

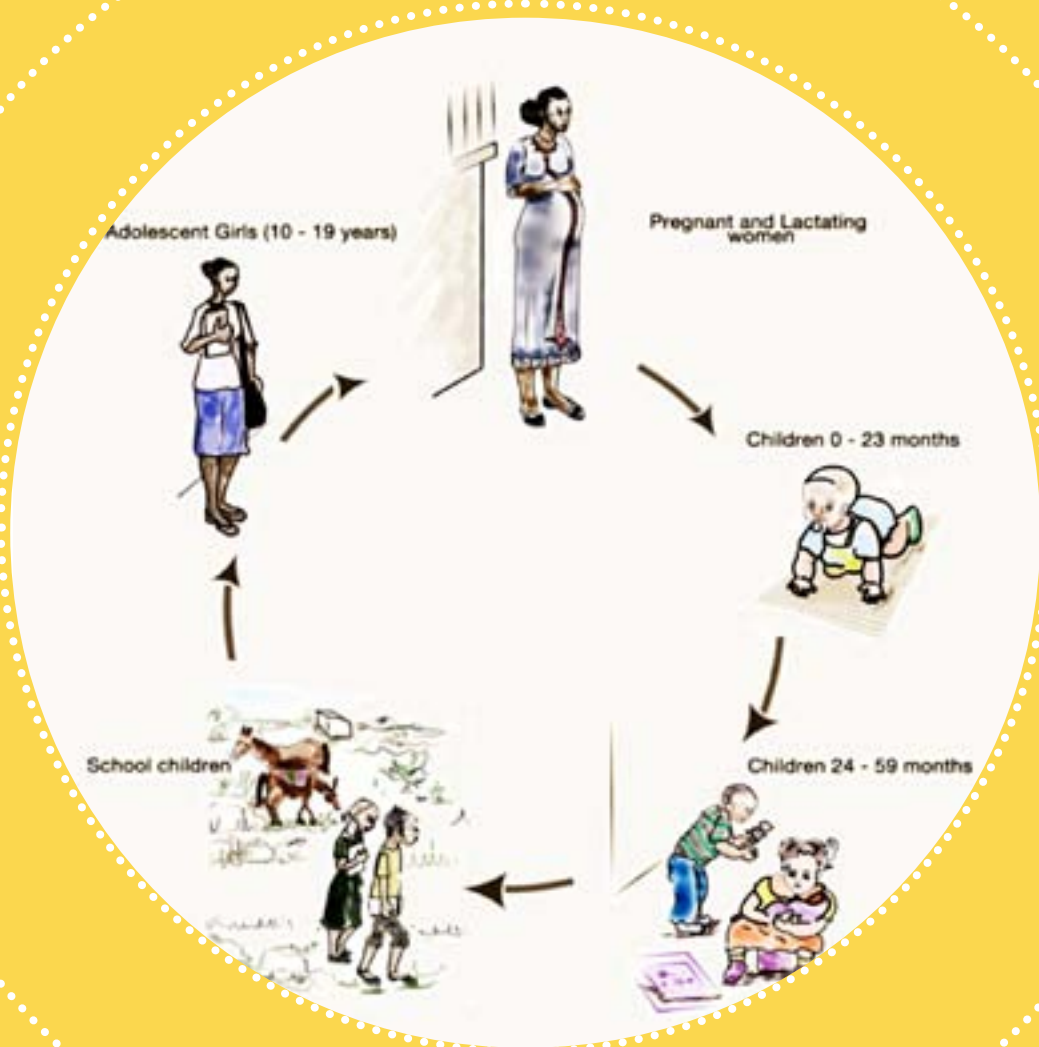


**Government of the Federal Democratic
Republic of Ethiopia**

National Nutrition Programme

June 2013 – June 2015

Government of the Federal Democratic Republic of Ethiopia



Government of the Federal Democratic Republic of Ethiopia

**National Nutrition Programme
June 2013-June 2015**



Government of the Federal Democratic Republic of Ethiopia National Nutrition Programme 2008-2015

National Nutrition Programme Implementing Sectors Declaration

We the undersigned, representing the Government of the Federal Democratic Republic of Ethiopia, National Nutrition Coordination Body, fully recognize each Ministry's mandate and pledge our commitment to support the achievement of the targets laid out in this revised National Nutrition Program document and will strive towards equitable and sustainable multisectoral actions towards the realization of optimal nutritional status for all Ethiopian citizens.

We, as a government, found the high malnutrition rates reported in EDHS and various surveys over the years completely unacceptable. We shall work through enhanced strategic partnerships to prioritize the elimination of malnutrition from Ethiopia as one of the most viable strategies for achieving the Growth and Transformation Plan and the Millennium Development Goals. Attainment of positive nutrition outcomes will be achieved through evidence based programming and responsiveness and the promotion of accountability towards these results by each Ministry here undersigned.

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ACRONYMS

AEW Agriculture Extension Worker	ISS Integrated Supportive Supervision
ANC Antenatal Care	ITN Insecticide-treated Bed Net
BCC Behavioral Change Communication	IYCF Infant and Young Child Feeding
BMI Body Mass Index	LBW Low Birth Weight
BOA Bureaus of Agriculture	M & E Monitoring and Evaluation
BOE Bureaus of Education	MDG Millennium Development Goal
BOFED Bureaus of Finance and Economic Development	MOA Ministry of Agriculture
BOLS Bureaus of Legal Service	MOE Ministry of Education
BOWCY Bureaus of Women, Children and Youth Affairs	MOFED Ministry of Finance and Economic Development
BOWE Bureaus of Water and Energy	MOI Ministry of Industry
CBN Community Based Nutrition	MOLSA Ministry of Legal and Social Affairs
CBO Community Based Organization	MOWCYA Ministry of Women, Children and Youth Affairs
CHD Community Health Day	NDD Nutrition Directorate Director
CMAM Community Management of Acute Malnutrition	NNCB National Nutrition Coordination Body
CSA Central Statistical Authority	NNP National Nutrition Programme
DRMFSS Disaster Risk Management and Food Security Sector	NNTC National Nutrition Technical Committee
EDHS Ethiopia Demographic and Health Survey	NSUH Nutrition Special Unit Head
EHNRI Ethiopian Health and Nutrition Research Institute	ORS Oral Rehydration Salt
ENCU Emergency Nutrition Coordination Unit	PASDEP Plan for Accelerated and Sustained Development to End Poverty
EOS Enhanced Outreach Strategy	PFSA Pharmaceutical Fund and Supply Agency
FBO Faith Based Organization	PHCU Primary Health Care Unit
FMHACA Food Medicine and Health Care Administration Control Authority	PHEM Public Health Emergency Management
FMOH Federal Ministry of Health	PLHIV People Living with HIV
FP Family Planning	PLW Pregnant and Lactating Women
GDP Gross Domestic Product	PM Prime Minister
GMP Growth Monitoring and Promotion	PMO Prime Minister Office
GTP Growth and Transformation Plan	PMTCT Prevention of Mother to Child Transmission
HC Health Centre	PSNP Productive Safety Net Programme
HDA Health Development Army	PTA Parent Teachers Association
HEP Health Extension Programme	RHBs Regional Health Bureaus
HEW Health Extension Worker	RNCB Regional Nutrition Coordination Body
HP Health Post	RTK Rapid Test Kit
HPN Health Population and Nutrition	RUSF Ready-to-Use Supplementary Food
HRN Human Resource and Nutrition	RUTF Ready-to-Use Therapeutic Food
HSDP Health Sector Development Programme	SAM Severe Acute Malnutrition
HTP Harmful Traditional Practice	SBCC Social and Behavioral Change Communication
ICCM Integrated Community Case Management	TOT Training of Trainers
IDA Iron Deficiency Anemia	TSF Targeted Supplementary Food
IDD Iodine Deficiency Disorder	TTC Teachers Training College
IGA Income Generating Activities	TWG Technical Working Group
IMNCI Integrated Management of Neonatal and Childhood Illnesses	UNSCN UN Standing Committee on Nutrition
IRT Integrated Refresher Training	USI Universal Salt Iodization
	VAS Vitamin A Supplementation
	WASH Water, Sanitation and Hygiene
	WMS Welfare Monitoring Survey
	WOHO Woreda Health Office

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CHAPTER 1

INTRODUCTION

Ethiopia, located in the northeastern part of Africa, also known as the Horn of Africa, lies between 3 and 15 degrees north latitude and 33 and 48 degrees east longitude. The total area of the country is around 1.1 million square kilometers. As of 2007, Ethiopia's population has been growing at a rate of 2.6 percent per annum (CSA, 2007). At this rate the total population will number 88.4 million by 2015. The majority of the population (84 percent) lives in rural areas. This rapid population growth exacerbates critical gaps in basic health services, and in food and nutrition security (MOH, 2008).

The government has been implementing a comprehensive economic reform programme over the past decade. The reform programme has resulted in remarkable economic performance; macroeconomic stability was attained. A real gross domestic product (GDP) growth rate of 11 percent per annum has been achieved since 2003. The poverty level as measured by the total population under the poverty line has declined from 49.5 percent in 1994/95 to 29.2 percent in 2009/10. The food poverty head count index also declined from 38 percent to 28.2 percent between 2004/05 and 2009/10. However, poverty still affects one-third of the population (MOFED, 2010a).

Ethiopia has developed a five-year development plan, the Growth and Transformation Plan (GTP), for the period 2010/11 to 2014/15. Key objectives of the GTP are ensuring high economic growth and achieving the Millennium Development Goals (MDG). Within the framework of the GTP, five-year sectoral development programmes have been outlined (MOFED, 2010b). Vital to the attainment of this plan are the systems and structures to reach communities and households.

Community based service delivery platforms have been made available in both the health and agriculture sectors to ensure decentralized and democratized public services. The Health Extension Programme (HEP) deploys two health extension workers per health post, who together reach a population of roughly 5,000. The Agricultural Extension Programme has a similar community level structure called the Agriculture Extension Programme. To strengthen and accelerate social and behavioral changes and the overall wellbeing of the population, a community level development army has been established using a "one-to-five network," wherein out of every six households one person takes a leading role, functioning as a key link with both health and agriculture extension workers. Five such leaders comprise a development team. Each development team looks after 25 to 30 households. This arrangement is contributing to Ethiopia's sprint toward the achievement of MDGs as we approach 2015 (MOH, 2011).

Schools promote quality health and nutrition services for school-age children and adolescents, who constitute 15 percent and 35 percent of the nation's total population, respectively (CSA, 2007). The Ministry of Education has developed the National School Health and Nutrition Strategy (SHN) to enable improved access to better health and nutrition services for 18,850,986 school-age children and some 376,937 teachers through 33,284 government and non-government schools (MOE, 2012).

1.1. Nutrition in Ethiopia

Worldwide, malnutrition is an underlying cause in the deaths of more than 3.5 million children under the age of 5 each year. Some 13 million infants are born each year with low birth weight (LBW). Fifty-five million children are wasted, and of these 19 million are severely wasted. About 178 million children around the world are stunted. Of the estimated 178 million, 90 percent live in 36 countries, one of which is Ethiopia (Black, 2008). Ethiopia has witnessed encouraging progress in reducing malnutrition over the past decade. However, baseline levels of malnutrition remain so high that the country must continue to make significant investments in nutrition.

Major investments in child health in Ethiopia have yielded a substantial decline in infant and under-5 mortality rates; it is expected that the country will achieve MDG 4. However, the last steps will be tough unless the underlying causes of child mortality are addressed. Under-nutrition is one of the main culprits causing high child mortality, accounting for 51 percent of all childhood deaths in Ethiopia (FMOH, 2003). Under-nutrition has an enormous impact on health, wellbeing and productivity. In both 2008 and 2012 the Copenhagen Consensus rated interventions to reduce under-nutrition of first priority among ten of the world's most important challenges (Copenhagen Consensus, 2012). Addressing the problem of under-nutrition is critical to achieving all MDGs, especially MDG1, MDG 4 and MDG 5. Under-nutrition represents the non-income face of poverty and is embodied within Target 1C of MDG 1.

Women's nutrition affects a wide range of health and social issues, including family care and household food security (FANTA, 2000). Food insecurity and malnutrition in adolescents and pregnant women, compounded by gender discrimination, leads to an intergenerational cycle of nutrition problems which manifest as stillbirths, miscarriages, low birth weight, growth failure, increased risk of maternal and neonatal mortality, impaired cognitive development, sub-optimal productivity in adults and reduced economic growth for the nation. For girls in particular, the chances of escaping this nutrition-poverty trap diminish as the child grows older. Over time her options for better education attainment and delayed marriage decrease. She is likely, in turn, to give birth to a baby of low birth weight. Hence the cycle begins again (Benson, 2006). This cycle must be broken, and it all begins with the mother or, rather, with adolescent girls.

There is a strong relationship between age and physical nutritional status; it is well recognized that the size and body composition of the mother at the start of pregnancy is one of the strongest influences on fetal growth (Kramer, 1987). Ensuring that adolescent girls are themselves nutritionally fit to become mothers is essential. In the United States it has been shown that in adolescent mothers who were still growing during pregnancy, there is a maternal-fetal competition for nutrients, and that birth weight is smaller by some 200g (Scholl, 1997).

According to the 2011 Ethiopian Demographic and Health Survey (EDHS), the median age for a first marriage is around 16.5. Twelve percent of adolescent girls (aged 15–19) are either already mothers or pregnant with their first child.

The government's efforts to address under-nutrition will be strengthened through the Lifecycle Approach, a comprehensive approach that emphasizes the first 1,000 days of a child's life. For instance, ensuring that a newborn is breastfed within 1 hour of birth could cut all neonatal mortality by 22 percent. Exclusive breastfeeding for the first 6 months of life can cut by about 15 percent the number of child deaths, and adequate complementary feeding could prevent an additional 6 percent of all such deaths (Jones et al., 2003).

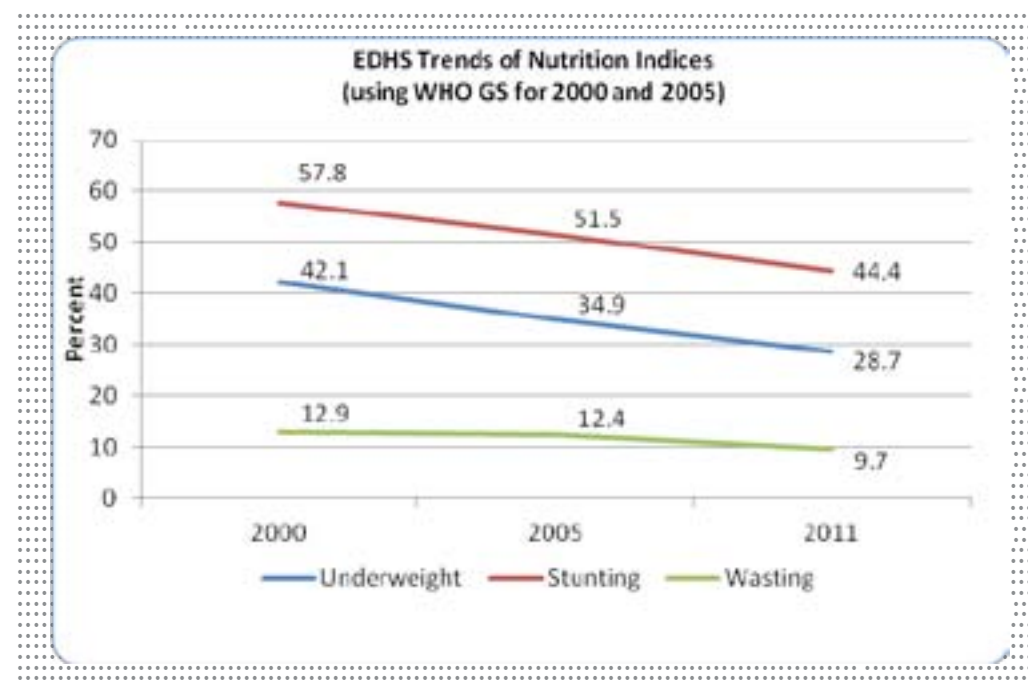
The first 1,000 days of life, from the first day of pregnancy until the child is 24 months old, is a critical window of opportunity for health and development. This is the period in which nutrition requirements are greatest and when adolescent girls, pregnant women and young children in Ethiopia in particular are

most vulnerable to inadequate care, inadequate access to health services and unsuitable feeding practices. The interventions in this revised National Nutrition Programme Guide will therefore target the following “windows of opportunity”: adolescent girls, pregnant women, infants 0–6 months old, and infants and young children 6–24 months old.

Nutrition trends in Ethiopia: The 2011 EDHS estimated the national prevalence of stunting among children at 44.4 percent, the prevalence of underweight at 28.7 percent and wasting at 9.7 percent. The survey also revealed that the level of chronic malnutrition among women in Ethiopia is relatively high, with 27 percent of women either thin or undernourished—that is, having a body mass index (BMI) of less than 18.5 kg/m². Similarly, the prevalence of anemia among women in the reproductive age group (15–49) was found to be 17 percent (CSA, 2011).

Between 2000 and 2011 the prevalence of both underweight and stunting declined 32 and 23 percent, respectively (Figure 1). While this trend is clearly progressing in the right direction, Ethiopia needs to accelerate efforts to reach the Health Sector Development Plan’s (HSDP IV) target of reducing the prevalence of stunting to 30 percent by 2015. Known high impact nutrition interventions must thus be scaled up and intensified.

Figure 1. Trends of nutritional indices in Ethiopia



Micronutrient deficiencies contribute significantly to morbidity and mortality among children. Micronutrient deficiencies, particularly iron, iodine and Vitamin A deficiencies, are significant public health problems in Ethiopia. The prevalence of anemia among children under 5 nationally has dropped by 19 percent between 2005 and 2011—from 54 percent in 2005 to 44 percent in 2011. Iodine is vital for healthy growth and mental development. According to the World Health Organization, salt iodization needs to reach 90 percent if Ethiopia is to be on track to eliminate iodine deficiency (WHO, 1993). The Ministry of Health and relevant NNP implementing sectors have taken important strides to ensure

progress towards universal salt iodization, including calling for mandatory use and sale of iodized salt. In addition to its effect on the eyes, Vitamin A deficiency increases the severity of childhood infections. Nationwide supplementation of Vitamin A is undertaken twice a year, covering 91.7 percent of children under 5 (MOH, 2011/12).

Levels of nutritional indices (stunting, wasting and underweight) and micronutrient deficiencies are high but showing improving trends. However, the feeding practices of Ethiopian families remain sub-optimal. According to EDHS 2011, only half of children under 2 living with their mothers are exclusively breastfed. Only 4.3 percent of children consumed the recommended four food groups and just 13 percent of children under 2 consumed iron-rich foods.

Table 1: Summary of programmatic indicators, nutritional status and trends among children and women, 2005–2011

Indicator	Source	Frequency	2005 (%)	2011 (%)
Infant mortality rate (per 1,000 live births [LB])	EDHS	Every 5 years	77	59
Children < 5 years mortality rate (per 1,000 LB)	EDHS	Every 5 years	123	88
Maternal mortality rate (per 100,000 LB)	EDHS	Every 5 years	673	676
Children < 5 years underweight	EDHS	Every 5 years	38	29
Children < 5 years stunted	EDHS	Every 5 years	52	44
Children < 5 years wasted	EDHS	Every 5 years	12.4	9.7
Newborns with low birth rate	EDHS	Every 5 years	14	11
Prevalence of anemia in women	EDHS	Every 5 years	27	17
Maternal malnutrition (BMI <18.5)	EDHS	Every 5 years	27	27
Anemia in children 6–59 months of age	EDHS	Every 5 years	54	44
Iodine deficiency disorder in children	EDHS	Every 5 years	39.9	NA
Vitamin A deficiency (VAD) (%)	EDHS	Every 5 years	61	NA
Institutions managing SAM at health posts and health centers	HMIS	Monthly	HP (-) HC (20)	HP (52) HC (59)
Early initiation of breastfeeding	EDHS	Every 5 years	69	52/
Exclusive breastfeeding under 6 months	EDHS	Every 5 years	49	52
Children aged 6–9 months who receive complementary food and continued breastfeeding	EDHS	Every 5 years	44	51
Children aged 6–59 months who received two doses of Vitamin A supplementation	Administrative report	Annually	94	88
Iodization of household salt	EDHS	Every 5 years	4	15
Children aged 2–5 years de-wormed	Administrative report	Annually	86	100
Pregnant women supplemented with iron foliate during their last birth	EDHS, NNP	Annually	10	17
Pregnant women supplemented with > 90 tabs of iron foliate during their last pregnancy	EDHS	Every 5 years	0.1	0.4

Nutrition and communicable diseases

When a person is infected with a communicable disease, the activation and maintenance of immune responses requires increased energy consumption. Malnutrition is a critical yet underestimated factor in susceptibility to infection, including susceptibility to the “big three” infectious diseases: HIV/AIDS, tuberculosis and malaria. Infection causes energy loss on the part of the individual, which reduces productivity on the community level and perpetuates an alarming spiral of malnutrition, infection, disease and poverty. Hence, it is essential to address the nutritional requirements of individuals who have infections in general and infections such as HIV, tuberculosis and malaria in particular.

Nutrition and non-communicable/lifestyle related diseases

In Ethiopia and elsewhere, there is growing recognition of the emergence of a “double burden” of malnutrition, with under- and over-nutrition occurring simultaneously among different population groups in developing countries, particularly when economic conditions improve. Because of changes in dietary and lifestyle patterns, non-communicable diseases like obesity, diabetes mellitus, cardiovascular disease, hypertension, stroke and some types of cancer are becoming increasingly significant causes of disability and premature death in both developing and newly developed countries, placing an additional burden on already overtaxed national health budgets. Moreover, under-nutrition in utero and early childhood may predispose individuals to greater susceptibility to some chronic diseases.

Gender dimensions of nutrition

Gender inequalities can be both a cause and an effect of hunger and malnutrition. Not surprisingly, higher levels of gender inequality are associated with higher levels of under-nutrition, both acute and chronic (FAO, 2011). There is always a co-existence of well-fed and malnourished persons in a household, as resources are not shared in an equitable manner (*Gender Influences on Child Survival, Health and Nutrition*, 2011). The nutritional status of girls and women is affected not only by biological factors but also by systematic inequalities within households and the sociocultural norms prevalent in a specific community. Given these unequal conditions, women and girls have poorer nutrition outcomes throughout the lifecycle, higher rates of mortality, less access to health care and greater household food insecurity (UNSCN, 2004).

These facts underscore the need for efforts that seek to mainstream gender into nutrition strategy and programming. Improvements in the nutritional status of women and girls will contribute to reducing gender inequality while at the same time breaking the cycle of intergenerational malnutrition. Women’s decision-making power relative to men’s has been significantly associated with improved nutritional status in children (Smith et al., 2003). Gender equality and women’s empowerment is an essential part of human development and is necessary for improvements in nutrition across the entire lifecycle (Oniang’o, 2002). Gender also plays a critical role in implementing nutrition interventions effectively at household and community level.

1.2. Progress and challenges since NNP 2008

The last 5 years have seen promising achievements in Ethiopia. For one, the policy landscape for nutrition has improved. The Growth and Transformation Plan has set stunting reduction as one of its goals for 2015. The Government of Ethiopia, in collaboration with nutrition development partners, has shown its commitment to reducing stunting at a faster rate, and signed the commitment for food and nutrition security at the G8 meeting in 2012.

Nutrition programmes have been scaled up to reach more children and women:

- Nutrition is one of the packages of services in the Health Extension Programme and is included in integrated refresher training (IRT).
- Eleven million children under 5 years old receive Vitamin A supplementation and de-worming.
- Community based direct nutrition interventions have been scaled up to more than 500 woredas following implementation of CMNCH IRT.
- Community management of acute malnutrition has been scaled up and decentralized to more than 10,000 health facilities.
- Salt iodization has been re-initiated and salt iodization legislation and enforcement are in place.
- Zinc supplementation for diarrhea treatment has been integrated into the HEP's Integrated Community Case Management.
- Nutrition and HIV interventions have been scaled up to 400 health facilities.

Moreover, a number of system-strengthening activities have been performed. For example, the HEP is now able to deliver interventions under the Enhanced Outreach Strategy, and human capacity for nutrition has been created through in-service and pre-service capacity building, including operational research.

Over the last 5 years, as indicated in Table 1, the nutritional status of children and women has improved, along with programmatic performance. The interest of development partners in supporting nutrition programmes has increased as well.

The following are some of the key challenges faced in the implementation of the 2008–2013 NNP:

- Nutrition is not well reflected in some NNP implementing sectors' strategies and programmes. The potential of these programmes to improve nutrition has therefore not been sufficiently utilized. The result is a critical missed opportunity to improve nutrition and complement successes both in these sectors and in exiting nutrition interventions.
- Nationally, horizontal ministerial-level intersectoral coordination mechanisms are limited; at regional level, these are either inadequate or nonexistent. It has been difficult to create operational, effective linkages with relevant sectors at all levels.
- Until recently, food fortification programmes had not been given much attention, despite food fortification being one of the sustainable ways of doing micronutrient interventions.
- Mechanisms for triangulated nutrition information that captures data from all relevant sectors (for use in improved programme implementation and early warning) are inadequately integrated.
- Even if gender has been identified as a determining factor in achieving nutrition related objectives, programmes were not designed based on gender analyses, and adequate structures and systems were not put in place to oversee gender mainstreaming and the building of human resource capacity for nutrition.
- Strategies for breaking the intergenerational cycle of malnutrition were neither focused nor complete, particularly in addressing the critical window of opportunities—the first 1,000 days. A strategic and logical scheme of activities to address chronic under-nutrition was lacking, as were focused interventions that would address nutrition in women and adolescents.

1.3. Rationale for revising NNP 2008

The National Nutrition Programme is being revised for the following main reasons.

- (1) To strategically address the nutrition problem in the country by
 - Taking into account the multisectoral and multidimensional nature of nutrition.
 - Focusing on the Lifecycle Approach to map key actions needed to improve the nutritional status of strategic target groups (women and children).
- (2) To strengthen initiatives that were not adequately addressed in the 2008 NNP and to include initiatives that have emerged since that NNP was devised, namely:
 - Accelerated Stunting Reduction Initiative.
 - National Food Fortification Programme.
 - Multisectoral linkages among key NNP implementing sectors.
- (3) To align the end of the first phase of the NNP with the GTP and MDGs—that is, to extend the first phase by 2 years to 2015.

The accountability and results matrix in this version of the NNP has been modified to show how each of the results can be realized and how each NNP implementing sector should contribute for better nutritional outcomes over the course of the lifecycle.

CHAPTER 2

STRATEGIC OBJECTIVES AND INITIATIVES

The government has already put in place programmes and initiatives with set targets that directly and indirectly contribute to the reduction of under-nutrition. These programmes include increasing agricultural productivity; promoting girls' education; immunization; integrated management of neonatal and childhood illnesses (IMNCI); water, sanitation and hygiene (WASH); family planning, prevention of mother-to-child transmission of HIV (PMTCT), skilled delivery and delaying of pregnancy. The government will facilitate and support the scale-up of these initiatives/programmes to achieve the strategic objectives outlined below.

The core performance indicators and targets of the NNP are listed below. However, the performance indicators and targets for each strategic objective are listed under the strategic objectives and in the accountability and result matrix of the NNP in Annex 2.

1. Reduce the prevalence of stunting from 44.4% to 30% by 2015;
2. Reduce the prevalence of wasting from 9.7% to 3% by 2015;
3. Reduce the prevalence of chronic undernutrition in women of reproductive age from 27% to 19%

Strategic Objective 1:

Improve the nutritional status of women (15–49 years) and adolescents (10–19 years)

2015 Targets

- Reducing the proportion of adolescent girls aged 15–19 with a BMI <18.5 from 36 percent to 25 percent.
- Reducing the prevalence of anemia among pregnant women from 22 percent to 12 percent.

Result 1.1: Nutritional status of adolescents improved

Interventions

1. Provide comprehensive and routine nutritional assessment and counseling services for adolescents at community, school and health facility levels.

2. Ensure adolescents' access to micronutrient services
 - ✓ Promote the use of iodized salt and strengthen enforcement of the Universal Salt Iodization (USI) regulation.
 - ✓ Provide school based biannual de-worming.
 - ✓ Promote the use of fortified foods.
 - ✓ Ensure adolescent friendly services.
3. Conduct Behavioral Change Communication to prevent harmful traditional practices
 - ✓ Delay early marriage till age 18.
 - ✓ Promote shift of social norms on food taboos preventing adequate nutrition for adolescent girls.
4. Ensure access to reproductive health information and services for boys and girls to
 - ✓ Delay first pregnancy after marriage.
 - ✓ Use family planning methods.
 - ✓ Promote utilization of adolescent friendly reproductive health services.
5. Conduct regular monitoring of the nutritional status of school-age children/students together with biannual de-worming.
6. Promote girls' education.
7. Promote economic empowerment for out-of-school adolescents through various economic strengthening opportunities.
8. Promote the development of life skills (such as assertiveness, negotiating, decision-making, leadership and bargaining) for both girls and boys.

Result 1.2: Nutritional status of women improved

Initiatives targeting pregnant and lactating women

1. Provide comprehensive and routine nutritional assessment, counseling and support services
 - ✓ Conduct nutritional assessment of pregnant and lactating women.
 - ✓ Promote maternal nutrition, including adequate intake of diversified foods and daytime rest during antenatal and postnatal periods.
 - ✓ Provide supplementary food to malnourished pregnant and lactating women.
2. Ensure that pregnant and lactating women have access to micronutrient services
 - ✓ Provide routine iron folic acid or multiple micronutrient supplementation.
 - ✓ Promote the use of iodized salt.
 - ✓ Provide deworming during the second and third trimester of pregnancy.
3. Ensure free distribution and utilization by pregnant and lactating women of insecticide-treated nets in all malaria-endemic woredas.
4. Support the involvement of women's development groups in nutrition sensitive agriculture and livelihood programmes.

5. Ensure access to time and labor-saving technologies.
6. Ensure that lactating mothers have access to appropriate reproductive health services.
7. Promote increased engagement of husbands and other household members in playing key roles in providing continuous care for pregnant and lactating women.
8. Promote shifts of social norms on food taboos preventing adequate nutrition for pregnant and lactating women.
9. Ensure male involvement in reproductive health services such as PMTCT, antiretroviral treatment, family planning, antenatal and postnatal service and child care, among others.

Initiatives targeting non-pregnant and non-lactating women

1. Promote the use of iodized salt and strengthen enforcement of USI regulation.
2. Promote women's nutrition, including adequate intake of diversified foods.
3. Ensure access to reproductive health services (birth spacing).
4. Ensure economic empowerment of single mothers with children less than 5 years of age.
5. Ensure the presence of alternative childcare facilities (institutional and community) while encouraging and supporting women to engage in income generating activities.

Strategic Objective 2

Improve the nutritional status of infants, young children and children under 5

2015 Targets

- Increase the proportion of infants 0–6 months old who are exclusively breastfed from 52 percent to 70 percent.
- Increase the proportion of breastfed children aged 6–23 months with the minimum acceptable dietary score from 4 percent to 20 percent.
- Reduce the prevalence of Bitot's spots in children ages 6–59 months from 1.7 percent to less than 0.5 percent.
- Reduce the percentage of children 6–12 years old with median urinary iodine concentration of less than 100 µg/l to below 50 percent.
- Increase the proportion of households using iodized salt from 15.4 percent to 95 percent.
- Reduce the prevalence of anemia in children 6–59 months from 44 percent to 25 percent.
- Increase zinc supplementation in the treatment of diarrhea from 5 percent to 50 percent.
- Maintain coverage of Vitamin A supplementation/de-worming at over 90 percent.

Result 2.1: Improved nutritional status of children 0–24 months

Initiatives

1. Promote, support and protect optimal breastfeeding practices for infants 0–6 months at community and facility level
 - ✓ Promote and support exclusive breastfeeding for the first 6 months.
 - ✓ Promote initiation of breastfeeding within 1 hour of birth.
 - ✓ Establish a baby friendly health facilities initiative.
 - ✓ Enforce the Code of Marketing for Breast Milk Substitutes.
 - ✓ Enforce the existing maternity leave in the private sector and promote enactment of maternity leave according to the International Labor Organization proclamation.
2. Promote, support and create access to appropriate complementary feeding for 6–24 month-olds
 - ✓ Promote timely initiation of semisolid/solid complementary foods at 6 months of age.
 - ✓ Promote and demonstrate utilization of diversified foods.
 - ✓ Create access and promote use of micronutrient enriched complementary foods.
 - ✓ Promote continued breastfeeding until the age of 24 months and beyond.
 - ✓ Promote active and responsive feeding for children 6 to 24 months old, and involvement of fathers.

- ✓ Promote feeding during illness and recovery.
- ✓ Conduct regular monthly growth monitoring and promotion for children 0–24 months with appropriate age-specific counseling.
- ✓ Promote local production of complementary food.

3. Prevent and control micronutrient deficiencies

- ✓ Identify and treat anemia.
- ✓ Provide Vitamin A supplementation for children 6–59 months of age biannually.
- ✓ Promote the use of iodized salt at household level.
- ✓ Provide zinc with oral rehydration sachets (ORS) for diarrhea treatment.
- ✓ Promote the use of fortified foods.

4. Early detection and management of acute malnutrition and common childhood infections

- ✓ Ensure access to quality management of severe and moderate acute malnutrition.
- ✓ Encourage local food processing factories to participate in fulfilling production requirements for ready-to-use therapeutic food (RUTF) and ready-to-use supplementary food.
- ✓ Ensure availability of appropriate supplies and commodities (supplements, anthropometric equipment, RUTF, F-100, F-75, supplementary food) in a sustainable manner in all health facilities.
- ✓ Ensure access to quality ICCM/IMNCI services.
- ✓ Strengthen monitoring and evaluation of nutrition services through harmonized data collection tools and Health Management Information System indicators (HMIS).

5. Ensure access and utilization of WASH¹ practices

- ✓ Ensure access to clean and safe water.
- ✓ Promote the use of household water treatment practices.
- ✓ Promote safe and hygienic preparation and handling of food.
- ✓ Promote handwashing with soap/ash.
- ✓ Promote proper disposal of child feces.
- ✓ Promote construction and utilization of household and community latrines.

6. Link food-insecure households with children under 2 years of age to social protection services and nutrition sensitive livelihood and economic opportunities

- ✓ Social safety net programme.
- ✓ Income generation schemes.
- ✓ Homestead production of vegetables and fruits and small-animal rearing.

7. Integrate Early Childhood Care and Development (ECCD) stimulation with existing community and facility based child nutrition programmes

- ✓ Promote appropriate adult-child interaction.
- ✓ Ensure the development and utilization of locally relevant early childhood development materials.
- ✓ Integrate ECCD into nutrition capacity building efforts (blended integrated nutrition learning module).

1 WASH activities are applicable to all stages of the lifecycle.

Result 2.2: Improved nutritional status of children 24–59 months

Initiatives

1. Promote appropriate dietary practices

- ✓ Create access to and promote utilization of diversified foods.
- ✓ Promote continued feeding during illness/recovery.

2. Prevent and control micronutrient deficiencies

- ✓ Identify and treat anemia.
- ✓ Provide Vitamin A supplementation for children 6–59 months of age biannually.
- ✓ Deworm children 2–5 years old biannually.
- ✓ Promote the use of iodized salt at household level.
- ✓ Provide zinc with ORS for diarrhea treatment.
- ✓ Provide multiple micronutrient supplements to children 6–59 months of age to enrich household foods.

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

- ✓ Conduct routine screening of children for malnutrition.
- ✓ Manage severe and moderate acute malnutrition.
- ✓ Encourage local food processing factories to participate in fulfilling production requirements for RUTF and RUSF.
- ✓ Ensure availability of appropriate supplies and commodities (supplements, anthropometric equipment, RUTF, F-100, F-75, supplementary food) in a sustainable manner in all health facilities.
- ✓ Ensure access to quality ICCM/IMNCI services.
- ✓ Strengthen monitoring and evaluation of nutrition services through harmonized data collecting tools and HMIS indicators.

4. Ensure access and utilization of WASH practices

- ✓ Ensure access to clean and safe water.
- ✓ Promote safe and hygienic preparation and handling of food.
- ✓ Promote hand washing with soap/ash.
- ✓ Promote proper disposal of child feces.
- ✓ Promote construction and utilization of household and community latrines.

5. Integrate ECCD stimulation with existing community and facility based child nutrition programmes.

- ✓ Promote appropriate adult-child interaction.
- ✓ Ensure the development and utilization of locally relevant early childhood development materials.
- ✓ Integrate ECCD into nutrition capacity building efforts (blended integrated nutrition learning module).

Strategic Objective 3

Improve the delivery of nutrition services for communicable and non-communicable/lifestyle related diseases (all age groups)

Result 3.1: Improved nutrition service delivery for communicable and non-communicable/lifestyle related diseases

Initiatives targeting communicable diseases

Nutrition and HIV/AIDS

1. Strengthen the capacity of facilities/health professionals to deliver quality standard nutrition services to people living with HIV (PLHIV)
 - ✓ Develop/revise and disseminate guidelines and training materials on HIV and nutrition.
 - ✓ Equip facilities with nutrition assessment and counseling materials.
 - ✓ Make available nutrition communication and advocacy materials to health service providers (in line with the national health and nutrition communication strategy).
 - ✓ Train health workers on nutritional assessment counseling and support (NACS) based on HIV and nutrition guidelines.
2. Integrate nutrition assessment counseling and support into HIV treatment, care and support services
 - ✓ Support facilities to integrate nutrition counseling and clinical nutrition services into existing HIV services.
 - ✓ Standardize clinical nutrition and HIV services as per national guidelines.
 - ✓ Ensure that nutritional care and support for women living with HIV is an integral part of antenatal, postnatal and PMTCT services.
 - ✓ Counsel and support HIV-positive mothers on infant feeding as per the national recommendations and strategies for PMTCT. These are:
 - Exclusive breastfeeding for the first 6 months of life.
 - Avoiding early cessation of breastfeeding, as this is associated with increased risk of death from diarrheal illnesses, malnutrition and pneumonia.
 - Introducing appropriate complementary foods at 6 months of age, with continued breastfeeding.
 - Stopping breastfeeding only when a nutritionally adequate diet without breast milk can be provided (usually at 12–18 months).
 - ✓ For women who choose to use replacement feeding, ensure HIV counseling on feeding choices on the basis of acceptable, feasible, affordable, sustainable and safe (AFASS) feeding options
 - Encourage local food processing factories to participate in fulfilling production requirements for RUTF and RUSE.
 - Ensure availability of appropriate supplies and commodities (supplements, anthropometric equipment, RUTE, F-100, F-75, supplementary food) in a sustainable manner in all health facilities.

- Strengthen monitoring and evaluation of nutrition services through harmonized data collecting tools and HMIS indicators.

3. Coordinate facility based therapeutic and community based preventive food and nutrition interventions for PLHIV
 - ✓ Coordinate and integrate food assistance and HIV programmes at all levels.
 - ✓ Strengthen nutrition education, including knowledge of water purification, food hygiene, preparation and handling, and other complementary interventions.
 - ✓ Employ strategies for client graduation through linkages to other services.
 - ✓ Establish linkages between community based nutrition interventions for PLHIV and livelihood support and food assistance interventions.
 - ✓ Facilitate linkages/coordination between various food and nutrition assistance implementers.

Nutrition and tuberculosis

1. Ensure (a) that a nutritional assessment is done to determine nutritional status and (b) that referrals are provided for nutrition support when essential.
2. Ensure that nutritional counseling and education is provided on symptom management and improved dietary intake during and after tuberculosis (TB) treatment.
3. Facilitate the provision of food assistance to treat malnutrition and increase treatment adherence in TB patients.
4. Arrange a potential collaboration between TB and HIV programmes on the one hand, nutrition on the other.
5. Review existing evidence on TB and nutrition to bridge knowledge gaps and identify operational research areas to fully integrate nutrition into TB treatment services.

Nutrition and other infections

1. Ensure that a nutritional assessment is done to determine nutritional status and provide referrals for nutrition support to individuals who have infections such as malaria and malnutrition.
2. Ensure that nutritional assessment and counseling are done during treatment of the infection.
3. Strengthen community based nutrition education through the health extension worker programme.

Initiatives targeting chronic non-communicable/lifestyle related diseases

The following initiatives will be conducted to address the nutrition problems related to lifestyle diseases, specifically in urban and semi-urban settings:

1. Strengthen institutional capacity in the leadership and management of programmes for the prevention and control of lifestyle related diseases.
2. Promote public awareness of healthy lifestyles, increased outdoor activities, increased consumption of fruits and vegetables, reduced consumption of soda beverages and avoidance of unhealthy behaviors.
3. Integrate the prevention and control of lifestyle related diseases with the urban Health Extension Programme.
4. Modify the environment to enhance physical activity in schools and communities (playgrounds and green areas).

5. Promote the establishment of community health clubs in urban settings.
6. Promote the engagement of professional associations (pediatric societies, Ethiopian Public Health Association, nutrition associations, etc.) to generate evidence for policy guidance and standard setting.
7. Strengthen the diagnostic and clinical management capabilities of the country's health system to treat lifestyle related diseases.
8. Enhance training of health professionals on lifestyle related diseases.
9. Formulate and enforce legislation (label cigarette packages, alcoholic beverages and *chat* with health hazard messages; impose taxation, etc.).
10. Address the gender dimension of non-communicable diseases, including **breast** and cervical cancer, and ensure women's access to information.

Strategic Objective 4

Strengthen implementation of nutrition sensitive interventions across sectors

Targets

- Increase the proportion of households consuming fruits and vegetables by 30 percent.
- Increase fruit and vegetable production from 894,000 (2011) tons to 5,905,000 tons by 2015 to improve food diversification at community level.
- Increase potable water coverage from 60 percent to 76 percent.
- Increase the proportion of primary schools with school gardening to 25 percent.
- Increase the proportion of schools that provide biannual de-worming to 60 percent.

Result 4.1 Strengthened implementation of nutrition sensitive interventions in the agriculture sector

The Ministry of Agriculture (MOA) has a food security programme that aims to sustainably ensure adequate quantity and quality of food. The programme has four components: the Productive Safety Net Programme (PSNP), the Household Asset Building Programme (HABP), Complementary Community Investment (CCI) and improved access to land (Resettlement). Moreover, programmes and established systems such as the Agricultural Extension Programme, the Agricultural Growth Programme, and Agricultural Research have been designed to increase production and productivity of agricultural products. All of these programmes have their own targets and contribute to reducing under-nutrition; each needs to be scaled up with more emphasis on increasing the quality of food produced and on mainstreaming nutrition.

Initiatives

1. Increase production of fruits, vegetables, nutritious roots, cereals and pulses to improve the consumption of a diversified diet at household level
 - ✓ Promote homestead gardening.
 - ✓ Promote community horticulture production.
 - ✓ Strengthen/support fruit and vegetable nursery sites.
 - ✓ Promote urban gardening.
 - ✓ Promote cost effective production and market linkages.
 - ✓ Promote appropriate technologies.
 - ✓ Promote and support school gardening.
2. Improve access to and utilization of animal source foods
 - Dairy
 - ✓ Establish and support milk collection centers in milk belt and pastoralist areas.
 - ✓ Support market linkages to dairy products.
 - Poultry
 - ✓ Promote backyard poultry raising.
 - Sheep and goats
 - ✓ Increase household income from sheep and goat production.
 - ✓ Promote sheep and goat milk consumption.
3. Increase production and consumption of fish
 - ✓ Support communities living around water bodies to improve fish production.
 - ✓ Establish community ponds.
 - ✓ Support training centers on net fishing.
 - ✓ Strengthen coordination of the fishery sector in MOA.
4. Promote appropriate technologies for food production and processing through handling, preparation and preservation for food diversification to ensure nutritious food utilization
 - ✓ Identify and scale up selected best practices in the preservation of fruits and vegetables, dairy products and fish.
 - ✓ Improve handling and transportation of fruits and vegetables, dairy products and fish.
5. Promote value addition to ensure availability and consumption of diverse, nutritious foods
 - ✓ Promote and disseminate bio-fortified micronutrient-rich staple food products, such as orange sweet potatoes and quality protein-rich maize.
6. Promote consumption of diversified foods through the Agricultural Extension Programme and through agricultural development agents (DAs) at community level
 - ✓ Build the capacity of AEWs and agriculture programme managers at all levels to implement nutrition sensitive agriculture
 - Incorporate nutrition training in the pre-service DA training curriculum.
 - Provide in-service training for AEWs and agriculture programme managers (agriculturists).

7. Strengthen the capacity of the agriculture sector to integrate nutrition sensitive interventions into agriculture programmes
 - ✓ Establish a nutrition unit in the MOA that will be primarily responsible for coordinating the mainstreaming of nutrition in the agriculture sector. This would entail the following:
 - Strengthening nutrition mainstreaming/linkages with livestock (fishery, dairy, poultry, etc.), horticulture, and so on.
 - Conducting nutrition training in the agriculture sector at various levels.
 - Supporting nutrition linkages in various agriculture programmes (PSNP, HABP, AGP, etc.).
 - ✓ Strengthen FTCs to implement nutrition sensitive interventions.
 - ✓ Strengthen the linkages between HEWs and DAs for improved household nutrition practices.
 - ✓ Mainstream nutrition interventions into the agriculture policy and investment framework plan.
8. Support local complementary food production and create economic opportunities for women through development groups and cooperatives
 - ✓ Organize women's groups and support the preparation of complementary food.
 - ✓ Provide revolving startup capital.
 - ✓ Identify, document and scale up best practices.
9. Support agriculture research centers to develop seeds of high nutritional value
 - ✓ Provide financial support to agriculture research centers and universities to undertake research.
 - ✓ Identify seeds of improved nutritional value from other countries and adapt them to the agro-ecological conditions in Ethiopia.

Result 4.2: Strengthened implementation of nutrition sensitive interventions in the education sector

The education sector is responsible for increasing access to primary, secondary and tertiary education. Girls' education is a priority initiative of the Ministry of Education (MOE). In addition, an adult literacy programme is being executed. All of these MOE programmes or initiatives have set targets and implementation plans. They will contribute to the reduction of under-nutrition in school children and adolescents and their families.

Initiatives

1. Promote key nutrition actions through teachers, parent-teacher associations (PTAs) and school clubs.
2. Encourage schools to promote and transfer sustainable and replicable school gardening models at community level.
3. Facilitate or implement targeted micronutrient distribution, such as provision of de-worming tablets, at school.
4. Improve water, hygiene and sanitation facilities in schools.
5. Promote the use of iodized salt at household level through school children.

6. Incorporate nutrition into school curricula at primary and secondary levels, TVETs and higher learning institutions.
7. Build the capacity of teachers, teachers' associations and PTAs on nutrition and food security.
8. Support and promote home-grown school feeding in selected schools.
9. Support higher institutions to conduct nutrition sensitive operational research.
10. Support higher institutions to produce nutrition professionals.
11. Promote girls' education.
12. Promote awareness of gender equality among school children.

Result 4.3: Strengthened implementation of nutrition sensitive interventions in the water sector

The water and energy sector is responsible for increasing access to potable water through its Universal Access to Potable Water Programme (UAP). Increasing access to potable water will improve nutrition, reduce the burden of disease and reduce the time spent fetching water, giving mothers more time to care for their children. Through the Irrigation Development Programme (IDP), sectors will increase the amount of irrigated farmland. This will increase food production and thus lead to improvements in nutritional status and economic wellbeing. The programme's target is to develop 27,882 hectares of irrigated farmland under small scheme irrigation by 2015.

Initiatives

1. Increase access to safe water
 - ✓ Provide water supply (urban, rural, pastoralist).
1. Provide water supply for sewerage facilities.
2. Increase irrigated farmland through IDP.
3. Develop water quality standards and monitor their implementation.

Result 4.4: Strengthened implementation of nutrition sensitive interventions in the industry sector

Initiatives

1. Strengthen the capacity of Ministry of Industry staff involved in supporting the production and distribution of food items.
2. Support industries in the use of appropriate technologies for food fortification.
3. Promote the provision of credits, grants and microfinance services to support low and medium scale industries, with primary on the production of fortified foods.
4. Ensure that the quality and safety of locally produced food items are as per the national standard.
5. Conduct awareness creation events for the private sector (producers) on nutrition related requirements and standards of locally manufactured food items.
6. Build industry capacity to produce fortified food (edible oil, flour, salt, etc.).

Result 4.5: Strengthened implementation of nutrition sensitive interventions in the trade sector

Initiatives

1. Strengthen the capacity of Ministry of Trade staff involved in the regulation of imported food items.
2. Ensure that the quality and safety of imported food items are as per the national standard.
3. Conduct awareness creation events for the private sector (importers) on the nutrition related requirements and standards of imported food items.
4. Conduct awareness creation events for consumers on the benefits of fortified food.
5. Support importation of fortified food (edible oil, salt, etc.).

Result 4.6: Strengthened social protection services for improved nutrition

Initiatives

1. Promote the implementation of gender-sensitive social safety net programmes and other social protection instruments to protect vulnerable groups from food insecurity and under-nutrition
 - Ensure that vulnerable households affected by nutrition emergencies are adequately targeted in safety net initiatives.
 - Appropriately integrate nutrition practices with social safety net programmes to improve the nutritional status of women and children.
2. Promote the provision of credits, grants, microfinance services and other income generating initiatives to support vulnerable groups, with primary focus on unemployed women, to increase access to nutritious foods
 - Improve the access of women's self-help groups to grants and credits.
 - Promote appropriate nutrition practices through women's self-help groups.
3. Increase access to basic nutrition services for all vulnerable groups
 - Employ fee-waiver schemes for management of acute malnutrition.
 - Expand basic preventative and curative nutrition services to pastoralist and other vulnerable areas.
 - Improve nutritional services for the poor, the elderly and persons with disabilities.
4. Strengthen and expand the Social Cash Transfer Programme for ultra poor and labor constrained families to
 - Improve the quality of life.
 - Enhance access to essential social welfare services, including health, nutrition and education.

Result 4.7: Households protected from shocks and vulnerabilities that affect their nutritional status

Initiatives

1. Strengthen and scale up early warning systems for food and nutrition information from the community to the national level
 - ✓ Support the monitoring and evaluation system's capacity to ensure credible and timely data collection and analysis.
2. Facilitate community participatory risk assessments and preparedness planning Support nutrition emergency response and recovery programmes
 - ✓ Develop, promote and implement in a timely fashion a comprehensive package of nutrition services and food items for emergencies and recovery periods.
 - ✓ Ensure early detection and management of acute malnutrition.
 - ✓ Integrate management of infant and young child feeding in emergency response interventions.
 - ✓ Undertake Vitamin A supplementation and measles vaccination.
 - ✓ Establish and strengthen supplementary and therapeutic feeding based on assessments.
 - ✓ Ensure provision of adequate and appropriate information during emergencies.
 - ✓ Ensure access to safe water, sanitation and hygiene during emergencies.

Result 4.8: Ensured quality and safety of nutrition services and supplies

Initiatives (regulatory sector)

1. Develop appropriate standards, legislation and manuals to control the quality and safety of
 - ✓ Nutrition supplies.
 - ✓ Fortified foods, food fortificants/Premix.
 - ✓ Micronutrient supplements (iron, zinc, folic acid, Vitamin A, etc.).
 - ✓ Breast milk substitutes, infant and follow-up formula, complementary foods (therapeutic and supplementary).
 - ✓ Salt iodization.
 - ✓ Water, hygiene and sanitation.

2. Issue a certificate of competence for micronutrient-supplies processing plants, quality control laboratories, importers, exporters, distributors and retail outlets.
3. Enforce and regulate manufacturers, importers and distributors of nutrition products and supplies.
4. Ensure the quality and safety of Premix, supplements and infant formula foods through laboratory analysis.
5. Register and issue import permits for nutrition supplies.
6. Ensure that the quality and safety of the public water supply is up to standard.

Result 4.9: Improved nutrition supply management

Initiatives

1. Ensure timely access to nutrition supplies
 - ✓ Conduct timely forecasting and procurement by involving all stakeholders.
 - ✓ Conduct proper warehousing and distribution through PFSA.
 - ✓ Conduct periodic follow-up and monitoring of consumption of supplies in order to take appropriate and timely action.
1. Build the capacity of regional, zonal and woreda health offices and health facilities in the management of nutrition supplies.
2. Coordinate all partners procuring, distributing and using nutrition supplies through an integrated logistics management information system
 - ✓ Put in place a coordinated information sharing mechanism showing stock on hand, quantity distributed, stock on pipeline (stock in transit).
 - ✓ The FMOH will develop a distribution plan on a quarterly basis, or at least every 6 months, and shares it with all stakeholders.
 - ✓ All stakeholders should follow up on the stock status of nutrition supplies at all levels.
 - ✓ Nutrition commodity security issues should be an agenda item in nutrition technical working group meetings.

Strategic Objective 5

Improve multisectoral coordination and capacity to ensure NNP implementation

2015 Targets

- Increase the proportion of the health development army (HDA; women) trained in the preparation of complementary food to 60 percent.
- 100 percent of nutrition sensitive sectors will integrate nutrition in their annual work plan in line with NNP.
- 100 percent of nutrition sensitive sector ministries will assign nutrition focal persons for the sector.
- Conduct five National Nutrition Coordinating Body (NNCB) meetings (two meetings per year).
- 100 percent of the regions will establish a Regional Nutrition Coordinating Body and technical committee.

Result 5.1: Community level nutrition implementation capacity of the development army improved

The government has initiated a strategy to adapt and scale up new health related technologies and best practices in health extension packages in a short period of time. The strategy is founded on establishing a health development army and building its capacity (MOH, 2010).

A health development army is a community level group of 30 households (women) organized in a “1 to 5” network, where one woman functions as leader of the network and five women operate as network members. Model women (leaders) are elected as “models” based on the status of her implementation of the 16 components of the Health Extension Programme (of which nutrition is one). Models are responsible for training network members, leading group discussions and monitoring the implementation of the agreed plan in the women’s houses.

The HDA is the best approach to building household capacity and improving knowledge, skills and attitudes when it comes to implementing health extension packages. The HAD approach facilitates horizontal and vertical support as well as monitoring activities that help identify bottlenecks and gaps to provide solutions as early as possible.

To effectively utilize the HDA for the promotion of optimal adolescent, maternal and child feeding practices, the capacity of health workers, HEWs and members of the HDA should be strengthened.

Initiatives

1. Improve the capacity of primary health care units (PHCU) and HDAs to implement gender responsive nutrition programmes
 - ✓ Provide nutrition trainings for health workers who are directly supporting the health extension workers.

- ✓ Ensure delivery of quality integrated refresher trainings to HEWs.
 - ✓ Prepare and make available IEC/social and behavioral change communication (SBCC) materials on optimal child, adolescent and maternal feeding practices for use by HEWs and the HDA.
 - ✓ Strengthen HEW nutrition monitoring and mentoring support to PHCUs and to the HDAs. This includes routine identification, analysis and provision of solutions for bottlenecks that hamper the exercise of optimal nutrition practices in the community.
 - ✓ Strengthen the PHCU linkage.
 - ✓ Mainstream gender issues in all nutrition related trainings.
2. Strengthen the community level linkage between HEWs, teachers and development armies.

Result 5.2: Strengthened capacity of women based structures and associations at all levels for NNP implementation

Initiatives

1. Strengthen the capacity of women based structures and associations at all levels to promote optimal maternal, infant and young child (MIYC) feeding and caring practices
 - ✓ Provide training for members of the Ministry of Women, Children and Youth Affairs (MOWYCA) at all levels on optimal MIYC feeding and caring practices.
 - ✓ Provide training for members of women based structures and associations at all levels on optimal MIYC feeding practices.
 - ✓ Disseminate IEC/SBCC materials.
 - ✓ Provide continued technical assistance in NNP coordination.
2. Prevent harmful traditional practices
 - ✓ Delay early marriage till age 18.
 - ✓ Promote social and behavioral change communication on food taboos.
3. Promote the development of life skills (such as assertiveness, negotiating, decision-making, leadership and bargaining) for girls.

Result 5.3: Improved capacity to conduct nutrition monitoring and evaluation as well as operations research

Initiatives

1. Strengthen the capacity of nutrition laboratories.
2. Provide training on nutrition monitoring and evaluation (including nutrition assessments, surveys and early warning, gender and nutrition) for staff across sectors.
3. Establish a triangulated database to allow monitoring of NNP progress.
4. Build the capacity of sectoral offices to undertake regular and structured review meetings to review the progress of NNP at all levels.
5. Strengthen the capacity of sectors and training and research institutions to undertake operational research (this includes engendering research on mainstreaming and conducting specific gender related research).
6. Collect and analyze sex disaggregated data.

Result 5.4: Improved capacity of the regulatory body

Initiatives

1. Strengthen the regulatory system throughout the country
 - Provide training for technical food inspectors on the quality and safety of nutrition supplies.
 - Establish and equip quality control laboratories at all levels.
 - Capacitate regional regulatory bodies and strengthen coordination among them.

Result 5.5: Improved multisectoral coordination

Initiatives

1. Strengthen multisectoral coordination at all levels
 - ✓ Strengthen the national and regional nutrition coordination bodies (NNCB and RNCB).
 - ✓ Strengthen the national and regional nutrition technical bodies (NNTC and RNTC).
 - ✓ Establish nutrition units at federal, regional and lower levels of the ministry of health.
 - ✓ Ensure assignment of an adequate number of dedicated staff in all NNP implementing sectors at different levels.
2. Improve the capacity of all NNP-implementing sectors
 - ✓ Ensure the capacity of the nutrition coordination body and nutrition technical committees at all levels.
 - ✓ Strengthen and increase the number of higher level nutrition trainings providing universities (for example, human nutrition, public health nutrition and dietetics).
 - ✓ Train nutrition focal persons/coordinators in nutrition sensitive sectors.
 - ✓ Prepare blended integrated nutrition learning module for in-service nutrition training.
 - ✓ Mainstream gender and nutrition in nutrition education.

Result 5.6: Improved capacity of media

Initiatives

1. Build the capacity of national and regional media personnel (journalists, editors) on
 - ✓ The magnitude and consequences of malnutrition (stunting) on the national development agenda.
 - ✓ The benefit of better nutrition at individual, family and country level in the context of Ethiopia.
 - ✓ The need for multisectoral responsibility for better nutrition.
2. Equip media with appropriate nutrition SBCC materials and pragmatic tools to promote positive nutrition practices.
3. Protect the public from media based commercial pressures (advertisements) that are against optimal nutrition practices.
4. Provide media based opportunities for open dialog between the general public and nutrition professionals.

CHAPTER 3

IMPLEMENTATION AND GOVERNANCE

Nutrition has a multidimensional and a multisectoral nature in terms of both effect and outcomes. Thus, in order to accelerate progress on NNP implementation, appropriate governance and programme implementation arrangements are vital. This issue will be addressed through a set of objectives and sub-components.

Objectives

1. Develop and enforce nutrition related policies and legislations.
2. Exercise political will and commitment on nutrition and make nutrition a priority agenda item in all NNP implementing sectors.
3. Strengthen multisectoral nutrition coordination so as to
 - Harmonize the multisectoral response.
 - Facilitate and support efficient resource mobilization and utilization for enhanced nutritional outcomes.
4. Define feasible and locally accepted communication for development activities to bring about behavioral changes required for improved nutrition.

3.1. Policy framework

The Government of Ethiopia has demonstrated its policy commitment to nutrition by developing a stand-alone National Nutrition Strategy (NNS) and a National Nutrition Programme (NNP), along with a set of guidelines. The government has also incorporated nutrition, in particular stunting, into its 5-year Growth and Transformation Plan (GTP). Sectoral strategies and programmes also provide a good opportunity to mainstream nutrition into other NNP implementing sectors and to enact legislation or establish legal frameworks to enforce key nutrition interventions. Table 2 summarizes the main regulatory, strategic and programme documents.

Table 2: Nutrition specific and nutrition sensitive strategies/programmes/guidelines in Ethiopia

Nutrition specific strategies/programmes/guidelines		
Document	Body	Date
Micronutrient guidelines	Federal Ministry of Health (FMOH)	2004
National Strategy for IYCF	FMOH	2004
Management of SAM Protocol	FMOH	2007
National Nutrition Strategy	FMOH	2008
National Nutrition Programme	FMOH	2008
Nutritional and HIV guidelines	FMOH	2006
Food Supplement and Infant Formula Registration guidelines	Food, Medicine and Health Care Administration and Control Authority (FMHACA)	2011
Nutrition sensitive strategies/programmes/guidelines		
Document	Body	Date
Poverty reduction and development		
Agricultural Development Led Industrialization (ADLI) Strategy	Federal Government	2007
Growth and Transformation Plan	Ministry of Finance and Economic Development	2010–2015
Agriculture and food security		
Agriculture Growth Programme	Federal Ministry of Agriculture	2010
Food Security Strategy	Federal Ministry of Agriculture	2007
Public health		
Health Policy	The Transitional Government of Ethiopia	1993
Health Sector Development Plan	FMOH	2010
Reproductive Health Strategy	FMOH	2011
National Strategy for Child Survival	FMOH	2005
Water Sanitation and Hygiene Strategy	Federal Ministry of Water and Energy	2011–2016
Education		
School Health and Nutrition Strategy	Federal Ministry of Education	2012
Social protection		
National Social Protection Policy	Ministry of Labor and Social Affairs	Draft
Health Insurance Strategy	FMOH	2008
Nutrition relevant regulations/standards/proclamations		
Civil Servant Proclamation (maternity protection)	Civil Service Commission	2007
Salt iodization legislation	FMHACA	2011
Iodized salt standard	FMHACA	2012
Iodized salt manufacturer, importer, exporter and wholesaler directive	FMHACA	2011/12
Fortified flour manufacturer, importer, exporter and wholesaler directive	FMHACA	Draft
Fortified oil manufacturer, importer, exporter and wholesaler directive	FMHACA	Draft
Fortified oil standard	FMHACA	Draft
Fortified flour standard	FMHACA	Draft
Infant formula directive	FMHACA	Draft
Food supplement directive	FMHACA	Draft
Food, Medicine and Health Care Administration and Control Proclamation	Government of Ethiopia	2009

3.2 Regulatory framework

Sustainable, long-term reduction of malnutrition requires complementary actions at various levels by all key stakeholders. In addition to direct nutrition interventions, this revised NNP identifies various nutrition sensitive interventions that require regulatory actions and quality control.

In 2009 the Ethiopian House of Representatives declared the Food, Medicine and Health Care Administration and Control Proclamation (No. 661/2009). The Ethiopian Food, Medicine and Health Care Administration and Control Authority (FMHACA) and regional health regulatory bodies are authorized to implement this proclamation. Both entities are mandated to promote and protect the public health by ensuring the safety and quality of products and health services through registration, licensing and inspection of food establishments, pharmaceuticals, health professionals and health institutions.

In relation to the National Nutrition programme, FMHACA is responsible for regulating nutritional supply manufacturers, importers, exporters and wholesalers. Regional health regulatory bodies regulate the food and medicine retail outlets and health institutions in their respective regions. According to their mandates, both organizations will ensure the quality and safety of nutritional supplies, including the following products:

- Fortified foods
- Food fortificants/Premix
- Micronutrient supplements (iron, zinc, folic acid, Vitamin A, etc.)
- Breast milk substitutes, infant and follow-up formulas
- Complementary foods
- Therapeutic and supplementary foods
- Iodized salt
- Water, sanitation and hygien

3.3 Multisectoral coordination and capacity building

The National Nutrition Programme is a long-term national programme that requires the involvement of all responsible sectors and partners. Timely and effective implementation requires an efficient operational framework as well as appropriate leadership and implementation capacity. The NNP will continue to use existing government structures to ensure sustainability and long-term achievement of objectives. The following sub-sections describe the institutional arrangements required to improve multisectoral coordination, along with human and institutional capacity building strategies to guide implementation.

3.3.1. Multisectoral coordination and linkages for nutrition

This component is designed to strengthen the linkages between nutrition in all sectors that deal with the underlying and basic causes of malnutrition (nutrition sensitive interventions are also being implemented by other sectors). The purpose is to enhance the nutritional impact of programmatic activity in these sectors. To improve existing multisectoral coordination and strengthen linkages based on lessons learned over the last four years of NNP implementation, this revised NNP has included the role of responsible sectors as shown in Strategic Objective 3 as well as in the result and accountability matrix, located at the end of the document. Ethiopia has well defined policies, strategies and implementation guidelines in those sectors with the potential to affect better nutrition. These will be the basis for nutrition linkages among various sectors (see Table 2).

To ensure viable linkages and harmonization among relevant sectors, the FMOH is mandated to house and manage the organizational and management structure of the NNP. The National Nutrition Coordination Body and the National Nutrition Technical Committee were established in 2008 and 2009, respectively, to ensure effective coordination and linkages in nutrition. This revised NNP outlines human resource capacity-building activities, with emphasis on all relevant sectors. These adjustments will ensure that implementation of the NNP is harmonized across all sectors and at different levels, particularly at regional, woreda and community levels.

3.3.2. Institutional arrangements for multisectoral nutrition coordination and linkages

The National Nutrition Coordination Body will remain the main mechanism for leadership, policy decisions and coordination of the National Nutrition Programme. The NNCB covers government sectors, donors, partners, civil society organizations, academia, and the private sector. Coordination and linkage mechanisms for nutrition at national level are indicated in the figures below. Similar multisectoral nutrition coordination framework and programme implementation arrangements will be put in place at regional, woreda and kebele levels using the decentralized structure. The terms of reference, membership, frequency of meetings and the roles and responsibilities of NNP implementing sectors will be detailed in a multisectoral nutrition coordination implementation guideline, which will be developed later.

Figure 2. National Nutrition Coordinating Body

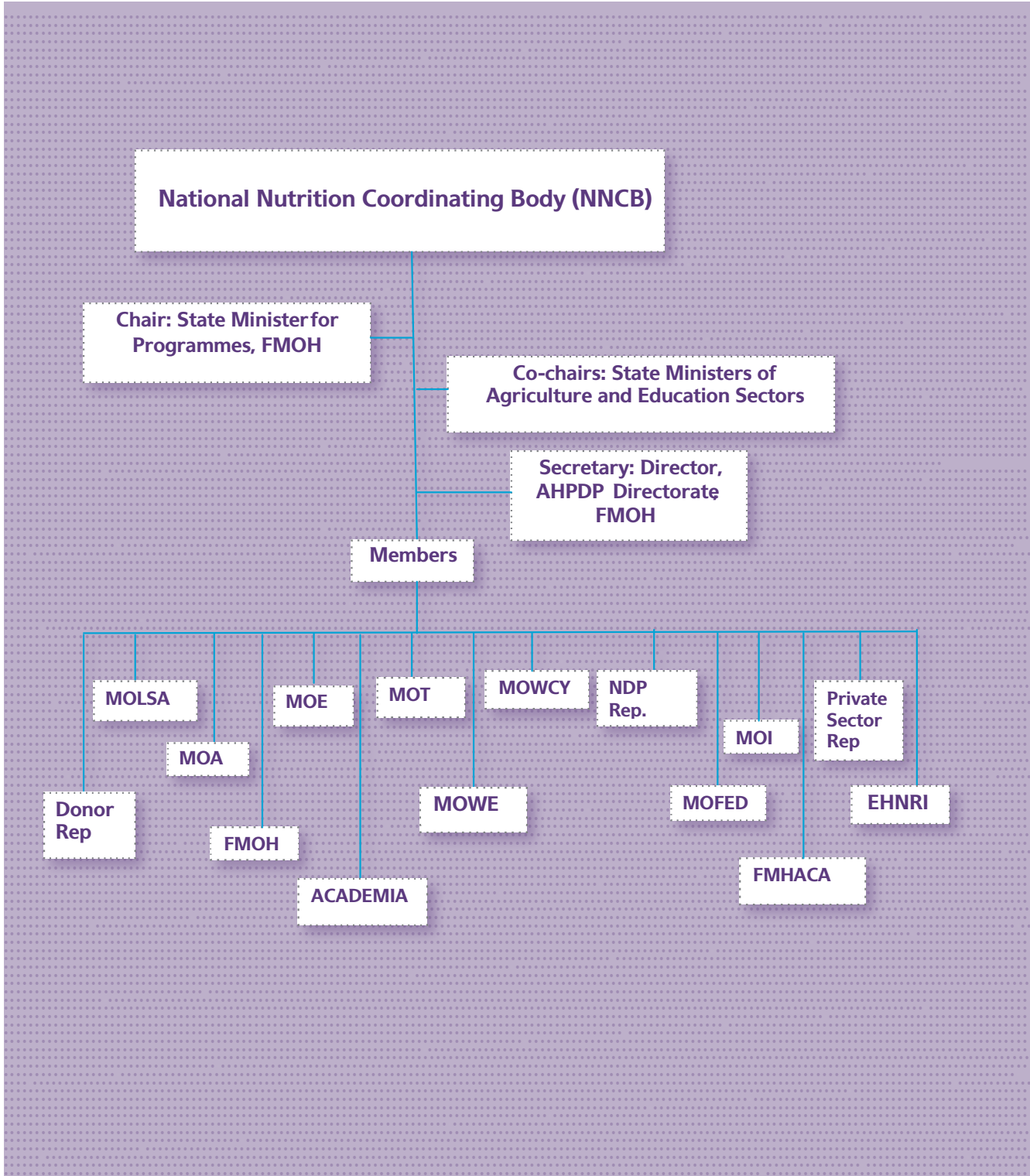
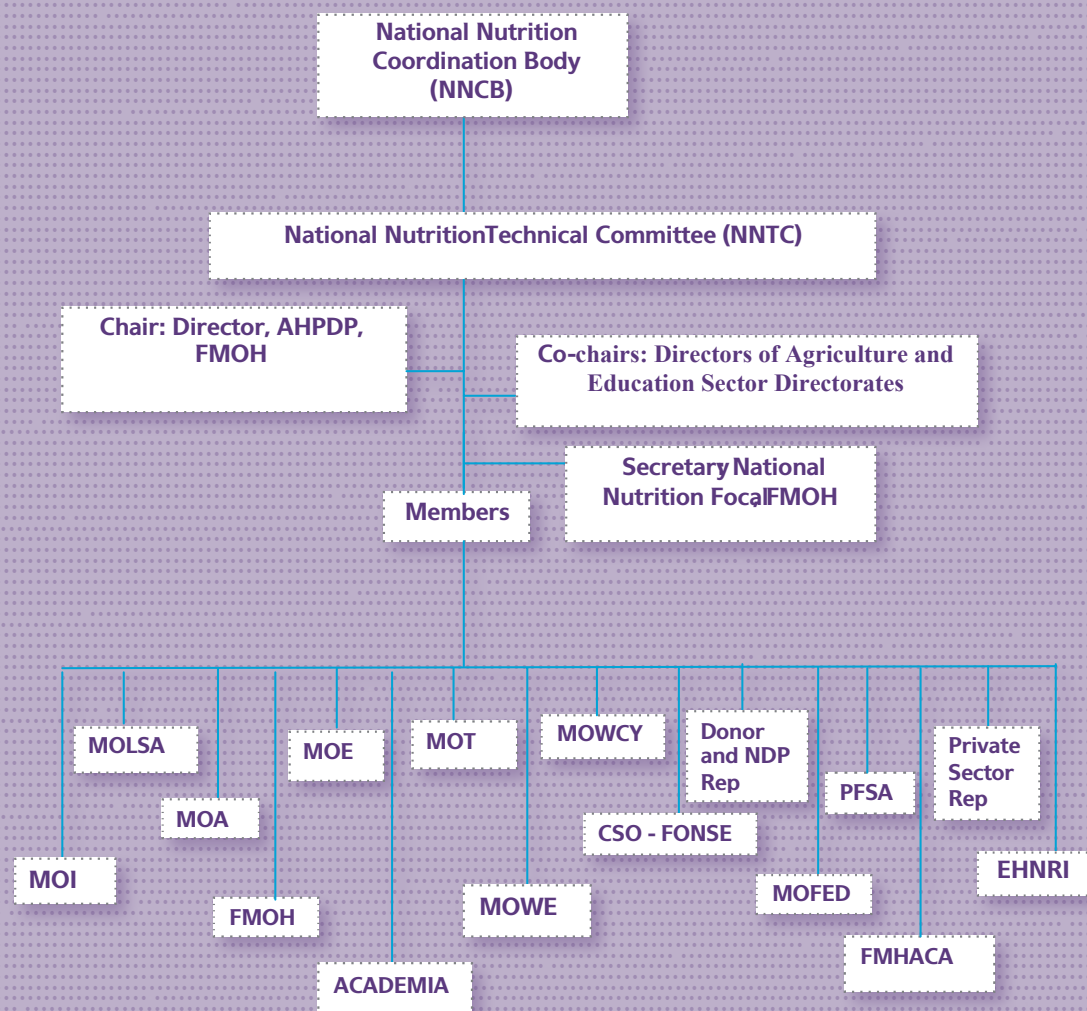


Figure 3. National Nutrition Technical Committee



3.3.2 Capacity building

Capacity building under the NNP has two main components:

(1) Human resource development

For effective and efficient implementation, sectors with stakes in the NNP should have an adequate number and mix of competent nutrition cadres or technical persons placed at all levels of service delivery and management (national, regional, zonal, woreda, community and facility). Procurement capacity, research and development capacity and the capacity of the regulatory body for food and nutrition will also be considered, as these are important to the quality of nutrition interventions and inform the redesign of the NNP's approach. The major strategies for availing necessary regular human resources are pre-service and in-service training.

Required human resource skills capacities for all relevant sectors/levels are summarized as follows:

- At the national level, all NNP implementing sectors will assign a focal person (or well staffed nutrition unit) to manage and coordinate nutrition within their respective sectors.
- The Ministries of Health and Agriculture will work with the Ministry of Education and regional governments to integrate nutrition into regional colleges to provide nutrition specific and nutrition sensitive pre-service training for students of health, agriculture and education.
- Training institutions (universities and colleges) will be supported with curriculum development and revision, procurement of educational materials and with technical assistance for critical skills that are not adequately available. Training will help create sustainable local capacity at middle and senior management levels as well as institutional capacity to undertake operational research.
- Regional health bureaus will assign nutrition officers at the regional level to ensure effective multisectoral coordination and linkages, provide leadership and establish a strategic and programmatic framework for planning, coordination and implementation of nutrition specific and nutrition sensitive interventions in all regional NNP implementing sectors.
- Regional agriculture bureaus will assign dedicated officers for nutrition at the regional level to ensure implementation of nutrition sensitive agricultural interventions.
- In-service (on-the-job or blended) training of health workers, health extension workers, agricultural extension workers, teachers and women's association members should also be facilitated across relevant sectors to develop skilled experts in nutrition programming, management, coordination and implementation at all levels.
- Systematic in-service capacity building will be provided for programme managers of concerned sectors.
- The pool of community level actors (women development armies, agricultural development armies, faith based organizations, and women's associations and groups) should be provided with strong orientation and be motivated to deliver key preventative nutrition messages and practices and facilitate nutrition sensitive community development interventions.
- School communities will be supported to implement key nutrition interventions (school gardening, feeding demonstrations, promotion of iodized salt utilization, vitamin and mineral supplementations, de-worming) through Parent-Teacher Associations.
- Nutrition sensitive small-scale food processing, fortification or distribution cooperatives, small-scale irrigation and use of WASH to enhance community nutrition interventions will be linked and promoted.

(2) Institutional capacity

Coordination capacity. To fulfill its direct implementation and national nutrition coordination role, the FMOH needs a dedicated nutrition unit with extensive training in nutrition. The nutrition unit will be responsible for (a) overseeing nutrition related strategies, guidelines and legislation; (b) implementing

the NNP's nutrition specific interventions at different levels; (c) coordinating with nutrition technical teams in other NNP implementing sectors; (d) acting as permanent secretariat of the National Nutrition Technical Committee and other National Nutrition Technical Working Groups.

All sectors will assign a focal person within their existing structure or establish a unit to oversee nutrition interventions, to act as a technical point for the NNTC and to advise their sector's NNCB representative.

Research capacity. Institutional capacity building also involves strengthening research expertise and ensuring that researchers conduct policy and programming related to nutrition, nutrition sensitive value chain and diversification, agricultural technologies on dietary quality of improved seeds, beans and bio-fortification and laboratory, as well as research on industrial development (food processing, production and fortification).

The NNP continues to support building the capacity of the country's nutrition research institutions—the Ethiopian Health and Nutrition Research Institute (EHNRI) and the Ethiopian Agriculture Research Institution (EARI). The EHNRI will further develop its strengths in conducting national level nutrition surveys and evaluations and the EARI will undertake nutrition sensitive agricultural research in appropriate agricultural technologies. Experts will be given opportunities to participate in national and international research to generate an evidence base for policy and programme decisions.

Supply and logistics capacity

The government of Ethiopia is implementing essential nutrition services at large scale using the decentralized structure of the health system. The Health Extension Programme is the system's key contact point with the community and with the agriculture, education and other sectors. Some community based nutrition interventions such as acute malnutrition management and micronutrient supplementation are heavily supplies dependent.

As the weight and volume of acute malnutrition management supplies for curing one severely malnourished child is much larger than that of other pharmaceuticals, there is a considerable challenge in the supply management of nutrition commodities, making it difficult to integrate the management of these supplies with the management of other health commodities. At national level, a clear plan to transfer the responsibility of supply chain management from the current vertical system to the Integrated Pharmaceutical Logistics System (IPLS) will be developed based on supply bottlenecks and capacity analysis. PFSA will be strengthened so that it has adequate capacity for forecasting, procurement, distribution and management of inventory, including acute malnutrition management supplies.

In the meantime, the nutrition unit, in consultation and collaboration with PFSA and developmental partners, will lead all supply chain management activities. Once PFSA is fully capacitated, it will assume all the responsibilities of nutrition supply management.

The nutrition supply planning and management process will be streamlined. The plan is to have an annual nutrition forecast for the country. The Ministry of Health will coordinate humanitarian and development partners to ensure predictable and timely availability of supplies. The MOH will also work with relevant sectors to encourage local production of essential nutrition commodities.

FMHACA, in line with its legal mandates, will ensure the quality, safety, efficacy and appropriate use of all nutrition health commodities. The capacity of experts on nutrition specific products and on nutrient value standard development, implementation, monitoring and control will be strengthened.

3.4 Nutrition communication

Feeding and caring behaviors are critical determinants of nutritional status. Improvement in these practices requires a clear, evidence based, well designed communication strategy at all levels. The NNP's priority nutrition communication activities are, in the main (i) policy and public dialogue on nutrition and (ii) social and behavioral change communication (SBCC).

The Public Relations and Communications Directorate of the Federal Ministry of Health will be responsible for coordinating the policy and public dialogue aspects of the NNP, in collaboration with similar directorates in other NNP implementing sector ministries, and with the nutrition unit of the FMOH. The SBCC aspect of nutrition communication will be led by the nutrition unit in close collaboration with the Public Relations and Communication Directorate and with similar nutrition unit focal points in other sectors implementing NNP. The capacity of health extension workers, health development armies, agricultural extension workers and teachers in delivering BCC for nutrition will be built through trainings, on site supportive supervision and provision of harmonized IEC/SBCC materials prepared in local languages. In view of the diverse livelihood and cultural settings, formative research will be used to identify key barriers for optimal nutrition practices, and to identify appropriate communication messages, as well as the most effective change agents and channels. The EHNRI and the nutrition directorate of FMOH will collaborate to undertake such studies.

Objectives and key activities for nutrition communication

3.4.1 Policy and public dialogue

Objectives

- Develop, adopt and enforce nutrition related policy and legislation.
- Build strong multisectoral nutrition coordination in the country.

Key activities

- Coordinate the development, adoption and enforcement of nutrition related policy and legislation and resource mobilization, while improving the involvement of the private sector.
 - ✓ Enforcement of salt iodization.
 - ✓ Enforcement of existing maternity leave in public and private sectors and extension of maternity leave to align with minimum ILO recommendations.
 - ✓ Code of Marketing on Breast Milk substitutes (BMS).
 - ✓ Mandatory food fortification.
- Organize and coordinate with government and private media institutions for harmonized, targeted nutrition messaging.

3.4.2 Social and Behavioral Change Communication

Objectives

- Strengthen the capacity of HEWs, AEWs and HDAs to communicate appropriate, targeted nutrition messages to promote optimal caring practices among women/girls and men/boys.
- Ensure that the quality and quantity of nutrition messages and materials are appropriate at all levels.
- Increase the adoption of appropriate nutritional practices at family level.
- Increase community participation in the promotion of nutrition practices.

Key activities

- Undertake appropriate studies to identify key barriers and facilitators to optimal nutrition practices, social norms and sociocultural traditions.
- Define priority nutrition practices, messages, groups of participants, accessible channels and influential actors.
- Harmonize existing nutrition communication materials to support both media and interpersonal communication in various languages.
- Promote social and behavioral change and strengthen community participation for better nutrition.
- Involve media to promote dialog on nutrition among experts and the public.
- Build the capacities of the most influential actors in effective interpersonal communication.
- Promote multisectoral coordination of the country's nutrition agenda by multiple government sectors, civic societies, international and local development partners and the private sector.
- Monitor and evaluate the impact of nutrition communication activities.

3.5 Gender dimensions of nutrition

Gender and nutrition are inextricable parts of the vicious cycle of poverty. Gender inequality can be a cause as well as an effect of hunger and malnutrition. Not surprisingly, higher levels of gender inequality are associated with higher levels of under-nutrition, both acute and chronic. Gender equality and women's empowerment is an essential part of human development and influence nutrition across the entire lifecycle. Gender and under-nutrition are highly correlated and interconnected with livelihood security at household and community levels throughout life: gestation, infancy, childhood, adolescence, adulthood and old age.

Chronic food insecurity takes a severe toll on the health of all household members, but research reveals that women and girls suffer the most. Deeply rooted sociocultural norms affect women's relative power and ultimately have an impact on women's health and longevity as well as on the productivity of their children. A mother's ability to make decisions within the household and in her community is an important factor in not only her own nutritional outcomes but also those of her children.

At the family/household level, the heavy workload resulting from the many household responsibilities that women shoulder—such as food processing and preparation, firewood and water collection and care for the sick—usually leaves women with little or no time to properly care for their children and themselves. There is some evidence that while women get a “disproportionately” small share of household food, they may expend a larger proportion of “household energy” (Khan et al., 1982).

Along with unequal, gender based resource distribution at the household level, a number of harmful traditional practices such as food taboos for women and girls (especially pregnant and lactating women), early marriage, and violence against women have contributed to the poor nutritional status of the majority of infants, young children and women in Ethiopia. According to a study of food security in southwestern Ethiopia, girls who are food insecure are twice as likely to report suffering from an illness compared to boys (Belachew et al., 2011). A 2009 study found that stunting and chronic under-nutrition are higher among female children than male children, and that both afflictions have a higher overall prevalence in female-headed households (Haidar & Kogi-Makau, 2009). Studies carried out in India clearly showed that women's inadequate dietary intakes and poor nutritional status is affected by the fact that women and girls eat “last and least,” a reflection of the inferior social status they are accorded (Chatterjee & Lambert, 1990).

Discrimination against female infants may manifest in postnatal neglect through inadequate feeding, clothing, biased care practices or treatment-seeking for illnesses (Willis et al., 2009). Girl infants are breastfed less frequently, for shorter durations and over shorter periods than are boys (Ghosh, 1985).

In order to address this multifaceted problem, several efforts have been put in place by the Ethiopian government in partnership with other development actors. Gender is considered a cross-cutting issue and has remained a crucial concern that has prompted the setting of clear objectives for gender mainstreaming at all levels of the various sectoral programmes. Proclamation No. 691/2010, which provides for the definition of powers and duties of the government's executive organs, mandates that all sectoral ministries address women's affairs in the preparation of policies, laws and development programmes and projects.

Most nutritional programmes target women and children but neglect an important stage of development—adolescence. The key role of men in achieving nutrition security is also overlooked. Nutrition interventions have principally tended to address factors that directly contribute to nutrient intake and health, missing other underlying and basic factors, such as the decision-making capacity of women in households, access to education and economic resources, to name a few.

The National Nutrition Programme has affirmed the reciprocal relationship between gender and nutrition and articulated a way to mainstream gender into various components of the programme. Some of the major recommended strategies are as follows:

- Incorporate a gender analysis as part of the regular nutrition situation analysis, analyzing the needs, priorities and roles of men and women.
- Promote meaningful male involvement in nutrition interventions. Women and girls may be targeted in view of their special vulnerabilities, but men and boys should also be reached to help address their needs as well.
- All human-capacity building interventions planned by NNP will consider mainstreaming gender equality within training programmes and will engage an equal number of male and female participants so far as is possible. For institutional capacity building, services friendly to women and adolescent girls will be institutionalized in light of both service provision and infrastructure development (gender-separated toilets, breastfeeding rooms, etc.).
- Integrate gender equality interventions into all sectors; go beyond addressing the symptoms. Interventions will try to tackle underlying causes. Interventions will include but are not limited to promoting girls' education, combating harmful traditional practices, putting in place reproductive services friendly to women and adolescent girls, ensuring energy and time saving technologies and promoting the economic empowerment of women.
- Give due attention to gender sensitive M&E.
- Mainstreaming gender into nutrition can only be accomplished if accountability is taken at all levels. The NNP has worked on the accountability framework at all levels to advance gender issues in nutrition. The Ministry of Women, Children and Youth Affairs and all other sector ministries will be accountable for gender and nutrition priorities in their respective areas.

CHAPTER 4

SUSTAINABLE FINANCING FOR NUTRITION

The government of Ethiopia is committed to accelerating implementation of the multisectorally harmonized National Nutrition Programme to make a strong impact on nutrition and on the overall wellbeing of the nation. This revised NNP is designed to address both long-term and short-term nutrition goals in Ethiopia. The programme outlines the plan for a package of proven, cost-effective nutrition interventions that will break the cycle of malnutrition and ensure child survival and health. So far, resource shortages, weak coordination capacity and low utilization levels have been the main challenges to implementation of the National Nutrition Programme. Implementation challenges therefore must be speedily corrected leading up to the MDG deadline in three years' time. This revised NNP is driven by a vision of speeding up and scaling up the nutrition strategies already in place.

Costing for the NNP has taken all of this into consideration. Costing was conducted using activity based approaches, which help estimate the cost for each activity. Each activity is then summarized to get a total cost for the relevant result and strategic objective. The total budget required for implementing the NNP over the next 3 years is estimated to be 547 million USD. Nearly 50 percent of the total budget is planned for the year 2014 while one-third will be used to finance the last year of the plan. Of the total budget, 88.5 percent will be applied to improving the nutritional status of mothers, infants, young children and children under the age of 5.

Table 3: NNP budget estimate by strategic objective, 2013–2015

S.NO.	Strategic Objective	Total budget estimated in millions (US\$)				
		2013	2014	2015	Total	Proportion of the total
1	Strategic Objective 1: Improve the nutritional status of women (15–49 years) and adolescents (10–19 years)	13.27	37.16	24.97	75.4	13.78%
2	Strategic Objective 2: Improve the nutritional status of infants, young children and children under 5 years	71.99	201.57	135.45	409.01	74.75%
3	Strategic Objective 3: Improve nutrition service delivery for communicable and lifestyle related/non communicable diseases affecting all age groups	1.88	5.26	3.54	10.67	1.95%
4	Strategic Objective 4: Strengthen implementation of nutrition sensitive interventions in various sectors	3.40	9.52	6.40	19.33	3.53%
5	Strategic Objective 5: Improve multisectoral coordination and capacity to ensure implementation of the NNP	5.76	16.13	10.84	32.74	5.98%
Total		96.30	269.64	181.20	547.14	100.00%
Proportion of the total		17.60%	49.28%	33.12%	100.00%	

To assess the funding gap for the implementation of NNP, the estimated total budget is compared to the projected resource commitment from Government treasury and nutrition development partners. The government contribution is 38 million USD, which will mainly be applied to salary, operational costs and pre-service training of professionals in the health sector.

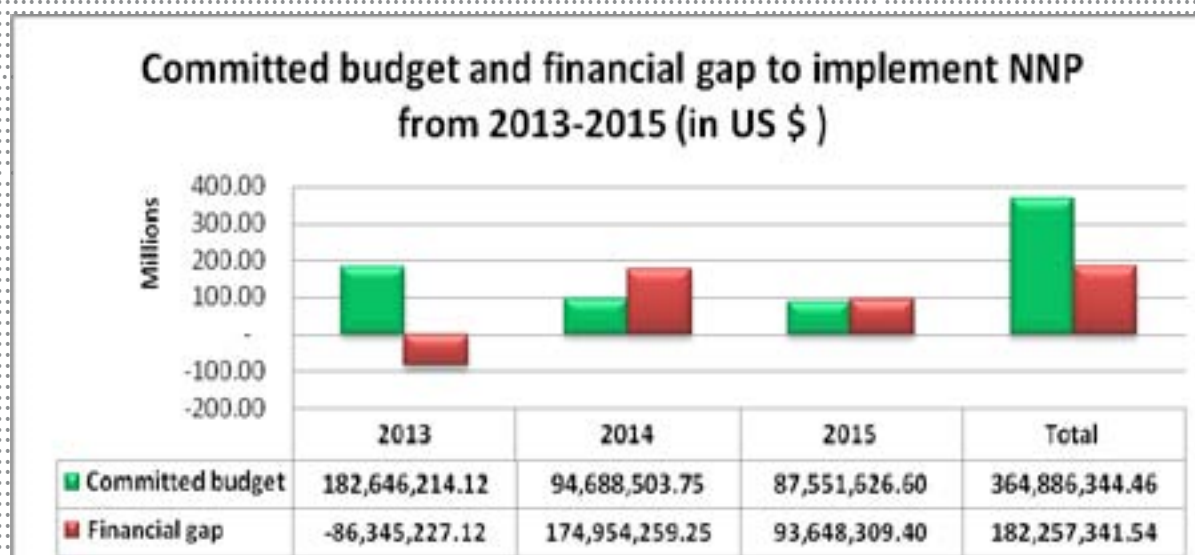
On average, there is a 33.3 percent gap in NNP financing over the coming 3 years. Taking into consideration the current poverty levels and the pace of the country's economic growth, there will likely be a significant financing gap that will need additional resource mobilization, with the consequence that a substantial

proportion of the required resources may have to come from the government treasury and nutrition development partners.

There is no pooled funding for NNP implementation. Even with the introduction of the MDG Performance Fund, a funding gap remains and there is limited commitment for financing NNP beyond 2013, leaving big uncertainties in planning for nutrition interventions. The major financing gap of US \$175 million remains high for 2014, followed by a gap of US \$93.6 million for 2015, as indicated in the below figure.

Hence, successful implementation of the NNP requires timely mobilization of resources and minimizing of uncertainties in the planning of nutrition interventions.

Figure 4. NNP Committed budget and financial gap, 2013–2015



CHAPTER 5

FRAMEWORK FOR MONITORING, EVALUATION AND OPERATIONAL RESEARCH

Monitoring and evaluation

The NNP assumes that there will be a strong national partnership among relevant NNP implementing sector ministries, nutrition development partners, multilateral and bilateral donors, academia and private sectors. This NNP document will be the source document for a harmonized plan of action with a clear monitoring and evaluation framework. The accountability and results matrix at the end of the document outlines the core results and their indicators as well as the sectors accountable and the measuring period for these indicators. The matrix hence serves as a monitoring and evaluation framework for all nutrition programmes and projects in Ethiopia.

The NNP accountability and results framework was developed to enable effective management and optimum mobilization, allocation and use of resources, and to make timely decisions to resolve constraints or problems of implementation (see annex 2). The sources of information for timely monitoring will be routine service and administrative records compiled through the sectoral information systems and the Early Warning System. To enrich the data, supervisory visits and review meetings will be conducted. The EHNRI in collaboration with nutrition sensitive sectors will also undertake periodic assessments, operational research and surveys to help identify programme strengths and weaknesses. Midterm reviews and end-of-implementation evaluation/operational research/surveys will be made by EHNRI in collaboration with NNP implementing sectors and nutrition development partners.

Monitoring and evaluation for the NNP will be integrated into an overall M&E system for evaluating NNP implementing sectors. To establish and strengthen the M&E component of nutrition, the FMOH, EHNRI and other NNP implementing sectors will do the following:

- Integrate the recording and reporting of sex disaggregated nutrition data within existing sectoral information systems. This includes appropriate use of the family folder for health related community level information.
- Ensure appropriate integration of nutrition sensitive and nutrition specific results in sector specific woreda based plans.
- Strengthen the HMIS to incorporate appropriate nutrition sensitive and nutrition specific indicators that can be collected at facility and community levels, including nutrition surveys and assessments.
- Build the capacity of MOH, MOA and MOE at all levels to collect and utilize nutrition data for action.
- Ensure incorporation of appropriate indicators in sectoral Integrated Supportive Supervision (ISS) and regular sectoral review meetings.
- Conduct an annual NNP review meeting at national and regional levels involving all relevant sectors.
- Develop a central database that allows triangulation of data from all sectors, including periodic surveys, as deemed necessary. The nutrition unit of FMOH should undertake surveillance of the

- nutrition situation through trend analysis of such triangulated information.
- Produce an annual publication on the nutrition situation in Ethiopia based on the triangulated data or on special surveys in policy and practice.
- Conduct evaluation, research and surveys
 - ✓ Conduct a national micronutrient survey at the end of 2013.
 - ✓ Evaluate the NNP in 2015.

M&E results dissemination and utilization

The sectors shall use various mechanisms to disseminate information to inform decisions at various levels of the implementation system and to inform the public at large. The major information products and dissemination mechanisms are described below. The nutrition unit of FMOH is generally responsible for the production and dissemination of most information products.

Table 4: Frequency and type of M&E reports to be disseminated under the leadership of the nutrition directorate in FMOH

Frequency	Type of report	Level
Quarterly performance report	The purpose of the quarterly performance report is to provide information on nutrition service coverage over the last quarter. These reports assist the sectors and partners to identify gaps and maximize resource utilization. The source for this report will be sector specific monthly and quarterly reports that come through sectoral management information systems. The NNTC will review this report each quarter.	Woreda, regional and federal levels
Biannual NNCB/ RNCB report	An NNCB/RNCB report will be produced biannually by FMOH to provide information on Ethiopia's progress in nutrition. This report will mainly be focused on the critical indicators of nutrition, which are reflected in the NNP accountability and results matrix but are collected and analyzed using sector specific information systems, the Early Warning System and administrative reports.	Federal and regional
Annual performance report	This report will review the implementation progress, challenges and status of outcome indicators and provide trend analysis of triangulated data from multisectoral sources. The FMOH will produce an annual nutrition monitoring and evaluation report that provides a comprehensive overview of Ethiopia's response to the country's nutrition status. The annual report will encompass all indicators contained in the national nutrition M&E framework and key observations in the evaluation report. The reporting period will follow the Ethiopian fiscal year (July to June). The report will be presented in the NNCB/ NNTC and NNCB/RNCB meetings, and will be used for preparing the plan and budget for the following year's national nutrition response.	Federal and regional

Operational research

Operations research is designed to test alternative intervention modalities and to answer key operational questions as they arise during NNP implementation. The EHNRI, as the lead nutrition research institute in the country, has the mandate to lead operational research. Therefore, in the course of implementing the previous (NNP 2008–2013), EHNRI held a workshop with NNP stakeholders and partners to specify and prioritize studies. The implementation status of these priorities is indicated in Annex 1.

Building on lessons learned, the focus areas of operational research will be as follows:

- Review and strengthen the capacity of EHNRI to coordinate, carry out, supervise and sub-contract operational research to other organizations/institutions.
- Carry out a mapping exercise of all nutrition related operational research to avoid duplication.
- Identify priority research areas based on the revised NNP following consultation with all nutrition stakeholders. EHNRI will facilitate the decision as to whether a given research topic will be handled in-house or outsourced.
- All organizations carrying out operational research should liaise with EHNRI during the entire process, including sharing topics and methods, requesting ethical clearance, sharing results and providing reports and data.
- A method of collecting, compiling and storing operational research (data, reports) needs to be set up and housed within EHNRI as the country's premier nutrition research institute. This will serve to avoid duplication of research efforts and facilitate the identification of key outstanding operational research areas. This information should be made accessible to all.
- EHNRI, in collaboration with other NNP implementing organizations and institutions where appropriate, will hold periodic workshops to disseminate research findings and recommendations.

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ANNEXES

Annex 1: Ethiopian Health and Nutrition Research Institute: Ongoing and recently completed operational research

Case studies: Implementation of community based nutrition

1. Effective modalities to improve pregnant women's compliance to daily iron supplementation.
2. Adaptation of CBN in pastoralist areas.
3. Assessment of the effectiveness of Integrated Refresher Training (IRT) and Integrated Supportive Supervision for (ISS) study.
4. Operations research in collaboration with public and international universities
 - a. Examining alternate means of reaching school and non-school-attending adolescent girls for iron supplementation.
 - b. Effectiveness of school based health and nutrition education to improve healthy dietary practices and nutritional status of primary school children.
 - c. Development and marketing of nutrient rich locally processed foods for under 2 children and pregnant and lactating women through village based women's enterprises.
 - d. Effectiveness of organizing newlywed women and adolescent girls through community based nutrition to improve coverage, utilization and access to community based nutrition services.
 - e. Assessing multisectoral coordination for nutrition policy effectiveness: analysis of facilitators, constraints and solutions for effective implementation.
 - f. Evaluating the bio-availability, digestibility and sensory acceptability of community based complementary foods.

ANNEX 2: Accountability and results matrix for NNP implementation

	2010/ 2011 (Baseline)	2012/ 2013	2014/ 15	Frequency and reports	Data Collection Instruments	Responsibility for Collection
Impact Objectives: Improve Nutritional status of women and children						
Proportion of under 5 children with height-for- age Z-score below -2 SD (Prevalence of stunting)	44.4%	38%	30 %	End line/ EDHS	End line/ EDHS	CSA, FMOH
Proportion of under 5 children with weight-for- age Z-score below -2 SD (Prevalence of under-weight)	28.7%	25%	21%	End line/ EDHS	End line/ EDHS	CSA, FMOH
Proportion of under 5 children with weight-for- height Z-score below -2 SD (Prevalence of wasting)	9.7%	7%	3 %	End line/ EDHS	End line/ EDHS	CSA, FMOH
Proportion of women of reproductive age (15-49 years) with BMI <18.5	27%	24%	19%	End line/ EDHS	End line/ EDHS	CSA, FMOH
Proportion of newborns who weighed less than 2.5 kg at birth	10.8%	11%	9 %	End line/ EDHS	End line/ EDHS	CSA, FMOH

Strategic Objectives

Strategic Objective/ Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Strategic Objective 1: Improve the nutritional status of women (15-49 years) and adolescents (10-19 years)												
Result 1.1 Nutritional status of adolescents improved	Provide a comprehensive and routine nutrition assessment and counseling services for adolescents at community, school and health facility level.	Proportion of health service providers (doctors, health officers and nurses) trained to Conduct assessment and counseling to adolescents	Input	Not Available		50%	100%	Training report/ proceeding	Annual	FMOH & RHBs	RHB, WorHO and HF's	Reports

Strategic Objective/ Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Result 11 Nutritional status of adolescents improved	Provide a comprehensive and routine nutrition assessment and counseling services for adolescents at community, school and health facility level.	Proportion of HC & Hospitals providing comprehensive and routine nutrition assessment and counseling services for adolescents integrated with youth-friendly health services	Input	Not Available		30%	50%	HMIS	Annual	FMoH & RHBs	Health facilities	HMIS reports
		Proportion of schools integrating a comprehensive nutrition education and promotion activities targeting adolescents	Input	Not Available		10%	30%	Administrative Report	Annual	FMoH, RHBs, FMOE, RBEs,	Schools	Reports
		Proportion of adolescent receiving nutrition assessment and counseling services	Output	Not Available		5%	15%	Survey	End line	FMoH & RHBs	RHB, WorHO and HF's	Survey reports
	Ensure adolescents access to micronutrient services:	Proportion of adolescents supplemented with IFA /MMMS	Output	Not Available		50%	70%	Survey	Annual	FMoH, RHBs, FMOE, RBEs,	RHB, WorHO and HF's	Survey reports
		Prevalence of anemia in adolescents aged 15-19 years	Outcome	13%		10%	8%	Survey	2-3 years	FMOH-CSA	community	Survey reports

		Prevalence of anemia among pregnant women aged 15-49	Outcome	22%		15%	12%	Survey	2-3 years	FMOH-CSA	community	Survey reports
		Proportion of adolescents received de-worming tablets	Output	Not Available		50%	70%	Administrative Report	Annual	FMoH, RHBs, FMOE, RBEs,	RHB, WorHO and HF's	Reports
		Percentage of HH using iodized salt	Output	15.40%		70%	95%	Survey	End line	FMoH & RHBs	RHB, WorHO and HF's	Survey reports
		Percentage of iodized salt produced and supplied per year	Input	300,000 metric tone		300,000 metric tone	300,000 metric tone	Administrative Report	Quarterly	FMOH	RHB, WorHO and HF's	Reports
	Promote use of fortified foods	Number of promotional campaigns conducted	Output	0.00%	1	2	2	Administrative reports	Annual	FMOH/ Regional	RHB, WorHO and HF's	Reports
		Proportion of food processing industries fortifying wheat flour	Output	-		5%	30%	Administrative reports (from Ministry of Industry)	Annual	Federal/ regional	Federal/ regional	Reports
		Proportion of imported oil fortified with Vitamin A	Output	-		60%	100%	Administrative reports (from Ministry of Industry)	Annual	Federal	Federal/ regional	Reports
		Proportion of food processing industries fortifying oil	Output			5%	30%	Administrative reports (from Ministry of Industry)	Annual	Federal/ regional	Federal/ regional	Reports

Strategic Objective/ Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
	Ensure access to reproductive health information and services for boys and girls	Proportion of HC & Hospitals providing youth friendly RH services	Output	Not Available		50%	100%	Administrative Report	Annual	FMOH & RHBs	RHB, WorHO and HF's	Reports
		Proportion of adolescent girls married below 18 years	Outcome	8%		4%	0%	Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Prevalence of teenage (15 - 19 years) pregnancy	Outcome	12%		10%	8%	Survey	2-3 years	FMOH-CSA		Survey report
		Number of SBCC materials (addressing food taboos, dietary diversification, nutrition practices, early marriage, teenage pregnancy) distributed	Input	Not Available				Administrative Report	Annual	FMOH & RHBs	RHB, WorHO and HF's	Reports
	Provide a comprehensive and routine nutrition assessment and counseling services for PLW	Prevalence of anemia among women of reproductive age (15-49 years)	Outcome	17%		15%	9%	Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Prevalence of anemia among pregnant women	Outcome	22%		15	12%	Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Proportion of non-pregnant women aged 15-19 years with BMI <18.5	Outcome	36%		30%	25%	Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Proportion of PLW provided acute malnutrition treatment or support in targeted woredas	Output	Not Available				Administrative Report	Annual	FMOH & RHBs	RHB, WorHO and HF's	Reports

Result 1.2 Nutritional status of women improved	Ensure pregnant and lactating women access to micronutrient services:	Percentage of women consuming at least one additional meal than usual during pregnancy	Output	Not Available				Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Proportion of pregnant women who received IFA	Output	17%		50%	70%	Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Proportion of pregnant women receiving IFA supplements for at least 90 days	Outcome	0.4%		30%	50%	Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Proportion of women who received de-worming drugs during recent pregnancy	Output	6%			70%	Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Proportion of pregnant women consuming vitamin A rich foods in the previous 7 days (dietary diversity score)	Output	NA				Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Percentage of HH using iodized salt	Output	15.40%			95%	Survey	Annual	FMOH & RHBs	RHB, WorHO and HF's	Survey report
		Proportion of HDAs trained on nutrition promotion	Input	NA				Administrative Report	Annual	FMOH & RHBs	RHB, WorHO and HF's	training report

Strategic Objective/ Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
	LLINs distribution in all malaria endemic woredas and utilization of the nets by pregnant and lactating women	Percentage of PLW living in malaria endemic woredas and who utilized LLINs	Output	NA				Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
	Ensure access to RH services (birth spacing)	Proportion of women (15-49 years) using any methods =CPR	Output	29%			66%	Survey	Annual	FMOH & RHB's	RHB, WorHO and HF's	Survey report
	Ensure male involvement in RH services such as PMTCT, ART, family planning, antenatal and postnatal service, child care and others	Proportion of married women (15-49) who decides on health seeking	Outcome	74%			100%	Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Percentage of currently married women age 15-49 who report that their husbands help with the household chores	Outcome	43%			70%	Survey	2-3 years	FMOH-CSA	RHB, WorHO and HF's	Survey report
		Number of SBCC materials (addressing male involvement, food taboos and nutrition practices...) distributed	Input	Not Available				Administrative Report	Annual	FMOH & RHB's	RHB, WorHO and HF's	Reports

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

Promote, support and protect optimal breast feeding practices for infants 0 to 6 months at community and facility level:	Proportion of infants 0-6 months exclusively breast fed	Output	52.00%	61%	0	70%	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HF's	Survey report
	Percentage of newborns who started breastfeeding within 1 hour of birth	Output	52.00%	65%	0	80%	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HF's	Survey report
	Number of hospitals certified for BFHI	Output	0		4	10	International BFHI assessment report	yearly	Hospitals and health centers	RHB, WorHO and HF's	Reports
	code of marketing for BMS ratified and enforced	Output	-		1		Ratified document	once			ratified document
	Number of awareness raising meetings between the private sector and regulatory body	Output	0		2	2	Meeting minutes	yearly	Federal/ regional	Federal/ regional	Report on the meeting between private sector and regulatory body
	Maternity leave proclamation revised to align with ILO/global recommendations	Output		0	1		Ratified document	once			ratified document

Strategic Objective/ Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Promote, support and create access to appropriate complementary feeding for 6 – 23 month olds		proportion of breastfed children age 6-23 months with minimum acceptable dietary score	Output	4%	0%	0%	30%	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HFs	survey report
		Proportion of infants 6–9 months of age who receive solid, semi-solid or soft foods starting at 6th month of age	Output	48%	55%	0%	60%	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HFs	survey report
		proportion of children age 6-23 months who receive minimum acceptable diet (four food groups)	Output	4%	0%	0%	30%	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HFs	survey report
		Proportion of children age 6-23 months who receive fortified baby foods	Output	6%			30%	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HFs	survey report
		Proportion of children who continued breastfeeding at age of 20 - 23 months	Output	82.20%			90%	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HFs	survey report
		Proportion of children 0 to 59 months age, given more food during diarrhea episode	Outcome	5.90%			20%	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HFs	survey report
		GMP participation rate among children 0 to 24 months	Output	NA	50%	60%	80%	Administrative reports	monthly	kebele	community	Reports

	KAP of mothers about appropriate maternal IYCF knowledge	Output	41.00%					Survey	2 - 3 years	Household	community	Survey report
	Number of kebeles with access to locally produced complementary food	Output	26				500	Administrative reports	yearly	kebele	community	Reports
Prevent and control micronutrient deficiencies	Number of children 6 to 23 months received MNP twice a year	Output	0				2,000,000	Survey	2 - 3 years	Household	RHB, WorHO and HFs	Survey report
	Prevalence of anemia in children 6-59 months	Output	44.00%	34%	0	>90%	25%	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HFs	Survey report
	Targeted coverage of VAS in children (6-59 months)	Output	>90%	>90%				HMIS	Biannual	kebele	community	Reports
	Proportion of 6 to 23 months children consuming vitamin A rich foods	Outcome	10.40%				30%	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HFs	Survey report
	Proportion of households utilizing iodized salt	Output	15.40%	50%	0	95%		Survey/EDHS	2 - 3 years	Household	community	Survey report
	Proportion of children 0 to 59 months receiving zinc for diarrhea treatment	Output	5.00%	25%	0	80%		Survey/EDHS	2 - 3 years	Household	community	Survey report
	Proportion of food processing industries fortifying wheat flour	Output	-		5.00%	30.00%		Administrative reports (from Ministry of Industry)	Annual	Federal/ regional	Federal/ regional	Reports
	Proportion of food processing industries fortifying oil	Output	-		5.00%	30.00%		Administrative reports (from Ministry of Industry)	Annual	Federal/ regional	Federal/ regional	Reports

Strategic Objective/ Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
	Early detection and management of acute malnutrition and common childhood infections	Number of severely malnourished children (0 to 59 months) treated	Output	320,000			200,000	Administrative reports	monthly	health facility	RHB, WorHO and HF's	Reports
		Performance of CMAM services	Output	RR: >80%: Defaulter : <5%: Mortality: <1%			RR: >85%: Defaulter : <2.5%: Mortality: <0.5 %	Administrative reports	monthly	health facility	RHB, WorHO and HF's	Reports
	Promote hygiene and sanitation practices	Proportion of households using improved water source	Output	54.00 %			60 %	Survey/EDHS	2 - 3 years	Household	community	Survey report
		Proportion of households with improved toilet facility	Outcome	18.00 %			25 %	Survey/EDHS	2 - 3 years	Household	community	Survey report
		Proportion of households practicing hand washing before feeding	Outcome	90.00 %			95 %	Survey/NNP	2 - 3 years	Household	community	Survey report
		Number of promotional campaigns on hygiene and sanitation conducted	Output								RHB, WorHO and HF's	
		Proportion of schools with toilet facility	Output	80.5	86	92	100	NWI	by 2015	Annually	School	Report

	Proportion of schools with water supply	Output	33.43	55.62	77.81	100	NWI	by 2015	Annually	School	Report
	Proportion of health facilities with water supply	Output	33.88	55.92	77.96	100	NWI	by 2015	Annually	Health institution	Report
	Proportion of health facilities with toilet facilities	Output	84.53	88	94	100	NWI	by 2015	Annually	Health institution	Report
Hand washing with soap	Proportion of households practicing household water treatment	Output	35	49	63	77	HSDP IV	by 2015	survey	community	Survey
Ensure the development and utilization of locally relevant early childhood development materials	ECCD included in HW and HEW training manual	Input			1 (in blended training material for HWs and CMNCH IRT)	Blended and IRT tools and materials		once		Federal level	Review of training materials
Promote feeding during illness and recovery	Proportion of children 0 to 59 months age, given more food during diarrhea episode	Outcome	5.90 %			20 %	Survey/EDHS	2 - 3 years	Household	community	Survey report
Prevent and control micronutrient deficiencies	Prevalence of anemia in children 6-59 months	Output	44.00 %	34 %	0	25 %	Survey/EDHS	2 - 3 years	Household	RHB, WorHO and HF's	Survey report
	Targeted coverage of VAS in children (6-59 months)	Output	>90 %	>90 %	>90 %	>90 %	HMIS	Biannual	kebele	community	Reports
	Proportion of households utilizing iodized salt	Output	15.40 %	50 %	0	95 %	Survey/EDHS	2 - 3 years	Household	community	Survey report
	Proportion of children 0 to 59 months receiving zinc for diarrhea treatment	Output	5.00 %	25 %	0	80 %	Survey/EDHS	2 - 3 years	Household	community	Survey report

Strategic Objective/ Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Result 2.2: Improved nutritional status of children 24 - 59 month olds	Prevent and control micronutrient deficiencies	Proportion of food processing industries fortifying wheat flour	Output	-		5.00%	30.00%	Administrative reports (from Ministry of Industry)	Annual	Federal/ regional	Federal/ regional	Reports
		Proportion of food processing industries fortifying oil	Output	-		5.00%	30.00%	Administrative reports (from Ministry of Industry)	Annual	Federal/ regional	Federal/ regional	Reports
	Early detection and management of acute malnutrition and common childhood infections	Number of severely malnourished children (0 to 59 months) treated	Output	320,000			200,000	200,000	Administrative reports		RHB, WorHO and HFs	
		Performance of SAM case management	Output	RR: >80%: Defaulter : <5%: Mortality: <1%				RR: >85%: Defaulter : <2.5%: Mortality: <0.5%	monthly	health facility	RHB, WorHO and HFs	
	Ensure access and utilization of WASH practices	Proportion of households using improved water source	Output	54%		57%	60%	Survey/EDHS	2 - 3 years	Household	community	Survey report
		Proportion of households with improved toilet facility	Outcome	18%			25%	Survey/EDHS	2 - 3 years	Household	community	Survey report
		Proportion of households practicing hand washing before feeding	Outcome	90%	90%	90%	95%	Survey/NNP	2 - 3 years	Household	community	Survey report
		Number of promotional campaigns on hygiene and sanitation conducted	Output		1	1	1	Admin report	annual	national/ regional	RHB, WorHO and HFs	MOH/ MOWA report

Strategic Objective 3: Improve the nutrition service delivery for communicable and lifestyle related diseases affecting all age groups	Ensure the development and utilization of locally relevant early childhood development materials	ECCD included in HW and HEW training manual	Input	NA	30%	70%	Admin report	annual	regional	health facility	Training report
Result 3.1: Improved the nutrition service delivery to communicable and lifestyle related Diseases	Improve the nutrition service delivery to chronic non communicable/ lifestyle related diseases	Proportion of health professionals trained on nutrition service delivery for lifestyle related disease	Input	NA			Admin report	annual	regional	health facility	Training report
		Number of public awareness campaign / media messages disseminated/ conducted on lifestyle diseases/ healthy lifestyle	Input	NA	4	4	Admin report	annual	national/ regional	national/ regional	Media messages broadcasted
		Proportion of urban health extension professional trained on lifestyle related diseases	Input	NA	30%	20%	Admin report	annual	national/ regional	national/ regional	Training report
		Number of promotional messages developed on healthy lifestyle activities	Input	NA	3	3	Admin report	annual	national/ regional	national/ regional	Review of promotional materials

Strategic Objective/ Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Result 3.1: Improved the nutrition service delivery to communicable and lifestyle related Diseases	Improve the nutrition service delivery to communicable diseases	No. of health facilities providing NAC to PLWHIV	Input	413		87	100	Admin report	annual	national/ regional	national/ regional	MOH report
		Proportion of PLWHIV assessed for nutritional status	Input		40%	50%	70%	HMIS	annual	facility	facility	HMIS reports
		Proportion of PLWHIV with MAM or SAM received therapeutic or supplementary foods	Input		40%	50%	70%	HMIS	annual	facility	facility	HMIS reports
	Increase production of fruit, vegetable, nutritious roots, cereals and pulses to improve consumption of diversified diet at household level	Proportion of households consumed fruits and vegetables	Output	15	20	25	30	DHS	5 year	Household	kebele	CSA report
		Proportion of households with homestead gardening	Output	NA	20%	25	30	DHS/Admin report	5 year	Kebele	community	CSA report
		Number of groups engaged in community horticulture production	Output	NA		100	66	DHS/Admin report	5 year	Kebele	community	CSA report
		Number of fruit and vegetable nursery sites established/ supported	Output	5		60	18	Admin report	annually	woreda	Woreda	MOA report
		Proportion of urban households in zonal capitals with urban gardening	Output	NA		1	1	Admin report	annually	zonal	zonal	MOA report

Strategic Objective 4: Strengthen implementation of nutrition sensitive interventions in various sectors

	Proportion of urban areas with at least 5 mushroom producing groups	Input	NA	5%	10%	10%	10%	Woreda agriculture report/ woreda trade and industry office	annually	woreda	Woreda	MOI/ MOA report
	Proportion of rural households practicing backyard poultry	Output	NA	3%	7%		5%	Woreda agriculture report	annual	kebele	household	MOA report
Improve access and utilization to animal source foods	Number of poultry multiplication centers supported	Input	NA	4	4	4	4	MOA report	annual	national	multiplication centers	MOA report
	Proportion of woreda with at least one milk collection center supported	Output	NA	10%	10%		10%	Woreda agriculture report	annual	kebele	household	MOA report
	Number of fish producing groups supported/ established around major lakes	Output	NA	2	5		3	Woreda agriculture report	annual	woreda	Woreda	MOA report
	Fish hatching center established/ supported	Output	1		1		1	MOA report	annual	center	center	MOA report
Increase production and consumption of fish	Number of community pond established	Output	1,500		20		20	MOA report	annual	woreda	Woreda	MOA report

Strategic Objective/ Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Result 3.1: Improved the nutrition service delivery to communicable and lifestyle related Diseases	Promote appropriate technology for food (fruit and vegetables, fish, dairy etc.) production and processing through handling, preparation and preservation for food diversification to ensure nutritious food utilization.	Number of fruit and vegetable preservation technologies/ practices identified and introduced	Input	NA		2	3	MOA report	annual	National	kebele	MOA report
		Number of fish preservation technologies identified and introduced	Input	NA		1	1	MOA report	annual	National	kebele	MOA report
	Promote nutritional value addition (bio-fortification) to selected staple seeds to ensure availability and consumption of diverse nutritious food	Number of nutritionally improved variety of seeds release/ adopted and disseminated (Vit A enriched cassava, quality protein maize, orange fleshed potato, iron enriched beans)	Input	NA		2	2	MOA report	Annual	center	national	MOA report
	Promote consumption of diversified food through agricultural extension programs and agricultural development agents (DAs) at community level	Proportion of DAs received in-service training on nutrition sensitive agriculture	Input	0	0	10%	20%	Admin report	annual	woreda	Woreda	training report
		Number of Home agents trained on optimal nutritional practices/ complementary food preparation (Refresher)	Input	0	0	100	100	Regional Agriculture report	annual	zonal	Woreda	training report
		Pre-service DAs training curriculum revised for nutrition	Input	0	0	1		ATVET/MOA report	once	national	Training center	MOA report

		Number of field days conducted on fruit and vegetable production and appropriate food preparation / nutrition demonstration (AGP woreda)	Input	NA		83	83	Woreda agriculture report	annual	woreda	kebele	Woreda MOA report
		Number of promotional materials on dietary diversity produced	Input	0	Brochures= 40000 Posters= 2000 Magazine= 40000	Brochures= 1800000 Posters= 9000 Magazine= 40000	Brochures= 1800000 Posters= 9000 Magazine= 40000	MOA report	annual	national	national	MOA report
		Number of awareness creation message produced and disseminated through local mass media	Input	0	12	12	12	MOA report	monthly	national	national/regional	MOA report
		Established nutrition coordinating unit/ body in MOA	Input	0	1			MOA report	once	Federal	Federal	MOA report
	Strengthen the capacity of agriculture sector to integrate nutrition sensitive interventions in the agriculture programs.	% of AGP woreda FTCs' supported to implement nutrition sensitive interventions	Input	NA	10	45	45	Admin report	annual	woreda	kebele	MOA report
		Number of regions strengthened/ revitalized home agents	Input	0	1	1		Regional Agriculture report	annual	once	regional	Admin report
		Nutrition interventions included in to agriculture policy and investment framework plan	Input	0	1			MOA report	once	national	national	PIF doc

Strategic Objective/Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Result 4.1: Increased production, access and utilization of diverse nutritious food	Support local complementary food production and create economic opportunities for women through women groups, and cooperatives	Number of woreda engaged in local production of complementary food	Input	4	50	150	100	MOA report	Annual	national	national	MOA report
	Support agriculture research centers to develop high quality nutritional value seeds	Number of agricultural researches supported to conduct nutritional value addition of seeds/foods	Input	0	2	3	3	research centers report	annual	center	center	Centers report
		Number of agricultural Researches conducted to improve nutrition value of seeds	Input	0	2	3	3	research centers report	annual	center	center	Centers report
Result 4.2: Strengthened implementation of nutrition interventions in education Sector	Promote selected key nutrition actions through School clubs	Proportion of schools promoting selected nutrition actions through school clubs	Input	0		25%	50%	Education sector report	Annual	National	REB, WoEO	Reports
	Encourage schools to promote and transfer sustainable and replicable model school gardening at community level	Proportion of school that have school garden	Input	NA		10%	25%	Education sector report	Annual	National	REB, WoEO	Reports

Strategic Objective/Results	Initiatives	Indicators	Type	Baseline (2011/12)	2012/13	2013/14	2014/15	Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
	Facilitate and/or implement deworming service at school every six months	Proportion of primary schools conducting six-monthly deworming	Input	NA		50%	60%	Health service report	Biannual	National	Kebele	Health service report
		Proportion of primary school students received six-monthly deworming tabs	Input	NA		50%	60.00%	Health service report	Biannual	National	primary schools	Reports
	Incorporate nutrition in to school curricula at all levels	Assessment done about the inclusion of nutrition in the curriculum	Input	NA		1		survey	annual	National	Regional	Reports
	Support and promote home-grown school feeding in selected schools	Number of primary schools with home grown school feeding program	Input	NA	50	60	70	Administrative Report	quarterly	National	Woreda	Reports
		Number of students benefited from HGSF	Input	NA	50,000	60,000	70,000		quarterly	National	Woreda	Reports
	Support higher institutions to conduct nutrition sensitive operational research	Number of higher institutions conducted nutrition sensitive operational research	Input	NA		6		survey	annual	National	facility/ community	Reports
		Number of higher institutions that graduate students in nutrition as field of study	Input	6			8	Administrative Report	annual	National	University/ college	Reports
	Support higher institutions to produce nutrition professionals	Cumulative number of nutritionists trained in higher institutions (M.Sc. and PHD)	Input	NA	120	270	470	Administrative Report	annual	National	University/ college	Reports

Strategic Objective/Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Result 4.2: Strengthened implementation of nutrition interventions in education Sector	Promote gender equality awareness among school children	Gender parity index in primary and secondary education(F/M)	Input	Primary 1st = 0.93 Primary 2nd = 0.97 Secondary 1st = 0.8 Secondary 2nd = 0.46		Primary 1st = 0.94 Primary 2nd = 0.97 Secondary 1st = 1.0 Secondary 2nd = 0.83	Primary 1st = 1.00 Primary 2nd = 1.00 Secondary 1st = 1.00 Secondary 2nd = 1.00	Administrative Report	annual	National	school/ university/ colleges	Reports
	Including nutrition education in Adult Literacy programs	Adult literacy program included nutrition in its curriculum	Input	NA		1		F MOE report	annual	National	national	Reports
Result 4.3: Strengthen nutrition sensitive interventions into Water and Energy Sector	Increase access to safe water	% of families with clean and safe water supply	Output	58	84	92	98	NWI/DHS	by 2015	National house, hold level	community	NWI/ DHS survey
	Develop irrigated farm lands under small schemes	Hectares of farm lands cultivated through irrigation	Output				27,882 ha	Report	Annually	National and Regional	MoWE	Report

Result 4.4: Strengthen nutrition sensitive interventions into industry Sector	Strengthen the capacity of industry staff involved in supporting production and distribution food items	Proportion of ministry of industry staff trained	Output	NA		30%	50%	Administrative report	Annual	MOI	Federal and regional	Report
	Conduct awareness creation events to private sectors (producers and processors) on nutrition related requirements and standards of locally manufactured food items	Number of awareness creation sessions conducted	Output	NA		2	4	Administrative report	Annual	MOI	Federal level	Report
Result 4.5: Strengthen nutrition sensitive interventions into trade Sector	Strengthen the capacity of ministry of trade staff involved in the regulation of imported food items	Proportion of ministry of trade staff trained	Output	NA		30%	50%	Administrative report	Annual	MOT	Federal and regional	Report
	Ensure that the quality and safety of imported food items are as per the national standards	Proportion of imported food items inspected for compliance with food safety and quality standards	Output	NA		100%	100%	Administrative report	Annual	MOT	Federal and regional	Report
	Conduct awareness creation events to private sector (importers) on the nutrition related requirements and standards of imported food items	Number of awareness creation sessions conducted	Output	NA		2	4	Administrative report	Annual	MOT	Federal level	Report

Strategic Objective/Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
	Conduct awareness creation event to consumers on the benefit of fortified	Number of awareness creation sessions conducted	Output	NA		2	4	Administrative report	Annual	TPCPA(Trade Practice and Consumer Protection Authority)	Federal	report
Result 4.6: Strengthened social protection services for improved nutrition	Promote the implementation of gender sensitive Social Safety Net programmes and other social protection instruments to protect vulnerable groups from food insecurity and under-nutrition	Number of families included in PSNP	Output	8.3 million								
	Promote provision of credits, grants, microfinance services and other income generating initiatives to support vulnerable groups with prime focus on unemployed women to increase access to nutritious foods.	Proportion of women self help groups received grants and credits	Input	Not Available		10%	20%			MOLSA& MoW/CYA, FMSEDA	Micro enterprises	Reports
		Proportion of women self help groups trained on key nutrition practices	Input	Not Available		20%	40%	Report	annual	MOLSA& MoW/CYA, FMSEDA	Micro enterprises	Reports

	Number of health facilities providing free of charge treatment for SAM; · Hospitals · Health centers	Input	NA			· Hospitals = 227 · Health centers = 3,535	· Hospitals = 227 · Health centers = 3,612	Health facility Report	annual	Hospitals and health centers	Hospitals and health centers	Health service report
Increase access to basic nutrition services to vulnerable groups	Proportion of pastoralist woredas with management of severe acute malnutrition (at list one SC per woreda and 50% of kebeles with OTP)	Output	MoA						Annual	MoA/ DRMFSS		
	Percent of elderly poor received nutritional services	Output	Not Available		5%	10%	15%	Report	Annual	MOLSA	National Associations	Reports
Scale up home grown School feeding programme	Number of primary schools in food insecure woredas with school feeding programme	Output	1187 schools		1246	1305	1364	Report	Annual	MOE	Schools	Reports

Strategic Objective/Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Result 4.9. Improved nutrition supply management	Ensure continuous availability of nutrition supplies	proportion of tracer nutrition supplies (Albendazole, Zinc/ORS, Plumpy Nut, vitamin A, iron foliate ...) stocked out.	Output	NA		0%	0%	Survey	Biannual	FMOH	All levels	Survey reports
		Transition plan developed for integration of selected essential nutrition commodities to be distributed through PFSA	Input			1		Transition plan document	once	FMOH	national	Transition plan document
	Build the nutrition supplies management capacity at all levels of the system	Number of private institutions involved in local production, importation and distribution of nutrition commodities		1			4	Admin report	annual	Federal	National	Reports
		Proportion of health facilities with at least one trained pharmacy personnel on nutrition supply management	Input	NA		70%	100%	Admin report	Quarterly	FMOH	All levels	Reports
		Number of warehouses renovated to accommodate nutrition commodities	Input	17		1	3	PFSA admin report	Biannual	FMOH	All levels	Reports

Strengthen coordination of all partners in procuring, distributing and using nutrition supplies.	No. of harmonized nutrition supply plan prepared	Input	-	4	4	4	4	Admin report	Quarterly	FMOH	National	Reports
		Number of health facilities reported supply status using standard Reporting and Requesting Format (RRF) on quarterly basis	process	NA		Hospitals = 227 Health centers = 3,535	Hospitals = 227 Health centers = 3,612	PFSA admin report	Quarterly	FMOH	National	Reports
	No. of stock status reports shared	Input	-	4	4	4	4	Admin report	Quarterly	FMOH	National	Reports

Strategic Objective/Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Strategic objective 5: Improve multisectoral coordination and capacity to ensure implementation of the NNP	Improve the capacity of PHCU for implementation of gender responsive nutrition programs	Proportion of HEWs trained on nutrition through IRT	Input	NA		100%		Admin report	Quarterly	FMOH	RHB, WoHO, HF's and community	Reports
		Number of health center and woreda staff trained on blended nutrition training course (3 per health center + 1 per woreda)	Input	NA		4,017	10,836	Training report	Annual	FMOH	RHB, WoHO, HF's and community	Reports
		Number of hospital staff trained on blended nutrition training course (6 per hospital)	Input	NA		4,086	1,362	Training report	Annual	FMOH	RHB, WoHO, HF's and community	Reports
	Strengthen the community level capacity of development army and linkage Teachers & Agriculture Extension Workers	Proportion of health facilities with at least 1 SBCC material on each of the optimal child, adolescent and maternal feeding practice	Input	NA			100%	NNP end line survey	once	national	national	survey report
		Proportion of woredas established a health (women) development army	Input	NA			100%	Admin report	Quarterly	FMOH	RHB, WoHO, HF's and community	Reports
		proportion of woredas provided gender responsive nutrition training to HDAs	Input	NA	30%	70%	100%	Admin report	Quarterly	FMOH	RHB, WoHO, HF's and community	Reports

Result 5.2: Strengthened capacity of women based structures and associations for Implementation of NNP	Strengthen capacity of women based structures and associations at all level for promotion of optimal MIYC feeding and caring practices	Proportion of kebeles with trained teachers and AEWs on nutrition	Input	NA		30%	70%	Training report	Quarterly	FMOH	RHB, WoHO, HF's and community	Reports
		Strengthen capacity of women based structures and associations at all level for promotion of optimal MIYC feeding and caring practices	Input	NA		605	1,412	Training report	Quarterly	MOWCYA	Federal, Regional, Woreda MOWCYA	Reports
		Strengthen capacity of women based structures and associations at all level for promotion of optimal MIYC feeding and caring practices	Input	NA		30%	70%	NNP end line survey	once	national	national	survey report
	Prevent harmful traditional practices	Proportion of women associations trained on optimal nutrition practices at federal, regional and woreda levels	Output	NA		30%	70%	NNP end line survey	Once	National	National	Survey report
		Number of sensitization/ orientation sessions addressing traditional harmful practices(delay early marriage, food taboo)	Output	NA		12	12	Administrative report	Annual	Federal MOYCA and regional RWAB	Federal and regional	Administrative report
	Promote the development of life skills for girls	Proportion of life skill trainings made nutrition sensitive and provided for girls	Output	NA		50%	100%	Administrative report	Annual	Federal MOWCYA and regional RWAB	Federal and regional	Training report

Strategic Objective/Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Result 5.3: Improved capacity to conduct nutrition monitoring, evaluation & operation research	Strengthen the capacity of different sectors to undertake monitoring and evaluation of the NNP	Number of sectors that included key nutrition indicators in their sectoral information systems	Output	1	3	9		Sectoral information system	once	national	Federal	Sectoral information system
		Woreda Based Plan tools and formats updated to include NNP indicators	process		1			FMOH	once	national	Federal	WBP format
		Multisectoral National Nutrition database established	Output	0		1		Administrative report	NA	EHNRI	National	Report
		Number of sectors that included nutrition indicators in their Integrated Supportive Supervision (ISS) tools	process	1	3	9		Sectoral review meeting reports	once	national	Federal	Sectoral review meeting reports
		Number of National level review meetings	Output	0		1	1	MoH report	Annual	National	National	Minutes of the meetings/ Report
		Number of regional review meetings conducted among all sectors and stakeholders	Output	0		22	22	RHB report	Bi annual	Regional	RHB	Minutes of the meetings/ Report

Result 5.4: Improved capacity of regulatory body for NNP	Strengthen capacity of nutrition laboratories	Number of nutrition laboratories capacitated	Output	1		4	4	EHNRI Administrative report	NA	National	National	Report
	Strengthen the capacity of sectors, training and research institutions to undertake operational researches	Number of nutrition laboratories accredited (AAU/ CFSN and EHNRI)	Output	0			2	Certification/ Administrative report	NA	MOH/ EHNRI/ Public Universities	MoH/EHNRI	Certification/ Report
		Number of training given on operational research	Input	0			2	Administrative report	NA	MOH/ EHNRI/ Public Universities	MoH/EHNRI	Report
		Annual nutrition bulletin including research briefs and selected field program experience	Output	0			1	FMOH Nutrition bulletin	annual	National	national	Publication
	Provide in-service training for technical food inspectors on quality and safety of nutrition supplies	number of trained inspectors	Input	0	15	59	63	administrative report	annual	Federal/ regional/ branch office	Federal/ regional/ branch office	Report
Result 5.5: Improved multisectoral coordination of the NNP	Establish and equip quality control laboratories at all levels	number of established and well equipped laboratories	Input	0	1	2	3	administrative report	annual	Federal/ regional/ branch office	Federal/ regional/ branch office	Report
	Strengthen the national/ regional nutrition coordination body (NINCB and RNCB)	Number of National Nutrition Coordinating Body meeting	Input	NA	1	2	2	Administrative Report	biannual	National	National	minutes of the meetings
		Number of regional Nutrition Coordinating Body meeting	Input	NA	1	2	2	Administrative Report	Biannual	Regional	Regional	minutes of the meetings

Strategic Objective/Results	Initiatives	Indicators	Type	Baseline (2011/12)	Target			Source	Periodicity	Level of Data Collection	Level of implementation	Means of Verification
					2012/13	2013/14	2014/15					
Result 5.5: Improved multisectoral coordination of the NNP	Strengthen the national/regional nutrition technical committee (NNTC and RNTC)	Number of quarterly National Nutrition Technical Committee meeting	Input	NA	2	4	4	Administrative Report	Quarterly	National	National	minutes of the meetings
		Number of quarterly Regional Nutrition Technical Committee meeting	Input	NA	1	4	4	Administrative Report	quarterly	Regional	Regional	minutes of the meetings
		Multisectoral guideline for nutrition coordination developed and disseminated	Input	0		1		Coordination guideline document	once	National	national	Coordination guideline document
	Establish nutrition unit at federal level of MOH that facilitates implementation of NNP through all sectors	Nutrition unit established	Input	0	1			FMOH	once	National	national	MOH organizational structure
	Establish nutrition unit at RHB level that facilitates implementation of NNP through all sectors	Number of regions with nutrition unit established	Input	NA		11		RHB Report	annual	Regional	Regional	minutes of the meetings
	Ensure assignment of adequate number of dedicated staff in nutrition sensitive sectors at all levels	Number of sectors established nutrition unit / or assigned focal point	Input	NA		7	9	Sector annual report	annual	National	National	minutes of the meetings

5.6 Improved capacity of media	Build the capacity of national and regional media personnel (journalists, editors)	Number of national and regional media personnel (journalists, editors) trained	Output	NA		100	189	Sector annual report	annual	National	National	Training report
	Equip media with appropriate Nutrition SBCC materials and pragmatic tools	Number of SBCC materials provided to national and regional media	Input	NA		30	52	Sector annual report	annual	National	National	Administrative report



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June 2013 – June 2015