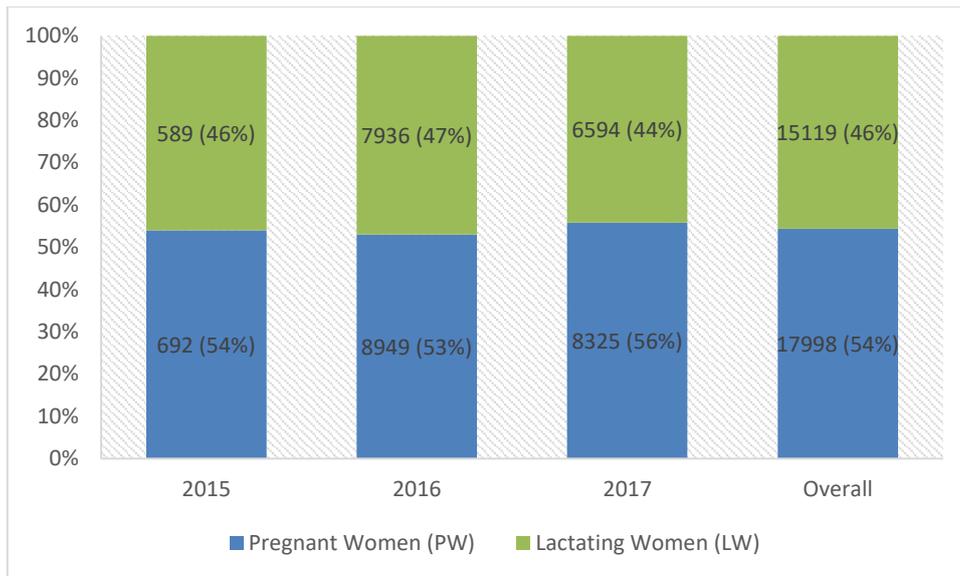


Figure 2.6: Total admissions of PLW according to status in 2016, 2017.

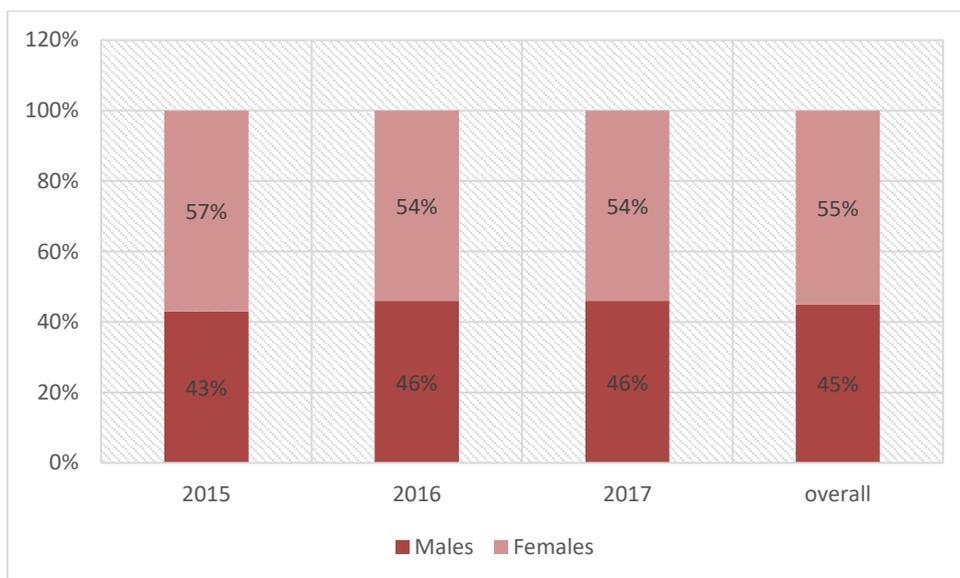


Figure 2.7: Recovery rates according to gender among U5 children in 2015, 2016, 2017.



Figure 2.8: Recovery rates according to age groups among U5 children in 2015, 2016, 2017.

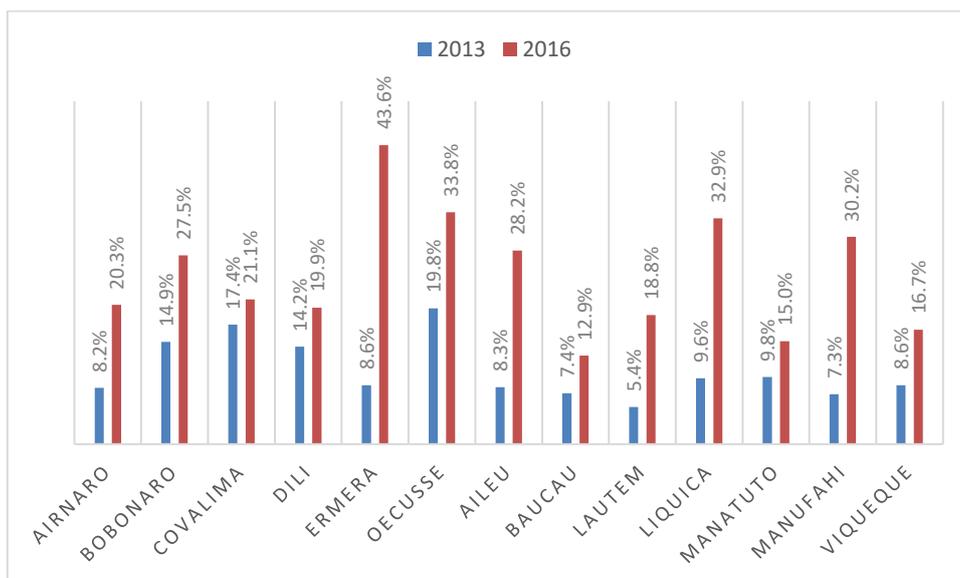


Figure 2.10: Trends of GAM prevalence in the 13 municipalities for the period 2013-2016

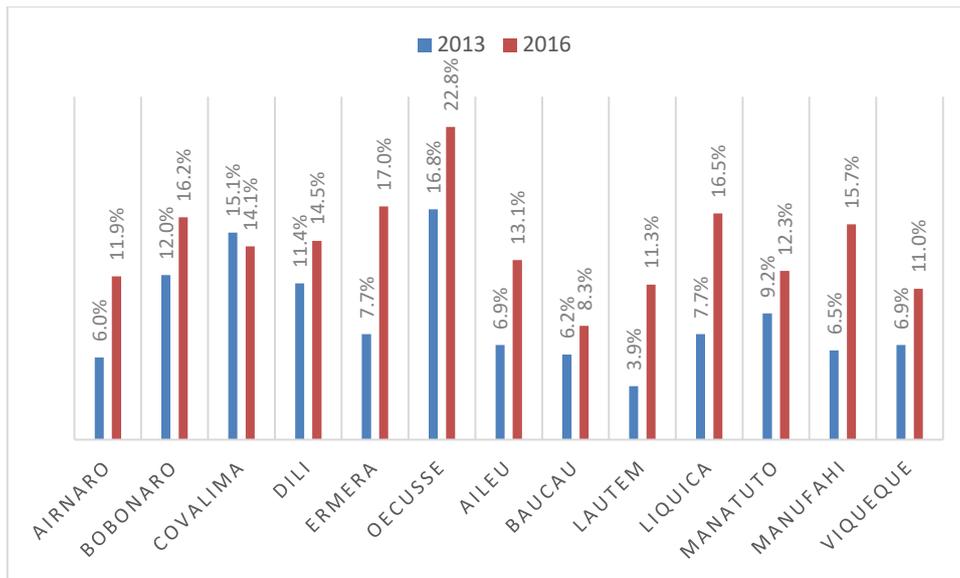


Figure 2.11: Trends of MAM prevalence in the 13 municipalities from 2013 to 2016

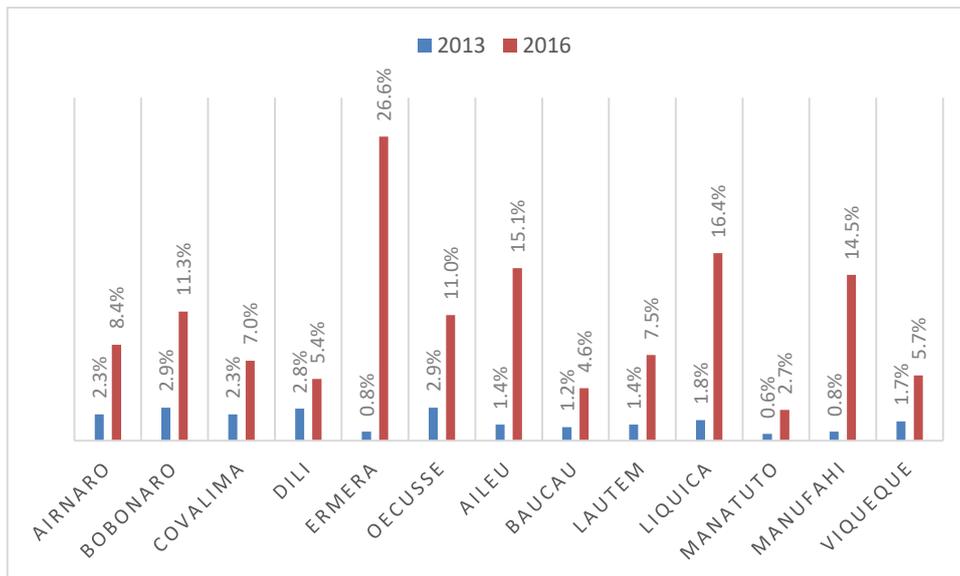


Figure 2.12: Trends of SAM prevalence in the 13 municipalities from 2013 to 2016

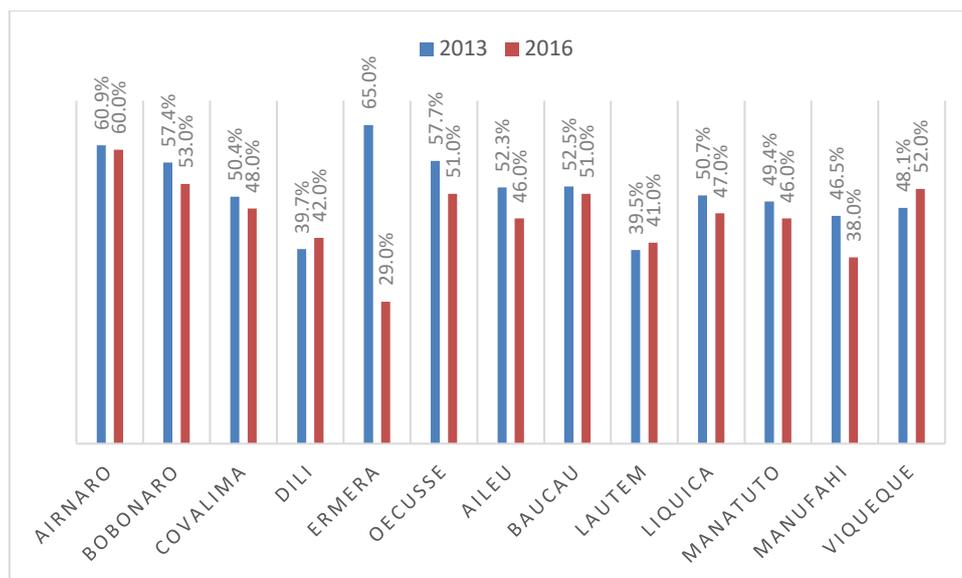


Figure 2.13: Trends of stunting prevalence in the 13 municipalities from 2013 to 2016

List of acronyms

ANC	Ante Natal Care
BCC	Behaviour Change Communication
CHC	Community Health Centre
CMAM	Community-based Management of Acute Malnutrition
CO	Country Office
CSP	Country Strategic Plan
DAC	Development Assistance Committee
DFAT	Department of Foreign Affairs and Trade
DEQAS	Decentralized Evaluation Quality Assurance System
DEV 200770	Development Project 200770
DHS	District Health Services
DHS	Demographic and Health Survey
EB	Executive Board
EC	Evaluation Committee
EU	European Union
FGD	Focus Group Discussion
ERG	Evaluation Reference Group
eWin	WFP Electronic Information Network
GAM	Global Acute Malnutrition
GEEW	Gender Equality and Women's Empowerment
GMP	Growth Monitoring and Promotion
HF	Health Facility
HMIS	Health Management Information System
HP	Health Post
HR	Human Resources
HQ	Head Quarter
ICSC	International Civil Service Commission
IFA	Iron and Folic Acid
IMAM	Integrated Management of Acute Malnutrition
INS	Instituto Nacional Da Saude
IYCF	Infant and Young Child Feeding
KOICA	Korea International Cooperation Agency
KONSSANTIL	National Council for Food Security, Sovereignty, and Nutrition in Timor-Leste
LW	Lactating Woman
MAM	Moderate Acute Malnutrition
MCHN	Mother and Child Health and Nutrition
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MoH	Ministry of Health
MNP	Multi-micronutrient supplementation
MSG	Mother Support Group
MPR	Monthly Progress Report
MT	Metric Ton
MUAC	Mid-Upper Arm Circumference
NFNSP	National Food and Nutrition Security Policy

NGO	Non-Governmental Organization
NNS	National Nutrition Strategy
OECD	Organisation for Economic Co-operation and Development
OEV	Office of Evaluation
PLW	Pregnant and Lactating Woman
PNC	Post Natal Care
PSF	Promotor Saude Familia or Family Health Promoter
PW	Pregnant Woman
QS	Quality Support
RB	Regional Bureau
RUSF	Ready to Use Supplementary Food
SAM	Severe Acute Malnutrition
SAMES	Serviço Autónomo de Medicamentos e Equipamentos de Saúde
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goal
SISCa	Servisu Integradu Saude Comunitaria (Integrated Community Health Care)
SNIP	Specific Nutrition Intervention Package
SPR	Standard Project Reports
TLFNS	Timor-Leste Food and Nutrition Survey
TLHIS	Timor-Leste Health Information System
ToR	Terms of Reference
TSFP	Targeted Supplementary Feeding Programme
U5	Under 5
UNDAF	United Nations Development Assistance Framework
UNCT	United Nations Country Team
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
WASH	Water Sanitation and Hygiene
WBG	World Bank Group
WFP	World Food Programme
WHO	World Health Organisation

WFP Timor-Leste
<http://www1.wfp.org/countries/timor-leste>

