

Government of the Federal Democratic Republic Of Ethiopia



National Nutrition Program (NNP)

(Draft Revised Plan of Action)

September 2012 –August 2015

Federal Ministry of Health

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## I. Background

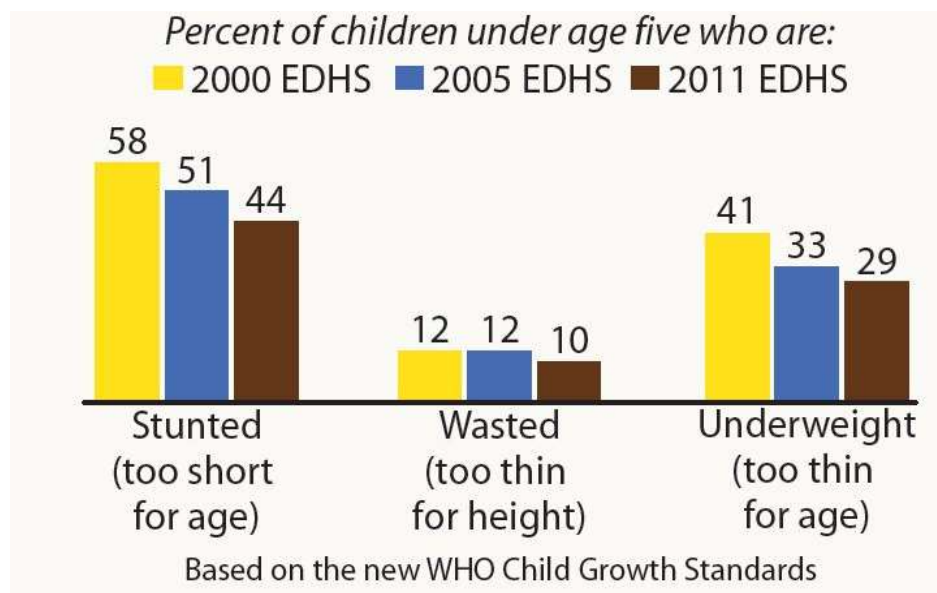
### 1. Why Nutrition for Ethiopia

**Although Ethiopia has shown progress, undernutrition is still public a health problem and remain a concern to its rapid economic development:**

Ethiopia is making progress towards food and nutrition security. As seen in Figure 1, both stunting and underweight prevalence has decreased by more than 10% between 2000 and 2010. The decrease has been steady, with both falling by 1.34 percentage points per year over the 10 year period. Wasting, which measures the more immediate effect of malnutrition, seems to have fallen slightly from around 12% in 2000 and 2005, to 9% in 2010. However, Undernutrition is still a public health problem and an overarching development concern, affecting not only food insecure areas of the country but also food secure areas. As shown in Figure 1, stunting affects 44% of children under five years of age (DHS 2011), which is too high. More than 1 out of 4 women in Ethiopia is affected by under-nutrition and anaemia, a key contributing factor to high maternal and neonatal mortality as well as infant under-nutrition.

There has never been a better time globally as well as in Ethiopia to work towards improved human development that has nutrition as a goal.

**Figure 1: Trends in Children's Nutritional Status**



### **Addressing undernutrition is critical to achieve all MDGs especially MDG1, MDG 4 and MDG 5**

Undernutrition represents the non-income face of poverty and is embodied within Target 2 of MDG 1. Addressing maternal and child undernutrition is, therefore, in itself a major MDG target and also a critical input factor for achieving MDG 4 and 5. Ethiopia is not on track to achieve MDG 1 with the current rate of decline. Major investments in child health in Ethiopia have yielded a substantial decline in infant and under five mortality. The neonatal mortality declined slightly and remains very high. It is expected that the country will achieve MDG 4. However, the last drops are tough unless the underlying causes of child mortality are addressed. Undernutrition is one of the main culprits for high child mortality accounting for 32%. For example, ensuring initiation of breastfeeding within 1 hour could cut 22% all neonatal mortality; exclusive breastfeeding for the first six months can cut down about 15% of all child deaths and; adequate complementary feeding could prevent an additional 6 per cent of all such deaths.

Ethiopia has still high maternal mortality rate and nutrition is one contributing factor to maternal death. Thus, it is critical for Ethiopia to address adolescent and maternal undernutrition in order to speed up the decline in maternal mortality.

Realizing the relevance of Nutrition for development and survival of children, Ethiopia prepared and implemented the NNS and its five year NNP for the last three years. This has led to substantial achievements in scaling up nutrition interventions and the policy landscape for nutrition. It has also faced some challenges. The next section describes some of the achievements and challenges and the need for the revision of the NNP.

## 2. Achievement

There have been some achievements in the last five years. To mention some of them:

The policy landscape for nutrition has improved in Ethiopia. The GTP has set stunting reduction as one of the goals for 2015. The FMOH in collaboration with partners has shown its commitment to reduce stunting at faster rate by developing the Accelerated Stunting Reduction Initiative. The prime minister signed the commitment for food and nutrition security at the G8 meeting in 2012.

Nutrition programs have been scaled up to reach more children and women. In terms of program implementation, nutrition is one of package of the HEP and integrated into IRT; 11 million children under five years old receive vitamin A supplementation and de-worming; Community Based direct Nutrition interventions scaled up to more than 500 woredas with a support of partners; CMAM has been scaled up and decentralized to more than 10,000 health posts and health centers; Salt iodization started and salt Iodization legislation approved; Zinc supplementation for diarrhea integrated into HEP ICCM; and nutrition and HIV scaled up to 400 health facilities. A number of system strengthening activities has been conducted too such as EOS transition into CHD and routine HEP has started; Human capacity for nutrition has been created through in-service and pre-service capacity building including operational research.

The interest of donors to support nutrition programs has increased. In the last five years alone, five big donors have funded NNP increasing the funding with a total budget of 150 million USD.

The nutritional status of the children and women and programmatic performances has improved in the last five years. Table 1 summarizes the main findings.

*Table 1. Summary of Nutritional status of children, women including programmatic performance 2005-2011*

<b>Indicator</b>	<b>Source</b>	<b>Frequency</b>	<b>2005</b>	<b>2010/11</b>
<b>Children &lt; 5 years underweight</b>	EDHS	Every 5 years	38%	29%
<b>Children &lt; 5 years stunted</b>	EDHS	Every 5 years	52%	44%
<b>Children &lt; 5 years wasted</b>	EDHS	Every 5 years	12%	9%
<b>Low birth weight (LBW) newborns</b>	EDHS	Every 5 years	14%	11%
<b>Prevalence of anaemia in women</b>	EDHS	Every 5 years	27%	17%
<b>Institutions managing SAM at health facility and health post</b>	HMIS	Monthly	HP (-) HC (20%)	HP (52%) HC (59%)
<b>Severe acute malnutrition treatment</b>	HMIS	Monthly	---	---
<b>Initial breastfeeding (outcome)</b>	EDHS	Every 5 years	69%	---
<b>Exclusive breastfeeding under 6 months (outcome)</b>	EDHS	Every 5 years	49%	52%
<b>Children 6-9 months receiving complementary food and continued breastfeeding (outcome)</b>	EDHS	Every 5 years	44%	51%

<b>Children aged 6-59 months who received two doses of Vitamin A supplementation (outcome)</b>	Admin Report	Annually	94%	88%
<b>Iodization of household salt (outcome)</b>	EDHS	Every 5 years	4%	20%
<b>Children aged 2-5 years de-wormed (outcome)</b>	Admin Report	Annually	86%	---
<b>Pregnant women supplemented with Iron during pregnancy (outcome)</b>	HMIS	Annually	10%	---

### 3. Challenges

Nutritional concerns are not adequately reflected in the policies and programmes of other sectors especially agriculture, PSNP, Social protection, Water sector. Thus, their potential to improve nutrition has not been utilized.

The existing high level ministerial intersectoral coordination mechanism at national level is inadequate and non-existent at the regional level. It has been difficult to create an operational and effective linkage with relevant sectors at all levels.

Breaking the intergenerational cycle of malnutrition by designing a Nutrition Programme for Adolescent Girls and women has been a challenge. The Accelerated Stunting Reduction Initiative is an answer to this challenge which wasn't addressed well in the existing NNP.

Iron and Folic Acid Supplementation for adolescent girls, pregnant women and lactating mothers is inadequate. Until recently Food Fortification programmes are not given attention despite it is the most sustainable way of dealing with micronutrient interventions.

There is no Comprehensive Nutrition Information System despite several efforts to have one.

### 4. Why the revision of National Nutrition Programme (NNP)

1. It is to incorporate new initiatives or approaches adopted by Ethiopia. The country developed Accelerated Stunting Reduction Strategy in 2010 to focus on stunting rather than underweight and targeting adolescents and first 1000 days to speed up the reduction of stunting, which is one of the highest in Africa.
2. The targets set by the existing NNP were conservative and not enough to achieve the MDG.
3. The NNP hasn't articulated well the roles and responsibility of other sectors to contribute to nutrition and the concrete plan of action for linkages among the sectors.
4. It is to align the NNP period which is 2008-2013 with HSDP IV and MDG period of 2010-2015 so that it is part of the bigger health system/ national and global plan of actions and targets.

## II. NNP Strategic Objectives and Interventions

### Strategic Objective 1: Improve the nutritional status of women (15-49 years) and adolescents (10-19 years)

#### Indicators:

The targets by 2015 include:

- Reduce the proportion of adolescents aged 15-19 years with BMI <18.5 from 36% to 25%
- Reduce the prevalence of anemia in adolescents aged 15-19 years from 13% to 8%
- Indicators for PLW

#### Result 1.1 Nutritional Status of Adolescents Improved

Efforts to improve adolescent nutrition are needed, especially to control anemia in adolescent girls. The NNP recognizes that it is far easier to reduce anemia before than it is during pregnancy. The use of weekly doses of iron is ideally suited to distribution through schools for example<sup>1</sup>. The NNP never carried out such activities, hence such an approach should be gradually developed in a few selected schools/ woredas, and experience created in how to do this. Such an approach should also be attempted by linking with the Ministry of Education and including nutrition/stunting issues into the school curriculum with adolescent anemia control activities as part of a school health and nutrition strategy. In addition efforts should also be directed towards developing community based Adolescent Girls Clubs linking them to the CBN and AEW/ HEW networks, in order to help with the early detection of teenage pregnancies in communities, as well as educating them with improved life skills for HIV/AIDS prevention as well as teenage pregnancy prevention.

Teenage pregnancy is also likely to be an important cause of stunting in Ethiopia. Although delaying the age of first pregnancy is not one of the LNS interventions, it is well recognized that the size and body composition of the mother at the start of pregnancy is one of the strongest influences on fetal growth<sup>2</sup>. The size of the mother in Ethiopia is heavily influenced by the mother's age, since the median age of marriage was 16.5 years and around 34% of mothers had at least one child during their adolescence in the 2010/11 DHS. Furthermore height of 5.6% of adolescents (15-19 year) was less than 145 cm compared to 2.2% amongst the 20-29 years age group, and more of the adolescent mothers were thin (36%) than in the women 20-29 years age group (20.8%). This means that the mothers below 20 years of age are still growing in Ethiopia. It has been shown in adolescents mothers in USA that were still growing during pregnancy that there is a maternal foetal competition for nutrients and birth weight is smaller by some 200g<sup>3</sup>.

#### Interventions - Adolescents

1. Establish a system to provide a comprehensive and routine nutrition assessment and counseling services for adolescents at community, school<sup>4</sup> and health facility level.

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<sup>1</sup>WHO 2009. Weekly iron-folic acid supplementation (WIFS) in women of reproductive age: its role in promoting optimal maternal and child health. Position statement. ([http://www.who.int/nutrition/publications/micronutrients/weekly\\_iron\\_folicacid.pdf](http://www.who.int/nutrition/publications/micronutrients/weekly_iron_folicacid.pdf), accessed [18 03 2011])

<sup>2</sup> Kramer, M/S. (1987). Determinants of low birth weight: methodological assessment and meta-analysis. Bulletin of the World Health Organization. 65: 663-737.

<sup>3</sup> Scholl TO, Hediger ML, Bendich A, Schall JI, Smith WK, Krueger PM, Use of multivitamin/ mineral prenatal supplements: Influence on the outcome of pregnancy. Am J Epidemiol 1997;146:134-41.

<sup>4</sup>Ethiopia's School Health and Nutrition Strategies, 2012.

2. Develop key action oriented nutrition behavior change communication messages for adolescents especially for girls and promote and demonstrate these messages through different communication channels, community and facility contact points
3. Ensure adolescents access to micronutrient services:
  - 1.1 Provide routine iron folic acid or multiple micronutrient supplementation for adolescent girls
  - 1.2 Promote the use of iodized salt
  - 1.3 Provide school based biannual de-worming
4. Ensure access to reproductive health services for boys and girls
  - 4.1. Delaying early marriage and early pregnancy,
  - 4.2. Family planning,
  - 4.3. Prevent harmful traditional practices
5. Ensure access and utilization of WASH practices at household, community and schools
6. Conduct regular monitoring of nutritional status of school-age children/student
7. Promote school gardening
8. Promote girls education
9. Promote economic empowerment for out of school adolescents<sup>5</sup> through .....

## **Result 1.2 Nutritional Status of Women Improved**

The influence of maternal nutritional status on pregnancy outcomes seems as important in early as it is in late pregnancy<sup>6</sup>, and the risk of delivering a low birth weight baby seems to be determined very early in pregnancy<sup>7</sup>. Growth in early pregnancy is especially important for length growth, as food supplementation trials in Guatemala showed that the amount of newborn length associated with each kilo of weight gain during pregnancy was ten times greater in the second trimester (0.24cm) than in the third (0.02cm)<sup>8</sup>. This is because foetal length growth velocity peaks at around week 20 and any nutritional insult during this time of rapid cell division phase of growth will have maximum long term impact, either by reducing the number of cells being formed and/or damaging them causing malformations and /or still births<sup>9</sup>. In addition, Evidence from Asia<sup>10</sup>, from rural India<sup>11</sup>, from Indonesia<sup>12</sup> and from refugee camps in Nepal<sup>13</sup> suggest that consumption of micronutrient-rich foods (milk, green leafy vegetables and fruits, parboiled rice, iodized salt) during early pregnancy is associated with increased birth weight and weight for age in young children. For this purpose, the following interventions are included in the revised NNP.

### **Interventions for Pregnant and Lactating Women [PLW]**

1. Establish a system to provide a comprehensive and routine nutrition assessment, counseling and support services
  - 1.1 Pregnancy weight gain monitoring

<sup>5</sup> Ethiopia's Social Protection Policy, 2012

<sup>6</sup> Neufeld LM, Haas JD, Grajeda R, Martorell R. 2004 Changes in maternal weight from the first to second trimester of pregnancy are associated with fetal growth and infant length at birth. *Am J Clin Nutr.* 79(4):646-52.

<sup>7</sup>Smith GCS, Stenhouse EJ, Crossley JA, Aitken DA, Cameron AD, Connort JM. Early-pregnancy origins of low birth weight. *Nature* 2002;417:916.

<sup>8</sup>Ruowei, L., Haas, J.D., Habicht, J-P. 1998. Timing of the influence of maternal nutritional status during pregnancy on fetal growth. *Am J Hum Biol.* 10:529-539.

<sup>9</sup> Tanner JM. 1978. *Foetus into Man: Physical growth from conception to maturity.* London: Open Books Publishing Ltd.

<sup>10</sup> Mason JB, Deitchler M, Gilman A, Gillenwater K, Shuaib M, Hotchkiss D, Mason K, Mock N, Sethuraman K. 2002 Iodine fortification is related to increased weight-for-age and birthweight in children in Asia. *Food Nutr Bull.* 23:292-308

<sup>11</sup>Rao S, Yajnik CS, Kanade A, Fall CH, Margetts BM, Jackson AA, Shier R, Joshi S, Rege S, Lubree H, Desai B. Intake of micronutrient-rich foods in rural Indian mothers is associated with the size of their babies at birth: Pune Maternal Nutrition Study. *J Nutr* 2001;131:1217-24.

<sup>12</sup>Semba R, de Pee S, Hess SY, Sun K, Sari M and Bloem M. 2008. Child malnutrition and mortality among families not utilizing adequately iodized salt in Indonesia. *Am J Clin Nutr.* 87(2):438-44.

<sup>13</sup>Shrimpton R, Thorne-Lyman A, Tripp K, and Tomkins A 2009. Trends in low birthweight among the Bhutanese refugee population in Nepal. *Food and Nutrition Bulletin* 30 (2) S197-206.

- 1.2 Promote maternal nutrition including adequate food intake, utilization of diversified food and day time rest during ante-natal and post-natal period
- 1.3 Provision of supplementary food to malnourished pregnant and lactating women
- 1.4 Ensure early identification and treatment of acute malnutrition amongst PLWs
2. Ensure PLWs access to micronutrient services:
  - 2.1 Provide routine iron folic acid or multiple micronutrient supplementation
  - 2.2 Promote the use of iodized salt
  - 2.3 De-worming during 2<sup>nd</sup> and 3<sup>rd</sup> trimester of pregnancy
3. Develop key action-oriented nutrition SBCC messages to increase the involvement of fathers grandparents and faith based/ traditional community organizations to support PLWs.
4. Ensure free distribution of ITN in all malaria endemic woredas and utilization of the nets by pregnant and lactating women
5. Ensure access and utilization of WASH practices
6. Support involvement of women groups in nutrition sensitive agriculture and livelihood programs
7. Promote gender equality to improve nutritional wellbeing of mothers
8. Ensure access to time and labour saving technologies

### **Interventions for Non – Pregnant and Non – Lactating Women**

Promote use of family planning methods to allow building reserves before another pregnancy with aim of reducing/ preventing low birth weight, anaemia and stunting amongst non-pregnant and lactating women. This will be supported by multiple micronutrient supplementations in order to prevent/ reduce mainly anemia, as well as other micronutrient deficiencies plus low birth weight and maternal mortality. The ultimate impact of these interventions is to reduce stunting occurring before and during early pregnancy which accounts for 50% of all stunting.

1. Ensure access to micronutrient services:
  - 1.1 Promote the use of iodized salt
  - 1.2 Provide iron folic acid or multiple micronutrient supplementation
2. Promote women nutrition including adequate food intake and utilization of diversified food
3. Ensure access to reproductive health services (birth spacing)
4. Promote male engagement in reproductive health services
5. Develop key action oriented nutrition social and behavior change communication (SBCC) messages to increase the involvement of fathers’ grandparents and faith based/ traditional community organizations to support women of reproductive age.

### **Strategic Objective 2: Improve the nutritional status of infants (0-6 months), young children (6-24 months) and children under 5 years; with emphasis on the first two years of life.**

#### **Indicators:**

The targets by 2015 include:

- Increase the proportion of infants 0-6 months exclusively breast fed from 52 % to 70%;
- Increase the proportion of breastfed children age 6-23 months who are given foods from four or more groups and also are fed at least the minimum number of times per day from 4% to 30%.
- Bitots spot or night blindness ???



- Reduce the percentage of children 6-12 years with median urinary Iodine concentration < 100 µg/l to below 50% and no more than 20% of values are below 50 µg/l<sup>14</sup>
- Reduce the prevalence of anemia in children 6-59 months from 44% to 25 %
- Zinc in the treatment of diarrhoea

## **Result 2.1: Improved nutritional status of children 0-24 month olds**

Poor infant and young child feeding practices are also likely to be causing stunting in Ethiopia. The LNS package of interventions includes the promotion of exclusive breastfeeding until 6 months and the promotion of adequate complementary feeding from 6 to 24 months as proven high impact interventions. In addition zinc supplementation and zinc in the management of diarrhoea, as well as hand washing and hygiene interventions are also recommended. Although exclusive breastfeeding rates are reasonable and need to be protected and further improved in Ethiopia, the complementary feeding pattern is extremely poor both in terms of timing of introduction as well as the quality of the foods used, and zinc deficiency is probably a dominant feature.

Although the breastfeeding practices are already reasonable during the first six months, they could be further improved by strengthening the messages around and continuing to promote the importance of consuming colostrum; not providing pre-lacteal feeds; and maintaining exclusive breastfeeding until 6 months, be it through existing CBN activities and/or through other channels of communication. As the health facilities and extension network expands it will be important to ensure that these establishments are developed in line with the Baby Friendly Hospital Initiative. It would be important to review current training materials for community workers and strengthen their skills for building their support for mothers to breast feed, especially for early initiation and establishment of exclusive breastfeeding.

The local production of foods appropriate for enriching complementary feeding was not included in the NNP, as presumably it was assumed that complementary feeding could be easily improved using local available foods, and if these were not available then they would be provided by the food aid programs linked to the PNSP. There is now a need to develop not only the improved complementary foods but also to link this to the production of such foods locally. Such linkages were envisaged in the previous NNP document (Page 55), but seem to have not been properly or systematically developed, most probably because of problems of coordination at all levels and lack of human resources to make this happen. A proposal exists to develop these linkages from the bottom up, starting in a few selected woreda and developing the models and testing them in a step by step way<sup>15</sup>. Existing NNP documents (2008) and PNSP documents (2009) already provide the policy framework for developing such a multi-sectoral approach. How to focus these linkages on the PNSP pregnant and lactating women and their children under two years has also be described as part of such an approach<sup>16</sup>. The approaches proposed include: working with Development Agents (DA) and Health Extension Workers (HEW) at kebele level to understand local patterns and address key gaps, as well as: supporting women to establish interest groups for production and income generating activities: inclusion of sprinkles for children under two during food or cash transfers. It would seem important to go ahead with these proposals and pilot the development of these linkages. It would seem logical to do this in the same woredas that the improved complementary feeding activities were being developed.

## **Interventions for children 0 – 24 months**

- 1. Promote optimal breastfeeding practices**(early initiation of breastfeeding within one hour; exclusive breastfeeding for the first six months; continued breastfeeding for 2 years, including during illness)

<sup>14</sup> It is proxy indicator for IDD for women too because Ethiopia's school enrollment rate is above 50% and girls enrollment is above 25%.

<sup>15</sup> Fracassi P and Berhanu L 2010. Linkages Report.

<sup>16</sup> Fracassi P 2010. Focused attention on PNSP pregnant and lactating women and their children under two years of age. Concept Note for initial Discussion. May 2010. .

- 1.1. Establish **Baby Friendly community and health facility practices**
- 1.2. Enact & enforce the **Code of Marketing for Breast Milk Substitutes**
- 2. Promotion of appropriate complementary feeding for 6 – 24 month olds**
  - 2.1 Create access to complementary foods.
  - 2.2 Promote and demonstrate utilization of diversified food
  - 2.3 Use micronutrient powder to enrich/fortify complimentary food
  - 2.4 Promote feeding during illness
- 3. Growth monitoring and promotion for children 0-24 months**
- 4. Prevent and control micronutrient deficiencies**
  - 4.1 Promote the production and utilization of micronutrient rich foods
  - 4.2 Identify and treat anemia
  - 4.3 Provide Vitamin A supplementation for children 6-59 months of age
  - 4.4 Promote the utilization of iodized salt at household level
  - 4.5 Provide zinc with ORS for diarrhea treatment
  - 4.6 Provide multiple micronutrient supplements to children between 6-59 months of age
  - 4.7 Ensure production and utilization of micronutrient fortified foods
- 5. Early detection and management of acute malnutrition and common childhood infections**
  - 5.1 Ensure access to quality CMAM services
  - 5.2 Ensure access to quality ICCM/IMNCI services
- 6. Ensure access and utilization of WASH practices**
  - 6.1 Ensure access to clean and safe water
  - 6.2 Promote safe and hygienic preparation and handling of food
  - 6.3 Promote hand washing with soap/ash
  - 6.4 Promote proper disposal of child feces
- 7. Link food insecure households with children under two years of age to social protection services and nutrition sensitive livelihood and economic opportunities.**
  - 7.1 Productive safety net program
  - 7.2 Income generation activities
  - 7.3 Homestead production of vegetable and fruits; small animal rearing

## **Result 2.2: Improved nutritional status of children 24-59 month olds**

### **Interventions for children 24 – 59 months**

- 1. Promotion of appropriate dietary practices**
  - 1.1 Create access to and promote utilization of diversified food
  - 1.2 Promote continued feeding during illness
- 2. Prevent and control micronutrient deficiencies**
  - 2.1 Promote the production and utilization of micronutrient rich foods

- 2.2 Identify and treat anemia
- 2.3 Provide Vitamin A supplementation for children 6-59 months of age
- 2.4 Promote the utilization of iodized salt at household level
- 2.5 Provide de-worming for children between 24 – 59 months
- 2.6 Provide zinc for diarrhea treatment
- 2.7 Provide multiple micronutrient supplements to children between 6-59 months of age
- 2.8 Ensure production and utilization of micronutrient fortified foods

**3. Early detection and management of acute malnutrition and common childhood infections**

- 3.1 Ensure access to quality CMAM services
- 3.2 Ensure access to quality ICCM/IMNCI services

**4. Ensure access and utilization of WASH practices**

- 4.1 Ensure access to clean and safe water
- 4.2 Promote safe and hygienic preparation and handling of food
- 4.3 Promote hand washing with soap/ash
- 4.4 Promote proper disposal of child feces

**Strategic Objective 3: Strengthen implementation of nutrition sensitive interventions in Agriculture, Education, Water sectors**

**Indicators**

- Increase fruit and vegetable production for 1, 200.8 (2009) tone to 5, 905 tons by 2015 to improve food diversification at community level
- Increase number hybrid livestock (milk cows) production and productivity from 140, 428 milk to 537,553 by 2015 to improve dietary diversity at community level

**Interventions:**

- Increase production of fruit, vegetable, nutritious roots and cereal crops to improve food diversification
- Increase number of hybrid livestock to create access to animal source food
- Promote appropriate processing technology for food preparation, processing/preservation /value addition of diversified food
- Support local complementary food production with locally available cereals and legumes and enrich with vegetable and fruits available in the community.
- Promote linkages and nutrition sensitivity with in Productive Safety net Program ( PSNP),Agriculture Growth Program ( AGP) and Household asset building program(HABP)
- Empower women; through income generation activity, homestead agriculture, and business model of local complementary food production
- Promote utilization of diversified food through agricultural extension program
- Support bio diversification of locally produced foods by agricultural research centers

**Result 3.1. :** Increased production, access and utilization diverse nutritious food

**Result 3.2:** Strengthen implementation of nutrition interventions in education sector  
Interventions:

- Establish and promote implementation of school gardening of vegetables and fruits ;
- Promote key nutrition actions through School clubs (youth, girls, environment club, mini media etc.)
- Encourage schools to promote and transfer sustainable and replicable model gardening at community level
- Facilitate and/or implement targeted micronutrient distribution (Iron, , Deworming) at school
- Promote the utilization of Iodized salt at household level;
- Incorporate nutrition in to school curricula at all levels (1st cycle, 2nd cycle, high school, and higher institutions)
- Build the capacity of teachers/ PTA on Nutrition security
- Support higher institutions to conduct nutrition sensitive operational research

**Result 3.3:** Improve nutrition in to water sector

**Interventions:**

- Ensure access to adequate, safe and clean water
- Support irrigation and multiple use services of water for production of fruit, vegetable, nutritious roots and cereal crops to improve food diversification

**Result 3.4:** Promote social protection interventions for improved nutrition of vulnerable children and women.

**Interventions:**

- Expand predictable social transfers (conditional and non-conditional) and protect vulnerable groups from falling in to extreme poverty, food insecurity and malnutrition ;
- Promote public works programme to enhance community assets;
- Expand credits, grants and other facilities and support to generate income and promote market linkages.
- Expand and standardise fee-waiver schemes such as free service for Management of acute malnutrition,
- Expand and standardize conditional transfers of basic services for the vulnerable group;
- Advocate for and promote school feeding programmes.

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**Strategic Objective 4:** Protect households from the impact of shocks and other vulnerabilities that affect their nutritional status.

**Result 4.1: Ensure nutrition is integrated in the National Emergency preparedness and response plans. (need more information ?????)**

## Interventions:

- Strengthen and scale up early warning systems on food and nutrition information from the community to the national level.
- Integrate nutrition in all disaster preparedness, response and recovery plans.
- Support sensitization programmes for communities to raise their awareness of prevention, mitigation, and response to risks of malnutrition during shocks.

## Result 4.2: Support nutrition emergency response and recovery programs

### Interventions:

- Develop, promote, and implement in a timely fashion a comprehensive package of nutrition services and food items to provide during emergencies and recovery periods.
- Ensure early detection and management of acute malnutrition
- Integrate IYCF in emergency response interventions
- Promote and support diversified production of drought-resistant crops, including vegetables, and
- Promote raising of animals tolerant to water shortage/drought

## III. Nutrition Governance

### 1. Legal and Policy Framework

Nutrition Specific Policies		
Policy	Body	Date
National Nutrition Strategy	Federal Ministry of Health	2008
National Nutrition Program	Federal Ministry of Health	2008 (being updated)
National Strategy for IYCF	Federal Ministry of Health	2007
Management of SAM	Federal Ministry of Health	2007
Management of MAM	Federal Ministry of Health	2011
Micronutrient Guideline	Federal Ministry of Health	2006
Nutritional support for PLWHA	Federal Ministry of Health	2011

Nutrition Sensitive Policies		
Policy	Body	Date
<b>Agriculture and Food Security</b>		
Agriculture Growth Program	Federal Ministry of Agriculture	2010
Agricultural Development Led Industrialization (ALDI) Strategy	Federal Government	2007
Food Security Strategy	Federal Ministry of Agriculture	2007
<b>Poverty Reduction and Development</b>		
Growth and Transformation Plan	Federal Government	2010
Plan for Accelerated and Sustained Development to End Poverty (PASDEP)	Federal Government	2007
UN Development Assistance Framework for Ethiopia (UNDAF)	United Nations System in Ethiopia	2012-2015
<b>Public Health</b>		
WASH Strategy	Federal Ministry of Water and Energy	2011-2016
Health Sector Development Plan	Federal Ministry of Health	2010

Health Extension Program	Federal Ministry of Health	2005
Reproductive Health Strategy	Federal Ministry of Health	2011
National Strategy for Child Survival	Federal Ministry of Health	2005
<b>Education</b>		
School Health Nutrition Strategy	Federal Ministry of Education	2012
<b>Social Protection</b>		
National Social Protection Policy (tabled)	Ministry of Labour and Social Affairs	2012

<b>Nutrition Relevant Laws</b>		
<b>Law</b>		<b>Date</b>
Maternity Protection Law (90 days)		
Implementation Code of the Marketing of BMS: final decision level		2012
Salt Iodization Regulation		2011
Status of flour fortification in wheat: planning		
Status of oil fortification: planning		

## 2. Multi-sectoral Coordination for Nutrition

At present, because of many stakeholders are involved, nutrition strategies and programmes are often planned and implemented by separate sectors and institutions- and the multi-sectoral nutrition coordination and linkage are the main business of none. Appropriate and coordinated nutrition action enables the creation of a healthy and productive labour force, which is vital to ensuring rapid social and economic development. Guaranteeing food security, proper child and mother care proactive, provision of adequate health services as well as maintaining appropriate hygiene and sanitary conditions are essential to optimal nutrition. These wide-ranging activities therefore involve a number of sectors, underlining the importance of coherent and coordinated actions among relevant sectors and institutions to improve the status of nutrition.

The FMOH is mandated, to house and manage the organizational and management structure of NNP. However, in order to have viable linkages and harmonization amongst the relevant sectors, the NNP implementation and coordination framework has a multi-sectoral implementation and coordination arrangements at policy and implementation level. Thus, the NNP proposed a four-tiered coordination mechanism that is in line with the decentralized administrative structure of the government; and considers the considerable support of the partners and Academia.

A National Nutrition Coordination body (NNCB) and National Nutrition Technical Committee (NNTC) have been established at the Federal level to ensure effective coordination and linkages at the national level. However, the implementation of these activities were not strong as per the outline in the NNP due to the change of structure in the MOH as NNP was designed based on the former government structure (MOH) at federal level. The regional, woreda and lower level coordination mechanisms were also similarly affected by this restructuring and NNP familiarization was not given due attention at lower level. Hence, this NNP revision is required to comprehensively address the lesson learnt during the last four years implementation and NNP extension.

### Objective

The overall multi-sectoral coordination for NNP implementation is designed to achieve the following objectives

#### General objective:

- To strengthen, develop and harmonize the multi-sectoral response for nutrition to fully address causes of malnutrition.

**Specific objectives:**

- To facilitate and strengthening the multi-sectoral nutrition coordination at all levels
- To provide guidance for the NNP implementation at all levels
- To enhance the political commitment and will on nutrition and make nutrition priority agenda at all levels in all implementing sectors
- To harmonize the multi-sectoral response for nutrition
- To facilitate and support resource mobilization and efficient utilization
- -To monitor and evaluate the progress of the NNP implementation at different level

**3. Multi-sectoral Nutrition Linkages**

The “Linkages” component of the NNP is designed to strengthen the linkages of nutrition to other sectors which affect the underlying and basic causes of malnutrition and, in turn, enhance the nutritional impact of programmatic activity in these sectors. Ethiopia already has well defined policies and strategies and implementation activities in these related sectors affecting nutrition and which lend themselves to cooperative nutrition linkages likely to benefit both sets of undertakings. Among these the most notable ones are: the Growth and Transformation Plan [GOE], National Food Security Strategy Agriculture Growth Program and Agriculture Extension Program [MOA], the National Health Sector Policy/ Strategy and its HSDP [MOH], the National Education Strategy and its ESDP [MOE], and the National Universal Access to Potable water (UAP) program [MOW&E]. Given that the government and donors already have mobilized human and financial resources in these programs, NNP’s responsibility vis-a-vis these sectors is to develop viable linkage activities with them.

The purpose of the NNP is to make sure that implementation of the NNP move in a harmonized way at all levels, and particularly at the woreda, kebele and community levels. The aim is to identify key linkage activities between nutrition specific managed by the FMOH and nutrition sensitive programs in other sectors so that they are mutually supportive. Some of these linkages activities will be introduced along with Health Extension and CBN/CMAM programs. While there are many valuable linkage possibilities, the NNP has decided to concentrate on the following listed sectors/projects below with the activities planned:

**Objective:**

- To identify key linkage activities between nutrition specific, managed by the FMOH, and nutrition sensitive programs in other sectors so that they are mutually supportive.

**4. Gender Dimensions of Nutrition**

Improvements in the nutritional status of women and girls will contribute to reducing gender inequality while at the same time, breaking the cycle of impact on intergenerational malnutrition. Gender empowerment is an essential part of human development and for improvements in nutrition across the entire life cycle (Oniango 2002). In unequal conditions, women and girls have poorer nutrition outcomes throughout the life cycle, higher rates of mortality, less access to health care, and greater household food insecurity (UNSCN 2004). Maternal mortality and malnutrition has been correlated with low value of gender development index and female to male literacy ratios (UNSCN 2004) and studies have shown that improvements in education of women specifically have contributed to a reduction in child malnutrition of more than 50% from 1970 to 1995 (Smith and Haddad, 2000). Furthermore, women's decision-making power relative to men's has been significantly associated with improved nutritional status in their children (Smith et al 2003).

Teenage pregnancy is also likely to be an important cause of stunting in Ethiopia. Although delaying the age of first pregnancy is not one of the LNS interventions, it is well recognized that the size and body composition of the mother at the start of pregnancy is one of the strongest influences on fetal growth. The size of the mother in

Ethiopia is heavily influenced by the mother's age, since the mean age of marriage was 16y and around 40% of mothers had at least one child during their adolescence in the 2005 DHS (NEED TO UPDATE WITH DHS 2011). Furthermore the mean height of the 15-19 year old group of mothers was 1.3cm shorter than the 20-29 years age group, and more of the adolescent mothers were thin (32.5%) than in the women 20-29 years age group (20.8%). This means that the mothers below 20 years of age are still growing in Ethiopia. It has been shown in adolescents mothers in USA that were still growing during pregnancy that there is a maternal foetal competition for nutrients and birth weight is smaller by some 200g (Shrimpton et al 2012).

By improving newborn birth weights, child growth faltering can be reduced in the first two years of life, and into adulthood. Improved cognitive function and intellectual development are associated with an increase in birth weight and reduction in stunting. The negative effects of lower birth weight on intellectual development are accentuated in lower socioeconomic groups, and can be mitigated by improved nutrition, health care and home environments (UNSCN 2011).

The associations between low birth weight and age at marriage are most likely influenced by confounding factors such as poverty, health environment, or women's education. This does however imply that longer term determinants of malnutrition which include addressing gender empowerment need to be addressed. This includes keeping girls in school and implementing laws to prevent under-age marriage. Postponements of first pregnancies until an adolescent girl or young woman is fully matured have significant benefits for the health of both mother and child. Indeed, this could be a crucial factor in breaking the intergenerational cycle of malnutrition, and accelerating the progress towards the normal growth and development (UNSCN 2011).

## **5. Nutrition Communication, Advocacy and Social Mobilization**

The role of nutrition in personal, family, social as well as national development is recognized much more in recent years. It is clear that malnutrition can take its toll not only on national health systems but also on the economic, social and political structures of nations. Investing and promoting nutrition security promotes productivity, economic growth, better education and human potential for the now, and for future generations. In order to ensure consistency and well concerted nutrition communication actions among different stakeholders and sectors such as health, education, water and agriculture, a well-designed national nutrition communication strategy is crucial. This national nutrition communication strategy shall fill the gaps, harmonize and strengthen existing nutrition communication activities, and shall serve as a guide for the integration and reinforcement of broader nutrition communication programmes. Thus, there is a need to have a harmonized national nutrition communication strategy to offer high quality standard approach to producing communication materials as well as creating shared objectives and goals for organizations using communication methods in their respective programs.

In the country there are different IYCF communication materials developed by partners. Most of the available IYCF materials developed by different partners, there have been a great lack of coordination among the nutrition communication materials producers. Moreover, there are few nutrition communication materials produced to impact knowledge, attitude and practice on adolescent and women nutrition. The IYCF related nutrition communication activities were fragmented and uncoordinated due to being implemented by different stakeholders, which led to inefficient and ineffective programme delivery as well as poor results even though there has been progress in awareness creation for better nutritional status. Most of the efforts were not planned on a sustainable basis.

In effect, priority social and behavioral change communication strategies and methods on nutrition communication will be identified and systematically incorporated into the communications systems functioning in the health, education, agriculture and in other sectors. The support of media, particularly radio will be enlisted to permit localized interactive programming at the community level while the behavioral change skills of front line workers (HEWs, teachers, DA's, and Development Army) will be strengthened in relation to the priority nutrition messages being disseminated.



The national nutrition communication strategy aimed at changing social conditions and individual behaviors. It operates through three key strategies, namely: advocacy, social mobilization and social & behavior change communication.

**General Objective:** To improve the nutritional well being of the country through strong nutrition communication, social mobilization and advocacy

**Specific objectives:**

- 1) To generate multi-sectoral ownership of the country's nutrition agenda by multiple government sectors, stakeholders and the public at large
- 2) To design the highest priority nutrition messages and incorporates these messages systematically into the communication channels and materials of the health, agriculture, education and other sectors.
- 3) To increase awareness of the community on optimal nutrition behaviour and practices
- 4) To strengthen the capacity of service providers to improve nutrition of children, adolescents and women, and to complement these efforts with SBCC messages in other media.

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