NiPN-Ethiopia
National Information Platform for Nutrition

Ethiopian Public Health Institute

National Nutrition Program (2016-2020): Progress Analysis: Evidence for the Development of the Food and Nutrition Strategy

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May 2020

The National Nutrition Program II

(2016-2020)

Progress Analysis

The Ethiopian Public Health Institute

National Information Platform for Nutrition (NIPN)

The NIPN is a global initiative supported by the European Union (EU), the Foreign Commonwealth and Development Office (formerly the United Kingdom Department for International Development) and the Bill and Melinda Gates Foundation. The NIPN in Ethiopia is hosted by the Ethiopian Public Health Institute (EPHI) and receives funding from the EU Delegation in Ethiopia. It supports evidence-based decision making for nutrition. Technical support to the NIPN is provided by the International Food Policy Research Institute (IFPRI).

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List of Acronyms

AgSS	Agricultural Sample Survey
AARR	Annual Average Rate of Reduction
ANC	Antenatal Care
BFHI	Baby Friendly Hospital Initiative
BMI	Body Mass Index
EDHS	Ethiopian Demographic and Health Survey
EMDHS	Ethiopian Mini Demographic and Health Survey
EPHI	Ethiopian Public Health Institute
FAO	Food and Agriculture Organization
FTC	Farmer Training Center
GMP	Growth Monitoring and Promotion
HMIS	Health Management Information Systems
ILO	International Labor Organization
IYCF	Infant and Young Child Feeding
LBW	Low Birth Weight
MAD	Minimum Acceptable Diet
MDD	Minimum Diet Diversity
MMF	Minimum Meal Frequency
MOA	Ministry of Agriculture
MOE	Ministry of Education
MOH	Ministry of Health
NCD	Noncommunicable Diseases
NFNP	National Food and Nutrition Policy
NFNS	National Food and Nutrition Strategy
NIPN	National Information Platform for Nutrition
NNP	National Nutrition Program
PLWHA	People Living with HIV/AIDS
PPM	Parts Per Million
PSNP	Productive Safety Net Program
SARA	Service Availability and Readiness Assessment
SBCC	Social and Behavior Change Communication
SD	Standard Deviation
SNNPR	Southern Nations Nationalities and Peoples Region
SO	Strategic Objective
VIP	Ventilated Improved Pit Latrine
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

Ethiopia has achieved remarkable success in the reduction of malnutrition in the past decade. However, despite the notable progress, the burden of malnutrition is still high. The National Nutrition Program (NNP) II (2016-2020) is a multisectoral program that aims to accelerate the reduction of malnutrition through the implementation of evidence-based interventions that address nutritional problems across the lifecycle. This report provides an analysis of the progress made since the start of the NNP II compared to its targets.

Progress in Child Nutrition

- Although stunting in children is declining, Ethiopia is not on track to achieve the NNP II target of reducing stunting rates to 26% by 2020. Stunting decline stagnated between 2016 and 2019 with large differences in stunting rates across regions, residence, and wealth status. Stunting remains a public health concern in Ethiopia and more interventions are needed to accelerate its reduction.
- Data was not available to accurately track progress in the reduction of low birth weight among newborns as well as anemia in children under five years of age.
- In 2019, 59% of Ethiopian infants aged 0-6 months were exclusively breastfed. Although this prevalence is much lower than the NNP II 2020 target of 80%, Ethiopia has achieved the World Health Assembly (WHA) target of at least 50% exclusive breastfeeding by 2025.
- The NNP II target for extending maternity leave was met when Ethiopia passed the Labor Proclamation 1156/2019, which granted four months (17 weeks) of paid maternity leave for women employed in the formal sector.
- The NNP II targets for Minimum Acceptable Diet (MAD) of 35%, Minimum Diet Diversity (MDD): of 40% and Minimum Meal Frequency (MMF) of 75%, were not met. Between 2016 and 2019 there was a 5% increase in MAD and an 11% increase in MMF while MDD showed no improvement during this time.

Progress in Nutritional Status of Women of Reproductive Age and Adolescent Girls

- The most recent data available to assess progress in the nutritional status of women of reproductive age, is the 2016 Ethiopian Demographic and Health Survey (EDHS). Using this data, chronic undernutrition (Body Mass Index [BMI] < 18.5) is declining slowly in Ethiopia. Although at 22% in 2016, it is still higher than the NNP II 2020 target of 16%. In contrast, rates of overweight/obesity are sharply increasing among urban women. In 2016, the prevalence of overweight/obesity among urban women was 21% which is much higher than the NNP II 2020 target of 6%. The prevalence of anemia was 24% nationally in 2016, which is double the NNP II 2020 target of 12%.
- There is a paucity of data on the nutrition situation of adolescent girls in Ethiopia, especially for younger adolescents (10-14 years). According to the 2016 EDHS, 29% of adolescent girls aged 15-19 years were undernourished and 20% were anemic.

Progress in Coverage of Nutrition-Specific Interventions

- During the implementation of NNP II, some improvements were seen in the coverage of nutrition-specific interventions. However, NNP II targets were not met for most of these interventions. The presence of iodized salt in households was the only intervention that had a high coverage at 88%, which is close to the NNP II target of 90%. In 2019, coverage of growth monitoring and promotion was 55%, which is low compared to the NNP II target of 80%. Coverage of at least 90 days of iron supplementation during pregnancy remains low at only 11% and far below the NNP II target of 40%.
- Between 2016 and 2019m improvements were also seen in some services notably, four or more antenatal care (ANC) visits (32% to 43%) and nutrition counseling during ANC visits (66% to 71%) between 2016 and 2019.

Progress in Coverage of Nutrition-Specific Interventions

- Although assessment only started in 2019, some progress was seen in the implementation of nutrition-sensitive agriculture interventions. NNP II targets for the establishment of fruit nursery sites, caged/fenced poultry production at the household level, and establishments of nutrition corners at farmer training centers were exceeded by large margins. The targets for the establishment of regional poultry multiplication centers, woreda milk collection and poultry multiplication centers, and urban mushroom producing groups were also achieved.
- The NNP II targets related to water, sanitation and hygiene (WASH) were reviewed. In 2019, 67% of households had access to safe drinking water. This is lower than the NNP II target of 90%. Progress was seen in the proportion of schools that have any water supply which was 87% and close to the 90% NNP II target for 2020.
- In terms of progress in nutrition-sensitive interventions in the industry sector, of the 13 oil processing industries in Ethiopia, only one is currently fortifying edible oil with vitamin A, and none of the flour producing industries fortifies wheat flour or blended foods.

Challenges in Multisectoral Coordination

Key multisectoral coordination related challenges faced during NNP II implementation included:

- Poor coordination and planning, weak collaboration and support among implementing sectors.
- Absence of a separate budget line for nutrition, weak monitoring and evaluation systems, and lack of ownership and accountability.
- Coordination has not yet filtered down to the regional, woreda (district) and community levels. This resulted in a lack of joint planning, actions, awareness and strategic alliances between sectors at sub-national level.
- Absence of standardized measurement indicators for multisectoral coordination.

Lessons Learned and Way Forward

- The NNP II initiatives targeting pregnant and lactating women were the most consistently implemented. Despite improvements, coverage of iron/folate supplementation during pregnancy remained low and requires focused attention.
- Implementation gaps remain in adolescent nutrition initiatives. The contact points for adolescents within the health system are limited and adolescent nutrition–related indicators are not adequately monitored. The National Food and Nutrition Strategy (NFNS) should outline modalities to reach adolescents, both in and out of school.
- To keep childhood obesity rates low and to address rising overweight and obesity among urban women, interventions that target overweight and obesity need to be included in the NFNS.
- Progress in the improvement of child diets is slow. To see progress in this area, interventions that increase the availability and affordability of nutritious foods and interventions that increase agricultural productivity and market access need to be expanded. Furthermore, social and behavior change communication (SBCC) interventions targeting mothers need to be adapted to different contexts, for example, taking into account differences in residence and livelihood.
- Limited data for some target groups (adolescents) and for indicators (women's diets and noncommunicable disease rates), hampers efforts to use evidence for malnutrition reduction programming.
- Although progress was observed for most of NNP II indicators, the majority of the targets were not achieved. To sustain the current momentum, Ethiopia has to reduce malnutrition and has to set realistic targets, taking past trends in indicators and global experiences into account.
- The establishment of multisectoral coordination teams at federal and regional levels could be a motivational factor to decentralize nutrition coordination to woreda level.
- Since the start of the NNP II, nutrition activities have appeared as strategic objectives in sectoral annual plans, and at federal level, plans have been aligned with the NNP II document, which is commendable.
- Multisectoral nutrition coordination is not functioning as per the expected goals in Ethiopia. The kind of leadership required to address the coordination gaps can only be provided by a higher government authority which has power over each signatory. No individual sector on its own has the authority to manage the level of coordinated action needed to achieve NNP II targets.

I. Background

Ethiopia has experienced significant progress in the reduction of malnutrition in the past decade[1-5]. The development of the National Nutrition Strategy in 2008[6] and the implementation of the first and second phases of the National Nutrition Program (NNP)[7,8] were major milestones that enabled the implementation of concerted efforts to reduce malnutrition. Furthermore, nutrition is a national priority, and the Government of Ethiopia has a strong political commitment to reduce malnutrition. Despite these achievements, Ethiopia still faces complex nutritional problems and malnutrition remains an important public health concern. Improvements in immediate, underlying, and basic determinants of malnutrition are still needed. In addition, inequalities in nutritional outcomes and access to services need to be addressed if Ethiopia is to meet the 2025 WHA targets[9].

The NNP II[8] aimed to maintain the achievements of the first phase of implementation and to address challenges to accelerate the reduction of malnutrition. It provided a framework for the implementation of evidence-based interventions to achieve the nutrition-related targets outlined by the sustainable development goals. The NNP II continued the use of the life cycle approach with a particular emphasis on the first 1000 days, but also included new focus areas; a stronger emphasis on multisectoral coordination, the integration of nutrition-specific and nutrition-sensitive interventions and interventions such as adolescent nutrition and noncommunicable diseases (NCDs)[8]. The NNP II has five strategic objectives (SO), namely:

- SO1: to improve the nutritional status of women and adolescents.
- SO2: to improve the nutritional status of children under five years of age.
- SO3: to improve the delivery of nutrition services for communicable and noncommunicable diseases.
- SO4: to strengthen the implementation of nutrition-sensitive interventions.
- SO5: to improve multisectoral coordination[8].

To facilitate the implementation of this multisectoral program, the NNP II is governed by a National Nutrition Coordinating Body composed of 13 sectors and other nutrition stakeholders. A National Nutrition Technical Committee and Regional Nutrition Technical Committees were established through the leadership of the Ethiopian Ministry of Health (MOH) to coordinate the program[8]. An important recent achievement was the development of the country's first National Food and Nutrition Policy (NFNP), which was endorsed by the Council of Ministers in November 2018[10]. The policy was developed in collaboration with multiple government sectors and development partners. The goal of the policy is to attain optimal nutritional status, at all stages of life, at a level that is consistent with a high quality of life, productivity, and longevity of life.[10] The Ethiopian Government is currently developing the National Food and Nutrition Strategy (NFNS) to operationalize the NFNP[6].

This report was prepared by the National Information Platform for Nutrition (NIPN), hosted by the Food Science and Nutrition Research Directorate of the Ethiopian Public Health Institute (EPHI).

The analysis was carried out in response to a request made by the MOH to the NIPN. In line with the NIPN objectives, the report provides an analysis of nutrition-related data and information to support evidence-based planning and decision-making. It reviews the implementation progress of NNP II between 2016 and 2019 to inform the final stages of the development of the NFNS. For this analysis, the Lancet nutrition framework[11] was used to present information on nutritional outcomes on immediate, underlying, and basic determinants of malnutrition, on the coverage of nutrition-specific and nutrition-sensitive interventions and multisectoral coordination. The following topics have been covered in this report:

- Trends in NNP II performance indicators between 2016 and 2019.
- Progress in indicator achievement against NNP II and global targets.
- Progress in the coverage of nutrition-specific and nutrition-sensitive interventions.
- Challenges with multisectoral coordination.
- Lessons learned and way forward (recommendations).

Data and Information Sources

This analysis mainly used nationally and regionally representative datasets. To show trends in NNP performance indicators, data from four rounds (2000, 2005, 2011 and 2016) of the EDHS and the 2019 Ethiopian Mini Demographic and Health Survey (EMDHS) was used. To analyze progress in agriculture and livestock production, data from the Annual Agriculture Sample Survey (AgSS) of the Central Statistics Agency was used. National food supply and food losses were estimated using data from the Food and Agriculture Organization (FAO's) food balance sheets (FAOSTAT). Two rounds of the Service Availability and Readiness Assessment (SARA) was used to review communicable and noncommunicable diseases service delivery. Annual Health Management Information Systems (HMIS) Health & Health-Related Indicators reports, administrative reports from the Ministry of Agriculture (MOA), Ministry of Education (MOE), and the Food Beverage and Pharmaceutical Industry Development Institute were used, to track progress in additional indicators. We also conducted a narrative review of published studies to identify the challenges with multisectoral coordination during the implementation of the NNP II. The results from this review were integrated into this report.

Limitations of the Analysis

The 2019 EMDHS is the most recent data source on the current nutrition situation in the country, but it has some limitations. Even though this survey is nationally and regionally representative, it had a smaller sample size and fewer indicators compared to regular rounds of the EDHS. Consequently, trend comparisons, using the 2019 EMDHS and regular EDHS, should be interpreted with this limitation in mind.

As data was not available to track progress for some NNP II initiatives and related performance indicators, the progress analysis focused on indicators with data. Indicators for which data was not available are listed below.

Impact indicators: The most recent data available for women's BMI and low birth weight in newborn babies is from the 2016 EDHS, which was conducted at the start of the NNP II. Therefore, it was not possible to track progress in these indicators over time.

Women and adolescent nutrition indicators: No data exists to track progress in women's diets in general, and during pregnancy and lactation in particular. Nationally and regionally representative data for anemia in women and adolescents was only available from the 2016 EDHS. Limited data exists to assess progress in adolescent nutrition. No data was available for young adolescents between 10-14 years, while some data was included for older adolescents between 15-19 years.

Child nutrition indicators: Data were not available to access progress in child anemia after the start of NNP II (2016), but anemia prevalence data was included from the 2011 and 2016 EDHS.

Service delivery indicators: Data were not available for most indicators outlined under SO 3 which focuses on communicable and noncommunicable diseases service delivery. Therefore, information from two rounds of the SARA survey was used to track progress in this strategic objective.

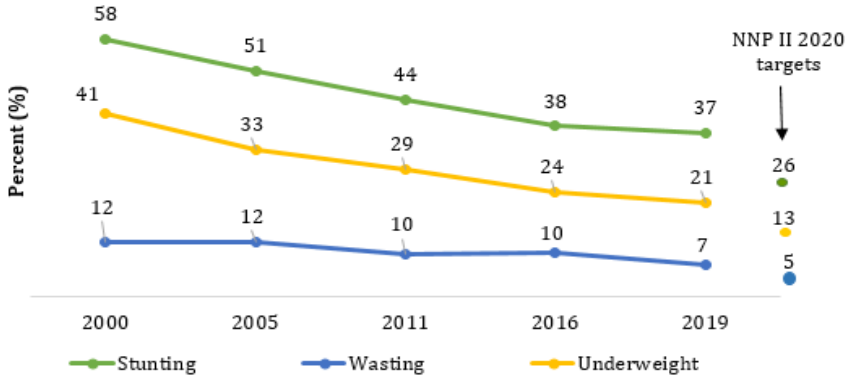
Nutrition-sensitive intervention indicators: Progress in nutrition-sensitive interventions across sectors was not assessed from the start of NNP II. The lack of data meant that progress in this area could not be measured. In addition, the COVID-19 pandemic limited our access to woreda and zonal level nutrition-specific and nutrition-sensitive intervention coverage data.

II. Progress in Child Nutrition

Child Undernutrition

The NNP II included various indicators to track improvements in the reduction of child undernutrition. The 2020 targets for stunting, wasting, and underweight were 26%, 5%, and 13% respectively[8]. While reviewing the progress made under the NNP II, it was important to assess trends in the last two decades. Between 2000 and 2019, stunting decreased from 58% in 2000 to 37% in 2019, and underweight decreased from 41% to 21%[1,4] (Figure 1). Between 2016 and 2019, the rate of decline in stunting seemed to stagnate, with minimal change during this period. Considering current trends, to achieve the WHA target[9] of a 40% reduction of the number of stunted children by 2025, a 5.3% Annual Average Rate of Reduction (AARR) is required[12]. The current AARR in Ethiopia is 2.3%, far below the required WHA rate. According to the World Health Organization (WHO), a stunting prevalence of 37% is an indication that malnutrition is of high severity in a population[13]. Thus, stunting remains a public health concern in Ethiopia. Between 2016 and 2019, wasting declined by 3%. At 7% in 2019, it is still below the 5% target of the NNP II. Table 1 shows progress in selected NNP II child indicators.

Figure 1. Trends in prevalence of stunting, wasting and underweight among children under five years in Ethiopia



Sources: EDHS 2000, 2005, 2011, 2016 and EMDHS 2019

Differences exist in stunting decline across regions, residence (rural vs urban), and wealth status. In 2019, 40.6% of rural children under five years of age were stunted compared to 25.6% in urban areas[5]. Furthermore, 14.3% of urban children were underweight compared to 23.3% of rural children[5]. The prevalence of stunting was 41.9% in the lowest wealth quintile and 24.1% in the highest wealth quintile (24.1%)[5]. The WHA targets aim for no increase in overweight among children[9]. In Ethiopia, childhood overweight/obesity (weight-for-height z-score > +2 Standard Deviation [SD]) did not increase between 2016 (2.8%) and 2019 (2.1%). Table 1 summarizes progress in child nutritional indicators.

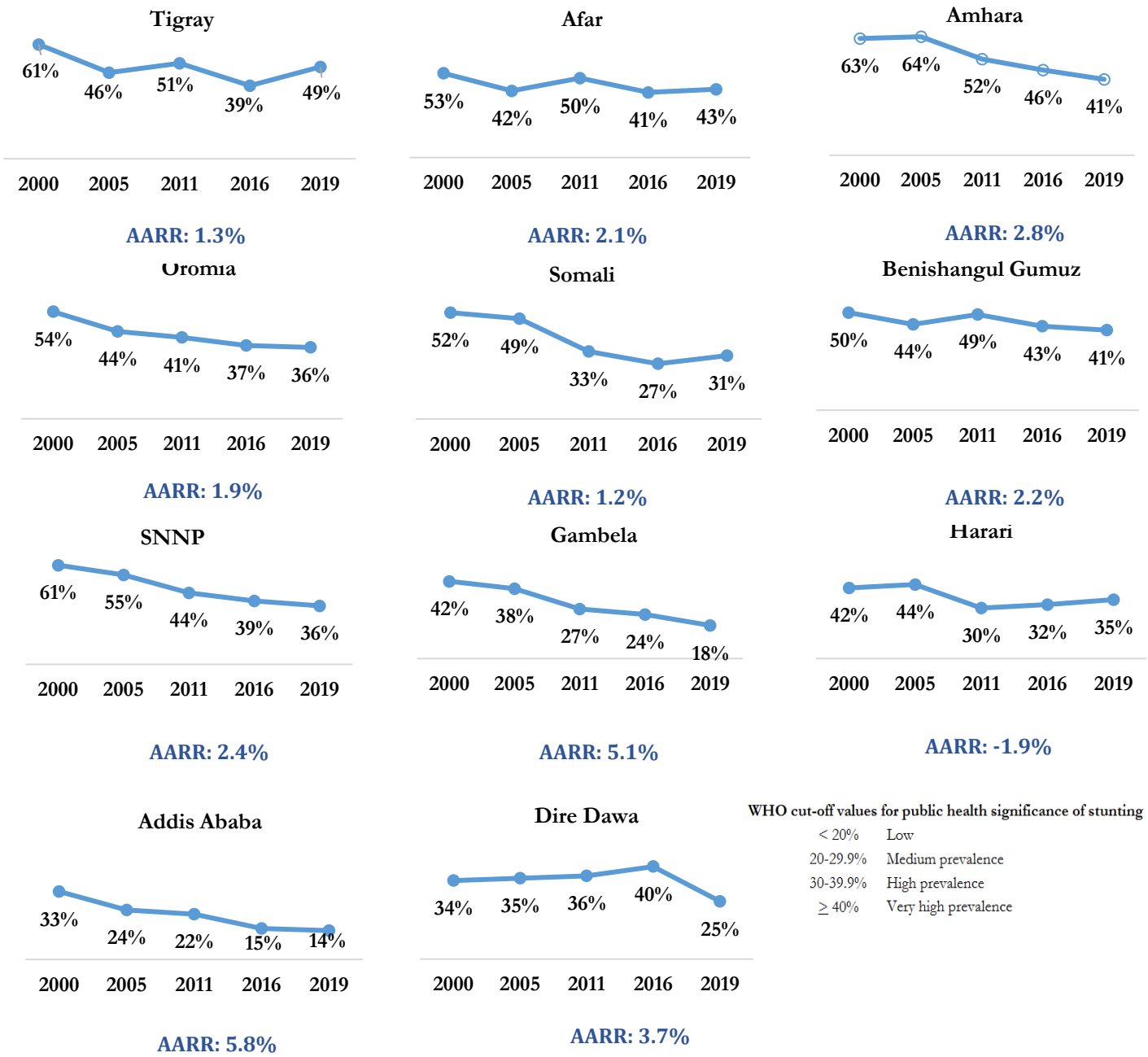
Table 1. Progress in selected NNP II indicators against local and global targets

Indicator	Baseline (2015)*	Progress (2016)**	Progress (2019)***	NNP II Target (2020)	WHA targets (2025)
Prevalence of stunting among children under five years	40	38	37	26	21***
Prevalence of wasting among children under five years	9	10	7	5	4
Prevalence of underweight among children under five years	25	24	21	13	--
Proportion of newborns who weighed less than 2.5 kg at birth	11	13	ND	5	8
Prevalence of overweight/obesity among children (Weight-for-height > 2)	ND	2.8	2.9	ND	1.7
Prevalence of anemia in children 6-59 months	39	57	ND	24	--

Sources: ND refers to No Data Sources available; *NNP I end line survey and NNP II implementation manual, **EDHS 2016, ***EMDHS 2019, **** WHA stunting target aims to reduce the number of stutned children by 40% by 2025. The target number of stunted children for 2025 is 3693000 which yileds a stuting prevalnce of 21%[14]

Figure 2 shows trends in stunting across regions. Between 2016 and 2019, stunting increased in Tigray (10%), Somali (4%), Afar (2%), and Harari (3%). Stunting rates declined in Dire Dawa (15%), Addis Ababa (1%), Oromia (1%), Benishangul Gumuz (2%), Southern Nations Nationalities and Peoples Region (SNNPR) (3%), Amhara (5%), and Gambela (6%). Region-specific AARRs are included in the figure.

Figure 2. Trends in stunting across regions (2000-2019)



Sources: EDHS 2000, 2005, 2011, 2016; EMDHS 2019

NNP II 2020 Stunting Target: 26%

Low Birth Weight and Anemia in Children

Low birth weight (LBW) is associated with an increased risk of morbidity and mortality and is a risk factor for the development of NCDs later in life[11]. The NNP II aimed to reduce LBW to 5% by 2020. Reliable data for LBW is not currently available for Ethiopia. Proxy variables used to represent birth weight in the EDHS are recalled birth weight and mother's perception of child size at birth. The first measure is prone to recall bias while the second is subjective. Using recalled birth weight, 13% of Ethiopian children weighed less than 2.5 kg at birth in 2016 (Figure 3). The prevalence of LBW is highest in Afar and Amhara. In the remaining regions, LBW ranged between 4% to 13%, with Harari having the lowest prevalence (4%).

The NNP II set a target of reducing anemia in children to 24% by 2020. Anemia prevalence in children was 57% in 2016. Tracking progress in this target is challenging since anemia in children was only measured in the 2016 EDHS with 57% of children being anemic. Moreover, anemia in children increased between 2011 and 2016 (Table 2). In seven regions in Ethiopia, the prevalence of anemia was more than 50%. Rates were very high in Somali (83%), Afar (75%), and Dire Dawa (72%). The NNP II aimed to decrease anemia by 4% annually to achieve the final 2020 target of 24%. Considering the trends between 2011 and 2016, it seems unlikely that the 2020 target can be achieved.

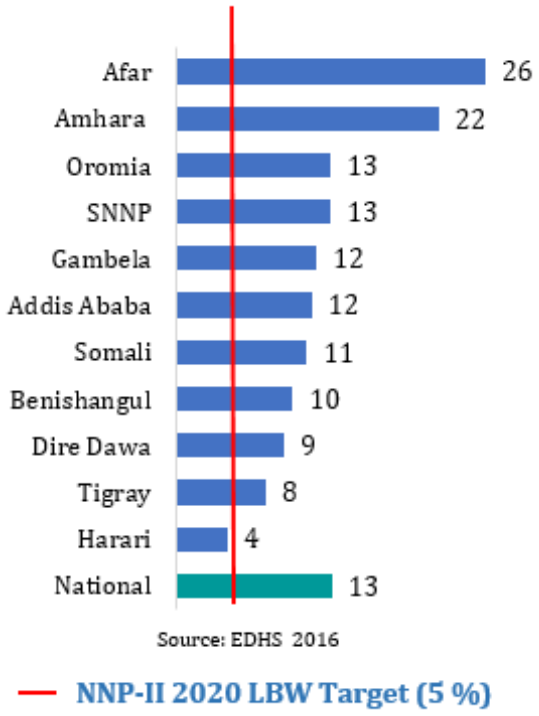


Figure 3. Prevalence of low birth weight across regions

Table 2. Child anemia trends

Regions	Anemia 2011	Anemia 2016
Tigray	38%	54%
Afar	75%	75%
Amhara	35%	42%
Oromia	52%	66%
Somalia	67%	83%
Benishangul Gumuz	47%	43%
SNNP	37%	50%
Gambela	51%	56%
Harari	56%	68%
Addis Ababa	33%	49%
Dire Dawa	63%	72%
National	44%	57%

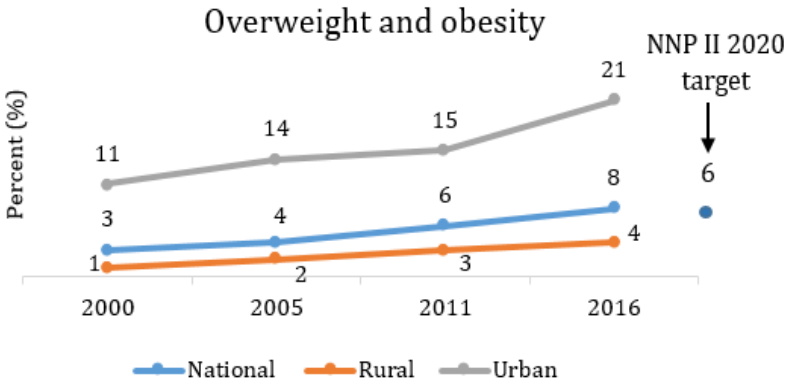
Source: EDHS 2011, 2016

NNP II 2020 Child Anaemia Target: 24%

III. Progress in Nutritional status of women of reproductive age and adolescent girls

Nutritional Status of Women

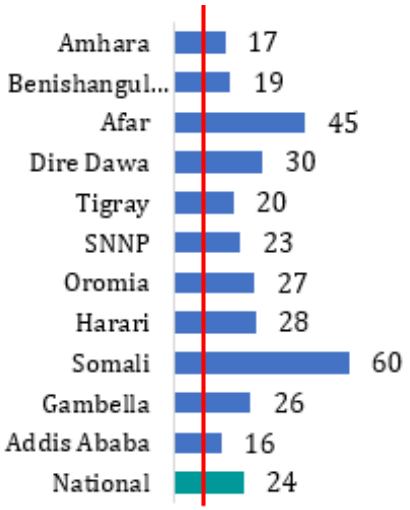
Women's nutrition is important to ensure that a child has the best start in life, especially in the first 1000 days[15]. Low BMI (<18.5) in women is an indication of chronic undernutrition. The NNP II set a target of reducing low BMI to 16% by 2020.[8] To assess the possibility of reaching the NNP II targets for chronic undernutrition and overweight among women, it was important to review the latest data available on women's BMI which came from the 2016 EDHS. According to the 2016 EDHS, 25% of women in Ethiopia have low BMI. More rural women (22%) had low BMI compared to urban women (15%). The prevalence of low BMI is declining, albeit slowly when one looks at trends between 2000 and 2016[1,4]. The 2016 national prevalence of overweight and obesity among women of reproductive age was 8%. Although this prevalence is low compared to other countries in sub-Saharan Africa[16], overweight and obesity have been sharply increasing among urban women in Ethiopia (Figure 4). Between 2011 and 2016, the prevalence of overweight and obesity among urban women increased by 6% compared to a 1% increase between 2005 to 2011. If these trends continue it is unlikely that the NNP II 2020 target of 6% overweight among women of reproductive age will be met[8]. Interventions that address overweight and obesity and that target urban women need to be ramped up to mitigate the double and triple burden of malnutrition.



Sources: EDHS 2000, 2005, 2011, 2016

Figure 4. Trends in overweight/obesity among women

Figure5: Prevalence of anemia in women



Source: EDHS 2016

NNP II 2020 Women Anaemia Target (12 %)

Anemia in women can lead to reduced work capacity and increased risk of birth complications. At the start of the NNP II in 2016, 24% of women in Ethiopia were anemic (Figure 5)[4]. Furthermore, anemia was very high in some regions. For instance, 60% of women in Somali and 45% of women in Afar, were anemic. No recent national or regional data was available on anemia in women, but

the 2016 EDHS showed the importance of this problem nationwide and the need to intensively target anemia reduction interventions in some regions to meet the 2020 NNP II targets.

National Status of Adolescent Girls

Adolescence is a period of increased nutritional need. Improving the nutritional well-being of adolescent girls, through nutrition intervention can improve, the nutritional wellbeing of their children as well[11]. Indicators related to adolescent nutrition were included in the NNP II, and targets were set for these indicators. However, limited data exist to accurately describe the nutrition situation of adolescents and the coverage of interventions targeting them. Data is especially scarce for younger adolescents (10-14 years) since they are not included in national surveys such as the EDHS. For older adolescents, some data exists and according to the 2016 EDHS, 29% of adolescent girls aged 15-19 years and 59% of boys of the same age were chronically undernourished. In contrast, 3% of adolescent girls, and 0.6% of boys are overweight or obese. Nationally, 20% of adolescent girls were anemic. Anemia among adolescents is high in Somali and Afar. Among pregnant adolescent girls aged 15-19 years, only 5% received iron supplements for at least 90 days during their most recent pregnancy.

Table 3. Progress in selected NNP II women nutrition indicators against local and global targets

Indicator	Baseline (2015)*	Progress (2016)**	Progress (2019)***	NNP II Target (2020)	WHA Targets (2025)****
Proportion of adolescent girls aged 10-19 years supplemented with IFA	ND	ND	ND	50	--
Prevalence of anemia in adolescents aged 10-19 years	28	ND	ND	13	--
Proportion of women of reproductive age with BMI <18.5	27	22	ND	16	--
Prevalence of anemia among women of reproductive age (15-49 years)	19	24	ND	12	9
Prevalence of overweight/obesity among women	9	8	ND	6	--
Proportion of adolescent girls married below 18 years	8	11	ND	2	--
Prevalence of teenage (15-19 years) pregnancy	12	13	ND	5	--

Sources: ND refers to No Data Sources available; * NNP I end line survey and NNP II implementation manual, ** EDHS 2016, *** EMDHS 2019, **** WHA targets

IV. Progress in Immediate and Underlying Determinants of Undernutrition

Poor child feeding practices are one of the major determinants of malnutrition in Ethiopia and these determinates were included in the NNP II. In this section, presents the progress related to these determinants during the implementation of the NNP II.

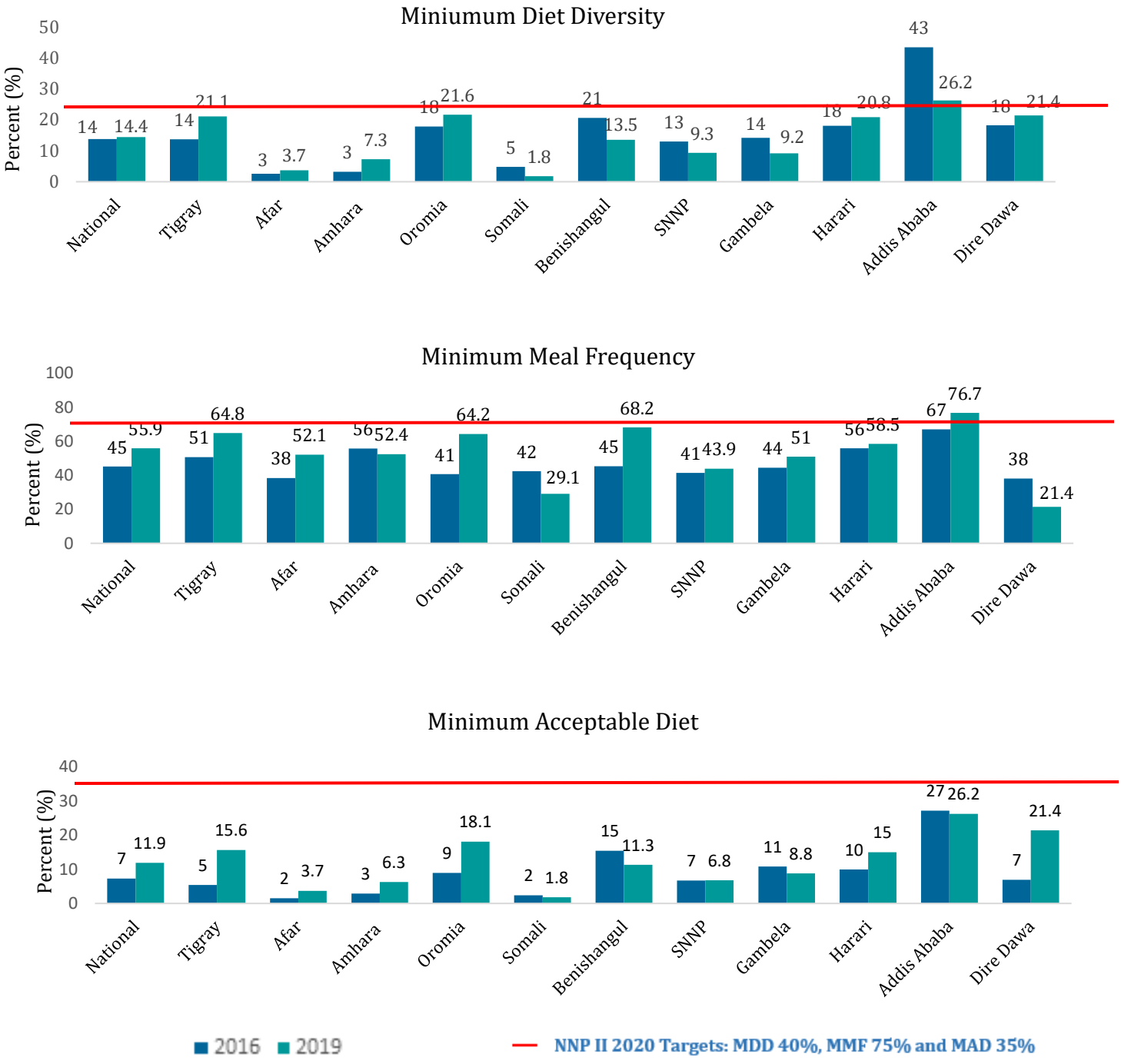
Infant and Young Child Feeding (IYCF) Indicators

Feeding only breastmilk to babies for the first six months provides them with the best possible nourishment[17]. It also protects them from common childhood illnesses such as diarrhea and respiratory infections[17]. The NNP II aims to increase the percentage of children between 0 to 6 months that are exclusively breastfed to 80% by 2020. While progress has been made, this target was not met. According to the 2019 EMDHS, 59% of Ethiopian children are exclusively breastfed.

The NNP II also promotes adequate paid maternity leave, as this is important to ensure employed women can exclusively breastfeed as long as possible. In 2019, Ethiopia passed the Labor Proclamation 1156/2019 which grants four months (17 weeks) of paid maternity leave to women. This meets the International Labor Organization (ILO) recommendation of at least 14 weeks paid maternity leave, and allowed the country to reach its 2020 target. The NNP II also anticipated that at least 30 health facilities should be implementing 10 steps of Baby-Friendly Hospital Initiative (BFHI) by 2020. The BFHI aims to ensure that health facilities provide a standard of care to support successful breastfeeding[18]. However, Ethiopia still does not have a health facility that is certified to implement the 10 steps of the BFHI[18].

After six months, breast milk alone is no longer sufficient to meet the nutritional needs of a growing baby. At this period in the baby's life, complementary feeding is introduced to meet its nutritional needs. Minimum Diet Diversity (MDD), Minimum Meal Frequency (MMF), and Minimum Acceptable Diet (MAD) are three indicators in the NNP II to assess progress in IYCF practices. MDD is met if, within a 24-hour period, a child consumes at least four out of seven recommended food groups[17]. None of the targets set in the NNP II for these indicators were met. Between 2016 and 2019 no improvement in MDD was observed nationally (Figure 4). Only 14% of children aged 6-23 months consumed four or more food groups. The WHO recommends that breastfed infants aged 6-8.9 months be given complementary foods at least twice a day, those aged 9-23.9 months three times a day, and non-breastfed children aged 6-23.9 four times a day[17]. Nationally, MMF increased from 45% in 2016 to 56% in 2019. Children who have met MDD and MMF recommendations are considered to have met the MAD needs. The prevalence of MAD increased from 7% in 2016 to 12% in 2019.

Figure 4. Changes in MDD, MMF and MAD among children from 2016 -2019



Sources: EDHS 2016; EMDHS 2019

The NNP II included indicators that aimed at assessing dietary quality during pregnancy, namely consumed five or more food groups and consumed an additional meal. However, currently, data is not available to track progress in these indicators neither nationally nor regionally. Table 4 below presents progress in selected diet-related indicators.

Table 4. Progress in selected diet-related NNP II indicators against NNP II targets

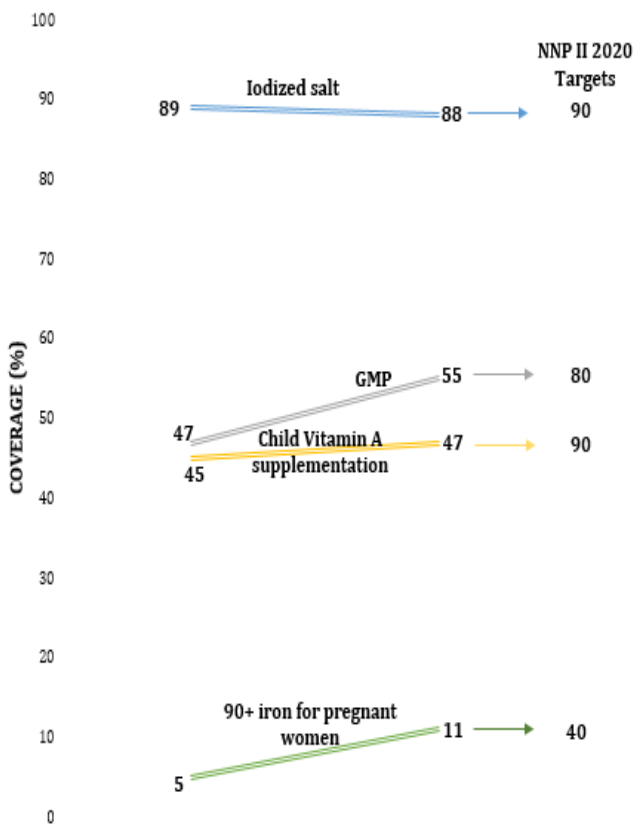
Indicator	Baseline (2015)*	Progress (2016)**	Progress (2019)***	NNP II Target (2020)
Proportion of PLW provided acute malnutrition treatment or support in targeted woredas	ND	ND	ND	50
Percentage of women consuming diversified meal (> 5 food groups) during pregnancy	20	ND	ND	31
Proportion of infants 0-6 months exclusively breastfed (%)	52	58	59	80
Number of health facilities implementing 10 steps of BFHI	ND	0	0	30
Maternity leave proclamation revised to align with ILO/global recommendations	ND	Achieved		Yes
Proportion of children age 6-23 months with minimum dietary diversity score	10	14	14	40
Proportion of children age 6-23 months who received minimum meal frequency	67	45	56	75
Proportion of children age 6-23 months who received minimum acceptable diet	4	7	12	35

Sources: ND refers to No Data Sources available; *NNP I end line survey and NNP II implementation manual; **EDHS 2016; *** EMDHS 2019

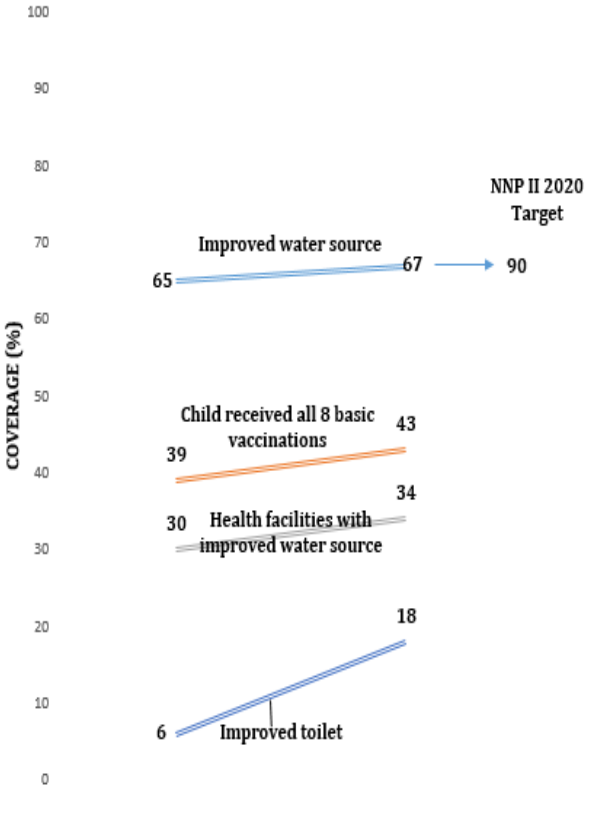
V. Progress in Coverage of Nutrition-specific and Nutrition-sensitive Interventions

Coverage of nutrition-specific and nutrition-sensitive interventions provides information on process indicators that can be used to track progress towards output and outcome indicators. The sections below provide information on progress in coverage of these interventions in Ethiopia which were anticipated in the NNP II. Figure 5 below presents a summary of the progress in selected nutrition-specific and nutrition-sensitive interventions. With regards to improvement in coverage of nutrition-specific interventions, from the indicators that had NNP targets, coverage of iodized salt coverage was the closest to the NNP II target. Among nutrition-sensitive interventions, 67% of households used an improved water source. With this coverage rate the NNP II target of 90% will most likely will not be met. Overall, only a few interventions have more than 50% coverage.

Figure 5: Progress in coverage of nutrition-specific and nutrition-sensitive interventions between 2016 and 2019 against targets



Progress in coverage of nutrition-specific interventions 2016 -2019



Progress in coverage of nutrition-sensitive interventions 2016-2019

Coverage of Nutrition-Specific Interventions

Iron supplementation during pregnancy is important to prevent birth complications and meet the fetus's iron needs[15]. The NNP II aimed to increase the coverage iron/folate supplementation for at least 90 days during pregnancy to 40% by 2020[8]. Coverage of iron supplementation for pregnant women for at least 90 days during pregnancy has increased by 6% between 2016[4] and 2019[5] (Table 5). Improvements were seen across regions, residence, and wealth status. However, pregnant women in urban areas and those in the highest wealth quintile were more likely to receive iron tablets during pregnancy. According to the 2016 EDHS, only 5% of pregnant adolescent girls aged 15-19 years received iron supplements for at least 90 days during their most recent pregnancy. Furthermore, only 6% of adolescents aged 16-19 years, who had a child in the five years before the survey, received deworming tablets.

Table 5. Coverage of nutrition-specific interventions provided to women and households

	Pregnant women who received 90+ iron tablets		Pregnant women who had 4 or more ANC visits		Pregnant women who received Nutrition counseling during ANC		Presence of iodized salt in households	Percentage of households using adequately iodized salt (>15 ppm)
	2016*	2019**	2016*	2019**	2016*	2019**	2016*	2018***
National	5	11	32	43	66	71	89	88
Tigray	16	9	57	64	83	75	88	69
Afar	5	9	21	31	54	75	74	50
Amhara	5	15	32	51	74	78	92	98
Oromia	3	12	22	41	59	64	92	97
Somali	2	2	12	11	48	62	63	82
Benishangul Gumuz	11	12	42	56	62	71	94	95
SNNP	4	4	38	34	62	73	86	88
Gambela	3	15	43	32	57	74	86	94
Harari	7	17	35	39	75	73	87	97
Addis Ababa	18	22	89	82	73	90	91	96
Dire Dawa	8	19	66	62	83	69	81	100
NNP II targets	**40**		**ND**		**ND**		**90**	

Sources: ND refers to No Data sources available;* EDHS 2016; **EMDHS 2019; ***EPHI 2018 Iodized salt coverage survey

Although, in the NNP II no targets were set for the number of ANC visits and nutrition counseling during ANC, the review included progress in these indicators since they reflect progress in nutrition service delivery during pregnancy. The proportion of pregnant women who had four or more ANC visits has increased by 10% between 2016 and 2019. The increase was seen across regions, except in Gambella which had a 10% decline in coverage. ANC visits offer a contact point to give nutritional counseling to pregnant women. According to the 2019 EMDHS, 71% women received nutrition messages during ANC visits. However, data is not available on the quality of the counseling given. Ethiopia has made great progress in universal salt iodization in the past decade. According to the 2016 EDHS, 89% of all households were using salt that contained iodine. A 2018 household and market survey conducted by EPHI showed that 88% of households used salt that was adequately iodized (> 15 PPM)[19].

From 2016 to 2019, the proportion of children who received vitamin A supplementation in the past six months increased by 2% (Table 6). However, coverage of vitamin A supplementation decreased in half of the regions in 2019. The proportion of children who received vitamin A

supplementation increased among rural children (2% increase), while it declined in urban children (7% decrease). The annual Health Management Information system (HMIS) Health and Health Related Indicators reports were used to track progress in coverage of growth monitoring and promotion for children under 2 years of age. Coverage only increased by 8% nationally between 2016[20] and 2019[21]. Progress in this area was also uneven across regions. Some regions still had very low rates of Growth Monitoring and Promotion (GMP) in 2019. GMP was very low in Somali (3%), Gambella (4%), and Afar (5%).

Table 6. Coverage of nutrition-specific interventions provided to children

	Percentage of children who received vitamin A supplementation		**Growth monitoring and promotion of children under 2 years of age**	
	2016*	**2019****	**2017*****	**2019******
National	45	47	47	55
Tigray	74	65	63	56
Afar	35	32	10	5
Amhara	48	58	60	48
Oromia	38	46	38	87
Somali	36	20	11	3
Benishangul Gumuz	64	63	17	31
SNNP	47	40	56	50
Gambela	57	64	5	4
Harari	40	49	17	30
Addis Ababa	54	56	100	29
Dire Dawa	72	62	3	10
NNP II targets	**90**		**80**	

Sources: *EDHS 2016, ** EMDHS 2019 ***MOH Health and Health Related Indicators 2016/2017, ****MOH Health and Health Related Indicators 2018/2019

Limited data exists to track nutrition-related service delivery in health facilities in Ethiopia. Small improvements were seen for some nutrition service delivery indicators between 2016[22] and 2018[23] (Table 7). While 100 health facilities were expected to provide nutrition services for people living with HIV/AIDS (PLWHA), in 2018, only 26% of health facilities offered nutrition rehabilitation services to PLWHA and 22% provided fortified protein supplementation for this target group[23].

Table 7. Nutrition related service delivery in health facilities

	Percentage of facilities offering screening or treatment of malnutrition for children	Percentage of health facilities offering nutrition rehabilitation services for HIV/AIDS care		Percentage of facilities providing fortified protein supplementation for HIV/AIDS care	
	2016*	2016*	2018**	2016*	2018**
National	79	24	26	16	22
Tigray	95	37	61	30	45
Afar	97	36	30	16	16
Amhara	83	19	22	13	19
Oromia	69	23	24	19	20
Somali	62	10	4	3	9
Benishangul Gumuz	98	28	48	14	40
SNNP	92	27	24	13	21
Gambela	88	32	12	11	12
Harari	82	25	25	19	20
Addis Ababa	63	25	31	16	25
Dire Dawa	69	18	32	16	27

Sources: *Service Availability and Readiness Assessment (SARA) 2016 ** Service Availability and Readiness Assessment (SARA) 2018

Coverage of Nutrition-Sensitive Interventions

Nutrition-Sensitive Interventions in the Agricultural Sector

Nutrition-sensitive interventions address underlying and basic determinants of malnutrition and are critical to accelerate the reduction in malnutrition. The NNP II included various nutrition-sensitive interventions and developed an extensive list of relevant indicators. The agricultural sector is important to ensure that nutritious food is available to the population. The sector has been tracking relevant NNP II indicators from 2019. Progress was seen in most of the indicators selected to reflect the strengthened implementation of nutrition-sensitive interventions in agriculture. Targets for the establishment of fruit nursery site, caged/fenced poultry production at the household level, and establishments of nutrition corners at farmer training centers (FTCs) were exceeded by large margins (Table 8). Targets for the establishment of regional poultry multiplication centers, woreda milk collection centers, poultry multiplication centers, and urban mushroom producing groups were also achieved.

Table 8. Progress in nutrition-sensitive interventions in agriculture

Indicators	Baseline (2015)*	Progress (2016)	Progress (2019)**	Target (2020)
Number of fruit nursery sites established/supported at national level	5	ND	7261	20
Proportion of urban areas with mushroom producing groups	3	ND	36	15
Proportion of rural/urban households practicing caged/fenced poultry	ND	ND	24801	5
Number of poultry multiplication centers (private and government) in each region	ND	ND	58	5
Proportion of woredas with at least one milk collection center supported	ND	ND	32	5
Proportion of potential lakes with fish producing groups supported	ND	ND	17	50
Fish hatching center established/supported	1	ND	4	6
Number of community ponds established	1500	ND	1642	2000
Number of food processing technologies/practices identified and introduced	ND	ND	4	5
% of FTCs with nutrition corner	ND	ND	391	50
Number of women's groups engaged in agricultural income generating activities	ND	ND	1417	3000

Sources: ND refers to No Data Sources available * NNP II implementation manual, ** MOA Administrative Report, 2019

It is obvious that increased production and productivity of cereals, legumes, fruits, vegetables and animal source foods increase the availability, and consumption of nutritious foods. Trends in agricultural production are important indicators to show to what extent food supplied through the agricultural sector can support the nutritional needs of the population.

Table 9 shows trends in the production of major food groups that are critical to acquiring a balanced diet from 2017 to 2019. The productivity of cereals, vegetables, and pulses increased during this time[24-26]. However, the productivity of fruits declined, especially between 2018 and 2019. The amount of milk, eggs, cattle, and sheep produced also increased between 2017 and 2019 [27-29] Food loss is a major problem that influences food availability. Between 2016 and 2017, the amount of cereals, roots, and tubers lost increased significantly (from 1,684/1000 tons to 2,154/1000 tons) (Table A1 Annex 1). The loss of vegetables increased marginally with approximately 160,000 tons of vegetables lost in 2017.

Affordability is another factor that drives food choices. A study that analyzed the cost of foods in Ethiopia using nationally representative monthly price data showed that the cost of nutritious foods has increased significantly between 2007 and 2016[30]. Prices for vitamin A-rich dark green

leafy vegetables (80% increase), other fruits and vegetables (40%), legumes and nuts (30%) and dairy, eggs, and meats (30%) increased significantly. In contrast, prices of grains, roots, and tubers did not show any change, while prices for sugar and honey (-24%) and oils and fats (-35%) showed a decline. Both productivity and food price trends have profound implications for diet transition in Ethiopia.

Table 9. Food production in millions

	2016/2017	2017/2018	2018/2019	Growth rate (%)*
Cereal yield (Quintal/hectare)	24.8	26.2	26.8	8.1
Fruit yield (Quintal/hectare)	73.4	74.5	69.6	-5.2
Vegetable yield (Quintal/hectare)	33.9	35.4	36.9	8.8
Pulses yield (Quintal/hectare)	18.2	18.6	18.6	2.2
Amount of milk produced (Liter)	3134.2	3317.8	3284.5	4.8
Number of eggs produced	127.6	136.8	151.5	18.7
Number of Cattle	59.5	60.4	61.5	3.4
Number of sheep	30.7	31.3	33.0	7.5
Number of goats	30.2	32.7	38.9	28.8
Number of poultry	59.5	56.1	59.4	-0.2

*Percent change between 2016 and 2019
Sources: Agriculture Sample Survey 2016/2017, 2017/2018, 2018/2019

Water, Sanitation and hygiene (WASH)

Access to safe drinking water, basic sanitation and hygiene are important for the nutritional wellbeing of a population. Recognizing this, the NNP II included WASH indicators and corresponding targets (Table 10). Progress against these and additional indicators was reviewed. In the last two decades, the percentage of households that use safe water has increased. In 2019, 67% of households were using an improved water source, a 2% increase from 2016. Although open defecation has significantly reduced, only 18% of households were using an improved toilet facility (An improved toilet includes any non-shared toilet of the following types: flush/pour flush toilets, and pit latrines; ventilated improved pit (VIP) latrines and pit latrines) in 2019. The availability of any household hygiene facilities still remains low in Ethiopia. According to the 2016 EDHS[4], only 13% of households had handwashing facilities that had soap and water available. In 2018, 34% of health facilities had access to improved water (Includes piped water, public taps, protected dug wells and springs, and rainwater). Access to improved water was 5% in health posts, 28% in health centers, 60% in primary hospitals, 80% in general hospitals, and 87% in referral hospitals. The proportion of schools with any water supply increased from 38% in 2016[31] to 87% in 2019[32].

Table 10. Progress in NNP II WASH indicators

Indicator	Baseline (2015)*	Progress (2016)**	Progress (2019)***	NNP II Target (2020)
% of households with clean and safe drinking water supply	58	65	67	90
Proportion of households benefited from small scale irrigation schemes with multiple use of water	ND	ND	ND	5
Proportion of schools with water supply****	33	38	87	90
Hectares (ha) of farmlands cultivated through irrigation (ha x 1000)	140	ND	ND	280
Proportion of households with hand washing facilities	ND	60	ND	68

Sources: *NNP I end line survey and NNP II implementation manual,** EDHS 2016 and ***EMDHS 2019. ****Education Statistics Annual Abstract, 2016 and 2019

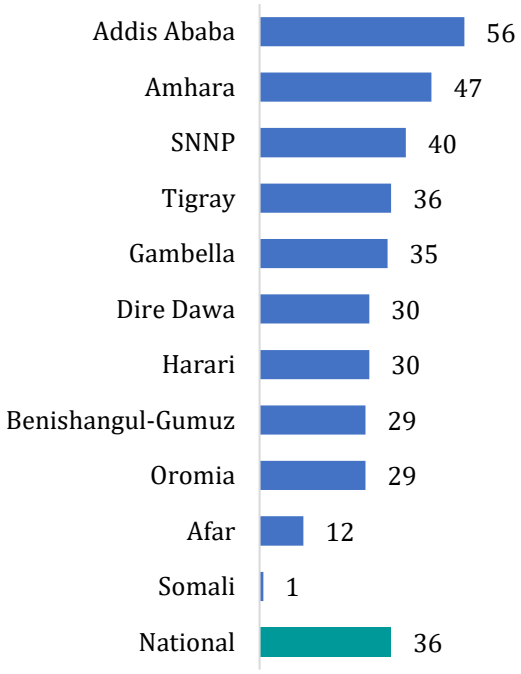
Social Protection

Social protection programs can benefit maternal and child nutrition. The NNP II includes six targets for nutrition-sensitive social protection, notably the proportion of households graduated from the Productive Safety Net Program (PSNP) and proportion of women's self-help groups that have received credits, and were trained on key nutrition practices. Data were retrieved for only a few of these indicators. In Ethiopia, the PSNP provides support to food insecure populations and the current program, the PSNP IV, includes nutrition-sensitive provisions, including nutrition related soft conditionalities. A midline evaluation of the PSNP IV showed that the program reduced self-reported food security (the number of months in a year a household cannot satisfy its food needs) by 0.18 months and marginally increased dietary diversity by 0.11 food groups. One of the key interventions of the nutrition-sensitive PSNP IV was to increase the use of health and nutrition services by PSNP beneficiary households. A detailed impact survey[33] assessed the progress between 2017 and 2019 and identified a trend of increased exposure to facility-based care among mothers with children less than two years of age, especially for ANC, child delivery, and checkup visits to the local health center. However, the exposure to community-based services delivered by the Health Extension Workers and the Health Development Army, such as nutrition counseling during pregnancy or growth monitoring reduced over time. On the other hand, exposure to nutrition information from food demonstrations and community conversations or gatherings increased significantly between 2017 and 2019.

Nutrition–Sensitive Health Services

Maternal and child health services are important to improve nutritional status of the mother and the baby. The increased use of family planning services for instance, reduces unplanned pregnancies, increases birth spacing, and can positively influence nutritional status of the mother and the baby. Nationally, 36% of married women had their demand for modern family planning methods met. Addis Ababa had the highest rate (56%) and Somali the lowest (1%). (Figure 6).

Vaccinations are key entry points to assess a child's nutritional status. There was a 4% increase in the percentage of children who received all eight basic vaccinations. The proportion of children who received all the basic vaccinations increased among rural children (10% increase), while it declined for urban children (11% decrease) (Table 11). Coverage of GMP) of children under the age of 2 years improved by 8% between 2017 and 2019.



Sources: EDHS 2016

Table 11. Immunization coverage

	Percentage of children who received all 8 basic vaccinations	
	2016	2019
National	39	43
Tigray	67	73
Afar	15	20
Amhara	46	62
Oromia	25	30
Somali	22	18
Benishangul	57	67
SNNP	47	38
Gambela	41	38
Harari	42	46
Addis Ababa	89	53
Dire Dawa	76	83

Sources: EDHS2016; EMDHS 2019

Figure 6. Demand for family planning satisfied with modern methods

Nutrition-Sensitive Interventions in the Industry Sector

The NNP II has also set indicators to track strengthened nutrition-sensitive interventions in the industry sector. Even though a voluntary food fortification guide is in place in Ethiopia, currently none of the flour producing industries fortify wheat flour or blended foods. Of the 13 oil processing industries, only one is currently fortifying edible oil with vitamin A[34].

Nutrition-Sensitive Interventions in the Education Sector

In the education sector, the NNP II included targets related to gender parity and school feeding[8]. The Gender Parity Index is defined as the female gross enrolment ratio divided by the male gross enrolment ratio for all levels. It is an important indicator that measures the level of equity in access to education between boys and girls. Although targets for gender parity were not met the gender parity index in both primary and secondary schools was closer to 1, which is the target.

In collaboration with partners, the MOE is implementing regular and emergency school feeding programs. These school feeding programs reached 431,287 students and 570 schools in 2017. In the 2019/20 academic year, 830,000 beneficiaries are being targeted through school feeding programs, including 300,000 in Addis Ababa.[35]

Table 12. Progress in access to education

Indicator	Baseline (2015)*	Progress (2016)**	Progress (2019)***	NNP II Target (2020)
Gender parity index: Grades 1-8	0.97	0.91	0.9	1
Gender parity index: Grades 9-12	0.80	0.93	0.87	1

Sources: * NNP II implementation manual ** Education Statistics Annual Abstract (2016) and *** Education Statistics Annual Abstract (2019)

VI. Multisectoral Coordination

The NNP II identified multisectoral coordination as critical for the success of efforts to reduce malnutrition. Multisectoral coordination simultaneously addresses multiple determinants of malnutrition. However, its effective implementation and evaluation require vertical and horizontal accountability structures at the local, regional, and national levels. All nutrition coordination stakeholders need to be clear about what they can do to reduce malnutrition. The NNP II placed great emphasis on multisectoral coordination and although progress has been made since then, its implementation is not satisfactory enough, mainly because of the lack of a suitable governance structure that can hold implementing sectors accountable.

The section below provides a summary of key challenges related to multisectoral coordination during NNP II implementation[36-41]. The challenges were identified through a narrative review of published literature. These challenges are to be considered for implementation in the new NFNS.

- Poor coordination and weak collaboration among implementers, poor planning, weak monitoring and evaluation systems, lack of ownership from implementing sectors and the absence of separate budget line for nutrition were major challenges[41] .
- The change of high-level government staff did not allow for some of the initiatives to come to fruition (as department heads and ministers were being frequently replaced)[41].
- The absence of standardized measurement indicators for multisectoral coordination hinders the effectiveness of coordinated implementation.
- The processes of joint planning and cascading the plans between sectors are very bureaucratic and not well coordinated.
- Lack of effective leadership; while there is general enthusiasm for a multisector approach to nutrition, it is no one's primary responsibility.
- There is some coordination and communication with specific stakeholders around policies, programs and emerging research, with some degree of success. However, coordination is yet to filter down to the regional, woreda/district and community levels[40].
- Since the start of the NNP II, efforts were made to increase staff to oversee its implementation. Nutrition focal persons were appointed at the national level whose mandate is to coordinate between sectors. However, these focal people require capacity development to allow them to effectively conduct their roles.
- Although the NNP II is multisectoral, the budget for nutrition is heavily donor funded and government sectors are less motivated to contribute their fair share as expected.
- Competing interests of government, civil society, and private sector stakeholders also present real challenges for advancing and operationalizing of multisectoral coordination for nutrition in Ethiopia.

VII. Lessons Learned and Way Forward

NNP II Indicator Progress Against Targets

Although significant progress has been made in nutrition in the past four years, Ethiopia still needs concerted efforts to accelerate the reduction of malnutrition. The lessons learned from the implementation of NNP II are useful and should be incorporated into future nutrition programming.

The lessons learned, and way forward/recommendations are summarized below.

- NNP II initiatives focusing on pregnant and lactating women were the most consistently implemented since ANC and postnatal care provided ideal contact points. Some progress was seen in the coverage of nutrition counseling during ANC visits. However, the quality of counseling was not assessed. Although there was some improvement, the coverage of iron/folate supplementation during pregnancy is still low.
    - More focused attention should be given to increase the coverage of nutrition-specific services for pregnant and lactating women.
- For the first time, the NNP II included initiatives to address adolescent nutrition. Although this is a step in the right direction, implementation gaps remain. The contact points for adolescents within the health system are currently limited resulting in few opportunities to conduct nutritional assessment and counseling at health facilities for adolescents. Furthermore, adolescent nutrition–related indicators are not monitored as part of Health Management Information system. Adolescents are also not included in nationally representative health surveys such as the EDHS. Consequently, data is not available to track most of the adolescent-related NNP II performance indicators included in NNP II.
    - The NFNS should outline modalities to reach both in school and out of school adolescents. Furthermore, ongoing adolescent interventions in the health system need to be adolescent-friendly and nutrition should be included in these services. Other sectoral adolescent interventions need to be nutrition-sensitive.
- Currently no information is available on women's diets.
    - The NFNS should prioritize to obtain this information which is vital to reduce undernutrition and to hold double-burden of malnutrition at bay.
- The extension of paid maternity leave was a major achievement during the NNP II.
    - To further maximize the benefits provided to children of working mothers, initiatives that promote breastfeeding-friendly workplaces are needed in the future.
- Great progress was made in salt iodization which needs to be maintained.
- With regards to IYCF practices, progress was seen in MMF. However, MDD still remain low. Several factors can explain the lack of progress in this area. SBCC has been expanded during NNP II, however it is not context specific.

    - Future SBCC messages need to take into consideration the different contexts (residence and livelihood status) in which these tools will be used.
    - To increase availability and affordability of nutritious foods, interventions that increase agricultural productivity and market access need to be expanded.
- Progress in increasing GMP coverage has been slow.
    - It is time to evaluate if the current implementation modalities are ideal to achieve targets.
- Although the inclusion of initiatives that target NCDs in NNP II is commendable, this action should be supported by the inclusion of indicators that track NCD outcomes.
    - Information on drivers of NCDs, such as diet and physical activity, should be included in national surveys.
    - Double-duty actions that target both undernutrition and overnutrition should be delivered through health services, social safety nets, educational settings, agriculture, food systems, and food environments.
    - Finally, nutrition services that are provided to NCD patients in health facilities should be standardized.
- The launching of Ethiopia's Nutrition Sensitive Agriculture strategy was a major milestone in the last four years with the inclusion of agricultural process indicators into the NNP II.
    - Output level indicators that track availability and affordability of nutritious foods should be added.
- Improvements were seen in WASH coverage in Ethiopia over the past decade. However, adequate hygiene practices remain low in Ethiopia.
    - WASH interventions and programs should place equal emphasis on water, sanitation and hygiene.
- The progress seen during NNP II showed that differences in nutritional outcomes and access to services are present in Ethiopia by residence and wealth status and across regions.
    - These differences need to be addressed to prevent the slowdown of progress in malnutrition reduction.
- Limited data for some target groups (such as adolescents) and some indicators (women's diets and NCD rates), hampers efforts to use evidence for programming.
    - It is important for the NFNS to include indicators related to these key nutrition-specific interventions to track progress over time.
    - The establishment of nutrition information platforms (such as the NIPN) that bring together existing nutrition data was a best practice seen in the last five years.
- Although progress was seen for most NNP II indicators, the majority of NNP II targets were not achieved.
    - In future programs historical trends and global experiences should be taken into account to set realistic targets.

- To adequately assess progress in future national program data for indicators that relate to process, outputs and outcomes needs to be consistently measured.

Multisectoral Coordination

Promoting sustainable development in nutrition will require an inclusive approach that reflects multidisciplinary determinants. Effective multisectoral coordination is vital to achieve this goal. Several challenges related to multisectoral coordination under the NNP II were mentioned earlier in the document. A way forward and recommendations to improve coordination in the NFSN are outlined below.

- Multisectoral coordination teams should be established at the federal and regional levels as this could be a motivational factor to decentralize nutrition coordination to woreda level.
- Having the ability to measure multisectoral coordination would facilitate an understanding of the process, track progress, and evaluate the interventions in each sector. As such, standardized measurement and assessment tools are needed.
- Assurance of high political commitment and awareness of the need to strengthen nutrition at decentralized levels should be continued and it should be practiced by all signatories, regardless of the role they play in coordination.
- Multisector analysis, cooperation, coordination, and negotiation across all stakeholders is required to devise a system of governance for national nutrition coordination. It will be important to allow each sector to contribute its part as a mechanism for achieving progress[36,41].
- Since the start of the NNP II, nutrition activities have started to appear as strategic objectives in sectoral annual plans. Furthermore, federal level plans have been aligned with the NNP II document. This is a commendable approach and should continue.
- Evolution of different multisectoral nutrition programs and strategies like the Sustainable Undernutrition Reduction in Ethiopia (SURE), and nutrition-sensitive agriculture strategy, are ideal for the implementation of NNP II in Ethiopia and should continue.
- Multisectoral nutrition coordination is not functioning as per the expected goals. No individual sector on its own has the authority to manage the level of coordinated action needed to achieve NNP II targets. A higher government body with authority over each signatory is needed to address the coordination gaps.
- There should be an inventory of work done and tracking of who is doing what among stakeholders to avoid duplication of efforts.
- To see concrete action from each signatory sector, nutrition focal person capacity building activities should be strengthened focusing on leadership and shared accountability.

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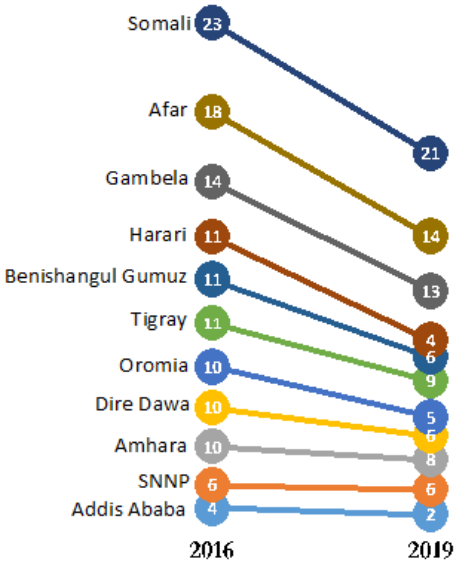
IX. Annexes

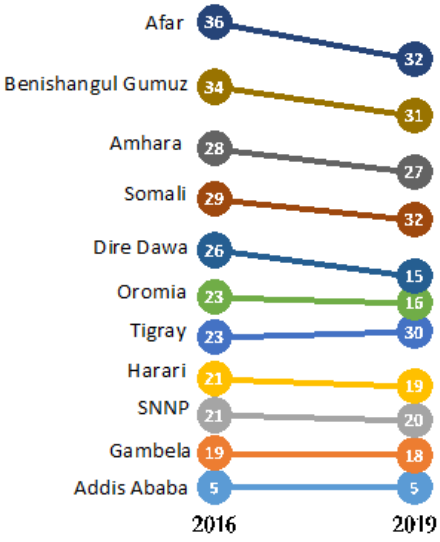
Annex 1: Progress in Additional Indicators

Figure A 1. Trends in wasting and underweight 2016-2019



Wasting

NNP II 2020 Target: 5%



Underweight

NNP II 2020 Target: 13%

Table A 1. Food loss by food groups per 1000 tons

	2016	2017
Cereals, roots and tubers	1684	2154
Legumes and nuts	564	158
Dairy	174	172
Flesh foods (meat, fish, poultry)	23	25
Eggs	3	3
Fruits	105	105
Vegetables	159	160
Total food loss	2853	2915

Sources: FAOSTAT (FAO food balance sheets)

Table A 2. Total dietary energy supply kcal/capital/day

	2016	2017
Cereals, roots and tubers	1729	1734
Legumes and nuts	230	225
Dairy	53	51
Flesh foods (meat, fish, poultry)	33	34
Eggs	2	2
Fruits	12	13
Vegetables	13	13
Total	2297	2304

Sources: FAOSTAT (FAO food balance sheets)

Annex 2: MOH Request Letter and Questions

የኢትዮጵያ ፌዴራላዊ ዲሞክራሲያዊ
ሪፐብሊክ
የጤና ጥበቃ ሚኒስቴር

Federal Democratic Republic of
Ethiopia
Ministry of Health

ቀን Date 26-06-2012

ቁጥር Ref. No. ሚጤ/18/45/210

በኢትዮጵያ የህብረተሰብ ጤና ኢንስቲትዩት
ለምግብ ሳይንስና ሥነ ምግብ ምርምር ዳይሬክቶሬት
አዲስ አበባ

ጉዳዩ፤- የጥናት ትብብር ስለመጠየቅ፤

የጤና ሚኒስቴር በአለም ባንክ ድጋፍ ሊተገበራቸው ከታቀዱ ተግባራት አንዱ በኢትዮጵያ የህብረተሰብ ጤና ኢኒስቲቲዩት የሚከናወነው የሁለተኛው ብሄራዊ ስርኣተ ምግብ ፕሮግራም ማጠቃለያ ጥናት (NNP II endline survey) አንዱ ሲሆን በቅርቡ ከለጋሽ ድርጅቱ ጋር በነበረው የአፈፃፀም ግምገማ ላይ ውይይት ተደርጎ በተደረሰው ስምምነት ለፕሮግራም ትግበራው የተያዘው አምስት አመት ጊዜ ባለመጠናቀቁ የጥናት ጊዜው በአንድ አመት እንዲራዘም ስምምነት መደረሱ ይታወቃል።

ይሁን እንጂ ጥናቱ በመራዘሙ ውጤቱን ለምግብና ስርዓተ ምግብ ስትራቴጂ ግብዓትነት ለመጠቀም ባለመቻሉ በጉዳዩ ላይ የጤና ሚኒስቴር ስርዓተ ምግብ ቡድን፤ የኢትዮጵያ የህብረተሰብ ጤና ኢንስቲትዩት ምግብ ሳይንስና ሥነ ምግብ ምርምር ዳይሬክቶሬት ባለሙያዎች እና ከዩኒሴፍ የሚመለከታቸው የስራ ሃላፊዎች በተገኙበት ውይይት ተደርጎ ዋናው ጥናት እስኪደረግ ድረስ ሊኖር የሚችለውን የመረጃ ክፍተት ለመሙላት በኢንስቲትዩቱ በኩል ካለው የመረጃ ቋት (NIPN) በመጠቀም ከምግብና ስርዓተ ምግብ ስትራቴጂ ጋር ተዛማጅነት ባላቸው ጥያቄዎች ላይ የመረጃ ትንተና (Desk Review) እንዲደረግና ከዚህ ጥናት የሚገኘው መረጃም ጥቅም ላይ እንዲውል በውይይቱ ወቅት ስምምነት መደረሱ ይታወቃል።

በመሆኑም ለዚሁ ጥናት መነሻ የሚሆኑ ጥያቄዎችን የስራ ክፍላችን ከዩኒሴፍ የስርዓተ ምግብ ክፍል ጋር በመሆን ያዘጋጀን በመሆኑ ከዚህ ደብዳቤ ጋር አባሪ ተደርጎ ቀርቧል ዝርዝር ጥያቄዎች መነሻ በእናንተ በኩል የመረጃ ትንተና (Desk Review) ውጤት በወቅቱ እንዲላክልን እንጠይቃለን።

ከሰላምታ ጋር

[illegible] ታደሰ (ዶ/ር)
የእናቶችና ህፃናት ጤና
ዳይሬክቶሬት ዳይሬክተር

ግልባጭ
- ✓ ለክብርት ሚኒስትር ዴኤታ ጽ/ቤት (ፕሮግራም ዘርፍ)
- ✓ ለእናቶችና ህፃናት ጤና ዳይሬክቶሬት
- ✓ ለስርዓተ ምግብ ኬዝ ቲም

ጤና ሚኒስቴር

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in reply Please Refer to our Ref. No.

Questions for Desk Review

1. Which activities/initiatives in the NNPII have been persistently implemented in the past 4 years by region? If not why?
2. What is the coverage of nutrition specific and nutrition sensitive interventions by region/Zone/woreda and result achieved?
3. What are the effects of SBCC interventions in improving feeding practice
4. What are the statistical trends of NNP II indicators in the past 4 years?
5. What are the best practices in the implementation of National Nutrition Program?
6. What are the main challenges in multi-sectoral coordination and implementation of NNP II?
7. Lessons learnt in the implementation process of NNPII