Ethiopia

Nutrition
Sectoral and OR+ (*Thematic*) Report

January – December 2016

Azalech and her five-month old baby boy on their way to the market in Halaba Town, SNNPR. ©UNICEF Ethiopia/2017/ Pudlowski

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Table of contents

Abbreviations and Acronyms

AMIYCN	Adolescent, Maternal, Infant and Young Child Nutrition
AMIYCF	Adolescent, Maternal, Infant and Young Child Feeding
BMS	Breast-Milk Substitute
CBN	Community-Based Nutrition
CHD	Community Health Days
CIF	Centralized Iodization Facility
CMAM	Community Management of Acute Malnutrition
CPD	Country Programme Document
C4D	Communication For Development
EDHS	Ethiopian Demographic and Health Survey
ENCU	Emergency National Coordination Unit
EOS	Enhanced Outreach Strategy
EPHI	Ethiopian Public Health Institute
FMHACA	Food, Medicine and Healthcare Administration and Control Authority
FMoH	Federal Ministry of Health
GDP	Gross Domestic Product
GMP	Growth Monitoring and Promotion
GTP	Growth and Transformation Plan
HEP	Health Extension Programme
HEW	Health Extension Workers
HRD	Humanitarian Requirements Document
HSDP	Health Sector Development Plan
IRT	Integrated Refresher Training
IYCF	Infant and Young Child feeding
IYCF-E	IYCF in Emergency
KAP	Knowledge, Attitude, Practices
NDPF	Nutrition Development Partner Forum
NDRMC	National Disaster Risk Management Commission
NNCB	National Nutrition Coordination Body
NNP	National Nutrition Programme
NNTC	National Nutrition Technical Committee
PSNP	Productive Safety Net Programme
RHB	Regional Health Bureau
RNTC	Regional Nutrition Technical Committee
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SDGs	Sustainable Development Goals
SNNPR	Southern Nations, Nationalities and Peoples' Region
UNDAF	United Nations Development Assistance Framework
UNISE	Unified Nutrition Information System for Ethiopia
VAS	Vitamin A Supplementation
WASH	Water, Sanitation and Hygiene

Executive Summary

Ethiopia has made a remarkable progress in reducing child malnutrition with a decrease in national stunting rates among children under five from 58 per cent in 2000 to 38 per cent in 2016. Over the same time period, underweight decreased from 41 per cent to 24 per cent. Despite this progress, the burden of malnutrition remains high in the country.[1] National levels of maternal undernutrition have remained constant, with 26 per cent of women underweight[2] and anaemia affecting 23 per cent of women of reproductive age[3].

The nutrition landscape continues to improve in Ethiopia, attracting greater degrees of political commitment. The Seqota Declaration (made in July 2015) is an exemplary embodiment of the Government of Ethiopia's high-level and multi-sectoral engagement which recognizes nutrition as a cornerstone of human and economic development. Following that, the Government of Ethiopia launched the second phase of the National Nutrition Programme (NNP II) addressing the multi-sectoral and multidimensional deprivation of malnutrition in Ethiopia, with a stronger focus on a life cycle approach and nutrition-sensitive interventions. The nutrition policy environment was further strengthened with the development of the Ethiopian Food and Nutrition Policy and National Food Fortification Plan, as well as the adoption of the Code of Marketing of Breast-milk Substitutes. Thanks to its large team of nutritionists and other specialists, UNICEF Ethiopia participated in all the different policy-level initiatives to ensure that nutrition for women and children is well positioned and that the realities of the field are taken into account in national plans and strategies.

To better inform the nutrition situation in Ethiopia and guide effective investments in nutrition, the Situation Analysis of the Nutrition Sector in Ethiopia 2000-2015 was launched by UNICEF and the European Union and used to feed into the NNP II as well as donor action plans. Other evidence generating activities in 2016 were the two important knowledge attitude practice (KAP) studies conducted in multiple regions; one on infant and young feeding (IYCF) practices and one on adolescent nutrition.

In 2016, UNICEF Ethiopia started a new five-year Country Programme (2016-2020). The nutrition programme under this contributes directly to United Nations Development Assistance Framework (UNDAF) Outcome Six of the Basic Social Services, which in turn supports the achievement of the NNP II and the Government's Health Sector Development Plan V objectives, and in the long term contributes to the newly developed Growth and Transformation Plan II (2015/2016-2019/2020) (GTP II).

Thanks to UNICEF's field nutrition specialist many tangible results were achieved in 2016 at the grass-root level: of note was UNICEF's ability to respond rapidly, ensuring the treatment of 320,883 cases of severe acute malnutrition (SAM) caused by one of the worst droughts in Ethiopia's recent history. As the Nutrition Cluster lead agency, UNICEF supported the coordination of the nutrition emergency response and ensured that gaps were identified and addressed without duplication of resources.

Despite ongoing emergencies affecting over half of the country, UNICEF was able to support the Government in ensuring that 11,287,238 children 6-59 months received vitamin A supplementation (89 per cent of all children this age group) and 7,741,812 children 24-59 months received treatment against intestinal worms (86 per cent of children this age group) countrywide. Furthermore, 61 per cent of all children under 24 months (1,794,840 children) in the agrarian regions[4] were weighed monthly as part of the Government-led growth monitoring and promotion (GMP) programme under the community-based nutrition programme.

The multi-sectoral coordination at federal and regional level to reduce chronic malnutrition (stunting) among young children in Ethiopia was strengthened with a growing involvement of nutrition-sensitive sectors including agriculture (creation of a nutrition case team and training of the agriculture development army),

[1] Ethiopia Demographic and Health Survey (EDHS) 2000 and EDHS 2016 Key Indicators Report, October 2016
[2] EDHS 2011
[3] EDHS 2016 Key Indicators Report, October 2016
[4] Tigray, Amhara, Oromia, and SNNP regions

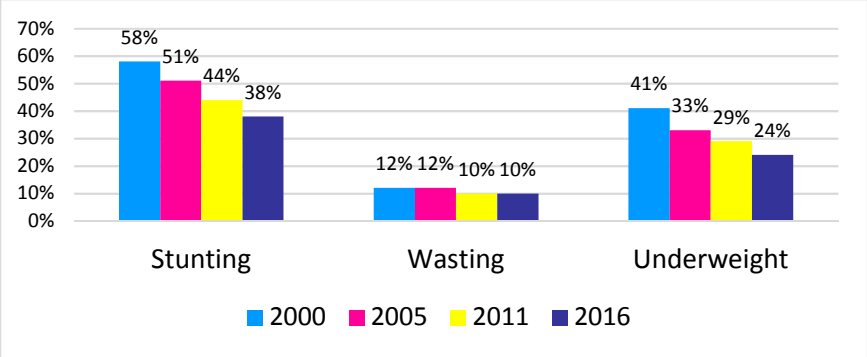
education (integration of nutrition in life skills trainings in schools, and deworming of adolescents using schools as platform) and social protection (nutrition provision in the Government's Productive Safety Net Programme (PSNP) IV).

Building on the successes achieved in 2016, in 2017 UNICEF will focus on implementing at the grass root level the various national strategies and programmes, ensuring that nutrition is well placed at each level.

Strategic Context of 2016

Despite encouraging reductions in child undernutrition since 2000, the burden of malnutrition is still widely felt in Ethiopia. Stunting rates among children under five have decreased sharply (from 58 per cent in 2000 to 38 per cent in 2016) however nearly 2 out of 5 children are still stunted[5]. Nearly a quarter of children under five are still underweight, and wasting affects a tenth of children country-wide[6].

Figure 1. Trends in Child Undernutrition in Ethiopia, 2000-2016



Maternal undernutrition continues to be a challenge, with 26 per cent of women underweight according to the 2011 Ethiopia Demographic and Health Survey (EDHS), and 23 per cent of women of reproductive age anaemic[2]. The recently published micronutrient survey (2016 Ethiopia National Micronutrient Survey) conducted by Ethiopian Public Health Institute (EPHI) also found that 32 per cent of women of reproductive age are deficient in folate which increases the likelihood of spontaneous abortions and pregnancies associated with low birth weight, preterm delivery and foetal growth retardation and deformities.

About 13 per cent of teenagers (15-19 years) are pregnant or have already carried a child which is particularly worrying as 12 per cent of girls in this age group are anaemic and 15 per cent suffer from folate deficiency and therefore enter pregnancies in nutritionally depleted state. For the adolescent girls who are not pregnant, this poor nutritional status compromises their ability to learn in class and increases the risk of dropping out of school. This emphasizes the importance of focusing on this age group to prevent intergenerational growth retardation leading to stunting and intergenerational poverty.

When it comes to malnutrition rates in Ethiopia, the latest EDHS from 2016 shows significant regional variation that is masked by national averages. Out of the 11 regions of the country, Amhara, Benishangul-Gumuz, and Afar are the most affected by stunting, with levels above 40 per cent. The burden of wasting (acute malnutrition) is heaviest for Somali (22.7 per cent), Afar (17.7 per cent), and Gambella (14.1 per cent) regions. Afar and Somali have the highest level of anaemia among women (43.4 and 59.1 per cent respectively) and children (73.2 and 82.6 per cent respectively). These regions also have the highest numbers of adolescent pregnancies and mothers.

[5] Situation Analysis
[6] EDHS 2016 Key Indicators Report, October 2016

The high levels of acute malnutrition are, in part, due to sub-optimal infant and young child feeding and care practices. Ethiopia has seen an improvement in key infant feeding indicators such as exclusive breastfeeding during the first six months of life, from 52 per cent in 2011 to 58 per cent in 2016[7]. However, the proportion of children under two receiving the minimum acceptable diet remains at a paltry 7 per cent.

Due to poverty and gaps in caretakers' knowledge and practices, a majority of Ethiopian children are not fed micronutrient-rich foods at home. As a result, micronutrient deficiency is a serious public health issue. Deficiencies of micronutrients such as vitamin A, iron, folic acid, iodine, and zinc affect physical growth and cognitive development, and increase the risk of morbidity and mortality.

According to EPHI's 2015 Micronutrient Survey, among children 6-59 months vitamin A deficiency affects 14 per cent, zinc deficiency 35 per cent, and anaemia 34 per cent. Of those with anaemia, 12 per cent is due specifically to iron deficiency.[8]

In 2016, various nutrition policy and programme initiatives of the Government bore fruit. The NNP II (2016-2020) was launched, which addresses the multi-sectoral and multidimensional causes of malnutrition with an enhanced focus on the life cycle approach and nutrition-sensitive interventions. In addition, the implementation plan for the 2015 Seqota Declaration was disseminated among stakeholders, demonstrating the Government's high-level and multi-sectoral engagement which recognizes nutrition as a cornerstone of human and economic development. The nutrition policy environment was further strengthened with the development of the Ethiopian Food and Nutrition Policy and National Food Fortification Plan, as well as the adoption of the Ethiopia Code of Marketing of Breast-milk Substitutes, which was integrated into two existing directives.

The Government of Ethiopia estimated that an investment of US$1.1 billion over five years is needed to achieve targets in stunting reduction through NNP II. In the past, nutrition-interventions in the NNP I were well supported by development partners, however commitments to date not only reveal a reduction in nutrition funding overall but also a shift in funding from nutrition-specific to nutrition-sensitive interventions, thereby compromising the sustainability of results achieved thus far.

In 2015 and 2016, Ethiopia was hit by the worst drought in decades. The failed 2015 summer rains (*kiremt*), that provide 80-85 per cent of the country's agricultural harvest, threatened the food and nutrition security of the whole country, devastating livelihoods and increasing malnutrition levels in Afar, Amhara, Oromia, Tigray, Southern Nations, Nationalities and Peoples' Region (SNNPR) and Somali.

Recognizing the gravity of the situation and the increased needs, the Government of Ethiopia presented the 2016 Humanitarian Requirements Document (HRD) requesting US$1.4 billion for relief efforts, compared to US$470 million in humanitarian needs for 2015. The 2016 HRD estimated that 9.7 million people were in need of food aid in 2016 and predicted that 420,000 children would require treatment for severe acute malnutrition, and that 3.2 million children and pregnant and lactating women would be affected by moderate acute malnutrition. UNICEF as the Nutrition Cluster lead agency supported the coordination of the emergency nutrition response via the Emergency Nutrition Coordination Unit (ENCU) embedded in the National Disaster Risk Management Commission.

The emergency inevitably shifted focus away from development to life-saving emergency interventions and severely hindered or delayed the implementation of certain activities. Several development partners increased nutrition funding for emergency and humanitarian needs, which further reduced the availability of financing for preventive interventions focused on stunting and other long-term nutritional outcomes.

In 2016, UNICEF Ethiopia developed a new five-year Country Programme (2016-2020). The nutrition programme aims to achieve the following outcome: *By 2020, an increased percentage of under-five girls and*

[7] 2016 EDHS
[8] 2016 Ethiopia National Micronutrient Survey (ENMS 2016), EPHI

boys, adolescent girls and pregnant and lactating women are appropriately nourished and cared for. The outcome will be achieved through four technical pillars of support:

1. **Policy and Multi-sectoral Coordination:** Multi-sectoral coordination and capacity of sectors engaged in implementation of the National Nutrition Plan are strengthened with a focus on policy, information systems, and knowledge management.
2. **Nutrition Knowledge and Caring Behaviour:** Percentage of pregnant women, caregivers of girls and boys under two, and adolescent girls equipped with knowledge of optimal nutrition and caring behaviour is increased.
3. **Nutrition Systems Strengthening:** Quality nutrition services for pregnant women, caregivers of girls and boys under five and adolescent girls are strengthened.
4. **Nutrition Coordination in Emergencies:** Government and partner capacities to respond to nutrition in humanitarian crises are strengthened.

Special attention was given to the first 1,000 days of life (from conception until two years) and the period of adolescence since these two life cycles are critical windows of opportunity to break the intergenerational cycle of malnutrition. The programmes directly contribute to UNDAF Outcome Six of the Basic Social Services, which in turn supports the achievement of the NNP II and the Health Sector Development Plan V objectives, and in the long term contributes to the newly developed GTP II.

With its national reach, knowledge, convening power and technical capacity, UNICEF is uniquely positioned to support the Government in reinforcing a system that addresses the immediate and underlying causes of undernutrition in women and children through nutrition-specific programming as well as nutrition-sensitive interventions such as health, water and sanitation, and social protection. UNICEF is the lead organization in supporting Ethiopia's nutrition programme both upstream and downstream, with specialists (nutrition, monitoring and evaluation, gender mainstreaming, communication for development) at federal level providing support and a team of nutritionists in Field Offices provide direct support at the sub-national level.

At upstream level, UNICEF provides strategic guidance through various coordination platforms such as the Government-led National Nutrition Coordination Body (NNCB) and the National Nutrition Technical Committee (NNTC) which represent the highest level of coordination and decision making structures for nutrition in Ethiopia. As the chair and secretariat for Nutrition Development Partners Forum (NDPF) and as the Cluster lead for nutrition, UNICEF plays an important role in bringing about better coordination, strategic discussions and synergy among UN Agencies, donors, and NGO partners in the development and emergency context.

At downstream level, UNICEF is a key partner supporting Government efforts to expand and improve nutrition — both preventative and curative — service delivery. As such, UNICEF supports the Government-led community-based nutrition (CBN) programme in 454 out of 771 rural *woredas* (districts)[9], which provides nutrition-specific, cost-effective, evidence-based and sustainable preventative nutrition interventions for communities. Alongside the CBN, UNICEF supports the Government-led community-based management of acute malnutrition (CMAM) for the detection and effective treatment of children with SAM in over 16,000 health facilities across the country. CMAM is also a key element of the emergency nutrition response to manage risk, sustain and accelerate recovery and enhance resilience. Both CBN and CMAM are fully integrated into the exiting health system.

UNICEF is the unrivalled source of information on the global situation of children. To continue to enhance the understanding of the situation affecting children and women in Ethiopia and to better respond to critical needs, UNICEF Ethiopia currently supports a number of different surveys and evaluations at national and regional levels.

[9] Of the 317 *woredas* not covered by UNICEF, 100 are supported by other partners, 67 are directly supported by the Government of Ethiopia, and 150 are supported by a partner with only part of the CBN package.

Results in the Outcome Area

In 2016, UNICEF continued to support the nutrition programme of the Government of Ethiopia in all regional states[10]. UNICEF interventions contribute to a set of outputs, which in turn contribute to the achievement of the outcome: *By 2020, an increased percentage of under-five girls and boys, adolescent girls and pregnant and lactating women are appropriately nourished and cared for.*

This report shows the previous Country Programme Document's (CPD) baselines and targets and the current CPD's baselines and targets. The current CPD started in July 2016 and will run until June 2020.

	CPD 2012-2016		**CPD 2016-2020**		
Outcome Indicator	**Baseline (2012)**	**Target (2016)**	**Baseline (2016)**	**Target (2020)**	**Status**
1. Children 0-5 months old who are exclusively breastfed (per cent)	52%	70%	52%	76%	58% (EDHS 2016)
2. Children 6-23 months provided with minimum dietary diversity (per cent)	4%	20%	Male 4.5% Female 5.1%	Male 20%, Female 20%	Data not available yet
3. Number of children 6-59 months affected by SAM who are admitted into treatment	265,000	302,605	254,326	250,000	320,883* (ENCU data)
4. Proportion of households consuming iodized salt	15.4%	95%	N/A	N/A	90% (ENMS 2016)

* Data from January to December 2016.

The 2016 Ethiopian Demographic and Health Surveys (EDHS) shows a 12 per cent increase in the national prevalence of excusive breastfeeding of children under 6 months, from 52 per cent in 2011 to 58 per cent in 2016. In light of this, Ethiopia has reached the 2025 the World Health Assembly global target for breastfeeding, with at least 50 per cent of children under 6 months exclusively breastfeed. However, the Government has more ambitious targets and would like to see 80 per cent of children under 6 months exclusively breastfed by 2020. Given this goal, the current rate of reduction is insufficient to meet Government targets. However, it is important to note that the 2016 EDHS data was collected during the height of the drought emergency, where mothers experienced disruption in breastfeeding as a result of stress and poor coping strategies to the emergency (internal displacement, working away from home, traveling long distances for water, poor nutritional status of women), and all of this may have impacted breastfeeding rates.

Once the full EDHS is available in March 2017, a further analysis of infant feeding practices by region and wealth quintile will likely show inequity in the improvement in exclusive breastfeeding. Therefore tailored messaging will be needed to bridge these gaps to ensure an equitable improvement in infant feeding practices and an overall increase in the prevalence of exclusive breastfeeding.

Regarding the second CPD outcome indicator, dietary diversity remains a major bottleneck to complementary feeding for young children in Ethiopia. The 2016 EDHS Key Indicator Report shows a slight improvement in the minimum acceptable diet (a composite indicator of diet diversity and meal frequency), from 4 per cent in 2011 to 7 per cent in 2016. Again, the 2015-2016 drought emergency may have curbed any substantial improvement in this indicator.

[10] Support for Addis Ababa, Dire Dawa and Harari (which are administrative states and not regions) was provided in the form of provision of supplies and quarterly review, in conjunction with the Health Section of UNICEF Ethiopia.

Several partners, including UNICEF, have supported the Federal Ministry of Health (FMoH) to launch pilot projects to improve complementary feeding at the grass-roots level. There is now a need to take stock of these different initiatives to better understand what works in improving complementary feeding in different contexts across Ethiopia. The full 2016 EDHS report (expected to be published in March 2017) will provide more detailed information on the quality and frequency of complementary feeding as well as on inequity.

UNICEF contributed to improving IYCF and ultimately the outcome by supporting the development of the National Adolescent, Maternal, Infant and Young Child Feeding (AMIYCF) multi-media campaign, supporting the Government in the adoption of the Marketing of Breast-milk substitute Code, training health extension workers (HEW) and health workers (HW) on Adolescent, Maternal, Infant and Young Child Nutrition (AMIYCN), supporting platforms such as the community-based nutrition programme and mother-2-mother support groups for effective transmission of timely age-appropriate and targeted AMIYCF messaging. In addition, UNICEF supported increased access to complementary food through production of complementary food and engagement with the agriculture sector.

In response to the El Niño-driven drought and nutrition emergency in 2016, UNICEF Ethiopia, as a sole procurer of the ready-to-use therapeutic foods (RUTF) for the Government of Ethiopia, made one of the largest single purchases of RUTF in UNICEF history.[11] The procured nutrition supplies were distributed with a particular attention to remote and hard to reach areas. Aside from the procurement and distribution of supplies, CMAM was strengthened through the provision of standardised opening kits for the establishment of new stabilization centres, refresher trainings and on-the-job mentoring for HEW by CMAM monitors, and timely dispatch of nutrition supplies for the treatment of SAM, ensuring quality treatment and increased geographical coverage. This not only improved access to services but also reduced the distance that had to be travelled by care-givers, thereby minimizing the risk of gender-based violence (which increased at the height of the emergency). In addition, the UNICEF-supported ENCU coordinated partners' support to CMAM in over 200 *woredas*, preventing duplication of resources and improved targeting of support to poorly performing *woredas*.

One major lesson learnt stemming from the emergency is the importance of having existing structures equipped with knowledge and supplies to treat SAM as well as coordination platforms involved in the full emergency response cycle, from preparedness to coordination of the response and recovery. UNICEF has been supporting both the steady roll-out of SAM treatment in facilities since 2009 and the ENCU, which has been preparing region-specific bi-annual response plans. Finally, review of routine data from the CBN programme shows that in *woredas* where the CBN programme has been operational, the quality of care and detection of SAM cases was better than in *woredas* without CBN. The prevalence of underweight children among participants of GMP programme in the CBN *woredas* remained low at 6 per cent despite the emergency and high levels of malnutrition. This clearly demonstrate the contribution of UNICEF to build the resilience of the health system and the communities to respond quickly to and mitigate the effects of shocks in Ethiopia.

With regards to salt iodization, Ethiopia has seen an impressive increase in the availability of iodized salt from 4.5 per cent in 2005 to 90 per cent in 2016. However, the problem of quality remains as only 26 per cent of the household salt is adequately iodized. UNICEF is one of three organisations supporting salt iodization in Ethiopia and has continued to advocate for the improvement of the quality of salt to reduce the burden of iodine deficiency in the country. When the Federal Ministry of Industry took the lead on salt iodization from the Ministry of Health, a shift in advocacy was needed from a public health perspective to making an investment case. Therefore UNICEF Ethiopia organised an experience-sharing visit for government officials and salt producers to the salt iodization factories in Azerbaijan at the end of 2015. After this, the Government of Ethiopia partnered with a private investor to establish a central iodized facility (CIF) which is expected to improve the quality of the salt iodization. Production of iodized salt in the CIF started in June 2016 and is expected to reach full production capacity within twelve months. Recognizing the importance of managing the process as the country shifts from small-scale iodization to modern industrial iodization, the Ministry of Industry established

[11] http://www.unicef.org/esaro/5440_eth2016_therapeutic-food.html.

a technical working group with technical support from UNICEF and other partners. UNICEF supports the Ethiopian Food Medicine and Healthcare Administration and Control Authority (FMHACA) technically and financially to enforce salt iodization regulations in the country.

Results Assessment Framework

This section reviews the indicators in the nutrition output area, showing the results achieved by 2016 compared to the baseline and targets as outlined in the current and previous CPD.

Output 1: Policy and Multi-sectoral Coordination

This output relates to the creation of a supportive and enabling policy and legal framework for nutrition, and promotion of multi-sectoral nutrition actions. In particular, this output aims to initiate and reinforce multi-sectoral engagement and pro-poor policies and plans to support nutrition in Ethiopia.

	CPD 2012-2016		**CPD 2016-2020**		
Standard Output Indicators	**Baseline (2012)**	**Target (2016)**	**Baseline (2016)**	**Target (2020)**	***Status***
National Multi-sectoral Committee for Nutrition available and functional	N/A	N/A	Yes	Yes	Yes
National management information system that includes disaggregated (age, sex, urban/rural) data on nutrition available	N/A	N/A	Yes	Yes	Yes. The database is housed at UNICEF and has not been transferred yet to the Government
Number of regional multi-sectoral committees for nutrition available and functional	6	8	8	8	8 Regional multi-sectoral committees
Number of regions with comprehensive nutrition information database	0	6	N/A	N/A	8 databases However, these databases require support from UNICEF
Number of sector plans with integrated nutrition intervention	0	5	N/A	N/A	6 plans Six sector signatories to NNP have included nutrition in their respective sector plans.
Number of federal and regional FMHACA inspectors trained, equipped and conducting regular monitoring of the quality of iodized salt	0	50	N/A	N/A	50 FMHACA inspectors were equipped with technical skills to conduct quality assurance and control of iodized salt Jan-June 2016.

National Nutrition Programme II: In 2016, the Government of Ethiopia has launched the second National Nutrition Programme (NNP II). UNICEF has been closely involved in the revision of the NNP II, from review of lessons learnt from NNP I to drafting of the NNP II and preparation of the high-level launch. UNICEF paid particular attention to gender mainstreaming by incorporating gender interventions and indicators under each strategic objectives in the NNP II, and contributed to the governance section of the NNP which addresses interventions that are not directly linked to the five strategic objectives, i.e. female economic empowerment, gender-based violence etc. This was achieved by having UNICEF staff in each of the strategic objective working groups.

The NNP II is operationalized through two mechanisms: the National Nutrition Coordination Body (NNCB) that leads higher-level decision making, and the National Nutrition Technical Committee (NNTC) which provides technical guidance in the implementation of the agreed-upon strategies and prepares advocacy notes

for the NNCB. This coordination mechanism has been replicated to regional or zonal level in the eight regions in Ethiopia.

Multi-sectoral coordination bodies: In 2016, the Government's focus on the emergency response meant that not all the planned meetings of the NNCB and NNTC could take place. Nevertheless, both coordination bodies managed to achieve results: the NNCB decided to develop a National food and Nutrition policy as well as provided much needed guidance on its remit.

Based on this decision, the NNTC drafted the policy for presentation by the NNCB to the Ethiopian Parliament for endorsement. UNICEF staff were fully engaged in the process to ensure that the policy is child-friendly, gender-sensitive and rights-based, and that nutrition was considered as something above and beyond the provision of food. Following advocacy by the NNTC, the NNCB approved the inclusion of four more line Ministries in the signatories of the NNP II (compared to NNP I), and the use of the Unified Nutrition Information System for Ethiopia (UNISE) for monitoring the NNP II. In both cases, UNICEF played an important role in developing the advocacy materials which were used by the NNTC to convince the NNCB. Finally, after several years of debate regarding national iron fortification within the Ministry of Health and other stakeholders, the NNCB proposed to organize a research committee, headed by EPHI, to explore the causes of anaemia in Ethiopia and decisions around iron fortification. UNICEF is part of this research committee, advocating for the most disadvantaged, who suffer from anaemia the most.

Following 2015 high-level experience sharing visits in Brazil and Uganda, the Government of Ethiopia is more supportive of the work of the NNCB and NNTC, and as such these coordination bodies have come into their own in 2016. With UNICEF guidance, the NNTC is better prepared with evidence-based justifications to convince the NNCB, and the NNCB members recognize the utility of bringing all stakeholders together regularly to discuss issues but more importantly also to reach consensus on nutrition-related issues.

At the sub-national level, the Regional Nutrition Coordination Body (RNCB) and the Regional Nutrition Technical Committee (RNTC) coordination platforms are supported by UNICEF staff with technical and financial inputs. In 2016, the RNCB and RNTC had varying degrees of success, due to conflicting priorities brought on by the drought and the emergency response. In order to better respond to the emergency, all regions set up incident command posts led by the regional health bureau and including several other sectors, such as water, sanitation and hygiene (WASH), food security and early warning sectors, all of which directed focus away from development-related nutrition activities.

Region	Planned	Achieved	Comments
Amhara	4 RNCB 6 RNTC	0 RNCB 9 RNTC	Despite advocacy from the RNTC, the RNCB meetings were not held in 2016 mainly due to the drought and the State of Emergency shifting focus away from nutrition coordination. The RNTC increased engagement of different sectors in nutrition-sensitive interventions and included nutrition in their monitoring checklist. There is now a need to revitalise the RNCB to maintain the interest of the different sectors at the regional level.
Tigray	4 RNCB 4 RNTC	2 RNCB 2 RNTC	The focus of the regional health bureau (RHB) shifted away from multi-sectoral coordination to the emergency and outbreak of Acute Watery Diarrhoea. The first meeting led to great engagement of different sectors including universities. At the second meeting four sectors submitted nutrition-sensitive plans. Several sectors are engaged in multi-sectoral coordination but there is a need now to re-focus RHB to their role in coordination of nutrition.
SNNP	6 RNCB 6 RNTC	0 RNCB 3 RNTC 14 Zonal Nutrition Technical Committee (ZNTC) were oriented	The drought and drought response meant that no RNCB meetings were held, and fewer RNTC meetings were held than planned. Six sectors have incorporated nutrition in their plans. Sectors have made efforts to work in synergy (e.g. the RHB and Hawassa University have jointly done two operational studies to generate useful evidence for decision making). An effective reporting mechanism has not yet been

			stablished between coordination structures in the region and in the zones.
Oromia	0 RNCB 2 RNTC	1 RNTC at least 1 ZNTC meeting was conducted in all 18 zones	Oromia has yet to establish a regional level nutrition coordination platform and the RNTC are working on advocacy materials to support the establishment of RNCB. However, due to the drought and State of Emergency the RNTC has not been successful yet.

Lessons learnt by the regional health bureaus in coordinating multi-sectoral platforms were useful in managing the multi-sectoral incident command posts for the coordination of the emergency response, thus contributing to system strengthening and resilience building. Furthermore, the launch of the NNP II and its implementation manual, which looks specifically at multi-sectoral coordination, has reignited the interest in nutrition at the federal level and it is hoped that this will spread to the regional level.

The Nutrition Development Partner Forum (NDPF), co-chaired by UNICEF and the European Union, met 12 times in 2016. The NDPF saw a stronger focus on linkages between development-humanitarian activities, with regular briefings on the emergency situation by ENCU as well as a first joint field visit to monitor effective linkages between humanitarian and development nutrition programmes in two regions. At the end of 2016, the NDPF conducted an internal review and identified key lessons learnt, namely the necessity to focus less on specific interventions and more on strategy in 2017.

Ethiopia Code of Marketing of Breast-milk Substitutes: The Food, Medicine and Healthcare Administration and Control Authority (FMHACA) is the lead Governmental agency for the regulation of the Marketing of Breast-milk substitute Code (the BMS Code). In 2015, UNICEF advocated for Ethiopia to adopt the BMS Code via information sessions and trainings of staff from FMHACA and FMoH, workshops targeting professional associations such as the Ethiopian Paediatrics society and an experience-sharing visit to Botswana. This prompted FMHACA to seriously consider adopting the Code and later the agency agreed to include some elements of the Code in two existing directives. In 2016, UNICEF continued to lobby FMHACA and was successful in including all elements of the BMS Code in the two directives. There is now a need to support the establishment of monitoring mechanisms for reporting and tracking violations of the Code.

Food Fortification Plan: With the high burden of micronutrient deficiencies in Ethiopia, fortification of commonly consumed foods is a relatively inexpensive and effective means of increasing micronutrient intake, particularly in urban settings and among those inaccessible by the health system (vulnerable adolescent girls and children). Despite the fact that only 19 per cent of the Ethiopian population is urban, the high rate of urbanization as well as the establishment of industrial parks highlights the importance of looking at fortification and underlines UNICEF's involvement in fortification. In 2014, the first Food fortification plan was drafted but never adopted as the mandate for fortification shifted from the Ministry Health to the Ministry of Industry. In 2016, the interest in fortification was revived and UNICEF as part of the technical working group supported the development of the National Food Fortification Plan. The plan looks at all elements of fortification and includes the regulatory framework, the coordination mechanism, communication and engagement and capacity building of the private sector.

Nutrition Sensitive Agriculture Strategy: The multi-sectoral technical working group (TWG) on nutrition-sensitive agriculture, co-chaired by the UN Food and Agriculture Organization and Ministry of Agriculture and Natural Resources, developed a 5-year multi-sectoral Nutrition Sensitive Agriculture Strategy for 2016-2020. The Strategy aims to mainstream nutrition into agriculture, livestock and fisheries sectors. UNICEF Ethiopia contributed to the formulation of the Strategy by providing technical knowledge on nutrition.

School health initiative: In 2014, the Ministry of Education launched the school health and nutrition strategy, co-chaired by the Ministry of Health. However, implementation of this strategy has been limited, therefore in 2016 the Ministry of Health launched the School health initiative; a comprehensive school health implementation plan composed of ten school health service packages, including nutrition. UNICEF was

involved in the development of the initiative with the aim to ensure that nutrition was effectively represented and the interventions were in line with global recommendations.

National Adolescent and Youth Health strategy: Improving adolescent nutrition is one of the strategic objectives of NNP II to break the vicious cycle of malnutrition. As such, the Ministry of Health developed the National Adolescent and Youth Health Strategy, which cements Ethiopia's commitment to transform the health and wellbeing of the nation's adolescent and youth population, both in and out of school.

The Strategy goes beyond sexual and reproductive health, and presents a strategic framework to tackle the broader aspects of health and health-related conditions such as nutrition, mental and psychosocial health issues and gender-based violence to name a few. Three platforms will be used for implementation: i) schools via implementation of the School health initiative; ii) health facilities; and iii) youth centres. UNICEF participated in all technical working groups, providing technical support to the Ministry and ensuring that nutrition was well addressed in the strategy. As part of the implementation of the strategy, the FMoH has drafted a National adolescent and youth health training manual and a UNICEF technical team worked extensively on the adolescent nutrition module. The training material will be tested in early 2017, with the roll-out expected later in the year.

National Guideline on AMIYCM: Cognizant of infant and young child feeding as the cornerstone of child survival and development, UNICEF supported the Government of Ethiopia in developing and rolling out the National Guideline on the Adolescent, Maternal, Infant and Young Child Nutrition (AMIYCN) in line with the NNP II. Based on evidence and tailored to accommodate the needs and the contexts of Ethiopia, the AMIYCN Guideline advises different cadres of nutritional practitioners on counselling and supporting optimal nutrition practices at different stages throughout the life cycle and during special health conditions.

Support for Nutrition-Sensitive interventions:

The multi-sectoral approach to reduce chronic malnutrition (stunting) among young children in Ethiopia was strengthened with a growing involvement of nutrition-sensitive sectors including agriculture (creation of a nutrition case team), education (integration of nutrition in life skills training) and social protection.

Integrated Nutrition-Social Cash Transfer-PSNP: In 2015, the Government launched Phase IV of the PSNP, one of its main safety-net programmes to address poverty and food insecurity. Periodic evaluations of the programme have shown that the PSNP has had positive effects on a number of outcomes, including improved food security and increased household assets, but with little effect on child nutrition status. Building on these findings, UNICEF Ethiopia supported the Government to design a pilot that expands the cash transfer by offering an integrated package of multi-sectoral nutrition services, including a variety of social and behavioural change communication messaging in selected PSNP *woredas* in the SNNPR.

The pilot is being supported by Concern Worldwide and will generate lessons and so influence further scale-up. In 2016, training and communication materials for HEW and social workers were developed and trialled. These will be used in 2017 in 14 new *woredas* piloting the nutrition linkages with PSNP.

Integration of nutrition into the life skills training manuals: Schools are an ideal platform for the introduction of life skills education as they play an important role in the socialization process of school children and are economically efficient way of reaching out to young people using existing infrastructure.

The Federal Ministry of Education (FMoE) developed a life skills training manual for primary and secondary school students. The initial drafts did not include nutrition, therefore UNICEF advocated for its inclusion. This was achieved in 2016 when UNICEF staff worked with FMoE to develop the nutrition section of the new life skills manuals. The manual for secondary school adolescents (over 14 years) has been finalized and 14,000 copies have been printed and distributed to all regions. The manual for primary school students is currently

being finalized. Once it is ready, the manual will be rolled out in all primary schools with support from different partners including UNICEF.

Unified Nutrition Information System: A selected set of nutrition indicators are currently being captured through the health management information system (HMIS). However, as this system does not include all key nutrition indicators, it fails to provide a complete picture of nutrition programming in Ethiopia. To address this issue, UNICEF has been working with the FMoH to build the Unified Nutrition Information System (UNISE). Designed to be a one-stop shop for both nutrition-sensitive and nutrition-specific indicators, UNISE has been adopted by FMoH as the monitoring tool for NNP II. In order to obtain wider buy-in, and demonstrate the compatibility and complementarity of UNISE with other nutrition information platforms, such as the new initiative National Information Platform for Nutrition, UNISE was presented to stakeholders at the NDPF and at the Ethiopian Public Health Institute (EPHI). However, the roll-out of the UNISE has been hampered by the difficulty in identifying a realistic set of nutrition-sensitive indicators to be captured by the system. This challenge was discussed at the NNTC, and as a way forward, preliminary nutrition-sensitive indicators have been identified with the FMoH and are currently being verified bilaterally with the different ministries. The pre-testing of the UNISE system is planned for the first half of 2017, to be followed by a pilot in select *woredas* and training of health and information technology personnel.

Situation Analysis of the Nutrition Sector in Ethiopia 2000-2015: In March 2016, UNICEF together with the EU launched the Situation Analysis of the Nutrition Sector in Ethiopia 2000-2015. Conducted with technical support from Tulane University, the findings of the analysis contributed to the EU+[12] Joint Programming on nutrition. The Joint Programme aims to develop a coherent and cohesive response to the NNP to improve nutrition in Ethiopia.

IYCF Knowledge Attitude Practices Surveys: UNICEF Ethiopia supported a series of baseline surveys to assess knowledge, attitude and practices (KAP) on IYCF in partnership with Tulane University and Save the Children in Afar, Amhara, Benishangul-Gumuz and Tigray. Preliminary quantitative and qualitative results indicate that region-specific traditional sub-optimal practices in IYCF persist. The results also showed that although limited availability, affordability and access to of diverse foods may curb nutritious and diversified diets in Ethiopia, there are still possibilities for social and behavioural change interventions to improve diet diversity and nutrition outcomes. Appropriately contextualized messaging is currently being designed by UNICEF in order to advance knowledge and practice of caregivers on IYCF.

KAP survey and formative assessments for Adolescents: Very little is known about the attitudes of communities and adolescents on adolescent nutrition and deworming. Therefore UNICEF in collaboration with the FMoH conducted a KAP assessment of adolescent girls in school on nutrition and associated factors, and formative assessments on community perceptions of adolescent deworming in four regions of Ethiopia (SNNPR, Somali, Gambella and Oromia). Both quantitative and qualitative methods were used in the assessments. The findings were that deworming campaigns targeting both girls and boys was more likely to be accepted by communities than those for adolescent girls only. In addition, communities had little knowledge in general about the importance of adolescent nutrition.

Output 2: Nutrition Knowledge and Caring Behaviour

The objective of this output to promote positive knowledge, attitude and practice of individuals and influencing social norms to initiate and sustain better nutrition outcomes, especially for children, adolescent girls, and pregnant and breastfeeding mothers. This requires an interactive and consultative process of communicating with, engaging, and empowering individuals, communities and societies, and institutions and systems.

[12] 20 EU Member States represented in Ethiopia and Norway (EU+)

	CPD 2012-2016		CPD 2016-2020		
Standard Output Indicators	***Baseline***	***Target***	***Baseline***	***Target***	***Status***
Community health workers trained with UNICEF support to provide Infant and Young Child Feeding (IYCF) counselling services in the reporting year	N/A	N/A	Female 33,911, Male 0	N/A	The main national training for HEW is the Integrated Refresher Training (IRT) held every 2 years. The last IRT was in 2015 therefore the next one will be in 2017.
# of communities with capacities to provide IYCF counselling service [No. of districts with CBN & mother to mother IYCF support groups]	N/A	N/A	434 Rural *woredas*	440 rural *woredas*	454 rural *woredas*
Number of development agents and specialists trained on improved technical skills and knowledge on nutrition-sensitive agriculture	N/A	N/A	100	997	874 Agriculture Development Agents
Percent of Growth Monitoring and Promotion (GMP) participation for girls and boys under 2 in CBN *woredas*	42%	70%	N/A	N/A	61% participation of children under 2 years
Percent of *kebeles* (sub-districts) in developing regions with active women-to-women support groups	0%	50%	N/A	N/A	45% In Somali and Gambella, the expansion of women-2-women support groups has been slow due to insecurity (Gambella) and focus on the emergency response (Somali).
Number of UNICEF supported *kebeles* producing locally processed complementary food	8	180	N/A	N/A	180 *kebeles*

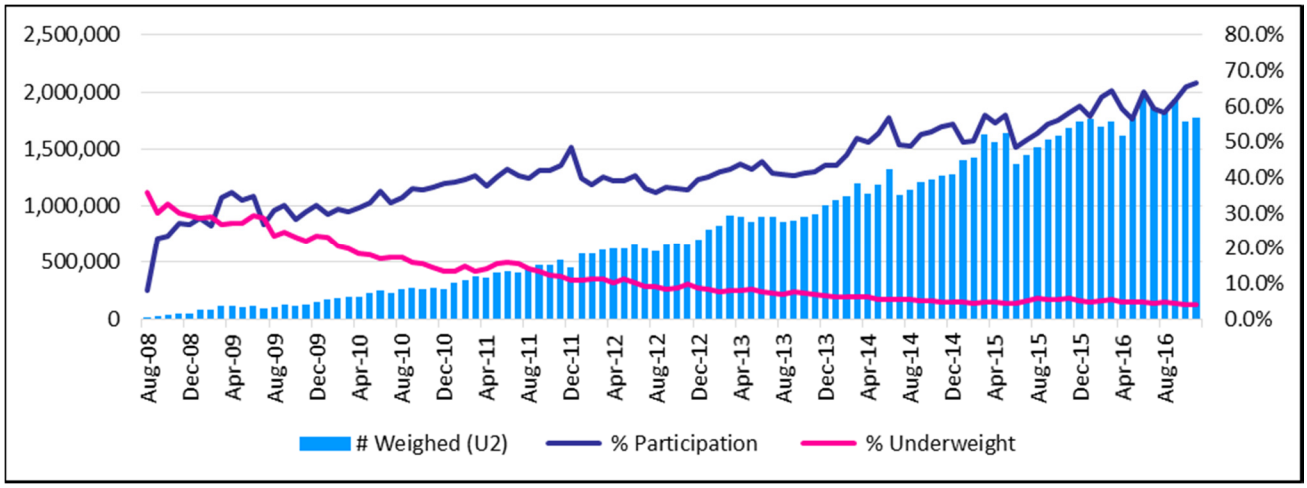
Integrated Refresher Training (IRT): Strengthening the capacity of frontline health workers is often one of the most important entry points to bring about behavioural and social change at grass roots level. To ensure harmonized capacity building of its HEW, the FMoH organizes the nationwide Integrated Refresher Training (IRT) every two years. No other health training is nationally endorsed. In 2015, in view of the oncoming drought emergency, the training was accelerated and completed by the end of the year, with financial and technical support from partners including UNICEF. Thanks to the IRT, 33,911 HEWs were capable of providing counselling and support on IYCF among many other health, nutrition, and WASH packages. The next IRT round is expected to take place in 2017. In 2016, as part of nutrition emergency response, IYCF in emergencies (IYCF-E) was integrated for the first time in the Government-led CMAM training. Training materials were developed and endorsed by the FMoH and shared to partners, and a master training was conducted with cascade trainings in the most affected *woredas* reaching 6,270 HEWs and HWs.

Blended Integrated Nutrition Learning Module (BINLM): A total of 76 regional-level master trainers and 1,168 *woreda* health officers/health workers in Amhara, Benishangul-Gumuz and Tigray gained skills and knowledge to supervise and support HEWs in the implementation of nutrition programmes. This was made possible with UNICEF-supported blended integrated nutrition learning module (BINLM), an innovative training approach consisting of computer-based learning and face-to-face skill transfer sessions.

Harmonized IYCF messaging: To facilitate and accelerate progress on improved knowledge of IYCF practices among families, UNICEF supported the FMoH to conduct a national IYCF mass media campaign in 2016. The campaign reached an estimated 30 million people with messages promoting maternal, adolescent, infant and young child feeding. Ten one-minute radio spots were developed and translated into the main languages of Ethiopia. The radio spots were broadcasted 1,800 times via the main national FM radio station with links to nine regional radio stations. The spots were also aired 900 times on national AM stations. In addition, the "First 1,000 Days" multimedia campaign, developed and launched with UNICEF's support, also helped communities' understanding of nutrition issues and their consequences, especially during the critical period from conception to a child's second birthday.

Growth Monitoring and Promotion (GMP): One of the main activities under this output, and also at the core of the Government's preventive and promotive CBN programme, is GMP, which is monthly weighing of children under five linked with age-appropriate counselling. Globally, GMP has been proven to increase caregivers' awareness about child growth, improve caring practices, and increase demand for other child nutrition and health services[13]. In 2016, GMP continued in the 386 CBN *woredas* and an average of 1,794,840 children benefitted from monthly weighing sessions and counselling on child feeding and caring practices. In addition, thanks to lessons learnt and advocacy by UNICEF, GMP activities have been fully integrated into the government-endorsed nutrition package and were carried out in *woredas* not supported by UNICEF through the health extension programme (HEP). This transfer of capacity highlights the sustainability of this approach as the Government is able to implement this intervention on its own. The average monthly GMP participation rate was 61 per cent in 2016, which is an improvement from 54 per cent in 2015. The average underweight was 4.7 per cent in 2016 compared to 5 per cent in 2015. There is now a need to increase coverage of GMP participation and improve the quality of counselling, including improved monitoring. More importantly, UNICEF needs to advocate for the Government to expand GMP in developing regional states.

Figure 2. GMP Participation and Underweight Trends, 2008-2016



Mother-to-Mother Support Groups: In 2016, in the developing regional states, community-level IYCF counselling services became available in 68 *woredas* (10 in Somali, 5 in Gambella, 34 in Afar and 21 in Benishangul-Gumuz) through the mother-to-mother support group structure. Facilitated by a model mother and under the guidance of a HEW, mothers and caregivers of children under two years met every 1-2 weeks and discussed how to promote IYCF in their communities and how to address their concerns. The groups used regions-specific booklets prepared by UNICEF. The group structure also provided an additional opportunity to

[13] Ashworth, A., Shrimpton, R. and Jamil, K. (2008), Growth monitoring and promotion: review of evidence of impact. Maternal & Child Nutrition, 4: 86–117. doi:10.1111/j.1740-8709.2007.00125.x

promote utilization of key health services such as institutional delivery and sanitation and hygiene among the member households.

Adolescent Nutrition: Adolescent girls remain one of the most vulnerable populations in Ethiopia, often subject to discriminatory gender norms and without regular access to basic social services. UNICEF Ethiopia's Country Programme for 2016-2020 therefore places an increased focus on adolescents as a cross-sectoral area, bringing attention to those aged 10-19. Improving adolescent nutrition is also one of the strategic objectives of the NNP II to break the vicious cycle of malnutrition. Taking this into consideration, UNICEF Ethiopia identified adolescent deworming as an entry point, as intestinal worms remain endemic in 89 per cent of all *woredas* in the country and pose a significant public health burden. Following a pilot phase of adolescent deworming in 2015, UNICEF Ethiopia continued to work with Ministry of Health and Ministry of Education in 2016 to fully integrate adolescent deworming into the national school-based deworming campaign, including behavioural change messaging for nutrition and WASH. The campaign reached 348,994 adolescents (179,557 girls and 169,437 boys) in 75 *woredas* in Amhara, SNNPR and Oromia. At the end of 2016, UNICEF successfully advocated for the scale-up of adolescent deworming campaigns in all 473 *woredas* identified with high and moderate caseloads of soil-transmitted helminths (parasites), with operational costs absorbed by the Government of Ethiopia, and UNICEF providing technical support and deworming tablets.

Local Complementary Food Production: Aware of the challenges in dietary diversity of children in the country, UNICEF Ethiopia collaborated with the Micronutrient Initiative and GAIN on the promotion of complementary feeding in rural and semi-urban areas in the agrarian regions. UNICEF Ethiopia's focus was placed on the semi-urban model, based on the production and sale of complementary foods to address the gap in current practices, while also enabling and empowering women as small enterprise owners. Women groups received training on production, entrepreneurship, marketing and small business management. Equipped with the skills to produce complementary food and with promotional materials, the production and sales started in early 2016. To increase the utilization of this prepared complementary food for children, UNICEF Ethiopia is discussing with the Ministry of Agriculture and Natural Resources on the potential use of the product as a PSNP ration for children.

Agriculture Development Agents Training: In order to improve dietary diversity of children and pregnant and breastfeeding women, UNICEF has been supporting the training of Agriculture Development Agents on nutrition-sensitive agriculture in the four large agrarian regions of the country. In 2016, 291 agents in Amhara, 874 in SNNPR and 1,053 in Tigray were trained, adding to the 877 agents trained in Amhara and Oromia at the end of 2015.

Output 3: Nutrition Systems Strengthening

The objective of this output is to support the health system to ensure quality nutrition services for pregnant women, caregivers of girls and boys under five, and adolescent girls, along the continuum of emergency, recovery and development. The activities include procurement and distribution of supplies for both emergency and development nutrition programmes, provision of technical support, and knowledge and skill development of the workforce for service delivery. The major government programmes supported by UNICEF Ethiopia are micronutrient supplementation including vitamin A (VAS) for children and iron folic acid for pregnant and lactating women, treatment for intestinal worm infestation, community-based management of acute malnutrition (CMAM), and promotion of salt iodization.

	CPD 2012-2016		CPD 2016-2020		
Standard Output Indicators	***Baseline***	***Target***	***Baseline***	***Target***	***Status***
Supply to provide two annual doses of Vitamin A supplements to all children aged 6-59 months available.	N/A	N/A	Yes	Yes	Yes
Existence of National protocols for the management of SAM based on WHO standards that includes CMAM available.	N/A	N/A	No	No	No
% of health facilities providing treatment for SAM.	N/A	N/A	80%	80%	84%
Number of *woredas* transitioning from EOS to CHD to routine services.	116	673	N/A	N/A	389 due to a drop in coverage of VAS and deworming. The FMoH has decided to slow the pace of transition of VAS and deworming in order to revisit how the transition is managed.
Percent of *woredas* with stock-outs of RUTF per quarter	34%	0%	N/A	N/A	0% Quarterly supplies are dispatched on time to regional and zonal levels and no shortages were reported during the period.
Number of *woredas* implementing the CBN package	372	475	N/A	N/A	621 454 directly supported by UNICF

Community-Based Nutrition programme: Supported by UNICEF Ethiopia and led by the FMoH, the CBN is an important service delivery platform and is the flagship development nutrition programme of the Government of Ethiopia. Acknowledged and endorsed for its community-based nature and reach, CBN was recognised as the way forward in the Government nutrition strategy as expressed in the NNP II and the 2015 Seqota Declaration. The CNB programme is rolled out through the Health Extension Programme, with health extension workers responsible for carrying out nutrition-specific activities as well as training and managing community volunteers. The CBN is the ideal platform to ensure linkages to nutrition-sensitive interventions such as the PSNP, the Agriculture Development Army and school health and nutrition. In 2016, UNICEF continued its support of CBN through joint support supervision, regional, zonal and *woreda* level review meetings, technical guidance and advocacy as well as printing and distribution of monitoring tools. In the 386 UNICEF supported CBN *woredas* in agrarian regions[14], an average of 1,794,840 children under two were weighed monthly (covering 61 per cent of all children under two enrolled in GMP). CBN has proven to be an important element of building resilience of the health system — enabling it to respond quickly when facing nutrition emergencies — and communities. The prevalence of underweight among participants of GMP has reduced from over 20 per cent in 2008 to less than 5 per cent in 2016, despite the drought affecting over half of the country and the subsequent dramatic increase in acute malnutrition.

Going forward there is a need to improve the quality of CBN services, particularly for pregnant and lactating women.

[14] Amhara, Tigray, SNNPR, and Oromia

Vitamin A Supplementation, Deworming and Nutritional Screening: In Amhara, Tigray, SNNPR and Oromia, the Government of Ethiopia planned to transition 430 *woredas*[15] from the existing community health days (CHD) and integrate them into routine services, as part of the strategy to fully integrate all services into the health extension programme and move away from costly campaigns. In the developing regional states, where the health system is much weaker, the Government aimed to transit 40 *woredas* from the resource-heavy Extended Out-reach Services (EOS) to CHD.

Tigray was the first region to transition fully from CHD to routine services in 2014. The change in service delivery resulted in a drop of VAS coverage (from 92 per cent in 2013 to 64 per cent in 2015) and a drop in reporting for deworming, as the latter was not included in the national health management information system. A review of the situation by UNICEF and partners revealed several underlying factors for this, including inadequate orientations of *woreda* officials while cascading the training on transitioning to health extension workers; poor reporting and monitoring; and lack of attention from the regional health bureau (RHB). Concerned about the drop in these essential interventions in Tigray, UNICEF advocated to the Government for a phased transition from CHD to routine service delivery and for additional support for the transition. As a result, the national transition plan was amended. In 2016, the focus was only on the region of Amhara, and although there was a reduction in VAS and deworming coverage (from 95 per cent pre-2016 to 75 per cent at the end of 2016), the effect of the transition was not as dramatic as in Tigray. For Oromia and SNNPR the transition plan was postponed and a new plan will be discussed in early 2017 by the transition technical working group in the FMoH, of which UNICEF is a regular participant. In the *woredas* implementing the services on a routine basis, UNICEF continues to support the RHB and implementing partners in effective advocacy, orientation meetings, strengthened training and improved monitoring.

Prior to starting the transition from EOS to CHD in the developing regional state of Afar, health staff from the RHB were sponsored by UNICEF to visit a nearby *woreda* in the Amhara region to help plan the process. However, by the end of 2016 only 11 out of the targeted 40 *woredas* (5 in Benishangul Gumuz and 6 in Afar) have transitioned as it was decided to pilot the transition in these first. The transition plans in Somali and Gambella regions have been put on hold. This was decided as the availability and functionality of health posts and capacity of HEWs is limited in Somali region, where the health system faces multiple challenges. The transition has been postponed until further notice in the region of Gambella due to the influx of refugees from South Sudan.

In 2016, using all three modalities (EOS, CHD and routine service delivery), 11,287,238 children 6-59 months old received vitamin A supplementations (89 per cent of all children this age group) and 7,741,812 children 24-59 months old received treatment against intestinal worms (86 per cent of all children this age group) countrywide.

As for screenings for acute malnutrition, the FMoH provided a guidance to undertake monthly screenings in priority *woredas* in order to enable early detection of acute malnutrition at the community level. Therefore the monitoring for screenings was conducted separately. Although monthly screening allowed the HEWs and communities to keep track of the nutrition status of children, "screening fatigue" was observed and reported from the HEWs due to their increase in workload, which raised concerns for the quality of data reports. In 2016, an average of 77.3 per cent of children 6-59 months and 65.9 per cent pregnant and breastfeeding women were screened for acute malnutrition on a monthly basis.

Community-based Management of Acute Malnutrition (CMAM): In 2015-2016, Ethiopia endured one of the worst droughts of recent history due to the El Niño weather phenomenon, followed by massive food and nutrition insecurity throughout the country. UNICEF's emergency nutrition response plan focused first and foremost on securing the life-saving nutrition supplies such as ready-to-use therapeutic foods (RUTFs) to meet

[15] 167 in Amhara, 46 in Tigray, 68 in SNNPR, and 149 in Oromia

the increased needs and avert a humanitarian catastrophe due to pipeline breaks. UNICEF also assessed areas with potential gaps in the Government logistics system, and supported timely and equitable dispatches and distribution of RUTF to hard-to-reach areas to prevent stock outs.

In parallel to supply procurement, UNICEF prioritized supporting the Government system to further expand the CMAM programme. As of December 2016, SAM treatment services were available in over 16,000 health facilities throughout the country. In 2016, a total of 320,883 children with SAM were admitted, out of whom 25,114 (8 per cent) were admitted to inpatient care. The SAM admissions were lower than what the initial caseload was projected to be (420,000 in the HRD), which was thanks to a robust management of cases of moderate acute malnutrition through a well-coordinated targeted supplementary feeding programme led by the UN World Food Programme, and other humanitarian interventions such as general food distributions and increased access to potable water. It is, however, important to note that the SAM admission levels remained higher than regular, non-drought years.

Figure 2. SAM Admissions 2015-2016

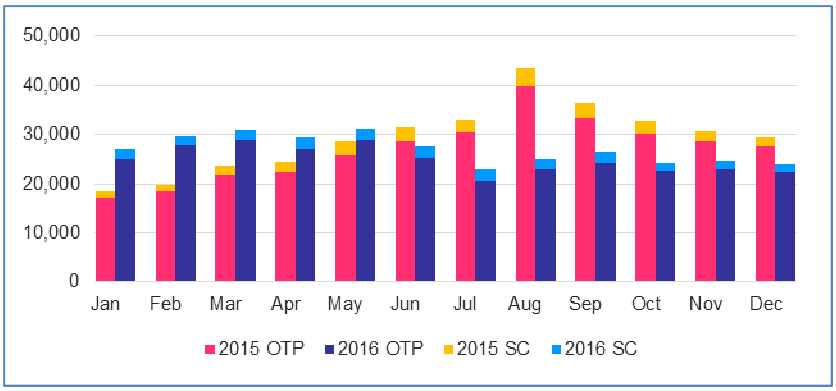
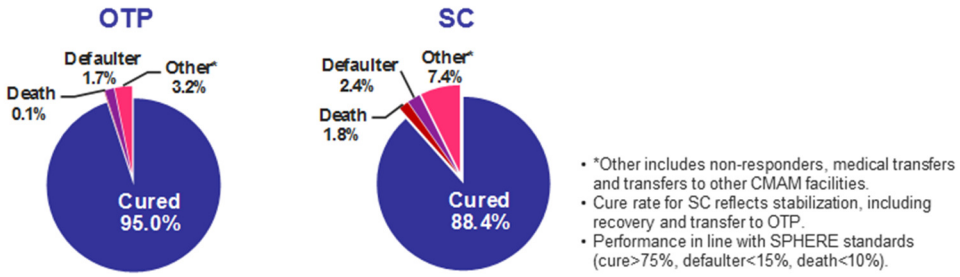


Figure 3. SAM Treatment Programme Performance



Output 4: Nutrition Coordination in Emergencies

This output aims to create and sustain the capacity of the Government and partners to respond to and coordinate nutrition in humanitarian crises.

Standard Output Indicators	*Baseline*	*Target*	*Status*
Emergency Preparedness Plan for nutrition developed and in place	No	Yes	Yes
UNICEF-targeted children aged 6-59 months with SAM in humanitarian situations admitted to SAM programmes and recover	89%	80%	91%

Emergency Nutrition Coordination Unit (ENCU): UNICEF has consistently facilitated emergency nutrition response coordination by leading the Emergency Nutrition Coordination Unit (ENCU) that is embedded into the National Disaster Risk Management Commission (NDRMC). Nutrition coordination improved by the identification of areas of high needs for prioritization, estimation of caseloads, mobilization of resources, and coordination of stakeholders while minimising duplication of efforts. The ENCU estimated the funding requirements for the emergency response at US$128.1 million, and via advocacy was able to ensure that 100 per cent of the emergency needs for nutrition were met. In addition, the ENCU reviewed NGO proposals for the Ethiopia Humanitarian Funds[16], securing US$21.5 million for nutrition support out of the US$75.6 million disbursed by the fund.

The ENCU provided technical assistance to the NDRMC on multi-sectoral assessments in pre-harvest seasons in June and November 2016 to evaluate the impact of the seasonal rains on various sectors including, but not limited to, agricultural production, food and nutrition security and livelihoods. The assessments conducted in 2016 informed the projection of populations in need and guided the mid-amendment of 2016 Humanitarian Requirements Document (HRD) and the preparation of the 2017 HRD.

The quality of CMAM data reports was improved with ENCU and UNICEF support. The rich and comprehensive CMAM data managed by the ENCU allowed UNICEF and other partners, including donors, to perform regular and systematic nationwide analyses of the programme, identify weaknesses and challenges, take remedial actions, and disseminate the information to a broad range of stakeholders on a monthly basis. Based on this database, SAM treatment performance indicators remained above international standards, with cure rate at 91 per cent, death rate at 0.2 per cent, and defaulter rate at 1.8 per cent.

With an aim to monitor the nutrition situation, the ENCU led 38 bi-annual nutrition surveys in 2016 using standardised SMART methodology in sentinel *woredas* in Afar, Tigray, Oromia and SNNPR. In addition, the ENCU reviewed seven SMART surveys conducted by NGO partners. The focus now is to shift away from SMART surveys as the hotspot classification, the robust routine data and the *Belg* and *Meher* assessments provide sufficient information on nutritional vulnerability. The ENCU and partners are now focusing on coverage surveys to monitor service uptake of SAM treatment before, during and after nutrition surveys.

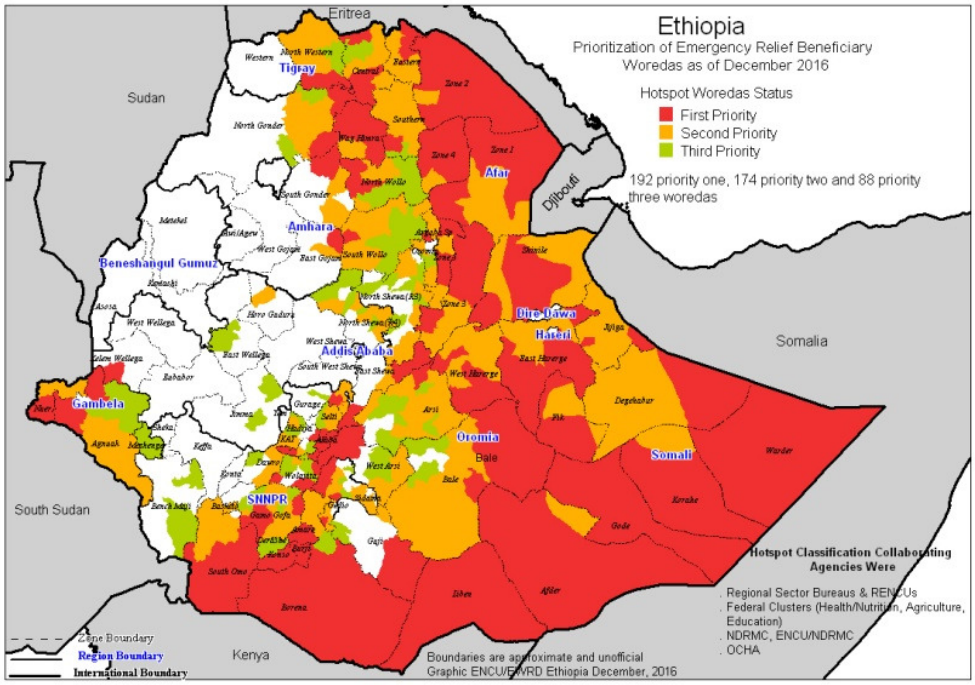
Finally, the ENCU supported bi-annual Emergency Preparedness plans of the NDRMC as well as region-specific plans.

Ethiopia is facing another round of drought in 2017 due to the negative Indian Ocean Dipole climate effect. The food and nutrition security is already deteriorating in Afar, Somali, and eastern and southern parts of Oromia and SNNPR, manifesting in rising number of SAM admissions in these areas. Based on the latest classification in December 2016, the number of hotspot priority 1 and 2 *woredas* remained high at 192 and 174 respectively (Figure 4).

Continued support for the coordination of the emergency response is essential in order to ensure a rapid, effective and efficient response to crises.

[16] OCHA pooled funds for emergency

Figure 4. Hotspot Priority Classification Map, December 2016



Financial Analysis

In 2016, a total of **US$ 67,750,113** was planned for the implementation of the Nutrition programme from all funding sources (RR, ORR and ORE) – Please see Table 1 below.

Table 1: Planned and Funded for the Country Programme 2016 (in US Dollar)
Outcome Area 4: Nutrition Ethiopia

Intermediate Results	Funding Type[17]	Planned Budget
002/001 Policy & Multi-sectoral Engagement	RR	475,213
	ORR	8,229,613
002/002 Nutrition knowledge and caring behaviours	RR	1,220,547
	ORR	13,128,982
002/003 Systems Strengthening	RR	129,851
	ORR	342,667
	ORE[18]	31,481,481
002/004 Nutrition in Emergencies	RR	919,783
	ORR	11,821,975
		67,750,113

[17] Planned and Funded budget for ORR and ORE excludes recovery cost. RR plan is based on total RR approved for the Country Programme duration
[18] As per the 2016 revised HAC figure (minus recovery cost)

By the end of 2016, a total of US$ 36,779,063 was spent by the Nutrition programme – please see Table 2 below. In response to Ethiopia's worst drought in 50 years, UNICEF Ethiopia continues to play a leading role in supporting the government's nutrition emergency response, handling a huge demand for procurement and distribution of emergency nutrition supplies, capacity building and monitoring.

Table 2: 2016 Expenditures by Key-Results Areas (in US Dollars)
Outcome Area 4: Nutrition Ethiopia

Organizational Targets	Expenditure Amount			
	ORE	ORR	RR	All Programme Accounts
002/001 Policy & Multi-sectoral Engagement	407,850	4,839,512	588,091	5,835,452
002/002 Nutrition knowledge and caring behaviours	630,936	3,626,000	269,429	4,526,365
002/003 Systems Strengthening	21,271,763	4,014,335	872,686	26,158,784
002/004 Nutrition in Emergencies	14,014	108,373	136,075	258,462
Total	**22,324,563**	**12,588,220**	**1,866,281**	**36,779,063**

Table 3 below summarizes expenditure of thematic funding by intervention areas.

Table 3: Thematic expenses by programme area

Row Labels	Expense
Other Resources - Emergency	**136,652**
04-01 Infant and Young child feeding	128,868
04-04 Community-based management of acute malnutrition	4,976
04-06 Nutrition - General	2,808
Other Resources - Regular	**17,685**
04-01 Infant and Young child feeding	-2,697
04-04 Community-based management of acute malnutrition	948
04-06 Nutrition - General	19,433
Grand Total	**154,337**

Table 4 below summarizes basic information about major interventions that were undertaken based on specific intervention codes in 2016. Out of the total of US$ 49.7 million, the largest proportion of the funds was utilized in support to CMAM (US$ 26 million) plus emergency response under the nutrition general IR (US$ 13 million) which accounted for 79 per cent of the total expenditures.

Table 4: Expenses by Specific Intervention Codes

Row Labels	Expense
04-01-01 Infant and young child feeding implementation (including BFHI)	4,488,244
04-01-03 Complementary feeding and food supplements	520,821
04-01-04 Growth monitoring and promotion	1,551
04-02-01 Vitamin A supplementation	4,063,442
04-02-02 Elimination of iodine deficiency	153,639

04-04-01 Treatment of Severe Acute Malnutrition	24,173,348
04-05-01 Nutrition # cluster coordination in humanitarian response	218,688
04-05-02 Nutrition # emergency preparedness and response	9,838
04-06-01 Nutrition # General	8,969,114
04-06-02 Maternal nutrition (excluding micronutrient supplementation)	1,520,646
04-06-04 Nutrition surveys, assessments and surveillance	695,521
04-06-05 Routine nutrition information systems and reporting	399,034
04-06-06 Nutrition technical assistance to regional and country offices	268,520
04-06-07 Nutrition support to achieving global and regional goals	2,400
08-01-01 Country programme process	721
08-01-06 Planning # General	14,477
08-02-02 Situation Analysis or Update focused on adolescents	72
08-03-01 Cross-sectoral Communication for Development	28,275
08-03-02 Communication for Development at sub-national level	1,561
08-03-03 C4D # training and curriculum development	862
08-05-01 Supply # General	40,784
08-09-06 Other # non-classifiable cross-sectoral activities	2,940,242
08-09-07 Public Advocacy	41,713
08-09-11 Emergency preparedness and response (General)	678,025
1011 Complementary feeding	329,674
1032 IDD Elimination	-
1044 Vitamin A supplementation	4,237
1067 Manage and treat Severe Acute Malnutrition	1,142
5903 Support to C4D interventions for multiple OTs within FA5	10
6901 Staff costs (includes specialists, managers, TAs and consultancies) for multiple Focus Areas of the MTSP	-904
7921 Operations # financial and administration	218,495
Unknown	1,879
Grand Total	**49,786,070**

Table 5 below presents the summary of planned budget vis-à-vis the available budget for the four Nutrition outputs in 2017.

Table 5: Planned budget for 2017
Outcome Area 4: Nutrition
Ethiopia
Planned Budget and Available Resources for 2017

Intermediate Result	Funding Type	Planned Budget [1]	Funded Budget [1]	Shortfall [2]
Policy & Multi-sectoral Engagement	RR	227,460	227,460	0
	ORR	2,947,677	2,309,680	637,997
	RR	1,815,579	1,815,579	0

Nutrition Knowledge and Caring Behaviour	ORR	10,316,869	4,130,561	6,186,308
Systems Strengthening	RR	211,114	211,114	0
	ORR	736,919	800,000	-63,081
	ORE	38,878,505	14,621,844	24,256,661
Nutrition and Emergencies	RR	876,237	876,237	0
	ORR	736,919	500,000	236,919
Sub-total Regular Resources		**3,130,390**	**3,130,390**	**0**
Sub-total Other Resources - Regular		**14,738,384**	**7,740,241**	**6,998,143**
Sub-total Other Resources - Emergency		**38,878,505**	**14,621,844**	**24,256,661**
Total for 2017		**56,747,279**	**25,492,475**	**31,254,804**

[1] Planned and Funded budget for ORR *(and ORE, if applicable)* excludes recovery cost. RR plan is based on total RR approved for the Country Programme duration
[2] Other Resources shortfall represents ORR funding required for the achievements of results in 2017.

Future Work Plan

A major lesson learnt from the NNP I was the poor penetration of this important document at sub-national levels. As such, with the Federal level launch of the new NNP II, extra efforts will be made to disseminate this document to every level with UNICEF support. In addition, as seen with the Federal launch of NNP II, sub-national launches will provide the RNCB/RNTC and the ZNCB/ZNTC with a key focal document around which other sectors can rally around. UNISE will be piloted in all regions in order to effectively monitor the NNP II with the expectation of starting full roll-out by the end of 2017.

The last round of integrated refresher training for HEW was conducted in 2015, therefore the next round of training is scheduled for 2017. UNICEF will support this important initiative and will continue the roll-out of BINLM for health workers to ensure that the lower level health facility staff are fully trained in both preventative and curative nutrition.

The newly developed AMIYCN guidelines clearly describe the supply side of nutrition services to be provided by the health system, however there is now a need to develop a comprehensive social behaviour change communication (SBCC) AMIYCN national strategy to address the demand side of the equation. UNICEF will mobilise both its nutrition expertise as well as its C4D expertise to support this initiative. UNICEF will also make use of its convening powers to bring together different stakeholders to specifically discuss complementary feeding, which will then feed into the National SBCC AMIYCN strategy. In addition to supporting the development of the National Strategy, UNICEF is in a unique position to support the roll-out of the strategy in 4-5 key regions, thus linking strategy development to field implementation as well as feedback from the field for future amendments of the strategy.

The AMIYCN also provides much needed guidance on key adolescent, maternal and child nutrition interventions and therefore the basis to ensure and monitor quality of nutrition services. UNICEF will continue to support the CBN as an important platform for the delivery of nutrition-specific interventions such as GMP, VAS, deworming, iron folic acid supplementation of pregnant and breastfeeding women and IYCF counselling. UNICEF will continue to support the transition for Vitamin A and deworming with the aim of ensuring a smooth transition from one modality to the next with minimal reduction in coverage. UNICEF will also look at innovative ways to improve iron folic acid uptake among pregnant women.

The CBN programme creates field level linkages to nutrition-sensitive interventions such as PSNP, agriculture and education. UNICEF will continue to support these linkages with the expansion of nutrition-sensitive PSNP in 14 more *woredas* while continuing to closely follow the 2 pilot *woredas* to document lessons. In addition, UNICEF will support the roll-out of the life-skill approach in primary and secondary school as well as deworming in all vulnerable *woredas* in the country. UNICEF will also support the review of the National adolescent and youth health training material pilot and contribute to the roll-out of the training to health workers.

Ethiopia is slowly coming out of a major drought affecting half of the country, but unfortunately is now entering another drought affecting mainly Afar, Somali and southern SNNPR and Oromia. In addition, with the situation in South Sudan deteriorating, a continued influx of South Sudanese refugees is to be expected. UNICEF will continue to support these emergencies by ensuring community level access to SAM screening and treatment as well as effective coordination via the ENCU. Quality of CMAM services will be improved by increasing the use of coverage surveys to better identify bottlenecks for effective service uptake.

Finally, the Government agency FMHACA will continue to be supported for the regulation of iodized salt as well as the marketing of breast milk substitutes. UNICEF will reinforce the regulatory capacity of the agency and will continue to be actively involved in the food fortification debate in Ethiopia.

Expression of Thanks

In 2016, much of the thematic funds were not used as the country faced an unprecedented emergency and life-saving activities were prioritized over development assistance, leading to the use of emergency funding to meet the emergency needs. Nevertheless, the generous contribution and flexible nature of the funds from the Japanese Committee for UNICEF enabled UNICEF Ethiopia to respond to urgent travel requests ensuring presence in the field quickly to respond to needs of vulnerable women and children.

Thematic funds were also utilized to fund consultants and technical assistants to support the nutrition section during the emergency. Furthermore, the thematic funds will be particularly important in 2017 as the country slowly transitions to recovery. The flexible funding allows for more responsive interventions as the effects of the severe drought on the coping mechanism of the women and children become clearer.

Annexes: Human Interest Stories and Donor Feedback Form

UNICEF Creates Alternative Approaches to Promote Optimal Infant and Young Child Feeding Practices in Pastoralist Communities

By Nardos Birru and Amal Tucker Brown

Mothers centered around the coffee-roasting pot at the mother-to-mother support group in Hinele kebele, Asayta woreda, Afar region ©UNICEF/2017/Pudlowski

ASAYTA, AFAR, 30 January 2017 – The wind blows sand around the outdoor coffee ceremony in the arid town of Asayta. A group of mothers, most with young infants, sit under a tree, making traditional coffee and popcorn to start off the biweekly mother-to-mother support group discussion. It is held at different locations each time, usually at one of their houses or like today, at the health post, in order to accommodate mothers living in different areas who need to stay close to home.

Seada, a mother of two, is here with her 2-year-old daughter, Zahara, and is especially alert today. Seada prepares herself mentally to present her experience. She joined the group over two years ago and having learned a lot in that time, she is ready to share with the new mothers to help them better understand optimal feeding for their infants.

A community approach: infant and young child feeding (IYCF) in the Afar context

According to the 2016 Ethiopia Demographic and Health Survey, the Afar region has the third highest level of stunting, a chronic form of malnutrition, at 41 per cent, and the highest level of wasting, an acute form of malnutrition, affecting 36 per cent of children under five.

Stunting and wasting among children is exacerbated by the arid and semi-arid climate of the region, which has low and erratic rainfall and, thus, is frequently affected by drought. In addition, only 40 per cent of the population in Afar has access to basic services.

Temporary homes of pastoralist communities in Asayta woreda, Afar region ©UNICEF/2017/Pudlowski

Static health facilities are not easily accessible to many Afaris, as the majority are pastoralists, moving with their herds for green pastures and water. Due to their nomadic lifestyle, an enabling environment must be created to promote optimal IYCF practices in these vulnerable communities in a way that is convenient for them.

As a result, UNICEF, in collaboration with the Regional Health Bureau has initiated community-IYCF in the region. Following a series of trainings for health extension workers (HEW) working in static health posts, a total of 413 mother-to-mother support groups have been established and mentored in 77 villages across all 32 districts in Afar.

The mother-to-mother support group discussion

Aysha, member of the mother-to-mother support group took the intitiatve to mentor the mothers on early initiation of breastfeeding in Hinele kebele, Asayta woreda, Afar region ©UNICEF/2017/Pudlowski

Now that all the mothers have arrived, the discussion begins. Led by Helen, a HEW from the nearest health post, she welcomes the newly-joining mothers and gives a brief orientation on how the group operates. She invites Seada to share her experiences and to describe how she has benefited from being a member of this group. "I learned about the importance of exclusive breastfeeding for the first six months, the timely introduction of complementary food and how to diversify porridge using locally available food items," says Seada. She points to mothers in front of her, "After being members of this group we were able to provide more nutritious diets for our babies. We breastfeed our babies eight times a day and when the babies reach six months, we introduce a porridge made of mixed flour, vegetables and milk. We add salt when the porridge is ready to be eaten."

She goes on, "Before the establishment of this group, we used to avoid giving the first yellow milk to our newborns because we didn't know how important it is. We also used to provide cow milk before the child reaches six months." The first yellow milk, colostrum, is particularly important to give immediately after birth as it protects both the new born and mother from infection and even death. Interestingly, while colostrum provides a natural immunity against many bacteria and viruses for newborns, early initiation of breastfeeding also benefits the mother by easing expulsion of the placenta and closing off blood vessels in the uterus, preventing excessive blood loss during labour and the aftermath.

Strengthened nutrition services

Seada has been benefiting from health and nutrition services at the nearby health post that is supported by UNICEF. She ensured that both of her daughters were vaccinated by 9 months old and regularly brings her youngest daughter for growth monitoring and promotion services.

"My second child, Zahara, was malnourished and received treatment at the health post. She became malnourished because I was sick and unable to breastfeed her. Thanks to the nutrition services at the health post, my daughter is healthy now. I feed her the diversified porridge and she eats it well. Last time I took her to the health post, her weight was found to be normal," explains Seada.

The discussion continues with the mothers enjoying the coffee and interacting with each other, asking questions and sharing their experiences.

"I am very happy with the nutrition services being provided. I really wish those mothers who live in the farthest locations could have access to these services, so that their children grow properly and they become healthy and clever students in the future," Seada concludes her contribution. Her presentation is complete and welcomed by the women

Seada holding her two year old daughter Zahra, Hinele kebele, Asayata woreda, Afar region
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Donor Report Feedback Form

UNICEF is working to improve the quality of our reports and would highly appreciate your feedback. Kindly answer the questions below for the above-mentioned report. Thank you!

Please return the completed form back to UNICEF by email to:

swzncdonorreports@unicef.org
pfothematic@unicef.org

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SCORING: 5 indicates "highest level of satisfaction" while 0 indicates "complete dissatisfaction"

1. To what extent did the narrative content of the report conform to your reporting expectations? (For example, the overall analysis and identification of challenges and solutions)

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what we missed or what we could do better next time?

2. To what extent did the fund utilization part of the report meet your reporting expectations?

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what we missed or what we could do better next time?

3. To what extent does the report meet your expectations in regard to the analysis provided, including identification of difficulties and shortcomings as well as remedies to these?

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what we could do better next time?

4. To what extent does the report meet your expectations with regard to reporting on results?

5	4	3	2	1	0

If you have not been fully satisfied, could you please tell us what we missed or what we could do better next time?

5. Please provide us with your suggestions on how this report could be improved to meet your expectations.

6. Are there any other comments that you would like to share with us?

Thank you for filling this form!