**Landscape Analysis on countries' readiness to accelerate the action**

**to reduce maternal and child under-nutrition.**

**The Ethiopian Assessment**

**BACKGROUND**

The Landscape Analysis project is a WHO-led interagency effort in accelerating the reduction of maternal and child under-nutrition to contribute to the achievement of the Millennium Development Goals (MDGs). The Lancet Series on Maternal and Child Under-nutrition launched in January 2008 provided a unique advocacy opportunity to accelerate evidence-based action in nutrition. In order to maximize the impact of this opportunity and for carrying forwards the findings of the Lancet Series to create inter-sectoral action for improving nutrition, the Landscape Analysis aims to identify gaps, constraints and opportunities for integrating new and existing effective nutrition actions and implement them at scale, in the 36 high-burden countries where the 90% of the world's stunted children live. The ultimate aim of the Landscape Analysis is to help lay the foundation to implement and scale up effective nutrition action in the high-burden countries in order to accelerate the support to achieve the MDGs, in particular MDGs 1, 4 and 5.

Nutritional status in Ethiopia (see Annex I, Boxes A – C)

**METHODOLOGY**

The Ethiopian assessment was conducted jointly by the Federal Ministry of Health (FMOH) and an international interagency team, consisting of the World Bank, UNICEF, FAO, Micronutrient Initiative (MI), Integrated Family Health Project (IFHP), Ethiopian Health and Nutrition Research Institute (EHNRI), Alive and Thrive, Save the Children UK, Save the Children USA, Action Against Hunger (ACF) and WHO from March 22 to March 30, 2010. The interagency team visited four Regional States in addition to the national level assessment. The team members, the places visited to conduct interviews and assessments are depicted in annex II A.

Prior to the field visits, the interagency team held three meetings (March 15, 18 and 22, 2010) regarding the Landscape analysis and to revise the tools and made modifications to fit into local circumstances. In addition, a review of national level stakeholders was undertaken in order to finalize the interview plans.

From Tuesday (23 March) to Tuesday (30 March), the national team and international team were divided into 4 groups to undertake the key stakeholder interviews and assessment in different areas: 1) in the capital, Addis Ababa, for the national level and Addis Ababa Administrative Region stakeholders interview; 2) in Oromiya Regional State; 3) in Southern Nations and Nationalities Peoples Region (SNNPR); and 4) in Afar Region (see Annex II B). All 4 groups came back to the Addis Ababa on Wednesday (31 March) and met for debriefing of the site visits.
The analysis of the assessment in 4 different areas was undertaken on Wednesday and Thursday (31 March & 1 April) using the common analysis framework prepared as part of the country assessment tools and further analysis and preparations for the stakeholder meeting (held on 20 April).

The main themes and findings arising from these assessments were presented and discussed at the stakeholder meeting held in May 2010 and suggested set of recommendations were agreed. These findings and suggestions were presented to the Director General of Health Promotion and Disease Prevention Directorate at the end of the country assessment as well as to the Chair of the National Nutrition Coordinating Body (State Minister of Health) when the representatives of the interagency team were able to have an audience with him on ____ 2010.

PURPOSE OF THE ETHIOPIAN ASSESSMENT
The aim of the in-depth country assessment was to review and outline the current nutrition situation in Ethiopia, especially with regards to the set of proven nutrition actions identified by the Lancet Nutrition Series, and to identify activities that need to be prioritized in order to act at scale and accelerate the reduction of maternal and child under-nutrition.

The expected outcome at the end of this process was a strategic plan for accelerating the reduction of maternal and child under-nutrition in Ethiopia, that could and should be used as a basis for incorporating increased resources, that must be invested if the MDGs are to be achieved in Ethiopia. Although facilitated by an international interagency team, the decisions on what needs to be done and how to do it are to be made by the national stakeholders.

The country assessment also aimed at contributing to the building of the capacity of national nutrition stakeholder to understand the strengths, opportunities and constraints of all aspects of the on-going programs, and in so doing enhance their collaborative efforts. For this reason the assessment process was as participatory as possible. Strong efforts were made to ensure the perspectives of all partners were heard, and all partners had the opportunity to discuss the validity and implications of the findings, and will work on ascertaining the capacity available to implement and follow-up on relevant recommendations.
LANDSCAPE ANALYSIS: MAIN FINDINGS

WILLINGNESS TO ACT – STRENGTHS

- In Ethiopia, there is political commitment for nutrition. To this end, the National Nutrition Strategy/ National (NNS)/ Nutrition Program (NNP), known by most national level respondents, was developed and launched in 2008. Nutrition indicator also included in HSDP IV

- The presence/ existence of coordination forum/ body, which is inclusive and interactive between sectors & development partners, was highly commended and attracted a lot of attention from stakeholders.

- The total financing requirement for the NNP over the next five years is estimated to be USD 365 million. The Government’s (circa USD 96 million) covers salary, operational costs and pre-service training of health workers (HEW).

- There is already commitment from development partners like the World Bank, UNICEF, MI, CIDA, Embassy of Japan and JICA, to support part of the total financial requirement. Total budget allocated for nutrition is showing increasing trends.

- UN agencies and donors have assigned manpower and resources for the support and implementation of the NNP

- Nutrition identified and included as one of the main task of HEW (public health interventions), and is also included in child survival strategies such as IMNCI, etc

- Decentralization of Outreach Therapeutic Program (OTP) into Health Extension Program (HEP).

- Very good and promising Community based nutrition program started through HEP, which includes; EOS/ TSF/ TFP/ CHD.

- Good coordination/ plan at grass-root level, that is, ‘kebele’ and ‘woreda’ level, where nutrition is covered by respective development committees.

WILLINGNESS TO ACT – WEAKNESSES

- Some coordination which was strong is losing momentum. The coordination at Regional and Zonal level is not as strong as ‘kebele’ and ‘woreda’ level.

- Coordination focuses mainly on emergencies and government capacity is limited to ensure timeliness of information sharing

- Deliberations at coordination meetings should be action oriented. There is lack of follow up and monitoring as well as no feedback
- High staff turnover and poor perception of what nutritional problems are, as well as interventions needed at Regional level.
- Agencies limited to acute malnutrition and emergency responses together with sub-optimal coordination of emergency food response.
- Limited coverage of Community Based Nutrition (CBN), Productive Safety Net Program (PSNP).
- Malnutrition/ under-nutrition seen as humanitarian problems. Moreover, maternal under-nutrition not given due emphasis.
- Most national stakeholders stated that insufficient financial resources are being directed at tackling nutritional problems

ABILITY TO ACT – STRENGTHS

1. HUMAN RESOURCE:
   - There are more than 30,000 HEWS. In-service training is ongoing (Eg. CBN)
   - Some health facilities have staff trained in SAM, ENA, etc…
   - National training materials are continuously updated

2. MANAGEMENT SYSTEMS:
   - The existing multi-sectoral coordination at national level is highly appreciated
   - Nutrition is integrated with primary healthcare services
   - CBN data is collected at local, woreda and regional levels. OTP data are used for planning in some woredas.

3. SUPPLIES:
   - Most essential nutrition drugs are available
   - RUTF is readily available in most facilities
   - Equipments for anthropometric measurements are available in most health facilities
ABILITY TO ACT – WEAKNESSES

1. HUMAN RESOURCES:
   - Lack of adequate staff at regional/ sub-regional levels as well as high staff turnover
   - No training provided on nutritional support for PLWHIV
   - Post-training supervision is not always available
   - Knowledge of health workers in health facilities is not satisfactory in hospitals and health centers.

2. MANAGEMENT SYSTEMS:
   - Nutrition activities are not integrated into other sectors (except MOARD) besides health
   - Nutrition information system is lacking
   - Poor information flow and feedback
   - NNS/ NNP is not well disseminated

3. SUPPLIES:
   - Protocols and guidelines are not available in health facilities at various levels
   - BCC materials are in short supply and not utilized well
   - Supplementary food is not available in some areas
LANDSCAPE ANALYSIS, ETHIOPIA – RECOMMENDATIONS

1. **Strengthen nutrition coordination and leadership across sectors/ partners and clarify roles and responsibilities of different actors**
   - Revitalize the National Nutrition Technical Committee (NNTC) to strengthen leadership and coordination of the National Nutrition Program. The National Nutrition Coordination Body also needs to meet regularly to guide the NNTC.
   - Establish Regional and Zonal nutritional coordination committee as indicated in the NNP with detailed responsibilities and roles of all stakeholders.

2. **Nutrition capacity in operational health system should be strengthened, with better orientation of resources.**
   - The need identified to strengthen human nutrition capacity is two-fold. Primarily, existing health professionals need to be trained on current/emerging nutrition practices/interventions and deployed at all levels. Continuous supervisory support also plays a major role here.
   - Secondly, clear long term plans are needed to revise medical curricula as well as support health, social & development workers to pursue nutrition at B.Sc. / M.Sc. level.
   - National guidelines and protocols and BCC materials need to be regularly updated and distributed to health facility and community levels.
   - For all these activities, a continuous and proactive fund raising is needed to meet the financial gap for this component of the NNP.

3. **Expand the coverage of CBN/ OTP/ TSF activities and proven nutrition interventions in areas where it has not started so as to include all woredas.**
   - At the moment, CBN only covers food insecure woredas due to resource constraints. The benefits of CBN and community satisfaction calls for the scaling up of CBN and proven nutrition interventions (such as complementary feeding, food fortification, breastfeeding and micronutrient supplementation), to reduce maternal, neonatal and child under-nutrition. In addition include areas where it has not started so as to include all woredas. For this purpose, government, donor and development partners need to mobilize resources to ensure Ethiopia meets MDGs by 2015.

   In addition, nutrition programs and interventions should be linked with food security programs to be able act at household level which in turn will aid to reduce chronic malnutrition in mothers & children thereby breaking the intergenerational cycle of under-nutrition.

4. **Rationalize the collection and use of nutrition information for decision – making purposes at central, regional, woreda and commune level.**
   - Adequate standard nutritional indications should be captured in some kind of NIS. The collection and compilation of data needs to be done at all levels and most importantly, interpretation and use of data at local levels must be addressed. Hence, capacity building of health professionals and organization of a platform for information sharing need to be planned and implemented.
5. **Institute and strengthen consistency of nutrition communication and advocacy by linking with other activities such as WASH/ Safety Net/ etc.**

The NNS and NNP must be disseminated at Regional, woreda and kebele levels. Moreover, advocacy is also needed using MDGs, etc at all levels involving all sectors. At community, kebele and woreda levels strong advocacy is also necessary about chronic malnutrition, cultural misbelieves as well as prevention and development aspects of nutrition.

6. **Integrate nutrition in non-health sectors, particularly in agriculture/ education/ etc where increased food production/ knowledge/ etc must reach mothers and young children.**

7. **Miscellaneous**
   - Develop a Nutritional Policy
Annex I: Nutritional Indicators of Ethiopia

BOX A: RATES OF MALNUTRITION IN ETHIOPIA

CHILD MALNUTRITION (DATA FROM NLIS COUNTRY PROFILE FROM 2005)
- STUNTING - 50.7%
- UNDERWEIGHT- 34.6%
- WASTING – 12.3%
- LBW – 20.3%
- ANAEMIA – 53.5%

MATERNAL MALNUTRITION
- UNDERWEIGHT – 26.5%
- ANAEMIA – 30.6% AS MEASURED IN PREGNANT WOMEN
- VAD – 22.1% [VAD IS CLINICAL VITAMIN A DEFICIENCY IN WOMEN, DETERMINED BY HISTORY OF NIGHT BLINDNESS DURING MOST RECENT PREGNANCY]

BOX B: UNDERLYING FACTORS

1. HEALTH SERVICES
- % BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL 5.7% (2005)
- CHILDREN 6-59 MONTHS RECEIVING VITAMIN A SUPPLEMENTS (DOSE 1) 88.0% (2007)
- CHILDREN 6-59 MONTHS RECEIVING VITAMIN A SUPPLEMENTS (DOSE 2) 86.0% (2007)
- CHILDREN AGED 1 Y IMMUNIZED AGAINST MEASLES 65.0% (2007)
- POPULATION USING AN IMPROVED SANITATION FACILITY 11.0% (2006)
- POPULATION USING IMPROVED DRINKING WATER SOURCES 42.0% (2006)

2. FOOD SECURITY
- % POPULATION BELOW $1 PER DAY - 39.0% (2005)
- POPULATION BELOW MINIMUM LEVEL OF DIETARY ENERGY CONSUMPTION - 46.0 (2004)
- IODISED SALT CONSUMPTION (% HOUSEHOLDS CONSUMING ADEQUATELY IODISED SALT - 15 PARATS PER MILLION OR MORE) - 20.0 (2005)

3. CARING PRACTICES
- % CHILDREN <5 Y WITH DIARRHEA RECEIVING ORT AND CONTINUED FEEDING 15.0% (2005)
- WOMEN 15-19 Y WHO ARE MOTHERS OR PREGNANT WITH THEIR FIRST CHILD 16.6 (2005)
- BREASTFEEDING – EXCLUSIVE BREASTFEEDING < 6 MONTHS – 49% (DOWN FROM 54.2%)
BOX C: BASIC FACTORS

1. COMMITMENT
   • GENERAL GOVERNMENT EXPENDITURE ON HEALTH AS % OF TOTAL GOVERNMENT EXPENDITURE 10.0 (2006)
   • MATERNITY LEAVE 90 DAYS (2009)

2. CAPACITY
   • NURSING AND MIDWIFERY PERSONNEL DENSITY PER 10,000 POPULATION 2.0 2000-2007
   • GDP PER CAPITA (PURCHASING POWER PARITY- PPP USS)  1,055 (2005)
   • LOW-INCOME FOOD-DEFICIT COUNTRY (LIFDC) YES (2009)

3. META-INDICATORS
   • % SEATS HELD BY WOMEN IN NATIONAL PARLIAMENT 21.9 (2009)
   • GENDER PARITY INDEX IN PRIMARY LEVEL ENROLMENT (RATIO OF GIRLS TO BOYS) 0.9 (2008)
   • HUMAN DEVELOPMENT INDEX (HDI) VALUE 0.406 (2005) [GDP; INFANT MORTALITY RATE & EDUCATION]
### Annex II A: Country Assessment Teams and members

<table>
<thead>
<tr>
<th>Team</th>
<th>Participants</th>
<th>Agency</th>
<th>Remarks</th>
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<tr>
<td>Overall coordinator</td>
<td>Dr Ferew Lemma</td>
<td>FMOH</td>
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<tr>
<td>National and Addis Ababa</td>
<td>Dr. Belaynesh Yifru*</td>
<td>FMOH</td>
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<td></td>
<td>Dr. Ephrem Teferi</td>
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<td>Frew Tekabe</td>
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<td></td>
<td>Eleni Asmare</td>
<td>FAO</td>
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<td>Dr. Chizuru Nishida</td>
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<td></td>
<td>Alisha Ali</td>
<td>MI - Ethiopia</td>
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Annex II B: Areas Visited by Ethiopia Country Assessment Teams

**NATIONAL LEVEL AND ADDIS ABABA ADMINISTRATIVE REGION [27]**

- **GOVERNMENT:** 5 (FMOH, MOE, MOARD, EHNRI, MOWR)
- **DONORS:** 5 (USAID, CIDA, DFID, MI, JICA)
- **UN AGENCIES:** 5 (UNICEF, FAO, WHO, WFP, WORLD BANK)
- **NGOS:** 8 (SC-US; SC-UK; CONCERN; GOAL; IMC; IFPH; ACF; ALIVE & THRIVE)
- **PRIVATE SECTOR:** 1 (HELINA)
- **ADDIS ABABA REGIONAL HEALTH BUREAU:** 1
- **HEALTH FACILITIES:** 2

**SOUTHERN NATIONS AND NATIONALITIES PEOPLE’S REGION [25]**

- **REGIONAL:** 13
- **ZONE/DISTRICT:** 4
- **HEALTH FACILITIES:** 8

**OROMIYA [21]**

- **REGIONAL:** 6
- **ZONE/DISTRICT:** 8 (2 ZHB; 2 ZDPPC; 1 WOHO; CARE; IFHP; GOAL)
- **HEALTH FACILITIES:** 7 (2 HOSPITAL; 2 HC; 3 HP)

**AFAR [5]**

- **REGIONAL:** 4 (RHB; MOARD; UNICEF; SC-UK)
- **ZONE/DISTRICT:**
- **HEALTH FACILITIES:** 1 (DUBTI HOSPITAL)

**Overall Total =** 78 institutions
Annex III: KEY STAKEHOLDERS OF NUTRITION IN ETHIOPIA

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<tr>
<th>No.</th>
<th>Stakeholders</th>
<th>Org Type</th>
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<td>1</td>
<td>Federal Ministry of Health</td>
<td>Government</td>
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<td>2</td>
<td>Ethiopian Health &amp; Nutrition Research Institute</td>
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Annex IV: ETHIOPIA: ON-GOING NUTRITION – RELATED POLICIES, PROGRAMMES, PROJECTS AND ACTIVITIES

3A. Nutrition related Policies

- National Nutrition Strategy
- IYCI
- SAM

3B. Nutrition programs, projects and activities

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3C. Legal and Institutional Framework

3D. Previously done assessments/ evaluations’ recommendations

- National Nutrition Assessment – EHNRI