Ethiopia National Nutrition Strategy

Review and Analysis of Progress and Gaps: One Year On

May 2009
Acronyms

Executive Summary

**Chapter 1**
1. Introduction
2. Background
   2.1. Nutrition and government policies
   2.2. The National Nutrition Strategy/Program
3. Objectives of the review
4. Methodology

**Chapter 2**
1. Implementation status of the National Nutrition Strategy/Program
   1.1. Preparatory work and complementary activities
      1.1.1. Development and approval of National Nutrition Strategy/Program
      1.1.2. Dissemination of the National Nutrition Strategy/Program
      1.1.3. Universal Salt Iodization
      1.1.4. Code of Marketing of Breast Milk Substitutes
      1.1.5. Micronutrient Guidelines
   1.2. Service Delivery
      1.2.1. The Health Extension Program
      1.2.2. Transition of Essential Outreach Services to the Health Extension Program
      1.2.3. Health Facility Nutrition Services
      1.2.4. Community Based Nutrition
      1.2.5. Micronutrient Interventions
   1.3. Institutional Arrangement
2. Nutrition and sector management process
3. Human Resource Development and Capacity Building
4. Research
5. Role of NGOs

**Chapter 3**
Financing the National Nutrition Strategy/Program
   1.1. Funding Requirements
   1.2. Government Commitment Allocation and Expenditure
   1.3. Commitment Allocation and Expenditure by Partners

**Chapter 4**
Conclusions and Recommendations

References
Annexes: List of interviewees
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>BFHI</td>
<td>Baby Friendly Hospital Initiative</td>
</tr>
<tr>
<td>CBN</td>
<td>Community Based Nutrition</td>
</tr>
<tr>
<td>CHD</td>
<td>Community Health Day</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
</tr>
<tr>
<td>EHNRI</td>
<td>Ethiopian Health and Nutrition Research Institute</td>
</tr>
<tr>
<td>ENA</td>
<td>Essential Nutrition Actions</td>
</tr>
<tr>
<td>EOS</td>
<td>Enhanced Outreach Strategy</td>
</tr>
<tr>
<td>ESHE</td>
<td>Essential Services for Health in Ethiopia</td>
</tr>
<tr>
<td>FMOH</td>
<td>Federal Ministry of Health</td>
</tr>
<tr>
<td>GMP</td>
<td>Growth Monitoring and Promotion</td>
</tr>
<tr>
<td>GoE</td>
<td>Government of Ethiopia</td>
</tr>
<tr>
<td>HAPCO</td>
<td>HIV/AIDS Prevention and Control Office</td>
</tr>
<tr>
<td>HEP</td>
<td>Health Extension Program</td>
</tr>
<tr>
<td>HEW</td>
<td>Health Extension Worker</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information Systems</td>
</tr>
<tr>
<td>HS DP</td>
<td>Health Sector Development Program</td>
</tr>
<tr>
<td>IDA</td>
<td>Iron Deficiency Anemia</td>
</tr>
<tr>
<td>IDD</td>
<td>Iodine Deficiency Disorders</td>
</tr>
<tr>
<td>IFPRI</td>
<td>International Food Policy Research Institute</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Diseases</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>JICA</td>
<td>Japanese International Cooperation Agency</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MI</td>
<td>Micronutrient Initiative</td>
</tr>
<tr>
<td>MOARD</td>
<td>Ministry of Agriculture and Rural Development</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non government organizations</td>
</tr>
<tr>
<td>NNC</td>
<td>National Nutrition Coordination Committee</td>
</tr>
<tr>
<td>NNP</td>
<td>National Nutrition Program</td>
</tr>
<tr>
<td>NNS</td>
<td>National Nutrition Strategy</td>
</tr>
<tr>
<td>OTP</td>
<td>Outpatient Therapeutic Feeding</td>
</tr>
<tr>
<td>RHB</td>
<td>Regional Health Bureau</td>
</tr>
<tr>
<td>RUTF</td>
<td>Ready to Use Therapeutic Food</td>
</tr>
<tr>
<td>SAM</td>
<td>Severe Acute Malnutrition</td>
</tr>
<tr>
<td>SDPRP</td>
<td>Sustainable Development and Poverty Reduction Program</td>
</tr>
<tr>
<td>TFU</td>
<td>Therapeutic Feeding Unit</td>
</tr>
<tr>
<td>TSF</td>
<td>Targeted Supplementary Feeding</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>USI</td>
<td>Universal Salt Iodization</td>
</tr>
<tr>
<td>VAD</td>
<td>Vitamin A Deficiency</td>
</tr>
<tr>
<td>VCHW</td>
<td>Voluntary Community Health Worker</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Program</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Ethiopia has the highest rates of malnutrition in Sub-Saharan Africa. The prevalence of malnutrition imposes significant costs on the Ethiopian economy as well as society. The high mortality due to malnutrition leads to the loss of the economic potential of the child. Until recently, the broad multi-sectoral factors contributing to malnutrition had been insufficiently emphasized, with the focus placed on addressing food security as the primary means to address nutritional insecurity. To address these, the National Nutrition Strategy (NNS) was formulated and launched in 2008. A year has passed since the launching of the NNS.

This study was commissioned by Save the Children UK to review the implementation of the NNS one year after its launch and was carried out between February and May 2009. The scope of work entailed analyzing the level of performance of the various components of NNS; its overall funding landscape including government commitment and level of interest by donors to finance the strategy; reviewing the institutional arrangement; and identifying implementation challenges, barriers and opportunities.

Progress in Implementing the National Nutrition Strategy
Preparatory activities and complementary measures
There was significant progress in implementing the NNS in its first year. The National Nutrition Program (NNP), that translates the strategies of the National Nutrition Strategy into program actions, has been developed, approved and launched. However, stakeholder participation was lower than during the launch of the NNS. Development partners were engaged during the development of the strategy, and to some degree in development of the program document, though the level of participation reported on, was not satisfactory. Furthermore, the momentum in the implementation of the NNP has been slow.

Two dissemination workshops, one for Regional Health Bureaus and the other one for non-health sector, have been carried out. The NNS was also presented to the Health and Population donor group. The RHBS developed a dissemination action plan; however poor follow up by the Federal Ministry of Health and consequent poor cascading to lower levels have been identified. Furthermore dissemination has been targeted mainly at governmental agencies but not development and implementing partners.

Iodization of salt in Afdera was launched to achieve Universal Salt Iodization. Laboratory technicians and machine operators were trained and production of iodized salt has started. The legislation on salt iodization has been drafted and a round of consultation carried out with stakeholders. The legislation is in the final stage of processing by the legal department of the FMOH and is expected to be launched in 2010. As an interim intervention, iodine oil capsules were distributed to 1.2 million under five year old children and 300,000 pregnant and lactating mothers with support from UNICEF, USAID, the Japanese government, and the Micronutrient Initiative.
A draft Code of the Marketing of Breast Milk Substitute, envisioned to form a legal framework, was prepared and is being processed with a plan to finalize it by 2010. Micronutrient Guidelines were revised and one round of consultation carried out with stakeholders. The final draft is under preparation. Resources have been secured for the procurement of iron-folate tablets. The plan is to scale up the supplementation for pregnant women, through the Community Based Nutrition program with the objective of increasing the proportion of pregnant women receiving iron/folate supplementation from 10% to 50% by 2013.

Service delivery
The Health Extension Program has shown very encouraging results and will remain the main vehicle for community action including community based nutrition programs for the coming years. The government has now put in all sedentary rural areas a Health Extension Program to reach every family in every Kebele for various preventive and health promotion services, including nutrition. All the Health Extension Workers (HEW) have been recruited and the government is working towards creating universal access in urban and pastoral areas. There has been significant progress in the training of the HEW’s since 2003. All 30,000 HEWs were trained and deployed by March 2009, with two HEW’s for each rural Kebele. However, the quality and effectiveness of the training needs to be reviewed and the NNP has clearly put this as one of its core activity in the coming years. The curriculum of the training institutions is being reviewed and Training Needs Assessment on front line workers is being carried out. It is necessary to ensure the HEWs and Voluntary Community Health Workers receive quality training on Community Based Nutrition before the initiation of the Community Based Nutrition Program.

Enhanced Outreach Strategy (EOS)/Targeted Supplementary Food (TSF) and the transition to Community Health Days
The outcome of the EOS/TSF has been promising as an interim strategy to addresses the acute nutritional needs of children and pregnant and lactating women in chronically food-insecure areas. Through EOS/TSF seven million children and 1.5 million pregnant and lactating women are screened for malnutrition every six months and if needed, are referred to the TSF and Therapeutic Feeding Program. It is reported that 1200 Therapeutic Feeding Units and Outpatient Treatment Program sites are providing service in 315 Woredas. The capacity for management of severe acute malnutrition increased from almost nil in 2003 to over 90,000 severely malnourished patients every month.

The major achievement of these efforts under the Health Sector Development Program III was over 90% coverage of vitamin A supplementation and de-worming coverage, compared to less than 60% in 1998. The coverage increased to 94% and 99% respectively during 2008/2009. The initiative to move from campaign mode of delivering Vitamin A, de-worming and nutrition screening through EOS, to locally organized Community Health Days was piloted in 39 Woredas and supported by UNICEF. Five hundred and sixty Woredas have either started or will soon start, implementing preventive community based nutrition activities. However, the transition period needs to be backed up with evidence based learning from the current operating Woredas. Experience from other similar programs showed that one should
demonstrate caution in implementing these types of strategies, as it led to declined program achievements in Kenya. The Health Ministry and the Micronutrient Initiative are planning to outsource a study that will chart out the modalities ensuring a smooth transition that will maintain a high coverage.

**Health Facility Nutrition Services**

One of the Nutrition Program’s objectives is to put in place Therapeutic Feeding Program services in 50% of the health centers and hospitals. The number of Therapeutic Feeding Program sites, both Therapeutic Feeding Units and Outpatient Treatment Program sites, increased from nearly 400 in 2007 to 1200 by October 2008. The other major achievement in the management of acute malnutrition in children is the decentralization of management of severe cases. This has been delegated to community level as the Outpatient Treatment Program which will increase coverage, and thereby improve access. The national capacity for management of severe acute malnutrition has increased from nearly nil in 2003 to over 90,000 severely malnourished patients every month to date. Ethiopia is importing and producing Ready-to-Use-Therapeutic-Food adequate enough when there is no emergency.

**Community Based Nutrition**

One of the interventions still high in terms of priority in the Nutrition Strategy and Program is the Community Based Nutrition which addresses the high level of chronic malnutrition. In the Nutrition Program, the aim is to cover the 560 rural Woredas with the community based nutrition project by 2013. Currently, about 103 Woredas (14% of all Woredas) have either started to implement or have secured funding to implement this activity and hence gaps remain in rolling out this strategy to the remaining Woredas. However the main challenge to the nutrition partners has been scaling up the comprehensive community based approach to nationwide scale.

**Coordination structure**

The coordination and leadership of the implementation of the national nutrition strategy has been given to the FMOH. The National Nutrition Coordination Body (NNC), the highest policy making organ, was established and is functional while the coordination structures at the regional and Woreda levels are yet to be established. If the multi-sectoral actions are to be fostered and strengthened, the establishment of these coordination structures at lower levels needs to be fast-tracked.

While most of the partners are likely to be members of the technical taskforce, their role in NNC seems very limited given its endorsed composition. Partners are represented in the NNC only by UNICEF. The composition of these structures, however, needs to be informed from the lessons learnt in the coordination of the HSDP, a weakness that prevented smooth functioning.

**Funding**

There is an improved financing landscape for nutrition at present. Excluding government contribution, the total financing requirement for the NNP over the next five years is estimated
to be USD 253 million without Targeted Supplementary Feeding and USD 365 Million with TSF. Of the total expected financing from development partners (365 million with TSF), only about ($71.5 million) or about 20 % of the estimated donor financing requirement) has been mobilized and another 24.8 million (or 7%) is pledged so far. There, however, remains a huge financing gap that needs to be filled. The government contribution is estimated to be USD 96 Million and this cost is mainly related to salary, operational cost and pre-service training of health workers involved in the implementation of NNP. A number of partners, namely the World Bank, UNICEF, CIDA, JICA, WHO and MI have already pledged commitment to cover part of the total requirement. Additional efforts and negotiation are ongoing to bring new partners and additional commitments.

**Commitment of Government and Partners**

One of the measures of commitment of any government for making an issue an agenda is its budget allocation. The resource mapping of November 2007 shows that only three development partners were financing the nutrition in the health sector. All other development partners including the government of Ethiopia did not reflect their commitment and expenditure on nutrition. Therefore, the FMOH and other sectors need to demonstrate real commitment by allocating resource and creating budget line for nutrition.

The World Bank fully supported the institutional strengthening component except the multisectoral linkages and partially supported the Community Based Nutrition and micronutrient intervention. The Japan government funds all Universal Salt Iodization activities. Some of the program activities remained under funded including Targeted Supplementary Feeding, Enhanced Outreach Strategy, Health facility nutrition services (TFP and Nutrition and HIV) and to some degree Community Based Nutrition.

While all partners are interested to technically coordinate their activities, there does not seem to be real commitment towards aligning their systems to government implementation modalities-using government planning, financial, procurement and monitoring mechanisms. Though the government prefers pooling funds into the MDG performance Fund (MDG PF), some development partners are still not willing to join due to fear of diversion. It appears that a lot of advocacy and confidence building work is necessary to maximize alignment of nutrition projects to government systems and procedures and to reduce transaction costs.

**Challenges**

A number of important challenges remain. The NNS and NNP have not been well disseminated to government implementing organs below the regional level. The HEWs are not well trained to manage the nutrition education and service provision as envisioned by the NNS and NNP. The health centers are yet to be strengthened and it is reported that there is significant delay between referrals and obtaining services at the health center level. Nutrition, as any other service in Ethiopia, is being implemented in a weak health system that is under staffed, and under-resourced. The investment requirement for the NNS and NNP implementation is quite significant and ensuring adequate funding will remain one of the critical challenges of all
stakeholders in the sector. While the role of NGOs in implementing the NNP is well recognized, the effort to bring them on board through information dissemination and ensuring their alignment to the program seems inadequate. The coordination mechanisms that are set out in the NNS are not fully functional. All other coordination organs, with the exception of NNC, are not in place. The capacity of the sector to lead, manage and implement the NNP is weak at all levels. The new FMOH structure implemented as a result of Business Process Re-engineering put nutrition as a core function of Case Teams in three Directorates. The strategies of NNS and NNP regarding the secretariat, therefore, require adoption and rethinking.

**Recommendations**
Stakeholders should work in concerted manner to sustain the achievements made over the last year and remove some of the constraints to fast-track the implementation of the NNS and NNP. The health systems capacity to roll out the NNP through the health extension program should be strengthened.

More work on harmonization is needed. Nutrition should be integrated into the annual planning process so as to ensure that it remains intrinsic part of government process of priority setting and decision making.

The government’s commitment in terms of developing the NNS and NNP and deployment of the human resources especially the HEWS and their supervisors is appreciable. However, the FMOH should show more commitment for nutrition through ensuring a separate budget line for nutrition in the planning process.

The gap for financing the nation wide scaling up remains huge: It is recommended that DPs should increase funding and align their funding management mechanisms towards supporting a sustainable approach.

The role of NGOs in supporting the implementation of NNP is crucial since they have the knowledge and expertise to work at implementation levels. However, they need to better appreciate the existing policy and strategic directions pursued in nutrition and define their niche within the framework of NNP.
CHAPTER 1

1. INTRODUCTION

In February 2008, the Government of Ethiopia launched its first ever National Nutrition Strategy (NNS) thereby achieving a major step forward in its efforts to tackle persistent malnutrition in the country. Chronic malnutrition among children in Ethiopia remains very high 47% and at periods during the year, prevalence of acute malnutrition escalates to emergency levels. Micronutrient deficiencies are rife, nearly one-third of women are undernourished and approximately 35 million people in the country are undernourished\(^1\). Progress has been made in Ethiopia to reduce child malnutrition; underweight prevalence has decreased by approximately 0.5 percentage points between 2000 and 2005. However, the proportion of underweight children in the country would need to reduce by more than 2 percentage points per year to achieve MDG 1 by 2015. Malnutrition in Ethiopia is the underlying cause of 57% of child deaths and thus failing to address this problem will also hold back progress towards reaching MDG 4 to reduce child mortality.

The draft NNS was formulated during 2005/2006 in consultation with various stakeholders in the country and with technical support from UNICEF and IFPRI. The situation analysis done to inform the strategy highlighted the importance of taking a multi-sectoral approach to addressing malnutrition. As a result, the NNS brings together various vertical and uncoordinated programs into one comprehensive sector-wide approach, led by the government with one coordination framework. Although nutrition is recognized in the NNS as being multi-sectoral, the overall responsibility for coordinating the strategy has been given to the Federal Ministry of Health (FMOH).

The development of the NNS has certainly helped to raise nutrition much higher up the political agenda in Ethiopia. However the GoE had already shown strong commitment to tackling malnutrition in the country. This process was initiated following the release of the 2005–2010 Plan for Accelerated and Sustained Development to End Poverty (PASDEP) which called for the development of the NNS and an Action Plan to achieve MDG1.

The overall goal of the NNS is to ensure that all Ethiopians are able to achieve an adequate nutritional status in a sustainable manner. The strategy is focused on reducing malnutrition among the most vulnerable groups, particularly young children, pregnant/lactating women, individuals with HIV and households affected by food insecurity. It also includes components to help promote healthy diets and lifestyles. Crucially, a specific objective of the NNS is to improve coordination of nutrition-related activities implemented by other government ministries and relevant partner organizations and to create links across sectors.

\(^1\) FAO statistics
Save the Children UK has been operating in Ethiopia since the 1930s and has extensive experience in implementing programs aimed at tackling the immediate, underlying and root causes of malnutrition. Save the Children recognizes the importance of the NNS and is committed to supporting its implementation. In order to facilitate this, Save the Children UK commissioned a review of the progress made in the year since the launch of the NNS. Although the Government of Ethiopia should be congratulated for developing a comprehensive National Nutrition Strategy to deal with malnutrition in the country, it is imperative that the NNS now translates into concrete actions. Without appropriate mitigation mechanisms, millions of children will continue to suffer and the development of the country will continue to be compromised. The overall objective of the review was to identify what needs to be done to ensure that the NNS is successfully implemented.

2. BACKGROUND TO THE NATIONAL NUTRITION STRATEGY/PROGRAM

2.1. Nutrition and the Policy Environment
Until recently, the broad multi-sectoral factors contributing to malnutrition had been insufficiently emphasized, with the focus placed on addressing food security as the primary means to address nutritional insecurity. Traditionally, there has been a food-biased approach towards combating malnutrition in Ethiopia, but there has recently been a growing understanding of the multidimensional and multi-sectoral characteristics of the causes of malnutrition among policy makers. Based on a thorough assessment and analysis of the situation, the draft National Nutrition Strategy was formulated during 2005/2006. The situation analysis report highlighted the importance of a multi-sectoral approach in addressing food as well as non-food factors including those related to health and nutrition.

The Government of Ethiopia developed the 2005-2010 Plan for Accelerated and Sustained Development to End Poverty, which explicitly called for the development and implementation of the NNS and an Action Plan to achieve the Millennium Development Goal 1 of halving poverty and hunger by 2015. Based on this, the FMOH in cooperation with relevant ministries and partners developed a National Nutrition Strategy, which was launched in February 2008. The Nutrition Strategy brings together the various isolated and uncoordinated interventions into one comprehensive sector wide approach, led by the government and by one coordination framework. It has changed the pervasive attitude of ‘nutrition is everybody’s business but nobody’s responsibility’ and from thinking nutrition as emergency and food related intervention alone. Nutrition is recognized in the NNS as being multi-sectoral and the overall responsibility for coordinating the strategy has been given to the Federal Ministry of Health.

---

2 The attempt to develop the NNS in 2005 as part of the PASDEP was not successful due to various reasons. The various analytical work and strategies proposed then helped to fast-track the development and launch of NNS later.
According to respondents of this review, the development and adoption of the NNS was assisted by a number of facilitative factors, including:

- The analytical and preparatory work carried out during 2005 that justified the need for investing on nutrition;
- The conditionality set to develop NNS during SDPRP and the development of PASDEP;
- Committed leadership of the FMOH;
- Existence of committed partners like UNICEF and the World Bank to assist and support the development process;
- The launching of the Lancet series about maternal and child under-nutrition in Ethiopia as part of the global launching;
- Most of the interventions were already being implemented as part of the Government-UNICEF five year agreements.

2.2. The National Nutrition Program 2009-2013

The National Nutrition Program (NNP) was developed in order to implement the NNS. FMOH is taking the lead role in overseeing the implementation of the key aspects of NNS, but other ministries and sectors are also involved in the process. The importance and critical need for a multi-sectoral approach, using one coordination but different financing mechanism, with committed involvement from all relevant sectors, is stressed in the NNS with multi-sectoral linkages as one subcomponent of NNP.

The overall Goal of the Ethiopia National Nutrition Strategy is to ensure that all Ethiopians attain adequate nutritional status in a sustainable manner, which is an essential requirement for a healthy and productive life. Its specific objectives are to:

(i) provide due attention to malnutrition of vulnerable groups of the society, particularly under 5 children, pregnant and lactating women;
(ii) ensure the citizens are free from malnutrition related health problems;
(iii) protect the society from unhealthy dietary patterns and unhealthy lifestyles that may affect their health and
(iv) Coordinate and support nutrition activities of all sectors, government, non-governmental organizations and individuals working to alleviate nutritional problems.

Through the implementation of the NNS, it was envisaged that by the year 2015, certain nutrition milestones would be realized in Ethiopia towards achievement of the MDGs. While the strategy seeks to ensure the nutritional well-being of the whole population, more nutritionally vulnerable groups are specifically targeted and these include:

- Infants and young children under the age of five with emphasis on those below their second birthdays;

---

- Women of childbearing age particularly pregnant and lactating; and
- Persons infected with HIV and those with acute food insecurity.

The first action to facilitate the NNS implementation and achieve its aforementioned objectives was to develop the national nutrition plan of action. Thus, the Federal Ministry of Health in collaboration with relevant government sectors and partners developed the National Nutrition Program (NNP) in order to guide the implementation of the NNS4. The NNP is a long-term program that will be implemented in two phases over the next coming 10 years starting 2008, with each phase lasting five years. The NNP I, for the first five years (2008/2009-2012/2013), was finalized and approved by the National Nutrition Coordination Committee in December 2008. The NNP targets the most vulnerable groups as mentioned above and also gives priority to the rural population while recognizing that significant malnutrition exists in low income urban areas. The program has primary impact, outcome, and intermediate objectives.

The primary impact objectives include:
- Reduce the prevalence of underweight (W/A < -2 z-scores) from 38% to 30% by 2013;
- Reduce the prevalence of stunting (H/A < -2 z-scores) from 46% to 40% by 2013;
- Reduce the prevalence of wasting (W/H < -2 z-scores) from 11% to 5% by 2013;

The Outcome Objectives include the following:
- Increase the proportion of infants 0-6 months exclusively breast fed from 32 % to 60%;
- Increase the proportion of infants 6-9 months introduced to complementary food at 6-7 months from 25% to 50%;
- Increase the proportion of children with diarrhea who were fed "same or more than usual" from 25% to 50%;
- Increase the proportion of pregnant women gaining at least 9 kg over the course of pregnancy5.
- Reduce the prevalence of Bitot’s spots in children aged 6 - 59 months from 1.7% to < 0.5%
- Reduce the prevalence of Iron Deficiency Anemia in women of childbearing age from 26.6% to 15%.

There are also outcome objectives relating to institutional strengthening including but not limited to the proportion of policies enacted, the number of universities and regional colleges with functioning undergraduate and graduate nutrition programs. There are also

Partners: some of them include: UNICEF,WHO, WFP, World Bank, Italian cooperation, CIDA, Irish Aid, USAID, Japan gov’t, MI, save the children USA, Concern and others
5 There will be monthly pregnancy weight gain monitoring at the community 50 household level under community based nutrition which will start in one year time
intermediate objectives under each subcomponent of the NNP. The NNP seeks to address/achieve the above objectives using eight strategies that are grouped into two main components: (i) Nutrition Service Delivery component and (ii) Institutional Strengthening component to support the service delivery.

The Nutrition Service Delivery component has four sub-components:

a) Sustaining Enhanced Outreach Strategy (EOS) with Targeted Supplementary Food (TSF) and Transitioning of EOS into HEP

b) Health Facility Nutrition Services (Management of severe malnutrition, nutrition and HIV, Infant and Young Child feeding (IYCF), women nutrition and Baby Friendly Hospital Initiative (BFHI)

c) Community Based Nutrition (CBN): it is preventive community-based nutrition program which empowers the community to assess, analyze and take action to improve children’s and women’s nutritional status through community conversation, under two years children community GMP, Pregnancy weight monitoring, individual and group counseling on child care and feeding (ENA), and maternal nutrition, community based screening and management of malnutrition, and linkages to community based food security, water and sanitation, productive safety net programs.

d) Micronutrient Interventions: It focuses on Universal Salt iodization (USI) as the main intervention for control and prevention Iodine Deficiency Disorder (IDD), and prevention and control of Iron Deficiency Anemia (IDA), Vitamin A Deficiency (VAD), and Zinc deficiency⁶.

The Institutional Strengthening for Nutrition Policy and Program Implementation has four sub-components.

a) Strengthening Human Resources and Capacity Building

b) Advocacy, Social Mobilization and Program Communication

c) Nutrition Information System/ Surveillance, Monitoring and Evaluation, and Operation Research

d) Strengthening Multi-Sectoral Nutrition Linkages.

These interventions are not new in themselves. Most of them have been carried out by different actors in the country, albeit in small scale, isolated and in a fragmented manner. NNP brings all these into one nutrition program that is sector wide, comprehensive, actionable and fundable by development partners.

3. OBJECTIVES OF THE REVIEW

The main objective of this review was to assess the level of implementation of the NNS one year after its launch, highlighting the milestones, level of funding, gaps and level of interest

---

⁶ For the implementation details refer the National Nutrition Program.
by donors to finance the strategy, implementation challenges, barriers and opportunities. The review findings are expected to provide appropriate recommendations for the way forward.

The main objectives of this piece of work were:

(i) To review progress towards establishment of an institutionalized nutrition coordination body;
(ii) To analyze level of funding for the implementation of the NNS, the level of interest to financially support the NNS;
(iii) Identify areas of interest by different donor groups and institutions, including analysis of gaps in terms of funding, opportunities and threats;
(iv) To examine the level of government commitment the challenges, barriers and constraints faced by government and its partners in implementing the NNS, and based on findings, make recommendations for the way forward; and
(v) To review the institutional arrangements for the NNS, perceived appropriateness and relevance of such arrangements in achieving desired outcomes;
(vi) Based on findings, make appropriate recommendations for the way forward.

4. METHODOLOGY

4.1. Interview and documents
The review of the NNS involved interviews with government officials at federal level, mainly in the health and agricultural sectors, major development partners that provide funding for the implementation of the nutrition programs in the country and implementing partners (mainly international NGOs) that are involved in the implementation of nutrition programs. The interviews were based on an interview guide developed by the consultant with input and comments from Save the Children UK. The review, where available, also examined available documents within the respective government ministries and/or departments, nutrition partners and other institutions that participated in this review. Most of the findings and conclusions were made after triangulation of information collected from the interviews and documents accessed by the consultant. The list of respondents and documents consulted during the review are presented in annexes. The review also used the recently published Lancet series as best practice on nutrition as a guide to comment on the technical relevance and effectiveness of the nutrition strategy in Ethiopia.

4.2. Coverage of the review
This review assesses the progress in implementation of the NNS one year after its launch. The strategy is an articulation of interventions and modalities of working and is not an ‘actionable’ and ‘fundable’ document that can be implemented right away. It required the development of a program, the National Nutrition Program (NNP). While the strategy has been in place for a year and at the time of writing this report, the actionable program was still waiting for its official launch.
According to the implementation plan reviewed, the first year was scheduled to getting strategy and the program known to stakeholders, putting the institutional arrangement and the necessary capacity in place. Though progress could be made to strengthen service delivery, the impact on the nutrition indicators is not expected to be significant. One of the major limitations of this review is, therefore, that it was initiated too soon to actually reflect progress or lack of it in the achievement of NNS objectives and results. The focus of the review was limited to processes and activities carried out during the year, particularly on the preparatory work planned in the NNS and its program document, the National Nutrition Program.
CHAPTER 2

1. IMPLEMENTATION OF THE NNS/NNP

1.1. PREPARATORY WORK AND COMPLEMENTARY MEASURES

There are some policy directives and guidelines that need to be developed to support the implementation of the NNS. These include the development and endorsement of the NNP, endorsement of Universal Salt Iodization legislation, development and endorsement of the Code of Marketing of Breast Milk Substitutes, and the revision of the micro-nutrient guidelines. Since the launch of the NNS in February 2008, some ground has been covered to translate the aspirations and targets of the NNS into reality. According to information gathered from various sources and stakeholders interviewed there is indeed significant progress in the implementation of most of the ground works. Below are highlights of some important milestones to date.

1.1.1. Development and Approval of the NNP

The National Nutrition Program, the program that translates the strategies laid out in the NNS into program actions, has been developed in consultation with partners like USAID, JICA, CIDA, WHO, WFP, Save the Children US, Concern, Italian Cooperation, Irish Aid, ESHE and led by UNICEF as the nutrition cluster and the World Bank as the lead donor. The National Nutrition Program has two components: (i) Service delivery and (ii) Institutional strengthening. Its development has been reported to be fairly participatory. The program was approved on the 29th of December 2008 for implementation by a multi-sectoral National Nutrition Coordination Body (NNC), which is lead by the FMOH.

Stakeholders reported that their involvement in the development of the program is not as much as their involvement in the development of the Strategy and much less so in its endorsement. There is a concern among stakeholders that the momentum created during the launching of the strategy has since slowed down. Stakeholders do recognize the critical role played by the leadership of the FMOH during the design of the Strategy and want to see more of the same commitment during the implementation process.

The NNP was officially launched for all national stakeholders on June 22, 2009. This could have been an opportunity to come up with a strategy with partners working at the regional level on how to disseminate the strategy and the program below the regional levels.

1.1.2. Dissemination of the NNS

The launching of the strategy was reported to be a very good forum for disseminating the NNS where high level government officials, most of the concerned multi-sectoral Ministries and partners were represented. Since then, the following has been carried out.

The FMOH carried out two NNS and NNP dissemination workshops on September 1st to 3rd, 2008. A two-day dissemination workshop targeting Regional Health Bureaus was carried out on the 1st and 2nd of September during which all region but Oromiya, SNNPR and Afar, participated. All in all 19 participants attended the workshop. Subsequently, on September 3rd, a one-day workshop that targeted relevant non-health sector bureaus (agriculture, education, water etc) was conducted and all regions with the
exception of Afar attended. There were in total 30 participants. Disseminating the strategy below the regional level has been the responsibility of Regions. Accordingly, the Regions prepared a dissemination action plan to cascade the workshop to lower levels during the two successive workshops.

The FMOH did not have a follow up information, and therefore, the status of implementation of the dissemination plan by the regions could not be understood from this review exercise. It is also reported that the strategy was presented and discussed at the Health, Population and Nutrition donor group.

The dissemination exercise seems very limited in its scope as it only targeted government agencies. Multilateral, bilateral agencies and NGOs were not involved, and hence, appear to be less informed on the strategy and the program. These partners also need to be better informed if they are expected to align their support and interventions. Moreover, the dissemination so far is shallow as it reached only regional levels and left out the whole implementing units below regional levels. Proper implementation of the strategy and the program requires that the National Nutrition Strategy and the recently approved National Nutrition Program is known to all. Given the impetus that the launching of the NNS has created, it is necessary to follow through and cascade down the dissemination exercise in terms of depth. Moreover, it is necessary to expand the scope of the launching of the NNP by including both development and implementing partners so that they are part of the implementation process. A lot need to be done to improve the impedingly low awareness of the NNS and NNP especially at the regional and Woreda levels, and for the partners.

1.1.3. Universal Salt Iodization
In spite of the availability of financial and technical support to carry out this work, there has not been satisfactory progress until recently. However, after several consultative meetings among the Federal Ministry of Health, Ministry of Mines and Energy, Afar Regional State, salt producers and companies, and partners like UNICEF and Micronutrient Initiative most of the bottlenecks had been removed. The iodization of salt in Afdera, Afar, was launched in April 11, 2009. Furthermore, training was provided for laboratory technicians and machine operators for producers. Production of iodized salt began and it is reported that there is adequate salt. The major challenge in this area is upgrading the production technology from simple technology as it is today to something better to ensure quality of production. Another critical policy required for the smooth implementation of the USI is the endorsement of relevant legislation. A draft legislation document has been developed and one round of consultation with stakeholders carried out. The next step involves revision of the draft based on the comments received. The revised draft will then go through the government legislative approval process as soon it is ready. According to the WB project memorandum, this task needs to be finalized by July 2010.

1.1.4. Code of Marketing of Breast Milk Substitutes
A draft code of Marketing of Breast Milk Substitute has been prepared and it is being processed as legislation by the legal department of the FMOH for approval. In the NNP, its approval is planned for 2010. This will provide the legal framework for implementation of the Infant and Young child Feeding Strategy, and facility based nutrition services interventions, Baby Friendly Hospital Initiative (BFHI), Nutrition and HIV, and Community Based Nutrition component of the NNP and NNS.

1.1.5. Micronutrient Guidelines
The micronutrient guideline has been revised, as it was outdated as compared to international recommendations and zinc was not included. The FMOH conducted one round of consultation with
stakeholders. The final draft is being prepared at the moment. This will guide the implementation of the micronutrient and community based nutrition components of NNS and NNP.

1.2. SERVICE DELIVERY
As was presented in the preceding sections, the implementation of the various elements of the NNP interventions has been carried out in a fragmented manner and at a smaller scale even before the adoption of the National Nutrition Strategy and Program. In spite of the fact that the NNP was officially launched in June 2009, the implementation of most of the interventions had already begun before its launch. What the program has done is getting the nutrition agenda move higher in the ladder of priorities within government, scale up the interventions that were carried out from pilot levels; harmonize and integrate these interventions with the implementation of the Health Extension Program for wider impact and sustainability. The achievements, challenges and gaps in service delivery are summarized in the following subsections.

1.2.1 The Health Extension Program
The hardware of creating accessible health care in the Ethiopian context is the Health Extension Program (HEP). The government has now put in place the Health Extension Program, the hardware of the health system in reaching out every family in every Kebele for various preventive and promotion services including nutrition, in all sedentary rural areas, and is working towards creating universal access by training Health Extension Workers (HEW) in urban and pastoral areas. The program has shown very encouraging results⁷ and will remain the main vehicle for community action including the community based nutrition for the coming years. The strategy uses the ‘diffusion model’ to change behaviors at the community level. Using this model, Health Extension Workers will train model households in the Kebele and these in turn will become role models for dissemination and training for their neighborhood. According to the recently finalized Business Process Re-engineering document, two HEW will train 360 model households in a year, and their model households that will be called ‘frontline agents” after graduation will also train between 180 to 288 household per year⁸. All in all there will be 2 HEWs and 50 ‘front line agents’ in each community working for and with the community to produce better health. Those households that practice 75% of what they have learnt will graduate as model household. The NNP tried to link HEWs with voluntary community health workers and model households.

This is in line with FMOH’s Motto of ‘producing big volumes, with high speed and minimum acceptable quality’. Given this strategy, vertical training and message sharing to community members by different agencies and entities will no longer be practiced since they are expected to be integrated with the HEP and model families. This means that training voluntary community health workers that will not support the HEWs will not be accepted. All training activities need to follow the standard curriculum for HEWs. The critical element and the challenge of all nutrition partners or any other community based services, is therefore ensuring that the required effective skills relevant to nutrition are included into HEP and the ‘model family package’ defined for households. Both the HEW and model family packages include breast feeding, complementary feeding, growth monitoring and maternal nutrition. The HEWs provide individual counseling to mothers and care takers at every contact. Health post visit for vaccination, Growth Monitoring and Promotion (GMP), sick child visits and home visit are among the main points of contact. They also give group education at health post during monthly community conversation

⁷ FMAOH, HSDP III Mid Term Review Report 2008
⁸ FMOH, 2008, Business Process Re-engineering draft document
sessions. The Volunteer Community Health Workers also counsel mothers and conduct Community Conversation session on Community Based Nutrition. In the model family package, the HEW train families on breast feeding, complementary feeding preparation, maternal nutrition and other preventive packages for 16 hours so that these families change their behaviors and influence their neighbors’ behaviors. The fact that the NNS and NNP use the HEP as the main vehicle for providing preventive, promotion, and basic curative services indicates that the program is aligned with the HSDP III.

1.2.2. Transitioning of Enhanced Outreach Strategy into the Health Extension Program

The Enhanced Outreach Strategy/Targeted Supplementary feeding (EOS/TSF) is an interim strategy until the HEP is fully functional to address the acute nutritional needs of children and pregnant and lactating women in recurring food-insecurity situations. The nutrition-services package includes bi-annual vitamin A supplementation, de-worming and screening for malnutrition. Malnourished children, pregnant and lactating women are then referred to the Targeted Supplementary Feeding Program (to address moderate malnutrition) or to the Therapeutic Feeding Program (to address severe malnutrition) if they meet the set admission criteria. The major achievement during HSDP III was over 90% coverage of vitamin A supplementation and de-worming coverage compared to less than 60% in 1998. In the Ethiopian fiscal year 2000 (2008/09) a total of 10.7 million children aged 6-9 months received Vitamin A supplementation and a total of 7.7 million children aged 24-59 months were given Albendazol tablets for de-worming. This increased the coverage of these services to 94 and 99 percent respectively. Evaluation of EOS coverage validation survey was done by an independent institution in 2008 (see research section below). Seven million children and 1.5 million pregnant and lactating women were screened for malnutrition every six months and referred to Targeted Supplementary Food and Therapeutic Feeding Program accordingly. It was, however, reported that there was significant delays between referrals and actual provision of the supplementary food rations.

An effort has been initiated to move from campaign mode of delivering Vitamin A, de-worming and nutrition screening through EOS to locally organized Community Health Days (CHD) delivered by the HEWs with support form the VCHW. This is in addition to the routine provision of these services provided through the health care service contact through the Health Centers and Health Posts. Transition of the EOS/TSF program to CHD has been piloted in 39 Community Based Nutrition Woredas supported by UNICEF.

While it is argued that the idea of gradually changing the EOS/TSF to CHD is a necessary step there are fears that it may bring down the coverage rates achieved by this program. The transition period need to be backed up through evidence based learning from the currently working Woredas. The experience from Kenya demonstrated that caution is necessary in implementing these types of strategies, as it led to declined program achievements. There are concerns that the Kenyan experience will be repeated in Ethiopia, and the FMOH and Micronutrient Initiative are planning to outsource a study to chart out the modalities of ensuring smooth transition that maintains high coverage.

1.2.3. Health Facility Nutrition Services

One of the NNP’s objectives is putting in place therapeutic feeding services in 50% of the health centers and hospitals. The management of severe acute malnutrition has improved in the past three years due to: (i) the identification of acute malnutrition during EOS campaigns, and treatment through

---

9 FMOH, HSDP III Mid Term Review Report, 2008
supplementary and therapeutic feeding programs; (ii) the presence of HEWs who identify and treat severe malnutrition and facilitate referral; (iii) well-functioning emergency mechanisms and (iv) rapid mobilization of resources for therapeutic feeding during outbreaks of severe acute malnutrition. The number of therapeutic feeding sites, both Therapeutic Feeding Units (TFU) and Outpatient Treatment Program (OTP) sites, increased from nearly 400 in 2007 to 1200 by October 2008. The other major achievement in the management of acute malnutrition in children is the decentralization of management to the health post or community level as Outpatient Treatment Program, which will increase the coverage by improving the access and reduce mortality as it helps to early detect and manage severe acute malnutrition. Currently, 315 Woredas have either inpatient or outpatient therapeutic feeding programs. The national capacity for management of SAM has increased from nearly nil in 2003 to the treatment of over 90,000 severely malnourished patients every month to date. Ethiopia is importing and producing Ready-to-Use-Therapeutic-Food (Plumpy’Nut) in adequate quantities when there is no emergency.

On the other hand the National guideline for nutrition and HIV is completed and published. Twenty million USD are allocated for the country under the food prescription program of PEPFAR/USAID in order to provide nutritional support to People Living with HIV/AIDS, who are on pre ART and ART in 45 health facilities. It is on the process of identifying implementing NGOs that will support the FMOH and HAPCO.

1.2.4. Community Based Nutrition
One of the interventions still high in terms of priority in the NNS/P is the Community Based Nutrition, which addresses the high level of chronic malnutrition by empowering the community to assess, analyze and take action (Triple A approach) to improve the children and women’s nutritional status through community conversation for collective action including age appropriate individual counseling on breast feeding, quality and adequate complementary feeding, care of the sick child, immunization and others using Growth Monitoring and Promotion (GMP) as tool. The Volunteer Community Health Workers supported by the HEWs are responsible for implementing the CBN working with 30 to 50 households within their community. The CBN packages are monthly Growth Monitoring and Promotion activities for children under 2 years (individual counseling based on growth trajectory and Essential Nutrition Action (ENA) messages on infant and young child feeding) supported by community conversations, follow-up home visits, referral and follow up for children with severe acute malnutrition, promotion, implementation and follow-up of biannual vitamin A supplementation and de-worming through community health days, promotion of maternal and adolescent nutrition, follow-up of iron supplementation for pregnant women, and promotion of use of iodized salt.

Even if it is not the full package of CBN, “Essential Nutrition Actions” is a preventive community based nutrition which is a behavior change model providing individual and group counseling on maternal nutrition and on infant and young child feeding (breast feeding, complementary feeding, and feeding of sick children) without looking at the child growth trajectory and it doesn’t have structured Community Conversation as in CBN.

In the NNP, the plan is to cover all rural Woredas with CBN by 2013. Currently, about 103 Woredas (14% of all Woredas) have either started to implement or have secured funding to implement CBN. The

10 FMOH, HSDP III Mid Term Review Report, 2008
implementation started in 39 Woredas in four regions (Amhara, Oromiya, Tigray, and SNNPR) through UNICEF support. UNICEF has secured additional funding to expand to additional 54 Woredas with the plan to gradually scale up to cover 150 Woredas within the next coming three years. Another 10 Woredas in Oromiya are being supported by JICA. Some additional Woredas are also expected to be financed through the World Bank. The Essential Nutrition Actions will be implemented with the support of NGOs especially the Integrated Family Health Program (IFHP) in 300 woredas and the last 10 Kilometers in 115 Woredas in the next three years. This shows the support provided by NGOs to FMOH in implementing the NNP is growing. In conclusion, 560 Woredas will implement preventive community based nutrition activities to improve the nutritional status of the young children and women but gaps remain in rolling out this strategy to all Woredas. However, the main challenge of the nutrition partners is the scaling up of the comprehensive community based approach nationwide.

The drivers of community actions are set to be the health extension workers supported by community volunteers and model households (one volunteer community health worker per 50 household). There is significant progress in training of health extension workers in Ethiopia since 2003. All the 30,000 HEWs were trained and deployed by March 2009, covering all rural Kebeles with 2 health extension workers. One of the 16 training modules of HEW is on nutrition. Anecdotal evidence of the HSDP mid-term review suggested the need to upgrade the capacity of HEW to identify malnutrition before it reaches the acute stage, improve their nutrition counseling and promotion skills and to strengthen their collaboration with agricultural extension workers to promote consumption of locally available food (see Box 1). Upgrading training for HEW was carried out to correct such weaknesses. Accordingly, 1649 HEWs were trained on CBN over the last two years. The quality and effectiveness of the training need to be reviewed and the NNP has clearly put this as one of its core activity in the coming years. The curriculum of the training institutions is being reviewed and training needs assessment of front line workers is being carried out (see research section below). It is necessary to ensure that the HEW and VCHW received quality training on CBN before its initiation and they also receive refresher training every six months.

Growth monitoring in the NNP is just one part of the overall community based nutrition with other components including individual and community conversation and collective actions. It is to be noted though, with its challenges, there is a big potential to influence behavioral change and monitor malnutrition and bring about changes in the nutrition area at scale rather than small scale pilot interventions.

The supervision of HEW is being strengthened but challenges remain. Overall the required 3000 supervisors, mainly clinical nurses, have been fully trained as of May 2008. However it is reported that these supervisors do not have adequate transport means, they lack budget to cover supervision,

Box 1: Issues of training of HEW on Nutrition

- HEW often cannot identify malnutrition before it reaches the acute stage, one reason being that they are not equipped with necessary tools/skills to monitor child’s growth, detect invisible forms of malnutrition and prevent further deterioration
- Confidence of HEWs and clinical staff to give nutrition counseling is low, and accuracy of nutrition information is inconsistent.
- Nutrition advice is not universally aligned with Essential Nutrition Actions (ENA) nor is nutritional content of locally available and accessible foods.
- Reference materials on nutritional messages, specifically ENAs, are not adequately supplied to clinical staff and HEWs

(Source HSDP III Mid Term Review report)
transport costs and per diem\textsuperscript{11}. The HSPD mid-term review recommended the assessment of the adequacy and effectiveness of the support supervision model between the Woreda health office, health centers, supervisors, HEW and VCHW.

The NNP clearly tries to link GMP with adequate referral to TSF and OTP/TFUs to address moderate and severe acute malnutrition. One particular challenge to using GMP as a platform for delivering community-based nutrition is that it tends to only be effective in settings where health staff are well trained, adequately supervised and paid appropriate salaries. The lack of any or all these things (as is commonly the case in Ethiopia) inevitably results in focus being placed on the monitoring component of GMP and not on the promotion. The 2008 Lancet Series on Maternal and Child Under nutrition emphasized that growth monitoring on its own is ineffective for reducing child malnutrition. A report produced by SC-UK in 2003, ‘Thin on the Ground’ documented that growth monitoring programs were not working well in Ethiopia. It argued that ‘for GMP to be effective there is a need to ensure that supplies, training, supervision and information are all in place’ and that ‘training and supportive supervision are at the heart of a well functioning GMP program’. Attempts have been made to correct the weaknesses of the GMP interventions in the past, like training, supervision, supplies and appropriate GMP data utilization at all levels especially by the community through community conversation. Putting a sound strategy in place is different from implementing the strategy. Experience has shown that some of the improvements made in the NNP to correct the weaknesses of GMP have been tried elsewhere and it was difficult to implement them in a resource scarce environment. We have not gone to the regions to verify the actual implementation of whether the supportive interventions planned in the NNP are actually being carried out by Health Extension Workers in the Woredas where CBN has been initiated. However, the capacity of health centers to provide referrals has not yet been strengthened; hence, the performance after just one year of implementation is expected to be low at the moment. There is willingness to scale up community based nutrition through the health extension program and resources are being allocated to this end. However, its effectiveness still needs to be systematically reviewed during the NNP mid-term review.

1.2.5. Micronutrient Interventions

a. **Control and prevention of Iodine Deficiency Disorders**: The objective of NNP is to increase the proportion of households that consume adequately iodized salt from the current 4.2% to 90% by 2013. All the financial and technical resources are mobilized and a lot of effort has been put to resolve the management issues that delayed the start of iodization of Salt in Afdera, in Afar, which is an important component to achieve the target set for universal iodization of salt within the NNP and HDSP. As an interim intervention, iodine oil capsule were distributed to 1.2 million under five children and 300,000 pregnant and lactating mothers with support from UNICEF, USAID, Japan government, and the Micronutrient Initiative.

b. **Control and prevention of Iron Deficiency Anemia**: There has been limited achievement to implement this activity. Resource is secured for procurement of iron-folate tablets and the plan is to scale the supplementation of pregnant women through community based nutrition with the objective of

\textsuperscript{11} FMOH, HSDP Mid Term Review Report, 2008
increasing proportion of pregnant women receiving iron/folate supplementation from 10% to 50% by 2013.

c. Control and prevention of Zinc Deficiency: Zinc is registered as an essential drug and training materials like IMCI and CBN are revised to include supplementation of zinc for children with diarrhea. Zinc technical working group, which is chaired by Drug Administration and Control Authority (DACA) and Family Health Department acting as a secretary, is formed to facilitate the registration, importation and local production of zinc tablet registration. Indian zinc formulation was registered by DACA in April 2009. Some resource has been mobilized from the World Bank to procure zinc tablets. The NNP target is to increase the proportion of children receiving zinc for diarrhea treatment from the current 0.2% to 25% by 2013.

Table 1: NNP baseline, target, 2007/08 achievement and 2008/09 plan

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% of infants under six months exclusively breast fed</td>
<td>32</td>
<td>60</td>
</tr>
<tr>
<td>% of infants aged 6-9 months fed solid food in addition to breastfeeding</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>% of children receiving one dose of Vitamin A supplementation in the past six months</td>
<td>93</td>
<td>maintain &gt;90</td>
</tr>
<tr>
<td>% of new mothers receiving iron supplementation for more than 90 days</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>% of children under 5 receiving de-worming treatment every six months</td>
<td>93</td>
<td>maintain &gt;90</td>
</tr>
</tbody>
</table>


1.2.6. Nutrition Information System and Surveillance

It is one sub-component of the NNP that aims to set up a proper nutritional surveillance system in Ethiopia as stated in the NNS. It is designed in such a way that it will build on the existing data collection structures and undertake the overall monitoring and evaluation of the National Nutrition Program as well as cover relevant operational research for the NNP. It has three main objectives:

1) To support timely early warning and adequate intervention at Woreda and higher levels;
2) To support the development, management and evaluation of the National Nutrition Program at all levels; and
3) To support nutrition-relevant programs in health, agriculture, water/sanitation, economic development, and other sectors.

The nutrition information system has six types information sources: 1) short term for rapid action to drought and crisis which include the Early Warning System under Disaster Management Food Security Sector including emergency nutrition surveys and EOS data; 2) the Health Management Information System (HMIS) under the FMOH to support the development, management and monitoring of nutrition activities at gotte, kebele, Woreda, regional and central levels; 3) Sentinel site data derived from
Demographic Surveillance Site to provide time series nutritional information to assess trend in underweight and to validate HMIS data.; 4) National surveys data like Demographic Health Surveys for long term planning and policy development, in health (including NNP) and other sectors; 5) Special surveys to get data on behavior changes and micronutrient status; and 6) NNP baseline and end line evaluation to assess whether the objectives of the program are on the right track or achieved. The Ethiopian Health and Nutrition Research Institute has the overall responsibility to coordinate and triangulate all these nutrition information systems in the country.

1.3. INSTITUTIONAL ARRANGEMENT
One of the two components of the NNP is strengthening organizational structure, staffing arrangements, physical capacity building and enhancing coordination mechanisms. The short term interventions, activities planned under NNP include:

- Ministry of Health be the lead agency to coordinate the implementation of the NNS and NNP;
- Strengthening the human resource capacity and structure to implement nutrition activities at different levels, initially through technical assistance and project funds until in house capacity is built;
- Strengthening the physical capacity (goods, equipment and vehicles);
- Ensuring the functionality of the various coordination structures at all levels (policy and technical bodies) at national, regional and Woreda levels;
- Strengthening the capacity of research and research institutions through the procurement of laboratory equipment and supplies, availing budget for operational research and short term visits and training; exploring new avenues to strengthen the capacity of the HEW by undertaking training needs assessment, revision and development of a curriculum and procurement of educational materials;
- Strengthen the human resource development aiming at frontline workers (HEWs and Volunteer Community Health Workers); middle level managers (at Woreda and regional offices), Clinical Nutritionists and high level Nutritionists. This is planned to be achieved through provision of funds to Integrated Refresher Training for HEWs and strengthening of universities and colleges and provision of technical assistance;
- Harmonization and improving the advocacy, social mobilization, and communication on nutrition. As part of preparatory work, EHNRI is developing the National Nutrition communication Framework and has already undertaken primary research to generate findings upon which the framework will be based;
- Harmonization and improving both the emergency and development nutrition information system and operational research.

Composition and functioning of the Coordinating structures
The NNS sufficiently described the need to establish a multi-sectoral coordination mechanism that sets policy and coordinate the technical aspects at national, regional and Woreda levels. In response to this, the NNP aspires to strengthen the linkages of nutrition to relevant sectors, which enhances the nutritional impact of programmatic activities in these sectors. Ethiopia already has well defined policies and strategies and implementation activities across major sectors affecting nutrition. The country Food Security Program (FSP) and Productive Safety Net Program (PSNP) under the rural development and
PASDEP frame work, the national health sector strategy and its HSDP under MOH, the national education strategy and its ESDP Under MOE, and the Universal Access to Potable water of Ministry of water resource and development. All these sectors have introduced sector-wide approaches as a way to coordinate the intervention of stakeholders. Thus, it is the responsibility of the line ministries or sectors to implement the nutrition interventions/programs which it is mandated in the strategies mentioned. However, in order to mainstream nutrition in each sector; and have viable linkages and harmonization with these sectors, the NNP implementation and coordination framework is designed to have multi-sectoral implementation and coordination arrangements at the policy and implementation level in all the decentralized administrative and service delivery levels. Thus, the NNP proposes a four-tier coordination mechanism that is in line with the decentralized administration structure of the government; and considers the considerable support of the partners and Academia (see figure 1).

Figure 1: Approved NNS coordination structures at different levels

According to the information generated during the interviews, the FMOH is given a responsibility of leading the multi-sectoral action to implement NNS and its program by the decision of the Council of Ministers. As a result this is incorporated in the NNP. The consultant has not come across any documentation showing the communication about this decision.

The FMOH as a lead agency since then was able to develop and endorse the strategy, developed and endorsed the NNP and has started working on the preparatory work necessary to implement activities set out for the coming five years. It is mandated to oversee the implementation of nutrition issues not only in the health sector but to coordinate the various sector ministries through putting an effective coordination structure\textsuperscript{12}.  

\textsuperscript{12} FMOH, 2008, National Nutrition Program.
The process of establishing the nutrition coordination structures is rather slow. The only coordination body established and started functioning is the National Nutrition Coordination Body (NNC), the highest policy making organ stipulated in the NNS. The NNC had its inaugural meeting on the 29th of December 2008. The NNC in this meeting endorsed its Terms of References and composition of its membership, approved the NNP, and request institutions to nominate and submit the names they will propose to be members of the National Technical Taskforce. The NNC is expected to meet quarterly during its first year and bi-annually afterwards. It held its second meeting in April 8 2009. It has taken about a year to establish this coordination office and the delay is mainly to (i) the Business Process Re-engineering that took time and energy of the MOH and (ii) the time it took to develop the NNP and articulate the Terms of Reference of the coordination structures. The coordination structures at the regional and Woreda levels are yet to be established, taking the same format as the national bodies.

The composition of the National Nutrition Coordination Body include the Minister of Health – Chair, Director General of health promotion and disease prevention of FMOH – Secretary and Ministry of Agriculture and Rural development represented by DMFSS and Agriculture Development sector, the Ministry of Water Resource and Development, the Ministry of Education, the Ministry of Finance and Economic Development – Treasury, and the Ministry of Women and Social Affair- all represented by their respective state ministers; Addis Ababa University, the School of public Health- representing academia; one independent senior nutritionist; one partner from Private sector (not yet identified); and one representative from the Partners as decided by NNC (UNICEF was selected in the second meeting)\(^{13}\). From the composition, it can be seen that this body is a high powered organ with decision makers of all concerned government institutions in the country. The role of partners in the NNC is rather limited, as they are represented by UNICEF only. Learning from the CJSC (Central Joint Steering Committee) of HSDP, it usually difficult to get all these members attend quarterly meeting on a regular basis, as they have other competing tasks and responsibilities to attend to. In such instances, the main responsibility will fall to the secretariat and/or the technical taskforce.

If the multi-sectoral actions are to be fostered and strengthened, the establishment of these coordination structures at lower levels needs to be fast-tracked. The composition of these structures, however, needs to be informed from the lessons learnt (from their weaknesses that prevent them from smooth functioning) in the coordination of the HSDP at these levels. Learning from the functioning HSDP governance structures at different levels, it is necessary to ensure that these structures functions as per their terms of reference.

Interviews with partners particularly development partners revealed that development partners were engaged during the development of the strategy and to some degree in development of program document, though the level of participation is reported not satisfactory. The participation of NGOs however is reported to be limited. Comparatively, development partners were more involved in the development and approval of the NNS than that of the NNP. While most of these partners are likely to be members of the technical taskforce, their role in the NNC seems very limited given its endorsed composition.

\(^{13}\) FMOH, Terms of Reference for the coordination structures
2. NUTRITION AND SECTOR MANAGEMENT PROCESSES

Since nutrition has been considered as a cross-cutting agenda in the Health Sector Development Program for a long time since its initiation in 1995/96, it has not been given enough attention and priority as compared to the eight other program components. There has been lack of clarity about the ownership and leadership role on nutrition between agriculture and health ministries. Consequently its treatment in the annual sector management processes (planning, budgeting, monitoring and review) is far from ideal.

The adoption of the National Nutrition Strategy and the granting of the stewardship role to the FMOH have started to give nutrition attention in the management processes in the health sector. However, the effort is still limited in considering nutrition as stand-alone priority program in its own right. Its inclusion and integration in operational planning and monitoring and evaluation system within the Ministry of Health is far from being institutionalized. On the other hand, according to the respondents of the interview, it has created drawback. The sector annual planning and reporting process incorporate nutritional program as part of its core targets and implementation reports over the last year. This in itself is progress, as it provides decision makers a platform to set targets to meet the objectives of the NNP and monitor its implementation. However, there is practically no NNP performance indicator in the HMIS.

The annual planning process is a combination of top-down and bottom-up approach that helps to develop operational plans starting from health facilities, consolidated to Woredas, Regions and finally at federal level based on the indicative targets and resource envelopes given from the FMOH and mapped needs and resources at local level. It is the mechanism for allocation and mobilization of resources for priority interventions in the health sector. It sets targets to be achieved in year at all levels. Contracts are signed between the FMOH and RHB to implement the plan after it is endorsed as part of the NNP in the annual planning process. Of these, two have been reflected in the annual performance report and Woreda Based Annual core plan: (i) Vitamin A supplementation and (ii) de-worming but all other indicators are not included.

At first glance, it seems that there are two sector wide approaches being pursued in the FMOH: one for health and another for nutrition. This has happened because HSDP is still functional where nutrition is seen as cross cutting theme. With the development of HSDP IV next year, it is expected that these 2 programs will converge, though nutrition might still maintain some of its peculiarities because of its multi-sectoral linkages.

Recommendations:

- More work on harmonization is needed to ensure that the necessary information for implementation of the NNP is collected and analyzed through the routine system without overburdening the information system at all levels.
- Nutrition should be integrated into the annual planning process so as to ensure that it remains intrinsic part of government process of priority setting and decision making.
- The nutrition targets should be planned and reported as part of the overall health planning and monitoring process, from Woreda to national levels through the Health Management Information
Systems. This requires discussion and agreement with the Health management information system of the Federal Ministry of Health.

- NNP should not be treated as a standalone program but as a key element of sector planning, budgeting, resource allocation and monitoring process. This calls for all nutrition partners to identify policy and programmatic issues/constraints by undertaking systematic review and studies on specific components of the NNP and feed the findings into the government routine management processes (e.g. undertaking nutrition studies that have implications on the pace and quality of implementation around June each year to ensure that it is set on the agenda on the ARM in October each year). This will ensure that the nutrition is maintained at the spotlight as a high policy agenda item.

- The integration of nutrition should go hand in hand with a focus on the role and responsibility of all stakeholders, strengthening of mutual accountability rather than focusing only on government actions and inactions; and the inclusion of NGO nutrition partners who also significantly contribute into the implementation of some components or interventions spelt out in the National Nutrition Program.

2.1. The Secretariat of the National Nutrition Coordination Body

The role of the secretariat in supporting the NNC and Technical Task Force will be very critical as they are going to set the agenda of the NNC. Although the NNP stated that the nutrition unit of the FMOH was to be the secretariat, the Business Process Re-engineering has restructured the organization of the FMOH including the nutrition unit. Currently, there are five persons working on nutrition under the agrarian, urban, and pastoralist health extension and EHNRI (now named as Research Technology Transfer and Public Health Management Agency). The development of the NNP was supported by a dynamic team of technical assistance that supported the FMOH to translate the NNS into the actionable program. The World Bank recently recruited a technical assistant to work with the FMOH in supporting the implementation of the NNP. Currently the available capacity at regional and lower levels, let alone the FMOH does not seem adequate to implement such a huge program and drive the agenda set by the strategy and program. Some of the delays in the implementation of the preparatory works has been reported to be owing to or linked to limited operational capacity. According to the assessment carried on availability and requirement for human resources as part of NNP implementation, it is reported that about 30 nutrition experts are required at the national and regional level and the gap is wide as we go down to the implementation levels.

There is shortage of nutrition staff within the FMOH; in fact the current restructuring seems to encourage the deployment of generalists. There is no focal person for nutrition in the FMOH in the new structure. The implication of this restructuring for the implementation of the NNP is not yet clear. From our interviews and discussions with stakeholders, there are institutions committed to finance the strengthening of the secretariat. Their major concerns are on reaching agreement on how to strengthen the secretariat on the one hand, and the implication of the Business Re-engineering Process on the structure and functioning of the nutrition technical arm in the FMOH on the other hand. Stakeholders also reported that there are challenges in coordination of nutrition program within government, horizontally across different Ministries and vertically between the federal and regional levels.

Recommendations: The NNC should have a thorough analysis on the implication of the new structure and develop strategies on how the restructured system should effectively function to support the
implementation of the NNP. This could mean creating a technical arm for the secretary of NNC, the Director General of Health Promotion and Disease Prevention of FMOH to enable him deliver the crucial assignment he is responsible for. If the secretariat is to become a mover and shaker of the NNS and NNP, the current capacity should be supported through putting additional capacity including technical assistance.

2.2. Vertical and horizontal coordination in the implementation of NNP
Another challenge mentioned by all stakeholders is the weak link between the nutrition and the food security program and Productive Safety Net Program. Though both programs have explicit targets to improve child nutritional status, there is no mechanism that is put in place to track and monitor its progress. The food security program reaches more than 7 million people and 20% of which are those that are nutritionally at risk. But there is no systematic effort to include some of the preventive and promotion measures of nutrition into the public works programs. This is partly caused by the lack of responsible person on both sides that works on the coordination between two programs. Some reported that food security program focuses more on its own activities and do not have enough interest in nutrition. Currently the PSNP is under review and there is ongoing discussion on how to better link these two programs. The World Bank and UNICEF are involved in this discussion and the secretariat of NNC need to be active participants too. It is also necessary to put in place a joint meeting between these programs at all levels to ensure that there is enough synergy.

There is a need for a strengthened and functional secretariat that can manage and steer the implementation of the NNP. The capacity gap in the management and coordination of the NNP within the health system (particularly at the federal and regional levels) should be examined and the implementation of strategies aiming at filling the identified gap should be one of the priority areas of funding.

3. HUMAN RESOURCE DEVELOPMENT AND CAPACITY BUILDING
One of the critical elements in getting the NNS/P implemented is ensuring that the needed human resources to envision, manage and implement the program is available at all levels of the health care delivery system. Currently the human resources available for nutrition are very scanty. At national level, there are four nutrition experts with limited training in nutrition and one technical assistant funded by UNICEF. According to the Project Appraisal Document of the World Bank additional technical assistants are going to be funded by the World Bank. Only two regions, Tigray and SNNP, are reported to have nutrition focal persons, with very little nutrition background. In all other regions, nutrition activities are add-ons to other functions. This scenario will continue to render nutrition as secondary as it not an essential key result area for those to which nutrition activities are add-on and thus, nutrition will remain suffocated until such time that drivers of the agenda are in place.

The Ministry of Health recognizing this and as part of the preparatory process for NNS/NNP, has commissioned a study through EHNRI to conduct a comprehensive analysis of the current human resource base of the Ministry’s nutrition staff at different levels; and based on the assessment mapping of the human resource and identifying short-and long-term human resource need to meet the capacity needed to implement the NNP. The study is financed by the World Bank and coordinated by ENHRI as per the Memorandum of Understanding signed with the FMOH. The scope of the study include reviewing the existing health system and human resource documentation of the MOH in relation to nutrition;
mapping available nutrition human resource within the FMoH, RHB and Woreda Health Office and the nutritional professional within the country as well as the gaps; identifying appropriate types and level of human resource required for implementing the NNP at various levels of MoH including research institute, and health facilities; and proposing a human resource structure for implementing NNP and define the roles and responsibilities of the suggested staffing at all levels at the time of writing a draft report was being shared with major partners for comments, but the final report has not yet been released. There have been some efforts to conduct on-the-job training on nutrition. In the past year 64 program coordinators and professional workers from the pastoralist areas (Benishangul Gumuz, Somali, Afar and Gambella) were trained on Essential Nutrition Actions. 70 professional staffs trained as master Trainers of community based nutrition and 168 Woreda health workers and HEW supervisors, 1,640 HEW, and 17,800 VCHW trained from 39 selected Woredas in four regions of Tigray, Amhara, SNNP and Oromia. In addition, training on HIV/AIDS and nutrition has been conducted for 55 professionals drawn from all regions. The efforts so far are related to building technical capacities of front line workers, who have a critical role in the implementation of the NNS. In addition to technical capacity, however, it is essential to build strategic and operational capacities of managers to ensure proper leadership and management of nutrition programs14.

4. RESEARCH

4.1. The Enhanced Outreach Strategy coverage and validation survey
The Government of Ethiopia in collaboration with UNICEF and the World Food Program initiated the delivery of essential preventive package for children aged 6 – 59 months using the Enhanced Outreach Strategy and targeted supplementary feeding (EOS/TSF) since 2004. The key component of the strategy is to reach as many children and women as possible during these mass campaigns twice a year. This survey aimed at validating the administrative routinely reported EOS service coverage through an independent post-campaign coverage. The survey has been completed and the findings showed that:

Overall coverage of the EOS campaign was very high and above the target 80%, though there were Woredas with coverage below 80%. The post-campaign coverage estimates for VAS, de-worming, and nutritional screening were found to be relatively low compared to administrative EOS reports. Overall EOS services and its mode of delivery are found to be acceptable for care givers. The success factor in EOS was also found to be timely community mobilization and the use of community volunteers (Addis Continental Institute of public health, October 2008).

4.2. National Nutrition Baseline Survey
This survey is planned to provide baseline information on nutrition data for the implementation of the NNP. By the end of 2000 Ethiopian Fiscal Year, preparations were under way to start data collection. At the time of writing, the study was still ongoing.

14 According to Bryce ,2008, Strategic capacity include knowledge , skills, leadership and human resources for envisioning; shaping and guiding the implementation of NNS and especially the capacity to broaden, deepen, and sustain the commitment on nutrition while hand operational capacity rest of the policy continuum: program and policy design, monitoring, and assessment and adoption of implementation and management; program and policy oriented research and analytical capacities, pre-service and in-service training.
EHNRI in addition to its operational research is now also working as a technical arm of the FMOH in the implementation of the nutrition information system, monitoring and evaluation sub-component of the NNS/P. Accordingly, the FMOH and EHNRI have signed a memorandum of understanding to undertake a number of studies and consultancy services, financed by a $ 550,000 grant from the World Bank. Table 2 below summarizes some of the studies, their objectives and status of implementation at the time of writing this report.

<table>
<thead>
<tr>
<th>Type</th>
<th>Objective</th>
<th>Status of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>Design the baseline survey; and develop a technical TORs with principles, methodologies and expected level of standard to facilitate the execution of the baseline survey planned in the NNP and IDA nutrition project.</td>
<td>The tools (questionnaire, enumerators’ and supervisors’ guide, Anthropometric instrument, area maps) have all been developed; Enumerators are identified and recruitment is ongoing. Training will soon be started. Training is scheduled to start on May 10th 2009. Data collection is completed data entry and cleaning is on-going.</td>
</tr>
<tr>
<td>Training needs assessment</td>
<td>to conduct a comprehensive analysis of the current training program in nutrition at different levels under the health, Agriculture or other training institutions and based on the assessment defining the training needs, mapping of the institutions and to identify short term and long term resource need to meet the capacity building of the training institutions and the human resource need for the NNP.</td>
<td>Draft report prepared, comments received from stakeholders and the document was shared with stakeholders.</td>
</tr>
<tr>
<td>Training needs assessment for agriculture</td>
<td>Conduct a comprehensive analysis of the current training of Agricultural Extension workers and Development Agents in nutrition; and based on the assessment defining the training needs, mapping of the institutions; and to identify short term and long term recommendations and resource need to improve their nutrition training.</td>
<td>It is initiated and first draft submitted to EHNRI.</td>
</tr>
<tr>
<td>Assessment of Demographic surveillance sites</td>
<td>to come up with body of information that advises FMOH to decide on whether or not use, and if accepted, how to use the DSS for the surveillance of key nutrition indicators of the NNP</td>
<td>The surveillance sites collected mainly health related info without nutrition. Agreement has been reached on the type of indicators to be collected with four universities: AA, Jima, Gondar and Haromaya. These universities have developed proposals for funding and are submitted to FMOH for approval. The requested budget was reviewed and institutions have been asked to revise and re-submit in accordance with the comments given.</td>
</tr>
<tr>
<td>Human resource assessment</td>
<td>conduct a comprehensive analysis of the current human resource of MOH for nutrition at different levels; and based on this, mapping of the human resource and identifying short and long-term human resource need to meet the capacity building for implementing NNP</td>
<td>Draft report produced; first round of comments are being received. The document has not yet been shared with stakeholders.</td>
</tr>
<tr>
<td>Communication framework</td>
<td>Assess the current scenario of health and nutrition communication in the country for the development of a National Nutrition Communication Framework.</td>
<td>First draft produced.</td>
</tr>
</tbody>
</table>

4.3. Strengthening institutional capacity

Another area of focus of the NNP is strengthening EHNRI. In this regard, given the timeframe, no significant progress has been made. EHNRI advertised twice to employ qualified nutritionists from the market. They were not able to attract candidates though. The incentive structure in the civil service is neither able to attract new employees not retaining experienced nutritionist already in the system. As an interim strategy, EHNRI has therefore opted for requesting development partners to second staff. Accordingly, the World Bank has seconded two international staff to support the implementation of the NNP. The capacity gap in EHNRI is evident. EHNRI envision a twin strategy to strengthen its capacity. In the short term, the plan is, on one hand to request staff secondment, on the other hand to organize short term tailor made courses to train the staff within the institution. The long term strategy is to pursue with formal training for staff within the EHNRI through various mechanisms. However, because of the mobility in the labor market, there is high turnover of staff, particularly senior level staff. This is
likely to reduce the speed, quality and effectiveness of some of the activities, as the new staff will require learning time to properly understand what is intended and the planned achievements.

5. ROLE OF NON-GOVERNEMENTAL ORGANIZATIONS

The Strategy and the Program explicitly emphasizes on community based actions to be implemented at larger or national scale to cover more beneficiaries. Stakeholders do appreciate that small scale and pilot projects managed by international NGOs helped to know what work and does not work in nutrition. Their impact, however, remains limited and their scalability questioned due to their high resource and management required. The playing field for NGOs seems changing. Given the new Civil Society law and the development of the NNS and NNP, NGOs working in the nutrition area need to be adaptive by revisiting their current strategies to align with the NNP. There seems a very big challenge in strengthening the capacity of providers (HEW, DAs) and their supervisors and as well health centers that are going to act as a referral points. The need for sustained capacity building to implement this program is immense.

NGOs have a comparative advantage in supporting the implementation of the NNP particularly through their practical and hands-on experience in training. The experience of CONCERN through the Irish Aid support in training health extension workers in four regions for 15 days on national screening is an activity that can be replicated and scaled up to a other regions by other NGOs with the capacity.

NGOs, therefore, should support the implementation of NNP in relation to:

- **Service delivery**: NGOs should align their implementation with the government structures and work with the health centers, health posts, and HEW. This requires in some cases for some NGOs a willingness to do away with or reduce own parallel implementation structures. This will help to put in more resources and knowledge in the existing structures to effect meaningful change and impact in the implementation of the NNS and NNP.

- **Capacity strengthening**: There is a knowledge gap that needs to be filled in the public sector. DPs and NGOs employ most of the nutrition experts in the country. Support government in the provision of training at all levels. Such training programs should be designed under government ownership and leadership. The training need and training gap needs to be identified and planned together with the government to ensure that the training programs designed to be demand rather than supply driven.
CHAPTER 3

FINANCING THE NATIONAL NUTRITION STRATEGY

True commitment for the implementation of the NNP should be reflected through the allocation of adequate financial, human and material resources to realize the objectives and targets set for the program. This also includes the follow up of financial flows to regions and Woredas as per the budget allocated by the government and commitment of the development partners. This section will review the cost estimates and the resources that were available during the first year of NNS implementation.

1. Funding requirements for the implementation of NNS/P

The five year cost of the NNP was calculated based on the targets and coverage set for each intervention, some are universal coverage for example salt iodization, vitamin A supplementation, and de-worming and some are targeted, i.e. targeted supplementary food and management of severe malnutrition. Excluding government contribution, the total financing requirement for the NNP over the next five years is estimated to be USD 253 million without TSF and USD 365 Million with TSF. The government contribution is estimated to be USD 96 million and this cost is mainly related to salary, operational cost and pre-service training of health workers involved in the implementation of NNP, taking into consideration the time they will spend on implementing NNP functions. Among the total financing requirement there is already some commitment from some development partners including the World Bank, UNICEF, CIDA, JICA, WHO and the Micronutrient Initiative. Moreover additional efforts and negotiation are being made to bring new partners and additional commitments from existing and new partners and currently this process is coordinated by the government and World Bank. This fund commitment is for the development component of NNP. It doesn’t include the fund allocated and required for emergency nutrition.

Table 3: Total financing Requirement of NNP by sub components in millions USD

<table>
<thead>
<tr>
<th>Components</th>
<th>Development partners without TSF</th>
<th>Development partners with TSF</th>
<th>Government contribution15</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. STRENGTHENING NUTRITION SERVICE DELIVERY</td>
<td>$224</td>
<td>$336</td>
<td>$67</td>
</tr>
<tr>
<td>1a. EOS/TSF</td>
<td>$64</td>
<td>$176</td>
<td>$8</td>
</tr>
<tr>
<td>1b. Health facility Nutrition Services</td>
<td>$78</td>
<td>$78</td>
<td>$25</td>
</tr>
<tr>
<td>1c. Community Based Nutrition</td>
<td>$62</td>
<td>$62</td>
<td>$31</td>
</tr>
<tr>
<td>1d. Micronutrient Interventions</td>
<td>$20</td>
<td>$20</td>
<td>$3</td>
</tr>
<tr>
<td>2. INSTITUTIONAL &amp; KNOWLEDGE BASE STRENGTHENING</td>
<td>$29</td>
<td>$29</td>
<td>$29</td>
</tr>
<tr>
<td>2a. Capacity Building, Program Implementation</td>
<td>$17</td>
<td>$17</td>
<td>$19</td>
</tr>
<tr>
<td>2b. Communication and advocacy</td>
<td>$2</td>
<td>$2</td>
<td>$5</td>
</tr>
<tr>
<td>2c. Nutrition Surveillance and Operations Research</td>
<td>$8</td>
<td>$8</td>
<td>$3</td>
</tr>
<tr>
<td>2d. Strengthening Inter sectoral Nutrition Linkages</td>
<td>$2</td>
<td>$2</td>
<td>$3</td>
</tr>
<tr>
<td>TOTAL FINANCING REQUIRED With TSF</td>
<td>$253</td>
<td>$365</td>
<td>$96</td>
</tr>
</tbody>
</table>

15 Government contribution is specified as salary, pre-service training and operational cost.
The NNP has also tried to disaggregate resource requirement over the first five years of the implementation. Of the total resource requirements 31% is expected to finance TSF, 21% facility nutrition services, 18% EOS, and 17% CBN. In terms of financing requirement by year, the program is scheduled to spend 38% each year in the first two years, another 20% each year in the next two years and 21% of the total financing requirement in the final year (see Table 4).

Table 4: Annual resource requirement by NNP components

<table>
<thead>
<tr>
<th>Component</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>TOTAL</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOS</td>
<td>13,647,624</td>
<td>13449024</td>
<td>13647624</td>
<td>11368512</td>
<td>11567112</td>
<td>63,679,896</td>
<td>17.5</td>
</tr>
<tr>
<td>TSF</td>
<td>27,089,142</td>
<td>24889444</td>
<td>22588733</td>
<td>20182924</td>
<td>17667782</td>
<td>112,418,025</td>
<td>30.8</td>
</tr>
<tr>
<td>CBN</td>
<td>3,317,696</td>
<td>4444400</td>
<td>17950888</td>
<td>17976613</td>
<td>18310403</td>
<td>62,000,001</td>
<td>17.0</td>
</tr>
<tr>
<td>Facility nutrition services</td>
<td>15,521,754</td>
<td>18070535</td>
<td>9514909</td>
<td>14484172</td>
<td>20475211</td>
<td>78,066,581</td>
<td>21.4</td>
</tr>
<tr>
<td>MN</td>
<td>3,845,604</td>
<td>3213993</td>
<td>3689409</td>
<td>4203524</td>
<td>4717640</td>
<td>19,670,169</td>
<td>5.4</td>
</tr>
<tr>
<td>Capacity</td>
<td>4,723,688</td>
<td>3057165</td>
<td>3303777</td>
<td>3221233</td>
<td>3183140</td>
<td>17,489,003</td>
<td>4.8</td>
</tr>
<tr>
<td>Communication</td>
<td>558,190</td>
<td>278293</td>
<td>446293</td>
<td>278293</td>
<td>188918</td>
<td>1,749,989</td>
<td>0.5</td>
</tr>
<tr>
<td>NIS</td>
<td>1,689,052</td>
<td>1381037</td>
<td>1617349</td>
<td>1511525</td>
<td>1688047</td>
<td>7,887,009</td>
<td>2.2</td>
</tr>
<tr>
<td>Linkages</td>
<td>541,485</td>
<td>271875</td>
<td>502625</td>
<td>271875</td>
<td>271875</td>
<td>1,859,735</td>
<td>0.5</td>
</tr>
<tr>
<td>Total NNP</td>
<td>70,934,235</td>
<td>69,055,766</td>
<td>73,261,608</td>
<td>73,498,671</td>
<td>78,070,128</td>
<td>364,820,408</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Total Percentage: 19.4 18.9 20.1 20.1 21.4 100%

Source: NNP detail cost sheet, FMOH document

2. Government commitment, allocation and expenditure

The commitment of the government could be reflected in various ways: increased allocation of human and financial resources, and putting the nutrition agenda as one of its core priorities in the planning and implementation of NNP in its sector program work. One of the pointers by which we can judge whether or not NNP is among the top government’s development policy agenda is to see the NNP as part of the resource mapping and allocation exercise that is carried out every year to inform resource allocation at all levels by major funding agencies, including government. Since nutrition was considered as a crosscutting area in the past, the resource mapping exercises carried out as per the HSDP components so far, with the exception of that of November 2007, has no data on allocation or expenditure on nutrition separately as nutrition was considered as part of Maternal and Child Health or Maternal Health services. The resource mapping of November 2007 shows that only three development partners were financing the nutrition in the health sector. All other development partners including the government of Ethiopia did not reflect their commitment and expenditure on nutrition (see table 5). The government is preparing the indicative resource framework for all sources for the planning exercise of 2002 Ethiopian fiscal year. At the time of data collection, the resource mapping document was under preparation and as such we could not ascertain whether or not nutrition is considered as one of the areas where resource need to be allocated to explicitly.

Table 5: Extract from Resource mapping Nov 2007, in million USD

<table>
<thead>
<tr>
<th>Name of Development Partners</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>DFID (through Merlin NGO)</td>
<td>246811</td>
<td>444756</td>
</tr>
<tr>
<td>JICA</td>
<td>120000</td>
<td></td>
</tr>
<tr>
<td>UNICEF</td>
<td>11474429</td>
<td>10678859</td>
</tr>
<tr>
<td>Total</td>
<td>11,721,240</td>
<td>11,243,615</td>
</tr>
</tbody>
</table>

The program is clear on what the commitment of the government is in terms of financing NNP. The total government commitment over five years is USD 96 million. This money is planned to finance the necessary human resources, mainly community Health Extension Workers and their supervisors. If one imputes the 5 years salary cost of health extension workers at monthly salary of ETB 600, the total resource requirements is about the same as what government pledges to finance. All of the 30,000 Health Extension Workers, as described in the preceding sections, are in place and the government is certainly financing as per the level set in NNP for HEW.

The cost of the deployment of the Health Extension Workers is part of the overall health systems strengthening exercise. They are working in all areas of service delivery, e.g. malaria, HIV/AIDS, or any other, that is being carried out at the community level. Attributing all the costs of the deploying HEW to national nutrition program is therefore wide of the mark. The NNP should take its fair share in financing HEW as should other programs. One of the measures of commitment of any government for making an issue an agenda is its increased allocation. The deployment of HEW at the community level is a running agenda that has been driven for the last five years, prior to the initiation of the NNS/P. If the commitment of the government is limited to what is described above, the priority it attaches to the nutrition agenda is at best not supported by financing. Therefore, the FMOH and other sectors need to show their real commitment by allocating resource and creating budget line for nutrition.

3. Commitment, allocation and expenditures by NNS partners
There is increased funding for NNP from some development partners, notably the World Bank and UNICEF, the Micronutrient Initiative, WHO, the Japan government and to some degree JICA. The Gates Foundation is also reported to have shown interest in financing the NNP communication and advocacy component. Of the total expected financing from development partners (365 million with TSF), only about $71.5 million (about 20% of the estimated donor financing requirement) has been mobilized and another 24.8 million (or 7%) is pledged so far (see table 6). The World Bank fully supported the institutional strengthening component except the multi-sectoral linkages and partially supported the community based nutrition and micronutrient interventions. The Government of Japan funds all the activities related to universal salt iodization. Some of the nutrition program activities remain unfunded include TSF, EOS, Health facility nutrition services (TFP and Nutrition and HIV) and to some degree Community Based Nutrition. The estimates presented below are, of course, an underestimate, as there are development partners financing nutrition through INGOs that are not reflected in this report. This data only show those development partners that are financing the NNP directly. It is necessary to ensure that the nutrition financing is captured in the annual resource mapping exercise and the allocated resource shown in the annual core plan.

<table>
<thead>
<tr>
<th>Partner</th>
<th>Committed</th>
<th>Pledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Bank</td>
<td>30,000,000</td>
<td></td>
</tr>
<tr>
<td>Japanese Government for USI</td>
<td>4,400,000</td>
<td></td>
</tr>
<tr>
<td>UNICEF *</td>
<td>10,122,124</td>
<td></td>
</tr>
<tr>
<td>Micronutrient Initiative</td>
<td>1,000,000</td>
<td></td>
</tr>
<tr>
<td>JICA</td>
<td>1,000,000</td>
<td></td>
</tr>
<tr>
<td>WHO</td>
<td>250,000</td>
<td></td>
</tr>
<tr>
<td>USAID/PEPFAR</td>
<td></td>
<td>10,000,000</td>
</tr>
</tbody>
</table>
The most significant NNP donor remains the World Bank. Some agencies have adopted a ‘wait-and-see approach’ before engaging and committing themselves to finance the program. All the major donors are supporting vertical programs of their own, using their systems and procedures. While all are interested to technically coordinate their activities, there does not seem to be real commitment towards aligning their systems to government implementation modalities-using government planning, financial, procurement and monitoring mechanisms. The government’s preferred modality is to use earmarked project funds and channel it through MDG Performance Fund (MDG PF), which was signed by the government and development partners recently. Though this opportunity exists to bring these funds under this pooled fund, some development partners are not willing to join due to fear of diversion of resources to other priority areas, as the MDG PF encourages development partners to provide un-earmarked support. It seems that a lot of work is necessary to advocate for more alignment of nutrition projects to government systems and procedures to reduce transaction costs.
CHAPTER 4

CONCLUSION AND RECOMMENDATIONS

Progress in Implementing NNS
The NNS and its program, NNP, have set out a clear sector-wide strategy in line with the international best practice interventions and have brought out nutrition as one of the government agendas to be pursued. It has set ownership and leadership to the FMOH, which is trying to put in place the Health Extension Program as the hardware for the strengthening of the health system. The comprehensive approach, if successful, has the potential to affect massively household nutrition practices at the grassroots level. Indeed there are many theoretical justifications for the adoption of the integrated approach. However, there should be caution on the quality of outcomes, which are not going to be as good as seen for projects that have been piloted in only few areas, with high technical and financial investment. Implementing community based nutrition (CBN) through the HEP and its associated interventions require sustained commitment from both donors and government. It is a significant achievement to start implementing CBN in more than 10% of Woredas but financing the remaining Woredas will continue to be a daunting task. According to the cost estimate done in the NNP, as presented in table 4, it will take $62 million to roll out CBN nationwide.

The adoption of the NNP and the ongoing attempt to finalize most of the preparatory work (some by the FMOH and others by EHNRI) shows the existence of continued commitment of both the government and the major nutrition partners (notably the World Bank and UNICEF) to get some of the institutional issues moving. The strengthening of most of the critical issues (human resources, nutrition information system and revision of the training programs) depends on the findings of these studies and actual actions taken based on these findings. The investment requirements to implement the study findings will be significant. The real commitment of government and donors in getting the NNS/P implemented will be seen not in financing these studies but in implementing the institutional arrangement that are going to come out of these studies.

The NNS and NNP have brought a significant focus on nutrition and it has now got the attention from policy makers better than any time before. Its maintenance as a policy agenda should not be dependent on the availability of resources as a program. Its programming process (planning, budgeting, reporting and reviewing) should be part of the already existing sector processes. Cutting corners will only provide a short term gain at the cost of long terms sustainability. The tendency to see it as a separate and uniquely placed program is necessary at this juncture until all the elements of its programming are included in the sector planning processes. It is thus necessary to ensure that the NNP is integrated into the HSDP IV as this is expected to constitute the
health and nutrition chapter of the forthcoming government five years development plan.

The coordination mechanisms that are set out in the NNS are not fully functional yet. It is only the NNC that has been established and undertook two meetings. Nutrition outcomes require multi-sectoral actions on the ground and this can be done only if and when these coordinating organs are in place. The establishment of these organs needs to learn from HSDP lessons (Regional Joint Steering Committees) which have not been functional at all. Development and implementing partners have not been adequately represented in the NNC. The involvement of the whole range of partners in the coordination body and program implementation needs to be strengthened in order to harmonize their contributions and interventions. The NNP should be implemented in close partnership with all stakeholders, bilateral, multilateral, and NGOs. It is therefore necessary, during the formation of the National Technical Taskforce, to consider the wider involvement of all stakeholders including NGOs.

There is a clear lack of linkage between nutrition and food security programs. The food security program, particularly its safety net component is being reviewed at the moment. Some development partners, notably the World Bank and UNICEF, are taking the initiative to integrate some of the nutrition activities in the safety net program. The secretariat of the NNP should take keen interest and get involved in these discussions and if necessary get the NNC get involved in the decision making for the improvement of the safety net program. The constitution of the NNC presents this opportunity as all key ministries sit around in one table to decide on issues related to nutrition.

The capacity of the health sector to lead, manage and implement the NNP is weak at all levels and requires strengthening. The program requires a dynamic secretariat with a capacity not only to manage the funds that are given to activities but also to create linkage with other programs. The regional level needs to have a person in charge of nutrition.

There is an improved financing landscape for nutrition. The government has employed all the HEW in the rural sedentary areas. Increased financing was available this year for nutrition, notably from the World Bank and UNICEF. Other new donors like the Spanish Development Cooperation came to the scene. This report was not able to document the contribution of NGOs, as their interventions are yet to align and reflect their contributions. Overall USD 46.7 millions are known to have been committed from development partners to fund the NNP. There is still a huge financing gap and the government and partners should work together to mobilize more funds for the successful implementation of the NNP.
Recommendations

- Stakeholders

Stakeholders should work in concert to sustain the achievements made over the last year and remove some of the constraints to fast-track the implementation of the NNS and NNP. In this regard, two overall and a separate recommendations to three different stakeholders are made in this report.

a. Strengthen the health systems capacity to roll out the NNP through the health extension program through:
   i. Strengthen capacity of the HEW and VCHW/model households with necessary practical skills in all aspects of promotion, care and referral related to nutrition
   ii. Making sure the trained supervisors are adequately supported to move around and provide mentoring and coaching to the HEWs
   iii. Strengthening the health centers to provide timely and appropriate treatment to those referred to them
   iv. Build the capacity of the federal, regional and Woreda health offices to manage and supervise the programs
   v. Providing adequate funding to support the implementation of the service delivery components of the NNP
   vi. Support financially the training and deployment of critical mass of human resources, particularly nutrition practitioners and/or nutrition focal persons at different levels as per the HR study.

b. More work on harmonization is needed. Nutrition should be integrated into the annual planning process so as to ensure that it remains intrinsic part of government process of priority setting and decision making. The nutrition targets should be planned and reported as part of the overall health planning and monitoring process, from Woreda to national levels. The NNP shouldn’t be treated as a stand-alone program but as a key element of sector planning, budgeting, resource allocation and monitoring process. The integration of nutrition should go hand in hand with a focus on the role and responsibility of all stakeholders, strengthening of mutual accountability rather than focusing only on government actions and inactions; and the inclusion of NGO nutrition partners who also significantly contribute into the implementation of some components or interventions spelt out in the National Nutrition program.

- Government

The government’s commitment in terms of developing the NNS and NNP and deployment of the human resources especially the HEW and their supervisors is appreciable. However, the FMOH should show more commitment for nutrition by:
I. Tapping the comparative advantage that NGOs and other development partners in emergency nutrition and international advocacy to provide improved service delivery and increased resource mobilization more than what it is currently doing;

II. Having an in-depth look on the implication of the new FMOH structure on the secretariat of the NNS and develop strategies on how the restructured system should effectively support the implementation of the NNP;

III. Developing nutrition capacity assessment and strengthening plan to guide the involvement of development and implementing partners in capacity building;

IV. Deploying skilled nutritionists at the federal office and in the regions and build the capacity of the Woreda health offices as per the findings and recommendations of Human Resources study;

V. Including nutrition in the planning and monitoring plan according to the NNP plan of action .e.g. including important nutrition activities of NNP, in addition to the existing ones, into the Woreda based annual plan and tracking some key indicators of NNP through HMIS;

VI. Increasing allocation of financial resources to fill the financing gap of NNP and creating budget line for nutrition;

VII. Selling the NNP to partners and continue providing the leadership necessary to get NNP moving faster and at scale;

VIII. Appreciating and responding to the concerns and challenges of NGOs in the implementation of NNP and presenting this to NNC since they have no direct representation in this coordinating body at the moment.

IX. Advocating for increased and wider representation of NGOs during the formation of the National Task Force.

- Development partners

There is increased funding from some development partners for nutrition. The gap for financing the national wide scaling up remains huge: It is recommended that development partners should:

I. Increase financing of nutrition as this also have direct impact on improving health outcomes in accordance with the MDGs;

II. Align their funding and management mechanism away from project mode towards harmonized, better aligned processes and procedures. It is necessary to use the opportunity created by the formation of the MDG Performance Fund, the preferred government modality, to reduce transaction costs associated with different management mechanisms. This is specially so in light of the weak capacity around nutrition in the system.

- Non-government Organizations

The role of NGOs in supporting the implementation of the NNP is crucial since they have the knowledge and expertise to work at implementation levels. However, they need to better appreciate the existing policy and strategic directions pursued in nutrition and define their
niche within the framework of the NNP. NGOs like Save the Children UK should join hands with government, development partners, and other NGOs to implement the strategies articulated in the NNS and interventions planned in the NNP and assist towards filling any perceived or real gaps. In this regard, it is recommended that NGOs, including Save the Children UK, should:

I. Review their comparative advantage in the area of community based nutrition and capacity building as well as their capacity and define their areas of involvement towards implementation of nutrition interventions in the country. This is so important because interventions at the grass root levels are going to be increasingly implemented through the HEP, as opposed to pilot scale NGO activities;

II. Proactively engage government on any technical gaps that they think exist in the implementation to address these jointly;

III. Advocate for increased funding for nutrition using their international and national networks;

IV. Select few Woredas and contribute to scaling up the comprehensive approach designed in the form of community based nutrition;

V. Ensure that they work through the government health delivery system in order to transfer their skills and knowledge to the health system on one hand, and to reduce the cost of creating parallel structures for implementation on the other hand;

VI. Play a significant role in strengthening and building EHNRI’s capacity both through secondment and training.
ANNEXES

Interviewees list

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Nigest Tesfaye</td>
<td>Director, Urban Health Extension Program</td>
</tr>
<tr>
<td>Dr. Belaynesh Mulugeta</td>
<td>FMOH former Nutrition Team Leader</td>
</tr>
<tr>
<td>Dr. Nejmudin Kedir</td>
<td>Planning Department, FMOH</td>
</tr>
<tr>
<td>Dr. Cherinet Aboye</td>
<td>Ethiopian Health and Nutrition Research Institute (EHNRI)</td>
</tr>
<tr>
<td>Dr. Iqbal Kabir</td>
<td>The United Nations Children’s Fund (UNICEF)</td>
</tr>
<tr>
<td>Dr. Habtamu Fekadu</td>
<td>The United Nations Children’s Fund (UNICEF)</td>
</tr>
<tr>
<td>Dr. Mulugeta w/Yoannes</td>
<td>United States Aid For International Development (USAID)</td>
</tr>
<tr>
<td>Ato Mudris</td>
<td>Canadian International Development Agency (CIDA)</td>
</tr>
<tr>
<td>Abeba Gobez</td>
<td>Food and Agriculture Organization (FAO)</td>
</tr>
<tr>
<td>Birhanu Hailegiorgis</td>
<td>Micronutrient Initiative (MI)</td>
</tr>
<tr>
<td>Fiona Quinn</td>
<td>Irish Aid</td>
</tr>
<tr>
<td>Dr. Tesfaye Bulto</td>
<td>Integrated Family Health Program (IFHP)</td>
</tr>
<tr>
<td>Zewditiu Getahun</td>
<td>Save the children USA (SC USA)</td>
</tr>
</tbody>
</table>

References

Addis Continental Institute of Public Health, 2008, Post campaign evaluation survey on Enhanced Outreach strategy in Ethiopia, first round campaign, Final report
ENHRI, 2008, Ethiopian National Vitamin A deficiency survey report
FMOH, 2008, National Nutrition Strategy
FMOH, 2008, National Nutrition Program
FMOH, 2008, Business Process Reengineering draft document
FMOH, 2008, HSDP III Mid Term Review Report
FMOH, 2008, Woreda Based Annual Core Plan 2001 Ethiopian Fiscal Year (2008/09)
FMOH, 2008, Approved Terms of reference for the NNP Coordination structure
FMOH, Resource Mapping Reports, 2007 and 2008