Making Nutrition Policy Central to Development
Understanding the Political and Institutional Conditions for Policy Change

Case Study of the Political Economy of Nutrition Policies in Ethiopia

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Acknowledgements

This study on the political economy of nutrition policies in Tanzania was conducted on behalf of the World Bank. It was completed as a shadow case study for the comparative study of nutrition policies in six countries in Africa: Benin, Burkina Faso, Gambia, Ghana, Madagascar, and Senegal. The World Bank is conducting this comparative study to understand the factors and strategies pursued in Tanzania for nutrition policy-making and implementation, as well as long-term sustainability of nutrition policy as a result of governmental commitment.

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### Acronyms and Abbreviations

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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADLI</td>
<td>Agricultural Development-Led Industrialization</td>
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<td>CF</td>
<td>Conceptual Framework</td>
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<td>CM</td>
<td>Council of Ministers</td>
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<td>CSD</td>
<td>Child Survival and Development</td>
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<td>CTC</td>
<td>Community-based Therapeutic Care</td>
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<td>DAG</td>
<td>Donor Assistance Group</td>
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<tr>
<td>DFID</td>
<td>Department for International Development (UK)</td>
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<tr>
<td>DPPA</td>
<td>Disaster Prevention and Preparedness Agency</td>
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<tr>
<td>EDHS</td>
<td>Ethiopian Demographic and Health Survey</td>
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<td>EHNRI</td>
<td>Ethiopia Health and Nutrition Research Institute</td>
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<td>ENA</td>
<td>Essential Nutrition Actions</td>
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<td>ENI</td>
<td>Ethiopia Nutrition Institute</td>
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<td>EPI</td>
<td>Expanded Program of Immunization</td>
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<td>EOS</td>
<td>Enhanced Outreach Strategy</td>
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<td>EWS</td>
<td>Emergency Warning System</td>
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<td>FAO</td>
<td>Food and Agriculture Organization (UN)</td>
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<td>FMOH</td>
<td>Federal Ministry of Health</td>
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<td>FSCB</td>
<td>Food Security Coordination Bureau</td>
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<td>FSP</td>
<td>Food Security Project</td>
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<td>GoE</td>
<td>Government of Ethiopia</td>
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<td>HEP</td>
<td>Health Extension Plan</td>
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<td>HEW</td>
<td>Health Expansion Worker</td>
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<td>HSDP</td>
<td>Health Sector Development Plan</td>
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<td>ICN</td>
<td>International Conference on Nutrition</td>
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<tr>
<td>IDA</td>
<td>Iron Deficiency Anemia</td>
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<td>IDD</td>
<td>Iodine Deficiency Disorder</td>
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<td>IFPRI</td>
<td>International Food Policy Research Institute</td>
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<td>IOC</td>
<td>Iodized Oil Capsules</td>
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<td>IYCF</td>
<td>Infant and Young Child Feeding Program</td>
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<td>JNSP</td>
<td>Joint Nutrition Support Program</td>
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<tr>
<td>LGA</td>
<td>Local Government Authorities</td>
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<tr>
<td>MDA</td>
<td>Ministries, Departments, and Executive Agencies</td>
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<tr>
<td>MOARD</td>
<td>Ministry of Agriculture and Rural Development</td>
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<td>MOE</td>
<td>Ministry of Education</td>
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<tr>
<td>MOFED</td>
<td>Ministry of Finance and Economic Development</td>
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<tr>
<td>MPPEE</td>
<td>Ministry of Planning, Economy and Environment</td>
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<tr>
<td>NCSS</td>
<td>National Child Survival Strategy</td>
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<td>NFW</td>
<td>Nutrition Field Worker</td>
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<td>NHP</td>
<td>National Health Policy</td>
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<td>NID</td>
<td>National Immunization Days</td>
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<td>NNP</td>
<td>National Nutrition Program</td>
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NNS  National Nutrition Strategy
OTP  Outpatient Treatment Program
PASDEP  Plan for Accelerated and Sustained Development to End Poverty
PEM  Protein Energy Malnutrition
PM  Prime Minister
Profiles  USAID-funded analysis on the human and economic development consequences of malnutrition
RRC  Relief and Rehabilitation Commission
SDPRP  Sustainable Development and Poverty Reduction Program
SIDA  Swedish International Development Cooperation Agency
SFP  Supplementary Feeding Program
SNP  Sidamo Nutrition Project
Triple-A  Assessment-Analysis-Action
UNICEF  United Nations Children’s Fund
USAID  U.S. Agency for International Development
VAD  Vitamin A Deficiency
WC  Woreda Council
WHO  World Health Organization
EXECUTIVE SUMMARY

Context of the study
This case study of the political economy of Ethiopian nutrition policies was completed as a shadow case study for the comparative study of nutrition policies in six African countries: Benin, Burkina Faso, Gambia, Ghana, Madagascar, and Senegal. The World Bank is conducting this Ethiopian study to understand the factors and strategies necessary for the formation of nutrition policies and increased commitment of government. The objectives of this case study are to:

i. Characterize and evaluate the trajectory of nutrition policies in Ethiopia; turning points that positively or negatively affected policy formulation and implementation; and government commitment of funding, policy approval, and resources for implementation; and

ii. Analyze the political, fiscal, and administrative factors and strategies as they led to policy formation and implementation.

The case study identifies strategies of key actors, institutions (formal and informal), and agencies; and evaluates the political environment during each stage of policy formation: agenda setting, design, adoption, implementation, and sustainability. The ultimate product will include recommendations and lessons learned that are derived from a clear trajectory of nutrition policy development in Ethiopia.

Study methodology
The World Bank developed a common conceptual framework and set of guiding questions for this study. The Ethiopia case study therefore utilized the methodology envisaged for this study. Information was gathered through literature reviews and interviews with key informants. All interviews were conducted by e-mail and phone for this case study.

Trajectory of Nutrition Policies in Ethiopia
Nutrition policies and activities have been implemented in Ethiopia since 1962. The trajectory of nutrition policy falls into five periods based on the primary focus of that era. However, though these periods appear distinct, many nutrition activities overlap other periods and continue to be promoted. The policy periods are:

a. Malnutrition as Food Insecurity (1962 – 1978): from the beginning of nutrition agenda setting, catastrophic droughts and famines have been constant drivers for action. This period focused on food production and distribution in response to mass starvation, conducted national surveys on food and malnutrition to monitor food supply systems, created the Early Warning System (EWS) and Relief and Rehabilitation Commission (RRC) to address disaster relief, published the first Ethiopian Guide to Emergency Feeding in 1974, and initiated the Nutrition Field Worker program to train high school graduates with technical knowledge on weighing and other measurement skills to assess malnutrition indicators.
b. Famine of 1984 (1977-1986): This period marked one of the worst national famines between 1984 and 1985 that claimed approximately one million lives and affected eight million others. Though drought was the underlying natural cause, the situation reflected the effects of a political conflict. This period reinforced the belief that food security was the main cause of disease and death, and thus represents a negative turning point for nutrition policy. Donors and the global community were generous in the face of famine and procured large quantities of funding and food aid. However, persistent drought and increasing instability were compounded with locust plagues in 1986 that made it difficult for donors to keep up with the rising demand. Government response was poor; thousands of peasants were forced to resettle around areas without basic livelihood provisions, such as water, schools, and health facilities. The RRC continued revising the EWS and conducted value assessments for food and nutrition surveys as a component of EWS.

c. Community-based Nutrition: Sidamo Nutrition Project (1984-1992): During this period, the first comprehensive community-based nutrition project was initiated by the WHO and UNICEF. However, the baseline year was also the beginning of the 1984 famine and therefore, it is uncertain whether the modest progress is attributable to the program. Unfortunately, Sidamo was not followed-up, so even the successful nutrition education and Growth Monitoring and Promotion components immediately ceased when the project ended in 1992. The primary barrier to the program was the lack of incentives for community nutrition workers to maintain these services. The project did not change attitudes toward malnutrition.

d. Micronutrient Supplementation and Consolidation of Health Policy (1987-present): This period marked the emergence of two policy discourses. The first discourse was the continuing assumption that nutrition was a food security issue. Actions to tackle this belief were undertaken by the Disaster Prevention and Preparedness Agency (DPPA), formerly the RRC. The second discourse that emerged was the realization that famine did induce debilitating micronutrient deficiencies; nutrition was also a food quality issue. The famine, coupled with an international pledge to control micronutrient deficiencies, led to the adoption of the National Health Policy and the National Guideline for Control and Prevention of Micronutrient Deficiencies, and promotion of Essential Nutrition Actions (ENA). This period has been a positive turning point for the prioritization of nutrition policy.

e. National Poverty and Nutrition Strategies Development (1997-present): This period was catalyzed by international pressure and Ethiopia’s recognition of its own underdeveloped health system. Following the ratification of the National Health Policy (NHP), the 2000s marked a period of national commitment to poverty reduction and health sector development. National commitment was deployed through the adoption of international and national policies, implementation strategies, and support programs. This period marks a positive turning point in the discourse and trajectory of nutrition policies as Ethiopia continues to form and strengthen strategies on immunization, micronutrient supplementation, child survival and development (CSD), health management, community-based nutrition activities, and monitoring and evaluation.
The Policy Making Process for Nutrition Policies: Characterizing the Scene, Actors and Strategies

The main actors in the nutrition policy-making process have changed throughout Ethiopia’s trajectory, and they reflect emphasis on discourse distinct to a policy period. The food and nutrition policy throughout the 1980s was contextually developed from the chronic nature of disaster that devastated food security and led to mass mortalities; the revelation and slow acceptance that famine-caused deaths are linked not to starvation but nutrient deficiencies and disease placed greater emphasis on health sector development and the delivery of health services. The relevant actors during each policy period have held significant roles in the agenda setting, design, adoption, implementation, and sustainability phases. They include government agencies, nutrition coordinating bodies, donors, and development partners. Their interests derive from the motivation to achieve Ethiopia’s development agenda as specified in international and national strategies. However, the reality remains that food insecurity is continually prioritized over nutrition insecurity.

Until the 2000s, nutrition actions and strategies were often reactive to disasters and international pressures but rarely initiated by the government. The current policy period reflects a strengthened government commitment to livelihood improvement, and nutrition policies are largely pursued at the national level in collaboration with development partners. The programs focus on community-based training and education that seeks to achieve a balance between nutrition and food needs, such as Community-based Therapeutic Care (CTC) and Enhanced Outreach Strategy (EOS).

Unfortunately, national strategies are not always coordinated with national efforts. Translating initiatives into district-level action varies and can be interrupted by lack of funding and skilled workers, low prioritization of the program, or emphasis on immediate food aid. This is evident from the wide micronutrient supplementation gaps between different regions. Donors often assist in this stage, thereby catalyzing the nutrition policy processes. Donors initiate projects, provide capital for construction, finance short-term pilot programs, and train health workers. However, famine and drought continually detract funding from nutrition programs to food aid.

Explaining Change: Factors Associated with Policy Change
Both top-down and bottom-up approaches were necessary for nutrition policy formulation and sustainability. Top-down factors include Government’s desire to achieve health and development goals set in PASDEP; the desire to achieve MDGs four (reduce child mortality), five (improve maternal health), and six (combat HIV/AIDS, malaria, and other diseases); and proactive donor support. National and donor commitment to child survival and development, community-based nutrition education, micronutrient supplementation, and therapeutic care have also contributed to adding nutrition on the agenda through a bottom-up approach. Challenges remain that hinder nutrition from becoming a top priority in Ethiopia: lack of collaboration at the government level, historical emphasis on food aid, and insufficient funding and resources for the implementation of nutrition policies on the ground. However, emerging nutrition
strategies and leadership (through the nutrition coordinating body) promise to reorganize and energize nutrition action.

Sequence (and Inter-Relation): Unpacking Key Factors
Ethiopia’s nutrition policy developed alongside natural crises that had a lasting impression on how “nutrition” was defined in daily life and politics and what interventions were pursued. A new discourse emerged as research developed, internal champions emerged, and external forces incentivized action, catalyzing the formulation of new policy and goals. The interplay between internal and external factors has been critical in agenda setting, design, adoption, implementation, and sustainability stages as each factor catalyzes and reinforces the policy process. These factors present in Ethiopia’s trajectory have coordinated well together at the right moment for agenda setting and broad policy-making, but the sequence must be cyclical to encourage attention to details and policy design.

Lessons Learned

The key lessons derived from this study are:

1. Malnutrition is nutrition insecurity, not food insecurity.
2. The Early Warning System must be revised to capture anthropometric nutrition indicators rather than solely relying upon agrarian indicators.
3. Government commitment to international conventions has been a major factor for national nutrition policy formation.
4. Multi-sectoral coordination and leadership for nutrition must be strengthened.
5. Regional councils are the key to successful nutrition policy implementation at district levels.
6. Donors play an integral role in nutrition policy development and implementation, but Ethiopia must take greater responsibility.
7. It is necessary to support and fund health research conducted for policy-makers.
8. Increased congruency must be afforded between lessons learned on nutrition approaches and nutrition action.
9. Training of workers needs to be improved and infrastructure developed.
10. Nutrition targeting must expand to rural areas and not restricted to drought-prone areas.
I. INTRODUCTION

Malnutrition is the most serious global health problem. It is intrinsically linked to poverty and perpetuated by poor health and lack of economic growth opportunities. Early childhood malnutrition has the potential to cause severe cognitive and physical growth impediments, increase susceptibility to infections, and reduce efficacy of vaccines. Recognizing this impact, the Millennium Development Goals (MDG) has set malnutrition reduction as its first priority. Despite this, international organizations and governments have often overlooked nutrition as a key development issue, even though persistent malnutrition has hindered progress on other MDGs, such as reducing maternal and child mortality and halving the incidence of HIV/AIDS.

The World Bank has supported the implementation of nutrition programs since 1976 when it approved its first nutrition-based loan in Brazil and recent developments have brought nutrition back to the forefront of the Bank’s top concerns. Yet though successful and sustainable operations have directly improved human health and alleviated poverty, there are political and institutional obstacles among development partners and at country level that impede advances in nutrition policy. To effectively advocate nutrition’s centrality in development, the Africa Region of the World Bank strives to understand the political discourse of nutrition policy.

The Bank subsequently tasked six consultancies to compile comparative studies of successful nutrition policies with longstanding government commitment in Benin, Burkina Faso, Ghana, Gambia, Madagascar, and Senegal. The comparative study investigated the political context as it related to the development of nutrition policies; the political and fiscal trajectory of implementation; the level of government commitment to nutrition; the frameworks used to design, implement, evaluate, and sustain nutrition programs; and the role of key actors and institutions, as well as tactics developed to counter political opponents. Together, these factors and strategies are expected to deepen the Bank’s understanding of the political economy surrounding successful nutrition policy, and strengthen the Bank’s ability to mobilize political factors towards a longstanding commitment to nutrition.

This case study on Ethiopia will contribute to these comparative studies by similarly analyzing the political economy of nutrition policies by (1) characterizing and evaluating the trajectory of nutrition through political, fiscal, and administrative frameworks; and (2) analyzing factors and strategies as they led to policy formation and implementation. This case study will identify both the strategies of key actors, institutions (formal and informal), and agencies; as well as the political environment during each stage of policy formation: agenda setting, design, adoption, implementation, and sustainability.

This case study is organized in the following way: Section Two describes the research methodology, Section Three presents the findings of the study, and Section Four concludes with lessons learned and recommendations.
II. STUDY METHODOLOGY

A common set of guiding questions/issues was created by the Lead Consultant, Marcela Natalicchio, and adopted for this case study (Annex 1). The methodology was directed by the Lead Consultant and utilized interviews and literature reviews. Interviews were primarily conducted by e-mail to determine the political, fiscal, and administrative factors that influenced the prioritization of nutrition on the development agenda.

The study utilized key informants representative of the World Bank, Friedman School of Nutrition Science and Policy, Saving Lives and Livelihoods, UNICEF, and USAID. They provided relevant information regarding the trajectory of nutrition development and factors that influenced the policy-making process.

The study was initiated on 18 March 2009 and completed on 25 May 2009.
III. FINDINGS OF THE STUDY

3.1 The Political Context in which Nutrition Policies Operate

Ethiopia is the oldest independent African country. Its current political system, the Federal Democratic Republic of Ethiopia (Ethiopia), was established in August 1995 as a federal parliamentary republic. The President is elected for a maximum of two six-year terms by a two-thirds majority vote of the bicameral Federal Parliamentary Assembly (House of People’s Representatives and the House of Federation). Though the President remains head of state, the highest executive authority is the Prime Minister (PM). The PM acts as the chief executive, chairman of the Council of Ministers (CM), and commander-in-chief. The PM is elected by the House of People’s Representatives without term limits, and he or she appoints the council ministers. The majority party within the House of People’s Representatives determines the power of government. The most recent general elections were held in May 2005.

Ethiopia is divided into nine ethnically-based regional states and two chartered cities, which, together, are subdivided into 68 zones. Zones are mentioned in the constitution but merely serve as an “administrative convenience.” Within this division exist 550 districts and six special districts. While the Executive, Judicial, and Legislative branches exercise federal authority, legislative and executive power is also granted to the regional states, which are authorized to establish their own governments according to limits of the federal constitution and maintain control over internal affairs. Each state houses one regional council, whose president and members are directly elected to represent the districts, and state houses implement their state mandates through an executive committee and regional sectoral bureaus. This executive and legislative structure is also exercised in the district levels.

Unfortunately, Ethiopia has been victim to long periods of political upheavals and instability. Emperors governed Ethiopia during the 19th century until a military coup in 1974 with a brief interruption between 1936 and 1941 when Fascist Italian forces invaded the country. The coup led to the formation of the military government Derg, which embarked on a violent campaign against all opponents in 1977 and 1978 that tortured and killed thousands of Ethiopians. However, the prolonged period of drought, famine, and political oppression catalyzed the rising of the Ethiopian Peoples’ Revolutionary Democratic Front, which successfully overthrew the Derg in 1991 and established a transitional government until the adoption of the current constitution.

While the country is peaceful and opposition leaders have been released from jail, the rifts exposed and deepened during the Derg’s authority are largely unhealed. Further, Ethiopia continues to experience border tensions with Eritrea despite a peace treaty signed to end their two-year war in 2000. Additionally, civil violence erupted following protests of the 2005 elections, resulting in over 60,000 arrests and at least 42 civilian and police deaths.

Policy-Making Process
The national policy-making process is overseen by Prime Minister’s Office and directed by the CM. The CM is responsible for developing framework policies and strategies; guiding implementation of the policies and strategies; coordinating with Ministries, Departments, and Executive Agencies (MDA); appropriating budgets to MDAs; and monitoring and evaluating MDAs. MDAs outline policies, develop implementation strategies, and formulate annual budgets that reflect executive and legislative frameworks and MDA-defined objectives.

Since the decentralization of policy-making in the mid-1990s, national policies of all sectors have committed to strengthening regional, zonal, and district authorities while stressing the autonomy of local government activities. While the regions are tasked with formulating regional policy (directed from federal policy), Woreda Councils (WC) are tasked with implementing policies according to the capacities and needs of the region. WCs are comprised of elected representatives and sectoral heads. It is at this level that development and budget planning are discussed and approved, policies are implemented and evaluated, and basic services from NGOs and private individuals are coordinated and delivered in local areas. Funding to cover the cost of these services are acquired through income and land use taxes raised by WCs and grants from the regional governments (approximately 80% to 90% of the budget), which are primarily funded by the federal government. The WCs develop and approve programs on education, health, and water and sanitation. Nutrition is not explicitly identified within a particular WC sector; however, it is implied that it is housed in the health office. This office is responsible for coordinating primary preventive and curative health care, constructing and administering health stations and health posts, administering clinics, and preventing and controlling HIV/AIDS and malaria.

Nutrition policy is directed by the Ministry of Finance and Economic Development (MOFED) and Federal Ministry of Health (FMOH), which houses the Ethiopian Health and Nutrition Research Institute (EHNRI). EHNRI was the result of a 1995 merger between the National Research Institute of Health, the Ethiopian Nutrition Institute, and the Department of Traditional Medicine within the FMOH. It acts as the coordinating body for nutrition policy and is the primary institute of research on national health and nutrition issues, intervention strategies, and traditional and modern medicine. The MOFED oversees the Plan for Accelerated and Sustained Development to End Poverty (PASDEP, 2005-2010), the current development strategy for the growth and reduction of income poverty, improvement of social well-being, and government accountability. The PASDEP Volume I issued specific responsibilities at woreda level that include the entitlement to untie block grants from regional governments; mobilization, allocation, and monitoring of financial resources; coordination of capacity building and information and communication technology development programs; coordination of program implementation at regional and local levels; and planning and implementation of development programs within their jurisdictions among other duties.

In conjunction with PASDEP, the National Health Policy (NHP) and National Nutrition Strategy (NNS) direct the nutrition agenda in Ethiopia. NHP was prepared by the
Transitional Government and adopted in 1993. NHP is responsible for formulating and implementing food and nutrition policies, promoting health education for target populations, and communicating the importance of maternal nutrition. The NNS (2008-2013) was formulated in 2005-2006 per request of the PASDEP and only recently approved in February 2008. Developed by the Food Security Coordination Bureau (FSCB) within the Ministry of Agriculture and Rural Development (MOARD), it is the first national nutrition strategy launched in Ethiopia. NNS promotes Essential Nutrition Actions (ENA), such as breastfeeding, growth monitoring and promotion, improving maternal and child care practices, and educating on nutrition in emergencies. It further addresses food security, water and sanitation, micronutrient deficiency, and the impact of malnutrition on communicable and non-communicable diseases. NNS was adopted in conjunction with the National Nutrition Program (NNP), which serves as NNS’s implementation framework. FMOH is leading this process; however, because nutrition is a multi-sectoral issue, other relevant actors are also involved. With support from the World Bank, FMOH established an official National Nutrition Coordinating Body ahead of its July 7, 2009 deadline.

Political Discourse and Budget Allocations

Health policy was not enunciated until the 1950s when the need for a framework of basic health services was identified. With guidance from World Health Organization (WHO) initiatives, the Health Services Policy emphasized prevention alongside curative services that were previously not promoted. Though the nutrition research institute derived modest beginnings from this era (the Ethiopian Nutrition Institute was opened in 1950), nutrition action was not articulated in the policy. Nor was health policy adopted – the end of the Imperial regime precluded its adoption. During the mid-1970s, the Derg developed a more comprehensive policy punctuated by disease prevention and control and a focus on rural community involvement with health service promotion. However, the Derg’s political landscape was not conducive to the commitment or encouragement needed for health policy formation; resources were primarily reserved for war rather than development.

Efforts to develop a national nutrition policy began in the mid-1980s but were not adopted. Often, the design lacked a clear strategy, and the policy-making process did not have institutional leadership to coordinate a comprehensive strategy against malnutrition. In its wake resulted distinct but unrelated programs that lacked a unified objective; it became difficult to coordinate donor and development partner efforts. It was not until 1993 that the transitional government established the National Health Policy (NHP). The NHP was responsible for nutrition policy formulation and implementation; nutrition-related school programs; and family health services that promoted, among other activities, maternal nutrition and breastfeeding. Nutrition was further incorporated into PASDEP, which, as previously described, tasked MOARD with the development of the national nutrition policy. Through a national steering committee, the policy was submitted to the CM in the third quarter of 2005 for approval. It was not until early 2008 that the Parliament approved its first national nutrition policy. This policy was developed in response to mounting national and international pressures for the development of
sustainable action against disasters, as well as evidence-based research suggesting that chronic malnutrition is found in both food deficit and food surplus regions with a common trend of health decline.

However, though language exists for the development of sustainable non-food prevention strategies, Ethiopia’s discourse on nutrition has historically been overshadowed by food security policies. These policies focus on food provision as a short-term solution to constant food shortages and food price increases.

Ethiopian nutrition and pro-social policies have been designed to meet the goals of MDGs and other international standards of human well-being and country progress according to the aspirations of the Ethiopian Millennium 2020 vision. As previously mentioned, the government development agenda is set by PASDEP (2005-2010), the third national policy framework focused on poverty reduction. PASDEP builds upon the Health Sector Development Program I (1997-2002), Interim Poverty Reduction Strategy Paper (2000), and the HSDP II (2002-2005), which is more commonly known as the Sustainable Development and Poverty Reduction Program (SDPRP). Together with the National Child Survival Strategy (NCSS) and Health Extension Program (HEP), these policies drive the achievement of Ethiopian Millennium 2020 and the MDGs.

In 1999, the EHNRI published an editorial identifying protein-energy intake (PEM), vitamin A deficiency (VAD), iodine deficiency disorder (IDD), and iodine deficiency anemia (IDA) as the most important forms of malnutrition. These disorders have not been included in policies reviewed by the author, but development strategies often point to proxies of chronic malnutrition (stunting) and acute malnutrition (wasting and underweight) as evidence of the state of poor health. These nutrition indicators are exacerbated by factors such as civil war, recurring drought and famine, insufficient periods of exclusive breastfeeding, low rates of immunization, poverty, inadequate consumption of high-energy dense foods and poor food diversification, high prevalence of disease, and cultural food taboos.

National progress on reducing malnutrition is slightly attributed to large-scale food aid but also the increasing emphasis on health worker training that is largely supported and driven by donors. However, there must be renewed commitment to children under-five, of which one in two children are stunted and one in three are underweight. Children are the most vulnerable age group to malnutrition. Additionally, little effort has been made to curb the growing malnutrition disparity between urban and rural households. Governmental budgets could not be procured, but historically, there has been an imbalance of resource and funding allocations. Government has favored urban areas, especially the capital Addis Ababa, and curative services, rather than preventative services in rural areas where 90% of poverty is concentrated. As a result, rural households suffer from low levels of nutrition program activity. Additionally, large funding gaps exist for the strengthening of health systems and the implementation of maternal and child health activities.

Ethiopia’s Prime Minister has recently intimated that economic growth remains around
12.8%, though experts at the World Bank and International Monetary Fund (IMF) believe Ethiopia’s growth will only register at 6% as a result of the economic downturn. Yet despite Ethiopia’s growth, the country has contributed little to its famine crises; rather, the country announced plans in early 2008 to increase its military budget by $50 million for national security purposes just after the US and UK pledged a combined $90 million in response to Ethiopia’s 2008 famine. It is true that the government contributes to approximately 60% to 70% of regional budgets for pro-poor project implementation, which is then channeled into woredas, but donors and development partners primarily support interventions. These actions are dominated by support for food aid (in 2008, the World Bank committed $250 million to the global food crisis response but only $30 million to nutrition), but programs also include immunization and micronutrient supplementation. Because pro-poor programs have been largely aid by international organizations and foreign governments, these actors have influenced the priority of issues, especially HIV/AIDS and malaria efforts, and approaches, such as immunization and micronutrient supplementation. These institutions include the Food and Agriculture Organization (FAO), United Nation’s Children’s Fund (UNICEF), World Bank, U.S. Agency for International Development (USAID), European Commission, UK Department for International Development (DFID), and World Health Organization (WHO), among others. To increase coordination of foreign aid efforts, Ethiopia follows guidelines established by the Development Assistance Group (DAG). DAG is chaired by the Minister of MOFED; heads of development partners, in particular the World Bank and the United Nations Development Program (UNDP); and other ministers.

The role of the state and policy elites in addressing malnutrition

According to one interviewee, nutrition policy makers are a mishmash of technocrats, various ministers, and relevant actors from the 1991 revolution. This reflects upon the multi-sectoral nature of nutrition. The challenge of understanding hunger in Ethiopia exists to this day and therefore, the interviewee implied, responsibilities of reducing malnutrition have not been clearly defined. Contextually, however, it can be derived that the state does view nutrition as its own responsibility, evidenced by the NNS and participation with donors in micronutrient supplementation and immunization programs. Further, a 1993 national policy mandates that the state must intervene against crises, which in the interest of nutrition is famine. While HIV/AIDS is fast becoming a popular health concern in Ethiopia, hunger is perhaps the most dire social security issue. Unfortunately, the government has relied heavily upon donors to fund food aid, while it spends a large percentage of its budget on national security.

Positively, PASDEP and NNS guidelines are evidence that the state has concretely defined nutrition policies, goals, and challenges, but budgetary commitment remains low and emphasis is still heavily placed on food aid. In light of poorly constructed disaster prevention and preparedness strategies, poor management, and an overwhelming percentage of non-income poverty (e.g. poverty of health and education), it will take enormous political and fiscal commitment to achieve reduction of malnutrition.

Nutrition Status in Ethiopia: Why Malnutrition Matters
The nutrition status in Ethiopia is dismal relative to other low-income countries, including those in Sub-Saharan Africa. PEM is the most serious nutrition problem in Ethiopia that particularly affects children, mothers, and the elderly in drought-prone regions of Afar, eastern Oromiya, and Somali. It is caused by insufficient protein intake in lieu of the ever-present food insecurity and poor care practices. PEM manifests into two types of malnutrition, marasmus and kwashiorkor, resulting in stunting (height-for-age), underweight (weight-for-age), wasting (weight-for-height), and child and maternal mortality.

National and localized nutrition surveys have been collected throughout the history of Ethiopia following famines and harvests, including the Health and Nutrition Survey (rural survey) in 1998 and the Welfare Monitoring Survey in 1996. In 2000, Ethiopia began the systematic collection of nationally representative Ethiopian Demographic and Health Surveys (EDHS) to gain accurate assessments of national health trends. These censuses have demonstrated the impact nutrition policy and action has had on the health of Ethiopians throughout each region.

According to the 2005 EDHS malnutrition has decreased in under-five children relative to the first EDHS collected in 2000. Progress has been made due to introduction to complementary feeding and noticeable increases in vaccination coverage (full immunization of children 12 to 23 months of has increased from 7% in 2000 to 17% in 2005, and the number of children without any immunizations by 12 months has declined from 51% to 28%); however, vaccination coverage is insufficient and routine Expanded Program of Immunization (EPI) coverage has been as low as 5% in the Somali and Afar regions. The overall increase in vaccinations has contributed to decreases in stunting (52% in 2000 to 47% in 2005) and under-weight (47% in 2000 to 38% in 2005). Comparatively, the WHO Africa Region experienced a rate of 33% underweight in 2000. Wasting, unfortunately, has not changed significantly. WHO found that children under five had a wasting rate of 10% in 2000, which saw a modest decline to 8% in 2004. This closely resembles 1992 data that found an 8.7% wasting rate. The 2005 EDHS found an 11% wasting rate and 2% severely wasted rate. This reflects the constant state of food insecurity. Clearly, chronic malnutrition (stunting, long-run malnutrition) is more prevalent than acute malnutrition (wasting and underweight).

Though PEM is a severe malnutrition disorder, activities to decrease PEM have not been as actively pursued as micronutrient supplementation or food aid. This is often because the DPPA responds to food-related crises by providing short-term solutions. One positive action towards the reduction of PEM is the near universal feeding of breast milk at a rate of 96% (EDHS 2005). However, exclusive breastfeeding of children under two months old has substantially decreased from 78.4% in 2000 to 67.3% in 2005, and breastfeeding of children under four months has decreased from 62.3% in 2000 to 56.8% in 2005. The median duration of exclusively breastfeeding has also decreased from 2.4 months (males) and 2.7 months (females) to 2.1 months for both sexes in 2005, especially

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1 The sample size for under-two months was 331 children in 2000 and 2005. The sample size for under-four months was 716 in 2000 and 791 in 2005.
in the Tigray, Oromiya, and Gambela regions where the median duration has been, at the least, halved.\footnote{The sample size in 2000 was 560 males and 518 females. The sample size in 2005 was 602 males and 507 females.}

Efforts to increase micronutrient supplementation, however, have not been positive, and micronutrient deficiency – VAD, IDA, and IDD – remains a serious barrier to good nutrition in Ethiopia. According to the EDHS 2005, 54% of children between six months and five years old are anemic (21% mildly anemic, 28% moderately anemic, and 4% severely anemic) and 27% of women are anemic (17% mildly anemic, 8% moderately anemic, and 1% severely anemic). Severe anemia is highest among male children between nine and 11 months old, but surprisingly is not influenced by urban-rural residence. This indicates the widespread nature of the problem and the need to intensify the various components of the anemia control strategy. Additionally, the EDHS records show a decrease in Vitamin A supplementation from 55.8% in 2000 to 40.55% in 2005 for children. In 2000, only 28% of children under three years consumed vitamin A rich foods in the 24 hours preceding the survey, which decreased to 14% in 2005. Action against VAD must be strengthened. Positively, vitamin A supplements for postpartum women has increased from 12% to 20%, though night blindness during pregnancy increased to 6% in 2005 from 5% in 2000. Iodation is also a major concern: properly iodized salt in households decreased from 28% to 20% in 2005. Urban areas were found to be almost twice as likely to use iodized salt in 2000 but no significant difference in residence or wealth quintile was found in 2005.

Maternal mortality remains one of the highest in the world; 720 maternal deaths occurred of 100,000 live births. Women in Ethiopia face nutritional challenges that manifest into communicable diseases, especially the Afar, Somali, Amhara, Oromiya, Tigray, and SNNPR regions of extreme drought. According to the 2002 MOH Second Appeal Document, many mothers and elderly remain at home rather than engaging in the community due to “lack of strength” that are a result of poor health and starvation. Five percent of pregnant and lactating women (approximately 750,000 women) are at high nutritional risk and require 37,500 metric tons of immediate supplementary food to prevent severe malnutrition. This implies that many women were already undernourished and perhaps suffered from moderate malnutrition before the survey. This is indicated by the 27% of women chronically malnourished (Body Mass Index (BMI) less than 18.5) compared to the 4% of overweight or obese women (BMI greater than 25) in 2005. However, some causes of undernutrition are due to cultural taboos regarding food. The 2000 EDHS found that 9% of women stopped eating certain foods while pregnant, including cheese and butter (36%), vegetables (29%), milk (27%), fruit (12%), and meat (15%). Food restrictions were more prominent in women under 20 years old.

Efforts to reduce malnutrition and communicable diseases has not been widely successful due to recurring droughts and subsequent famines that are not properly prepared for or prevented against. However, there has been some progress. WHO data show that under-five mortality has declined from 204 deaths per 1,000 live births in 1990 to 150/1000 in 2000 and 123/1000 in 2006. Infant mortality has also declined from 192/1000 in 1990 to...
92/1000 in 2000 and 77/1000 in 2006. It should be noted that these figures only represent areas where humanitarian aid has been established. Often, isolated communities remain unaccounted for; the WHO figures may under represent the health burden in Ethiopia.

In addition to PEM, micronutrient deficiencies, and communicable diseases, frequent droughts have had extremely negative impacts on food production and security. The 2002 Second Appeal by the MOH found that all the areas of study were littered with carcasses of animals, which produced an offending smell and unhealthy environment. The cause of death was attributed to lack of pasture and water and perhaps a disease. Unfortunately, Ethiopia is completely dependent upon its livestock and by-products for subsistence; as a result of massive livestock deaths, malnutrition has become endemic with visible deficiencies in under-five children, particularly IDA. Over seven million people are chronically food insecure, while another ten million reside in areas prone to drought. In 2000, the MDG database found that 44% of the population were not meeting daily food needs. In 2004, a range of 16% (Bahar Dar region) to 53% (Dessie region) of the population was below the food poverty line.

3.2 Trajectory of Nutrition Policies in Ethiopia: Characterizing the “Outcome”

The presence of nutrition policies in Tanzania began almost a decade before Independence and has continued through the current administration. The trajectory follows five policy periods:
<table>
<thead>
<tr>
<th>Time Period</th>
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<th>Actors</th>
<th>Activities</th>
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| 1962-1978    |                 | ENI, FMOH, RRC, Save the Children, UNICEF                | • ENI established (1962)  
• Ethiopian Guide to Emergency Feeding (1974)  
• Early Warning System (1976)  
• Nutrition Field Worker (1978) |
|              | Malnutrition as food insecurity                          |                                           |                                                                             |
| 1977-1986    | Negative Turning Point                                   | Agricultural Marketing Corporation, Derg, RRC, various donors and development partners | • Armed political conflict  
• Food aid: wet feeding and dry food rationing  
• Resettlement of citizens |
|              | Famine of 1984                                          |                                           |                                                                             |
• Conceptual Framework  
• Triple A Approach |
|              | Micronutrient supplementation and consolidation of health policy | DPPA, EHNRI, FMOH, UNICEF, USAID        | • Analysis on consequences of malnutrition (2001)  
• Publication of the National Health Policy (1993)  
• Promotion of Essential Nutrition Actions  
• National programs addressing IDA, IDD, and VAD |
• Child Survival and Development  
• Health Extension Program  
• Community-based Therapeutic Care  
• Enhanced Outreach Program/Supplementary Feeding Program  
• Food Security Project |
|              | Positive turning point                                  |                                           |                                                                             |

Each approach is included in a specific policy period to represent that era’s nutrition focus or event. However, the distinctive division of policy periods and approaches is slightly misleading as nutrition research and approaches have often been continuous and overlapped other policy periods.

**Malnutrition as Food Insecurity (1962 – 1978)**
The establishment of the Ethiopian Nutrition Institute (ENI) in 1962 was closely followed by a yearlong drought in 1964 and causing devastating levels of starvation. Natural disasters were not uncommon in Ethiopia and thus, from the beginning of nutrition agenda setting, catastrophic droughts and famines have been constant drivers for nutrition policy, convincing policy makers of the unquestionable link between nutrition and food security. This view was widely supported by physical evidence during the 1973-1974 drought-caused famine when, together with a period of political instability, claimed between 200,000 to 400,000 lives in the Wollo and Hararghe regions. The argument was strengthened when it was found that the famine was due to food shortages from a preceding series of droughts. As a result, UNICEF and the Ethiopian Relief and Rehabilitation Commission (RRC), which was formed in 1973 in response to the drought, began collecting national surveys of food and malnutrition to monitor food supply systems. ENI also contributed by publishing the first Ethiopian Guide to Emergency Feeding in 1974.

In 1976, the Early Warning System (EWS) institutionalized UNICEF and RRC’s surveys into a monitoring system unique to Africa. EWS also surveyed regions of possible food shortage to ensure early interventions. To bolster the effectiveness of EWS, the RRC, FMOH, and ENI partnered with Save the Children to initiate the Nutrition Field Worker (NFW) program in the Wollo region in 1978. This program trained 25 high school graduates with technical knowledge on weighing and other measurement skills to assess malnutrition indicators. The workers were deployed in rural health centers and found that 10% of children were experienced wasting, but these data assumed malnutrition was a result of food insecurity.

Famine of 1984 (1977-1986)

Ethiopia experienced one of its worst national famines between 1984 and 1985 with medium-term effects and is undeniably a negative turning point for nutrition policy as malnutrition was again inextricably associated with food insecurity. Though drought was an underlying natural cause, the situation reflected a political conflict pitting the Derg against two primary insurgent groups in the north and south regions of Ethiopia.

Though 1977 brought drought, the EWS and RRC assessment of the 1980 and 1981 food supply was “above normal”, and the 1982 harvest was the largest ever recorded except in Tigray. Yet in spite of the harvest, RRC estimates of at risk individuals increased from 2.8 million in 1982 to 3.9 million in 1983. The initial indication of famine became apparent as the nation witnessed impoverished farmers frequenting feeding centers; donors began responding with aid while RRC reviewed and amended its assessment strategies. It was further predicted that the 1984 yield would be lower than in previous years due to less rainfall; however, preventative measures were not pursued.

Ethiopia’s vulnerability was exacerbated by political upheaval. The RRC was initially afforded greater independence from Derg than other ministries due to its strong relationship with donors and its pool of highly skilled colleagues. However, this relationship and the commission’s responsibilities changed as the government grew more
violent. The RRC became a political tool for the Derg, serving as the middleman between the government and development partners and deliberately denying food aid to Derg opponents and rebel areas. To further cut off food supplies, the RRC convinced donors to establish relief programs in regions with surplus grain production. This allowed the Agricultural Marketing Corporation, a coalition that oppressively regulated grain production of rural peasants and led to an unequal trading system, to collect the food aid and distribute it as desired. The RRC covered up the conflict by assuring the international community that the famine was merely a result of drought and overpopulation and that food aid was evenly distributed. British journalists eventually exposed the situation.

Donors’ intentions should not be mistaken; they have continued to be generous in the face of famine. For example, donors expanded selective feeding programs to wet feeding and dry ration and provided for 9,000 to 12,000 individuals per day in Koram. However, in addition to RRC’s manipulation of relief, persistent drought and increasing instability were compounded with locust plagues in 1986 that made it difficult for donors to keep up with the rising demand. In contrast, government response was poor; the Derg forced the resettlement of thousands of peasants around areas with basic livelihood provisions, such as water, schools, and health facilities, but often these services were not provided.

The famine affected approximately eight million Ethiopians and resulted in the death of approximately one million. Despite the redirection of RRC’s responsibilities, the commission continued revising the EWS and conducted value assessments for food and nutrition surveys as a component of EWS.


The 1984 famine simultaneously coincided with the first comprehensive community-based nutrition project initiated by the WHO and UNICEF. The Joint Nutrition Support Program (JNSP) was funded by the Italian Government and undertaken by ENI in the Sidamo region. Sidamo was selected due to its ease of accessibility, diverse agro-ecological zones that allowed for broad comparative experiences, and its large population density. The project was slated for commencement in 1984 but did not begin until 1986. It was phased out in 1992.

The project was based on community and regional nutrition needs and comprised of the Conceptual Framework (CF) and Triple-A Approach (Assessment-Analysis-Action). The overall objectives were:

1. Reduction of infant and under-five mortality;
2. Better child growth and development;
3. Improvement of health and nutrition;
4. Development of feasible and sustainable strategies of community-based nutrition programs through community empowerment
The first three objectives reflected expected impacts from the Sidamo Nutrition Project (SNP), while the fourth defined the methodology to achieve the results. The results were impressive. The Sidamo Regional Health Department recorded an immunization coverage rate of 90% in 1990 in the project area, which was a dramatic increase from 2.34% in 1984. The CF served as a flexible structure to the Triple-A Approach to identify direct, indirect, and underlying causes of malnutrition per region and/or village (Assessment); develop multi-level solutions to under nutrition concerns (Analysis); and implement sustainable programs within households and villages (Action). Additionally, SNP emphasized the importance of social mobilization, which utilized community relationships to disseminate new knowledge and practices.

However, the baseline year was also the beginning of the 1984 famine and therefore, it is uncertain whether the modest progress is attributable to the program. Unfortunately, Sidamo was not pursued further, so even the successful nutrition education and Growth Monitoring and Promotion components immediately ceased when the project ended due to lack of incentives for community nutrition workers.

**Micronutrient Supplementation and Consolidation of Health Policy (1987-present)**

Two policy discourses emerged from the famine. The first was the continuing assumption that nutrition was a food security issue. Actions to tackle this were undertaken by the Disaster Prevention and Preparedness Agency (DPPA), formerly the RRC until 1995. The second discourse that emerged was the realization that famine induced debilitating micronutrient deficiencies; therefore, nutrition was also a food quality issue. The famine coupled with an international pledge to control vitamin A deficiency (VAD), iodine deficiency disorder (IDD), and iron deficient anemia (IDA) led to the adoption of the National Health Policy, National Guideline for Control and Prevention of Micronutrient Deficiencies, and promotion of Essential Nutrition Actions (ENA). This represents a positive turning point.

Though disasters are chronic in Ethiopia, the capacity for action against famine has been reduced to emergency food aid. There exists limited governmental commitment to build capacity for other emergency responses, limited emphasis on non-food aid (e.g. immunization, micronutrient supplementation, and governance), weak EWS, and poor response and recovery from ministries such as the FMOH, MOARD, and Ministry of Water Resources. Though health posts, water and agriculture bureaus, and disaster response committees exist in disaster-affected regions, these institutions typically lack the authority, technical skills, and resources to address the needs of that region. Despite these institutional deficits, donors’ first and primary response is short-term food aid because the EWS is commonly linked to agricultural indicators, such as rainfall and crop yields. And yet even with enormous levels of food aid activity, mechanisms to ensure that nutritious rations are distributed to vulnerable regions remains underdeveloped. Donors have responded by surveying nutrition levels and the DPPA has released guides on food relief targeting and nutrition surveillance. But EWS non-food indicators must be improved and aid must be properly prioritized before non-food approaches are emphasized and efficient food aid is delivered. Further, attitudes toward disaster must be
changed: donors and the Government of Ethiopia (GoE) both view these crises as isolated, nature-made events rather than preventative – or in the least, controllable – processes that require social, political, environmental, and health preparation inputs.

There has been some progress toward non-food interventions. While famine was initially blamed for food insecurity and starvation, reports of scurvy and other micronutrient deficiencies surfaced in refugee camps. Looking deeper, researchers found that famine-related deaths occurred more often from disease due to low levels of vaccination than outright starvation. But policy makers met these findings with skepticism because it challenged their understanding of malnutrition. At first glance, the increasing prevalence of malnutrition between 1983 and 1992 was logical because of the high percentage of food shortage. Yet these figures were confronted with evidence that malnutrition existed in food surplus regions, and eventually these data convinced politicians that nutrition relied upon a balance of food quantity and quality.

From a culmination of global micronutrient deficiency cases, the international community, including Ethiopia, gathered in 1992 for the International Conference on Nutrition (ICN). Together, each country pledged to control IDA and completely eliminate VAD and IDD by 2000. In response to international pressures, Ethiopia developed its first Ethiopian National Guidelines for Control and Prevention of Micronutrient Deficiencies in 1995 and prioritized interventions against VAD and IDD first to most efficiently use their resources. IDA was tackled after action was taken on VAD and IDD because it required a greater amount of resources and more complicated strategies. The FMOH also mobilized to promote ENA, an approach that educates communities on seven groups of nutrition behaviors that had been empirically tested to reduce mortality rates. Integrated with other Child Survival and Development (CSD) programs, these included exclusive breastfeeding, complementary feeding with breastfeeding, nutrition provision to children under two and women, and control of VAD, IDD, and IDA.

Around the same time, Ethiopia published the National Health Policy (NHP, 1993), which was responsible for formulating and implementing food and nutrition policy. The NHP responded to the staggering need for health care and the inefficiencies of the centralized service delivery system. NHP developed the framework for preventative, curative, and rehabilitative primary health care with emphasis on school health and nutrition programs, capacity building through its four-tier health facility system, immunization, integration of traditional and modern medicine, and ENA approaches, especially breastfeeding.

**Vitamin A Deficiency**
VAD is a significant micronutrient problem in Ethiopia. In 1996, a joint EHRNI and UNICEF survey was conducted in southern, northern, and eastern regions. It found that children had serum retinol levels below 20 milligrams/deciliter at rates of 28%, 63% and 96% respectively. Profiles, a USAID and GoE joint analysis in 2001 on consequences of malnutrition, found that 17% of child mortalities are attributable to VAD. Information was not found for lactating women with breast milk retinol levels below 30 mg/dl.
However, vitamin A is not only essential for children between six months and six years old but also for pregnant women and especially for lactating women. VAD has been tackled with supplementation, fortification, promotion of exclusive breastfeeding, and advocacy of Vitamin A-rich foods.

The first national program to control VAD began in 1996 and delivery continues in collaboration with EPI-plus, a national immunization program. The initial programs targeted children under one year old, and between 1998 and 2000, these were expanded to provide biannual rounds of supplementation to children under five. Distribution during national immunization days (NID) covered 80% of children. The programs briefly stopped operating until the end of 2002. By 2003, vitamin A was supplemented in all drought-affected areas for children aged six months to 14 years old, which was equivalent to 20 million children. However, according to the 2005 EDHS, only 46.8% of 4,762 children aged 12 to 59 months received vitamin A supplementation within the last six months. In 2008, some areas, such as Liben and Afer zones in the Somali region, report 0% supplementation, though the Bale zone in the Oromia region experiences an average of 92.8% coverage. The HEP is being utilized to raise awareness of vitamin A and increase demand for supplementation. The 2004 National Guidelines for Control and Prevention of Micronutrient Deficiencies, published by the Family Health Department of FMOH, also strategizes how to achieve Ethiopia’s ultimate goal to eliminate VAD by 2015. The primary action will be the biannual provision of vitamin A capsules to six to 59 months old (80% coverage) and to postpartum mothers within 45 days of delivery (70%).

**Iodine Deficiency Disorder**

According to data cited in the 2004 FMOH guideline on micronutrient deficiencies, one in 1,000 Ethiopians experience IDD and approximately 50,000 per year prenatal deaths are attributable to IDD. An ENI survey in the 1990s found average goiter rates of 26%, though some areas had rates between 50% and 95%; this average increased in 2005 to a 39.9% prevalence rate in youth age six to 12 years old and 35.8% for women between 15 and 49 years old.

IDD and goiter are easily alleviated through salt iodation. Yet, though Ethiopia has been capable of supplying its own salt, it was not until 2003 that the country began producing its own salt and 2004 that the iodine content of properly iodized salt was defined. Monitoring and quality control remain nonexistent due to the lack of regulation on the distribution of non-iodized salt, but the FMOH is slowly working to coordinate the implementation of legislation. This will aid Ethiopia’s goal to eliminate IDD and decrease goiter rates by 50% by 2015 through Universal Salt Iodization (USI) for humans and animals and through the provision of oral iodized oil in areas with high IDD rates. Further, the Health Sector Development Policy Phase II (HSDP II) aimed to increase the availability of properly iodized salt up to 80% in households. This clearly did not occur: on average, only 20% of households had properly iodized salt in 2005. However, efforts have been renewed and strongly supported by the Minister of Health Dr. Tedros Ghebreyesus who recently reaffirmed Ethiopia’s commitment of USI by 2010. The National Iodine Deficiency Control and Prevention Program (FMOH and Micronutrient
Deficiency Control Task Force: EHNRI, Ministry of Trade and Industry, Ethiopian Authority of Standards, Ethiopian Mineral Resource Development Enterprise, Ministry of Information, and MOE) will need to work tirelessly to ensure this goal is met.

Iron Deficiency Anemia
Anemia is caused by iron deficiency. According to the 2005 EDHS, over half of children under five are anemic and about one in four women are anemic. However, IDA studies have tended to be localized and therefore do not capture IDA rates throughout the entire country. There is evidence that IDA does not differ by residence (urban or rural), implying the widespread nature of the deficiency and need for diverse strategies.

Ethiopia aims to reduce IDA rates in women and children under five by one-third by 2015. This is an ambitious goal because as of 2004, Ethiopia did not have consistent, nationally guided supplementation programs due to being unaware of the scope and implications of IDA. Case diagnoses and treatment are available through outpatient and inpatient facilities, and supplementation of iron and folic acid is a strategy in the 2004 FMOH Guideline. Additionally, diagnosis and treatment of malaria is important for the control of anemia that is not caused by iron deficiency.

National Poverty and Nutrition Strategies Development (1997-present)
The chronic nature of famine without the realization of preventative needs continues to pose a challenge to the evolvement of nutrition discourse. However, catalyzed by international pressure and the recognition of its own underdeveloped health system, the 2000s marked a period of national commitment to poverty reduction and health sector development following the ratification of the NHP. These policies include MDGs, HSDP, SDPRP, PASDEP, and NNS, and various supportive strategies and programs. This period marks a positive turning point in the discourse and trajectory of nutrition policies as Ethiopia continues to form and strengthen strategies on immunization, micronutrient supplementation, CSD, health management, community-based nutrition activities, and monitoring and evaluation. Yet despite government commitment and national nutrition activity, government funding and continued emphasis on food aid present challenges. The PASDEP is slowly integrating the two discourses into the same strategy, while the formulation of the first NNS is promising to address nutrition needs in Ethiopia and coordinate relevant actors and plans for the advocacy of nutrition.

New social development and poverty reduction policies
The MDGs were derived from a decade of UN conferences and summits and established at the Millennium Summit in 2000. In 2001, recognizing the dire need to aid countries in their efforts to reduce extreme poverty, the MDGs were adopted by UN members. This international commitment to achieve eight goals by 2015 has been a powerful driving force in Ethiopia.

Prior to the adoption of MDGs, Ethiopia published the NHP in 1993, its first comprehensive health policy framework to deliver preventative, curative, and rehabilitative primary health care. To deliver this policy in an efficient and cost-effective
manner, the GoE, development partners, FMOH, and regional states developed the 20-year implementation strategy, the Health Sector Development Program (HSDP). The details of this program are found in the July 1998 Program Action Plan. Together, the policy and program respond with realistic plans and commitment of internal resources to address the root causes of poor health, need for decentralization, and lack of health attention to the rural population.

HSDP is nationally guided by the Central Joint Steering Committee, regionally coordinated with bureaus of parallel sectors represented in the steering committee, and implemented by the FMOH and Regional Health Bureaus. The HSDP has eight priorities: deliver quality care and services, improve and expand health facilities, train health workers, utilize Information, Education, and Communication to raise consciousness in communities, improve pharmaceutical services, develop a strong monitoring and evaluation system, strengthen health management and information systems, and raise capital for health services. Each priority will be exercised through action on communicative diseases, nutritional deficiencies, environmental health, and hygiene. Particular attention is afford to maternal and child care, immunization campaigns, nutrition education, and treatment of infectious diseases. Its first phase was implemented from 1997/1998 through 2001/2002 and second phase continued from 2002/2003 through 2004/2005.

In 2002, the GoE ratified the second phase of HSDP, the Sustainable Development and Poverty Reduction Program (SDPRP) that is comprised of four sector approaches: Agricultural Development-Led Industrialization (ADLI) and food security, Justice System and Civil Service Reform, Decentralization and Empowerment, and Capacity Building in Public and Private Sectors. ADLI manages the agriculture sector to reduce poverty, improve food security, and promote industrialization. Related to nutrition, SDPRP concentrates on providing poverty and food insecurity relief to rural areas. These national endeavors, however, are more clearly defined in the third phase of HSDP and better implemented through LINKAGES.

In 2003, Ethiopia joined LINKAGES, a USAID funded project to provide education, assistance, and training on child and maternal nutrition and the promotion of exclusive breastfeeding. LINKAGES is responsible for creating coalitions for nutrition, guiding policies on malnutrition for women and children, training workers at all levels of nutrition action, and designing nutrition programs at the community level. The project is also credited with the development of ENA, which was adopted by the GoE in 2004. Its four primary approaches to reduce malnutrition and increase policy discussion on nutrition issues are: policy and advocacy, capacity building, community involvement, and behavior change communication. LINKAGES published and presented one of the first evidence-based reports that demonstrated the impact of malnutrition on human and economic development in Ethiopia and how malnutrition and HIV/AIDS is linked together. Its results provided the motivation and necessary evidence for the advocacy of nutrition’s vital role in development and nutrition’s inclusion in the PASDEP.

These includes ministers from the MOH, MOE, and MOFED; and development partners.
PASDEP (2005/2006-2009/2010) is the third phase of HSDP that addresses remaining shortcomings of service coverage and quality, human resource capacity, and supply of medicines, especially in rural areas. PASDEP continues to build upon the objectives and successes of HSDP I and SDPRP through programs such as the National Child Survival Strategy (NCSS), Health Extension Program (HEP), Enhanced Outreach Strategy (EOS), and Community-based Therapeutic Care (CTC). Nutrition, which encompasses food, health, and care practices, is finally afforded proper attention in development strategies in collaboration with the MOARD and FMOH. The MOARD has been responsible for food production and distribution, while the FMOH takes responsibility for health interventions. PASDEP has successfully regulated drug distribution and implemented a training program to improve service coverage and quality.

Internal leadership alongside external funding and pressure were the major forces behind Ethiopia’s first National Nutrition Strategy (NNS). Though several attempts to draft and approve a nutrition strategy had been made since the mid-1980s, the political discourse on nutrition did not convince policy-makers of a need for nutrition strategy distinct from agriculture policy. However, as international conferences began pressuring Ethiopia to eradicate micronutrient deficiencies and lower child and maternal mortality, nutrition champions emerged within Ethiopia and actively rallied for increased national nutrition activity and policy. These champions include both the former and current Ministers of Health, Dr. Kebede Tadesse and Dr. Tedros Ghebreyesus, respectively. By early 2000, Ethiopia had accepted a World Bank offer of both budget support and background research on nutrition conditional on the creation on NNS. Together, these forces led to an agreement to incorporate a comprehensive nutrition strategy into PASDEP. Unfortunately, the outbreak of violence after the 2005 elections resulted in a withdrawal of donor support; however, the momentum of NNS and determination of the Minister of Health pushed the policy to completion.

The FSCB within the MOARD was given the responsibility of formulating the policy, and in turn established the national steering committee to draft the NNS with guidance from UNICEF and the International Food Policy Research Institute (IFPRI). The World Bank resumed an instrumental role with NNS. The vision of NNS is to address the underlying causes of malnutrition from a multi-sectoral approach and promote fourteen actions, including child growth monitoring and promotion, “outreach as a key element in community-based nutrition activities”, “building Knowledge, Attitudes, and Practices for improved nutrition”, nutrition in emergencies, and the establishment of an institutionalized nutrition coordination body (NCB). The NCB derives its membership from a variety of relevant sectors, agencies, and actors and serves to ensure that each sector’s actions are complementary to each other. The NCB also act as an oversight committee and manages budget acquisition and allocation. Decentralization ensures that regional governments are still the primary implementers of NNS.

**Child Survival and Development**

Two important programs exist to improve CSD, the National Child Survival Strategy (NCSS) and the Infant and Young Child Feeding Program (IYCF). The NCSS is a policy framework that directs HSDP implementation with the ultimate objective of reducing
under-five mortality to 67 deaths per 1,000 live births by 2015. This MDG goal is progressing to achievement as it addresses the main causes of child mortality, such as malnutrition, diarrhea, and other communicable diseases. According to the WHO, the under-five mortality rate was 123 deaths per 1,000 live births in 2006. The Infant and Young Child Feeding Program (IYCF) is an implementation strategy that was developed in 2003 by the WHO and Family Health Department of the FMOH to integrate micronutrient protocols into the HSDP. It further provided the basis for the National Strategy for Infant and Young Child Feeding and the National Guideline for Control and Prevention of Micronutrient Deficiencies, which were both published in 2004. IYCF has developed training guides on nutrition and provides in-service training to health workers. Additionally, the program has been a strong advocate for optimal breastfeeding.

*Health Extension Program*

The HEP is a community-based health prevention and promotion program that was developed after an evaluation of HSDP I revealed that centralized delivery was a large barrier to universal health care coverage. The HEP was introduced through HSDP II to implement HSDP strategies, and it focuses on three community-based health categories: disease prevention and control, family health (e.g. nutrition, immunization, maternal and child health, and family planning), and hygiene and environment sanitation. These areas are tackled through the Health Education and Communication approach, which is disseminated by two female Health Extension Workers (HEW) who are trained for a year at Technical and Vocational Training and Education Centers. The HEW then lead a council of elected community members, agricultural development representatives, and community teachers to create a multi-sectoral authoritative body that clearly achieves the goal of decentralization.

*Community-based Therapeutic Care*

Case detection of malnutrition and proper referral for treatment are critical for the assurance of high levels of health care coverage at the community level. However, these factors are often overlooked because treatment of severe malnutrition cases is typically addressed through intensive, inpatient treatments that are costly for the medical facilities and the family. These high resource and financial costs limit the capacity of medical facilities and reduce the potential for universal coverage.

Community-based Therapeutic Care (CTC) has been designed as a decentralized mechanism to address these burdens by utilizing outpatient treatment programs (OTP), small inpatient units, and community health workers that detect and monitor malnutrition cases. Two treatments exist: 1) Patients suffering from severe malnutrition but do not have medical complications or eating disorders are treated in an OTP and receive ready-to-use therapeutic food and medicines to take home; 2) Patients suffering from severe malnutrition who do have medical complications or eating disorders are treated in an inpatient stabilization center and receive WHO-recommended primary care until they can graduate to the OTP. Case detection and appropriate referrals are dependent upon community mobilization, nutrition education, and increasing demand for health system improvement.
CTC programs were initially developed for crisis response of the high levels of malnutrition and micronutrient deficiencies, but the need for CTC has diminished slightly as food and nutrition became more secure and as more efficient programs were developed, such as the Enhanced Outreach Program.

Enhanced Outreach Program / Supplementary Feeding Program
In 2004, the GoE, World Food Program, and UNICEF collaborated together and formulated the Enhanced Outreach Strategy (EOS), a targeted supplementary food program that serves more than seven million children under five and pregnant and lactating mothers in 325 at risk districts. This population is served through Therapeutic Feeding Centers, outpatient therapeutic program sites, and supplementary feeding programs (SFP) for interventions such as vitamin A supplementation, de-worming, growth and nutrition monitoring, and referrals to SFP or therapeutic feeding programs. In addition, EOS combats malnutrition by actions such as raising awareness of nutrition needs among mothers, training health workers on what malnutrition looks like, and mobilizing community members on the importance of diet diversification and the effects of malnutrition. These nutrition activities are vital for community understanding of malnutrition for timely prevention and proper response to crisis.

Food Security Project (May 30 2002- June 30 2009):
In 2002, the GoE collaborated with the World Bank and the governments of Canada, Italy, and the UK to provide community-based grants to poor rural households under the Food Security Project (FSP). The main objectives of FSP are to increase income, resources, and employment opportunities as a short-term alleviation to poverty while simultaneously promoting proper nutrition and child growth monitoring for long-term reduction of malnutrition. The six program components include community funding, funding and capacity building for community-based CSD activities, capacity building funding to all government levels for project-specific activities, investing at federal and regional levels to reduce transaction costs in food marketing, investing in Information, Education, and Communication for increased transparency, and overseeing administration and monitoring and evaluation of the project.

Turning points

Turning points are moments of inflexion in which the policy went from a “low priority” to a “high priority” status or vice versa. As previously indicated, there were three main turning points in the trajectory of nutrition policy in Ethiopia that are highlighted in this section.

The 1984 famine was the height of food-centric discourse that was developed from the chronic nature of disaster, and it marks a negative turning point. Though drought catalyzed the famine, the political conflict between the Derg and counterinsurgents exacerbated the effects. This event serves as a negative turning point because of the response it evoked. The famine exposed the vulnerability and mass starvation of the country to the world, which has left memorable impressions of Ethiopia, and led to enormous food aid efforts. While food aid was and is necessary at times, the GoE has
become dependent upon this short-term strategy for every famine or drought rather than improving the DPPA. Policy-makers continue to view crisis as an unpreventable event, in spite of DPPA’s institutionalization, instead of an even that occurs because long-term strategies have not been put in place.

Over one million Ethiopians perished from the famine. Initially, it was believed that the deaths occurred due to starvation, but as reports of micronutrient deficiencies surfaced, it was realized that famine-related deaths resulted more often from disease. The rise of micronutrient deficiency between 1983 and 1992 ironically marks a positive turning point as policy-makers began recognizing its widespread nature in regions with food shortage, which was logical, and also in regions with food surplus. In addition to the domestic confrontation with micronutrient deficiency, international commitments for the elimination of VAD and IDD pressured Ethiopia to begin concentrating on the link between health and nutrition. Though the NHP was quickly enacted in 1993 and contained responsibilities for creating nutrition policy, national action against VAD, IDD, and IDA has been sporadic and uncoordinated. Treatment of VAD did not begin until 1996 with a brief hiatus of any activity between 2000 and the end of 2002; proper iodine content in salt was not defined until 2004; and Ethiopia has not yet created a strategy for IDA. Nonetheless, this period was a necessary shift away from complete disaster-centric policies. And positively, the FMOH began promoting ENA in 2004, a community-based nutrition education approach, which has yielded success on breastfeeding behaviors.

Following the ratification of NHP, continued emphasis on health, and international pressures, government commitment in the 2000s proliferated into poverty reduction and health sector development strategies. This period marked another positive turning point as many national policies incorporated language on nutrition. This in turn developed or strengthened strategies and increased nutrition activities concerning immunization, micronutrient supplementation, CSD, health management, community-based nutrition activities, and monitoring and evaluation. The government recently approved its first NNS, released in 2008, which indicates governmental recognition of nutrition’s importance. However, despite increased verbal support, the government has spent more on military funding than on malnutrition reduction, instead requesting financial aid from development partners. Because governments have historically ended due to inability to address national social crises and given the current tension with Eritrea, it is understandable why the GoE believes military defense is important. But reliance on external sources does not offer security that the GoE is capable of responding to country needs or that the government is prioritizing livelihood needs at the same level as national protection.

3.3 The Policy Making Process for Nutrition Policies: Characterizing the Scene, Actors and Strategies

The main actors in the nutrition policy-making process have changed throughout Ethiopia’s trajectory to reflect emphasis on discourse distinct to a policy period. The food and nutrition policy throughout the 1980s was contextually developed from the chronic nature of disaster that devastated food security and led to mass mortalities. The
dominant actors were the DPPA (formerly known as RRC), FMOH, ENI, UNICEF, and MOARD. However, the “nutrition” focus of ENI was still food-centric. The revelation and slow acceptance that famine-caused deaths are linked not to starvation but nutrient deficiencies and disease placed greater emphasis on health sector development and the delivery of health services. The actors in this policy period were the FMOH, Regional Health Bureaus, WC, woreda-level health posts and disaster relief committees, national steering committee for the NNS, EHNRI, MOARD, UNICEF, and USAID. These actors have held significant roles in the agenda setting, design, adoption, implementation, and sustainability phases. There have been many donors throughout the past few decades, which include the World Bank, DFID, WFP, FAO, and WHO.

Their interests derive from the motivation to achieve Ethiopia’s development agenda as specified in PASDEP, MDGs, HSDP, SDPRP, NHP, and NNS. There has been slow achievement of these goals; however, recognizing the myriad of problems in Ethiopia, the government’s establishment of health development and poverty reduction strategies has translated into modest policy action. In turn, policy has outlined the scope of government’s framework adoptions, which has motivated increased national attention and involvement in nutrition interventions, such as ENA, EPI, nutrition worker training, and formulation of NNS. Further, the government and development partners have conducted nationally representative surveys to map the prevalence of disease. These results have bolstered the argument that nutrition deficiency is a nationwide problem and activities to decrease malnutrition have been taken. However, addressing micronutrient deficiencies through the agenda setting and implementation stages has been slow due to the prioritization of disaster relief, slow national initiative, political conflicts that have resulted in periodic withdrawal of donor funding, and inequality of intervention distribution. The reality remains that food insecurity continues to be a priority over nutrition insecurity, as the DPPA has not taken appropriate long-term action against famines that hit Ethiopia approximately every three years. The government is ratcheting up action but direct effects on nutritional indicators remains to be seen.

There have been two primary nutrition-related policies in Ethiopia, the NHP and NNS. Finalization of NHP was laborious. Development of a national nutrition policy began in the mid-1980s but was impeded by lack of leadership, coalitional support, and strategy. It was not until the institution of the transitional government that Ethiopia strongly pushed for the approval of the NHP in 1993, which oversaw nutrition policy design and implementation. The formulation of a national nutrition policy did not occur until 2008. With the adoption of PASDEP, the process became surprisingly uncomplicated and advanced quickly. The nutrition strategy was prepared by the third quarter of 2005 and approved by Parliament in early 2008. Parliamentary approval of nutrition interventions, such as the national Vitamin A campaign and promotion of ENA, have also been slow despite persuasive evidence of their need and despite positive results from short-term donor-funded programs in Ethiopia and other African countries.

Until the 2000s, nutrition actions and strategies were often reactive to disasters and international pressures but rarely self-started by the government. The current policy period reflects a strengthened government commitment to livelihood improvement, and
nutrition policies are largely pursued at the national level in collaboration with development partners. The programs developed have focused on community-based training and education that theoretically reaches a median between nutrition and food needs, such as CTC and EOS. But national strategies are not always coordinated with national efforts. For example, one national objective is to reduce IDA by one-third by 2015, yet as of 2004, nationally guided supplementation programs had not been designed. Translating initiatives into district-level action varies and can be interrupted by lack of funding and skilled workers, low prioritization, or emphasis on immediate food aid. This is evident from the wide micronutrient supplementation gaps between different regions. Donors often assist in this stage, thereby catalyzing the nutrition policy processes. Donors initiate projects, provide capital for construction, finance short-term pilot programs, and train health workers. However, famine and drought continually detract funding from nutrition programs to food aid.

The ratification of NNS is proof that government is changing its attitude towards food-related aid and development, recognizing it as an unsustainable and ineffective approach against malnutrition. Yet many challenges still impede nutrition policy implementation. These include lack of authority, technical skills, and resources by regional health bureaus to address disaster the needs of that region; low levels of funding; poor distribution of health and food services throughout the country; absence of studies correlating malnutrition and social and economic costs to motivate government commitment; stagnation of routine immunization coverage for vaccine-preventable diseases; and poor monitoring and evaluation at national and district levels. Weak EWS that is linked to agrarian indicators rather than malnutrition indicators coupled with chronic famine continues to set the need for food provisions.

3.4 Explaining Change: Factors Associated with Policy Change

Both top-down and bottom-up approaches were necessary for nutrition policy formulation and sustainability. Top-down factors include Government’s desire to achieve health and development goals set in PASDEP; the desire to achieve MDGs four (reduce child mortality), five (improve maternal health), and six (combat HIV/AIDS, malaria, and other diseases); and proactive donor support. National and donor commitment to child survival and development, community-based nutrition education, micronutrient supplementation, and therapeutic care have also contributed to adding nutrition on the agenda through a bottom-up approach. Challenges remain that hinder nutrition from becoming a top priority in Ethiopia: lack of collaboration at the government level, historical emphasis on food aid, and insufficient funding and resources for the implementation of nutrition policies on the ground. However, emerging nutrition strategies and leadership (through the nutrition coordinating body) promise to reorganize and energize nutrition action.

The key factors contributing to policy change at each stage of policy-making include:

*Agenda Setting*
Narratives play an important role in setting the policy agenda. They present clear, simple, and pressing arguments for government action. In Ethiopia, reports of micronutrient-related diseases and deaths during the 1984 famine and NHP in 1993, and Profiles and LINKAGES were advocacy events and policies that brought critical light to nutrition insecurity and lack of health care access. The reports on micronutrient-related diseases were Ethiopia’s first pieces of evidence that morbidity and mortality during famine are typically the result of poor nutrition rather than starvation. Yet nutrition actions remained uncoordinated until the ratification of the NHP in 1993, which was developed by the transitional government in response to the national need for preventative and curative care and decentralized health systems in rural areas. Nutrition efforts remained sporadic and isolated throughout the 1990s even though international pressures were present. Nutrition was not strongly incorporated into development and health policy until PASDEP, which was heavily motivated by evidence-based Profiles (2001) and LINKAGES (2003) reports that demonstrated the impact of malnutrition on human and economic development in Ethiopia, as well as the link between malnutrition and HIV/AIDS. Based on these studies, the GoE mandated the inclusion of the NNS into PASDEP, but it was at the urging of influential, pro-nutrition Ethiopian health leaders and the World Bank, which negotiated the NNS as a condition for financial support, that the task was given weight. With the induction of Minister Ghebreyesus, the FMOH has been more proactive with implementation of nutrition action than in past years and there is potential for increased commitment to nutrition and community-based action as the NNS matures.

Undeniably, donors have been major champions for setting nutrition policy on the government’s agenda. In particular, the key champions have been USAID, LINKAGES developed by USAID, World Bank, UNICEF, and WHO, which have collaborated with MOARD, DPPA (formerly the RCC), FMOH, MOFED, EHNRI, Micronutrient Deficiency Control Task Force, and Regional Health Bureaus. Together, these organizations and agencies have influenced the narratives on nutrition policy and mobilized support in favor of gaining greater priority for micronutrient deficiencies, community-based ENA, health management, CSD, and immunization campaigns. Steering committees have also been influential, forming to guide the nutrition policy-making process, while FMOH has been the key advocacy “coalition” that has advocated for nutrition and followed policy through to implementation and evaluation. However, initiation of micronutrient actions and vaccination campaigns has not matched policy commitment nor has protein energy malnutrition been addressed.

Together, these narratives heighten the desire to achieve the national and international health goals. However, one disadvantage by focusing upon measurable health outcomes is narrowing nutrition efforts for health during the status quo (or non-famine years). A critical but often forgotten sector for nutrition action is crisis prevention and preparation. Nutrition is regarded as a humanitarian concern rather than a development policy. Even though outcomes of food crises support the importance of investing in malnutrition prevention, the GoE efforts to reduce long-term versus short-term food and nutrition insecurity is imbalanced. The country is long dependent upon food aid as both relief and a development tool, but though government has recently recognized the unsustainability
of food aid, it continuously fails to reform its crisis policies. Recent developments of NNS and the Minister of Health’s aggressive action against malnutrition show government movement away from short-term food aid strategies and towards broader actions against insecurity, but appropriate physical and human resources, such as proper training, medical supplies, transportation, nutritious infant-appropriate foods, and drought-resistant seeds, are still in shortage. These inputs are necessary to combat root causes of nutrition and food insecurity, such as low economic activity, social food taboos, poor crisis warning systems, unequal distribution of health systems and services, and political disorganization on nutrition.

Coupling nutrition interventions with other high-priority health interventions is also a challenge because nutrition interventions will receive less funding, resources, and attention. Development partners have donated generously to nutrition activities and food aid in response to famine and drought, which has taken external pressure off the government to commit a large percentage of its own budget to nutrition. This is one reason why the GoE has not needed to improve and reform its crisis response. Lack of internal pressure due to an absence of institutional leadership is another reason why nutrition fails to gain greater financial support. While Regional Health Bureaus are in authority positions, they are limited in their ability to mobilize political leadership and parliamentary support. Even though the regional level approves and translates policies and budgets, Parliament dictates the overall policy framework and budget appropriation.

Design
The FMOH is the primary institution responsible for planning, initiating, evaluating, and revising food and nutrition programs, while donors have been responsible for providing worker training and resources, researching on food and nutrition issues, and funding nutrition activities. These actions are aimed at the prevention and control of malnutrition in Ethiopia in collaboration with MOARD. There does not exist a rigorous monitoring and evaluation component. However, the NNS policy includes a nutrition information surveillance that collects and records anthropometric nutrition indicators, which will be used to monitor project progress, evaluate project effectiveness, improve targeting, and counsel local governments on project constraints. Currently, this information is largely impossible to collect but evaluation reports continually emphasize the need for a surveillance system.

Though the NHP, PASDEP, and NNS established the importance of nutrition and is supported by donors, a significant percentage of funding is still earmarked for food aid, though there is increased activity for micronutrient supplementation, especially universal salt iodization. Because much of nutrition funding is derived from development partners, donors can influence the design of policy and affect the success of a program. Ethiopia has learned a lesson on dependence after interplay between internal political conflict and international development support. In the early 2000s, the UK and US withdrew much needed funding after disproving a military conflict between Ethiopia and Eritrea. This severely crippled Ethiopia, which was coming out of a famine between 1997-2000 and quickly fell into another between 2002-2003. This could explain why there was a reversal in health indicators between 2000 and 2005.
Further, the country is under funded for health research, which could be used to bolster political support for nutrition, as well as efficiently design policy to maximize response. The lack of effective health research is due to misdirecting the findings to academic audiences rather than pragmatically conducting research to influence policy. Additionally, research is poorly documented, prioritized, funded, managed, and staffed. Therefore, health research has had an unsubstantial impact on policy design; greater participation amongst stakeholders is necessary to translate valuable information into useful action. Because of this absence, the GoE relied upon regions, federal level ministries, and approximately 20% of districts rather than research as it prepared to write the second phase of HSDP, the SDPRP. NGOs were also conducive in this comprehensive policy-making process. At this time, the design does not include rewards or sanctions into its framework.

Adoption, Implementation and Sustainability
The adoption of effective, long-term policy designs is based upon rationale established in the agenda setting process. Policy adoption leads to implementation and eventual sustainability if the policy meets the goals of the agenda with proper monitoring, evaluation, and revision procedures. Adoption of policy in Ethiopia either requires direct Parliamentary approval, such as Proclamation No 4 (1995) that required the FMOH to conduct research that determined the nutritional value of food, or incorporation of strategies and plans into larger policy documents, such as CSD and universal salt iodization into PASDEP and NNS, as well as promotion of ENA through LINKAGES. Policies and strategies are also agreed upon during international conferences; these avenues provide an opportunity for greater emphasis on nutrition because member countries provide support, define indicators, share ideas, and monitor each other. It is through the second channel that key champions and advocacy coalitions are most influential in policy making. The adoption of these policies and strategies provide the political support necessary for Parliamentary approval of annual plans and budgets. But, as previously mention, nutrition policies are often adopted and implemented with other health issues or as food aid rather than treated as a standalone issue. This severely detracts from focusing on nutrition policy implementation.

Policy has been finalized in various time frames depending on the political stability at the time and urgency for the policy. For example, formulation of the NHP began in the mid-1980s but was not approved until 1993 by the transitional government as a result of the obvious need for improved health care. This was largely due to political upheaval during the Derg’s regime in which the Derg often withheld aid provisions from opposition groups and territories. In contrast, the NNS resulted from recognition that food aid and food-centric strategies were unsustainable and too narrow to tackle malnutrition. Advocated by Ethiopian leaders and development partners, the formulation of NNS was included in PASDEP in 2005. The first draft was completed in the third quarter of 2005 and approved in 2008.

The diversity of relevant federal agencies and institutions, regional and district level actors, donors, and NGOs is present throughout the design, adoption, and implementation
phases, though FMOH is the leader in nutrition issues. Steering committees comprised of these organizations guide policy discussion but exist only to design policy and are dissolved after the policy has been created, thereby exerting limited political authority. Beyond these steering committees, there is poor national collaboration and little regional collaboration. The nutrition coordinating body that has recently formed has the potential to serve as the first nutrition institution to bring together various stakeholders.

Regional Health Bureaus are the major implementers of policy, charged with applying policy to the needs of their respective regions, training health workers, establishing health clinics and hospitals, procuring medical equipment, coordinating nutrition and health activities, and preventing and controlling diseases. However, breakdowns between policy adoption and actual application can occur when the policy goals are poorly disseminated, resources are scarce, workers are limited or untrained, or there is inadequate evaluation and monitoring. Further, though district-level councils appropriate approximately 80% to 90% of their budgets to social policy implementation through income and land use taxes, this is only a small percentage of the overall cost of many strategies.

Therefore, donor support is vital in this stage, acting as a driving force in all aspects of policy-making, implementer of pilot programs, and leader of research. USAID has been a major actor by implementing LINKAGES, leading Profiles research, introducing ENA, and training workers. Realistically, donors are limited to their own agenda and therefore implement aspects of nutrition policy that further their goals. The end goal is often reduction of maternal and child mortality, but commitment to reduce stunting and wasting has been small, except for the promotion of exclusive breastfeeding. Additionally, development partners operate in select areas, while the government is responsible for the remainder of the regions that may be less accessible by transportation.

Implementation and sustainability of community-based programs has been challenging. The GoE has been relatively unresponsive to the serious need for nutrition security and has over emphasized food security. In turn, as noted throughout this paper, donors have stepped in to control funding, determine the scope of work, and set a time line for projects. Without government support and continuous funding, donors’ progress and successes may stagnate or decline if health workers are not properly trained, the community does not have the resources, or the community lacks knowledge of how to utilize the capital. While projects are supported and supervised from all levels of health offices and two trained health extension workers staff health posts, there is still disorganization. This is caused by Ethiopia being slow at defining nutritional values and standardizing iodine content, among other necessary actions, because it had neither appropriate health research nor a consistent, nationally guided strategy. Stagnation and inequitable distribution of health services is still abundant.

3.5 Understanding Sequence (and Inter-Relation): Unpacking Key Factors Identifying and Strategies
The sequence of factors and their interrelations in the policy-making process is important to understand the evolution of nutrition policy and to glean insight from the successes and challenges throughout the policy’s trajectory for external application in similar countries.

Ethiopia’s nutrition policy developed alongside natural crises that had a lasting impression on how “nutrition” was defined in daily life and politics and what interventions were pursued. The interplay between internal and external forces has been critical in agenda setting, design, adoption, implementation, and sustainability stages as each factor catalyzes and reinforces the policy process.

The change in discourse began after the 1984 famine, one of Ethiopia’s worst, and decades long oppressive militaristic regime, the Derg, left the country vulnerable to poor health. Though policy-makers first associated mass deaths from the famine with starvation, data soon gave way to a new thought: famine-resulting deaths and illnesses were due to micronutrient deficiencies. This research was paramount to the emergence of a new discourse that slowly separated nutrition from food security. At the end of the Derg’s authority, the transitional government recognized the critical necessity for health care, nutrition care, and decentralized health delivery and immediately ratified the National Health Policy in 1993. Simultaneously, nutrition and micronutrition emerged on the international level, bringing together countries that pledged to control and eradicate vitamin A deficiency, iodine deficiency disorder, and iron deficient anemia. The external pressure in accordance with internal awareness of the importance of micronutrition caused an even bigger shift in policy discourse. However, nutrition interventions were isolated and uncoordinated.

While conversation on causes of malnutrition finally broadened, little action to develop sustainable programs and a unifying national nutrition policy took place until the late 1990s and early 2000s when additional research was presented and champions emerged. Research on the effects of malnutrition on economic and human development bolstered the importance of nutrition action, but it was pro-active, influential policy-makers who utilized this information into aggressive action against malnutrition. As an added incentive, many donors enthusiastically supported Ethiopia’s efforts and even offered budget support in exchange for the formation of a coordinated nutrition strategy. The combination of three powerful factors during a time that needed and wanted direction was what ultimately led to the National Nutrition Strategy. Donor and government support guarantee some financing for program design, Parliamentary approval for policy adoption, and resources, such as training, for implementation.

Though the necessary factors are present and have motivated good nutrition action, implementation and sustainability realistically remains ineffective because there is under funding, prioritization of food security, inappropriate use of internal health research, and poor monitoring and evaluation. Donors have been steady partners to drive nutrition policies but are very influential in dictating the issues pursued, which can lead to diversion of funding away from nutrition for other high priority health issues like HIV/AIDS and malaria or food aid if there is an immediate need. Also, though there is a strong basis for its need that was established in the agenda setting, study results have not...
always translated into nutrition action and successful nutrition activity has not always been championed or well defined throughout Ethiopia’s policy trajectory. For example, government continues to use food aid as a solution for famine and drought crisis rather than arm the country with education about nutrition or improving micronutrition. Though need for micronutrient supplementation is apparent, iodine content in salt was not determined until 2004 nor is IDA understood despite it affecting 25% of women and over 50% of children. Also, vaccination campaigns have lagged and are inconsistently covered throughout the country. Policy elites acknowledge that these solutions are unsustainable and that a lack of education is an underlying cause of malnutrition, but implementation strategies prefer to focus on “quicker” solutions. This may be because governments and donors are unaware of cost-effective solutions to underlying causes of malnutrition.

The factors present in Ethiopia’s trajectory have coordinated well together at the right moment for agenda setting and broad policy-making, but the sequence must be cyclical to encourage attention to details and policy design, such as how much funding is available, what IDA is, and how can programs be scaled-up.
IV. Lessons Learned

This report concludes with lessons learned on policy strategies and nutrition approaches that must be pursued for the reduction of malnutrition:

1. **Malnutrition is nutrition insecurity, not food insecurity.**
   Disaster is chronic in Ethiopia and has led to an association between malnutrition and food insecurity. Food aid has been the first choice solution used by both donors and the government and for this reason dominates nutrition and crisis policies and strategies. However, the aftermath of the 1984 famine proved that malnutrition is due to micronutrient deficiency and occurred in food shortage and surplus areas. Fortunately, policy is shifting away from unsustainable food aid towards nutrition education and community-based nutrition interventions to eradicate malnutrition. The major nutrition challenge in Ethiopia is the establishment of medium and long-term strategies that address the root problems of malnutrition.

2. **The Early Warning System must be revised to capture anthropometric nutrition indicators rather than solely relying upon agrarian indicators.** The EWS has depended upon indicators such as rainfall and crop yields to determine crisis vulnerability levels for a particular region. However, as the first lesson established, malnutrition is nutrition insecurity, not food insecurity. Therefore, basing a warning system upon agrarian indicators overlooks the possibility of extreme malnutrition levels in areas, for example, that have high rates of malaria transmission, low availability and use of iodized salt, improper infant feeding frequencies, and poor sanitation. Still, the Disaster Prevention and Preparedness Agency has not developed long-term strategies to deal with the health effects of famine or drought owing to the mistaken belief of policy elites that crises are natural events that cannot be controlled, rather than a process that can be prevented against. Therefore, the DPPA must complement its current warning indicators to include nutrition, health, and sanitation. This will aid differentiation between chronic and acute malnutrition to enable government and donors to most effectively and efficiently use scarce resources in the face of pending crisis emergencies.

3. **Government commitment to international conventions has been a major factor for national nutrition policy formation.** International standards, such as the MDGs and ICN, have directed national policy not only on nutrition, but also other issues related to development. Donor involvement is typically driven by these goals. It is therefore prudent to align policies, strategies, and interventions with these frameworks.
4. **Multi-sectoral coordination and leadership for nutrition must be strengthened.** A major challenge to nutrition policy prioritization stems from a lack of leadership to unify relevant actors by a clear, overarching objective and framework. Many sectors have not taken ownership of nutrition and therefore, advocacy coalitions for nutrition policy-making and funding do not exist. Sectors also often fail to clearly understand how nutrition policy affects their activities, which can minimize the impact of policy and disrupt the chain of action on the district level. A solely nutrition-focused leader is essential to mobilize the policy setting and implementation processes amongst donors, NGOs, federal agencies, and district-level offices.

5. **Regional councils are the key to successful nutrition policy implementation at district levels.** Discussion of implementation strategies and budget allocation, as well as coordination of services occur at the district level according to the community’s needs. Because policy frameworks are established at the federal level but implemented at community level, it is imperative that the policy goals are clearly explained and that WCIs are motivated and committed to enact nutrition initiatives.

6. **Donors play an integral role in nutrition policy development and implementation, but Ethiopia must take greater responsibility.** Donors have consistently been involved in Ethiopia’s nutrition activities. They often direct the agenda, initiate pilot programs, lead research, and most importantly, fund the majority of nutrition activity. This has led to dependence on donors and other development partners. Donors should encourage the government to take financial ownership of its programs.

7. **It is necessary to support and fund health research conducted for policy-makers.** Policy-makers are highly influenced by quantitative and comprehensive data. Performing quantitative assessments of the cost of malnutrition and providing linkages between malnutrition and other health or economic indicators arm policy-makers with the evidence needed for government action against malnutrition. However, much of health research in Ethiopia has been catered towards academic professionals. This misguided approach is a major reason why research is poorly funded, managed, and staffed and has been insignificant to the policy-making process. It is vital that researchers and nutrition stakeholders collaborate together to ensure that valuable information is translated into useful action.

8. **Increased congruency must be afforded between lessons learned on nutrition approaches and nutrition action.** Evaluations of projects in both Ethiopia and other Sub-Saharan African countries have demonstrated the effectiveness of community-based nutrition action and social mobilization, while reports have repeatedly emphasized the link between micronutrient deficiency and mortality. But much of government and donors’ strategies rely on food aid without medium to long-term sustainable action. These sustainable actions educate families about
frequent feeding, mixed diets, exclusive breastfeeding especially when children are experiencing diarrhea, complementary feeding, or proper hygiene actions.

9. **Training needs to be improved and infrastructure developed.** Unfortunately, untrained workers, low levels of resources, and poor distribution methods constrain policy and program effectiveness. And because infrastructure is weak in Ethiopia, some villages do not have close access to health clinics and medical supervision. To enable sustainability of good health and nutrition indicators, the government must undertake long-term plans to improve access to health clinics and qualified health workers.

10. **Nutrition targeting must expand to rural areas and not restricted to drought-prone areas.** Ninety percent of the Ethiopian population is concentrated in rural areas where nutrition activity is low. Urban areas also experience malnutrition, but funding and program implementation tends to be better coordinated there, especially in the capital city. This study also found that malnutrition is not constrained to areas with food insecurity or are vulnerable to agricultural crises. In fact, even among rural households that are considered food secure, malnutrition rates are as low as 50% of the population.
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Annex 1

World Bank Study—Human Development (Africa Region): Making Nutrition Policy Central to Development, Understanding the Institutional and Political Factors for Policy Change

Guiding Questions/Issues for the Country Case Studies

1. The Political Context in which Nutrition Policies Operate

a) Characterize the political environment (and typical policy-making environment) in which nutrition policies operate.

b) How are nutrition policies placed in the government agenda, in regards to other pro-poor policies, in particular social expenditures? Provide budget comparisons of nutrition expenditures with respect to other social expenditures. Look in particular at its evolution over time. Is Nutrition following the same trend as other social expenditures? Is there a particular area/topic that is gaining importance on the government agenda?

c) What has been the traditional role of the State when it comes to social policies and pro-poor policies? What has been the role of the State for nutrition policies? Has it experienced any changes? Please, specify.

d) What is the dominant discourse of the policy elites on nutrition in your country? In particular, what are the views on the role of the State in combating malnutrition? Do they believe that public policies should be place to combat it, or that it is problem at the household level?
   - Are the policy elites in your country convinced by arguments that it is important to address nutrition as a human right or that is important for sustained economic development?
   - What are competing policy narratives (in other policy areas) on human development issues that seem to be more successful than nutrition in motivating the commitment of policy elites? Why do they resonate better with the elite?
   - How are the malnourished viewed by the policy elite? Are the malnourished differentiated—some more worthy of public support than others?

2. Trajectory of Nutrition Policies in the Country: Characterizing the “Outcome”

a) Describe the nutrition policies (programs, projects and actions) that have been implemented in your country since Independence
   - Can you divide the trajectory into “periods” based on type of approach to nutrition (i.e. food access, micronutrients, community-based, etc.); predominant institutional arrangements (type of Ministry that housed it, existence and location
of coordination body, etc); type of funding (government, donors, etc.), and other relevant categories?

b) Can you assess the level of government’s commitment to the nutrition policy for each of the periods identified?

Utilize the definition of “success” for the comparative study to ensure consistency across cases. The definition of “success” in establishing nutrition as a priority in the government’s agenda “when nutrition policies and programs are accompanied by a budget commitment and consistent and adequate implementation over time, so as to develop a certain degree of institutionalization and a sustained reduction of malnutrition”

Evaluate the following:

- Government’s discourse (nutrition discourse, relationship to government’s (development) agenda)
- Budget commitment (evolution of budget for nutrition, budget mechanisms to fund nutrition policies, evolution of social expenditures in general)
- Level of Implementation (level of execution and agencies involved, involvement of central and local governments)
- Government data gathered on nutrition indicators
- Outcomes reached in terms of malnutrition and nutrient deficiencies

c) Identify “turning points” in the policy trajectory. These are moments of inflexion in which the policy went from a “low priority” to a “high priority” status or vice versa. These “turning points” are particularly important as they imply change. The study will focus its attention particularly in these turning points, although maintenance of the accomplished change when positive is also relevant.

3. The Policy Making Process for Nutrition Policies: Characterizing the Scene, Actors and Strategies

For each stage in the policy making process for nutrition policies (agenda-setting, design, adoption, implementation and sustainability) identify:

- Main actors (for example, for the agenda-setting it could be the Prime Minister, donors, NGOs, Parliament, Ministries, a coalition of nutrition-minded reformists, etc.)
- Interests and Power (Identify main interests of actors in regards to nutrition and their power to influence the decision-making process)
- Main Institutions (formal and informal) It is important to note the role of both formal institutions (Parliament approval, budget approval mechanisms, elections, party competition, etc) and informal institutions (unwritten rules for budget approvals, clientelistic networks, etc.)
- Main Agencies: Identify government agencies involved in each of the policy-making stages.
• Identify actions and strategies adopted by the actors that are most important and their influence of the decision-making process.

4. Explaining Change: Factors Associated with Policy Change (or Lack of It)

Identify the factors that seem to put nutrition into the government’s agenda and to allow for its sustainability over time. Conversely, identify the factors that seem to get in the way of making nutrition of government’s priority. Below, see a list of relevant factors usually associated with putting nutrition into the government’s agenda. Consider them for your country case and add any other factors that seem to make a difference.

• Agenda Setting What seems to determine if nutrition gets into the government’s agenda in your country?

a) Role of Narratives: The Narrative is a discourse that presents a clear, simple and pressing argument for government action in regards to nutrition. Usually this narrative is present to get an issue in the government’s agenda. Is this narrative present? How was it articulated? What is its content? What type of information influences the narrative? Are there competing narratives coming from different actors? Which are the main ones? What is the discourse on nutrition that the government has? How does it relate to other topics in its agenda, and to the main theme in the government’s agenda? If there is a National Policy on Nutrition, how does this narrative relate to it?

b) Role of Agents for Policy Change: Policy change typically occurs through the action of agents. These are individuals or networks who influence policy through the ways in which they define problems, link them to solutions, … translate them into simplified images and understandings…successfully mobilize the attention of policy makers, and sustain their interest in an issue or program over the longer run (Porter 1994). Identify the existence of these agents. The literature distinguishes between:

• Champions (usually well-connected public officials, ministers, who advocate for nutrition within government)
• Advocacy Coalitions (this could include public officials, politicians, donors, NGOs, and beneficiaries. They advocate for nutrition and followed it through all stages of policy making)

   c) Role of donors: In nutrition policies, in particular in Africa, donors are known for being influential in shaping the government’s agenda. Assess their role in influencing the nutrition agenda in your country. What are the most relevant actors among donors? How they influenced government? What are the main channels for influencing government? What has been the specific impact in the content of the government’s agenda? Do they coordinate their efforts with other donors? Evaluate the impact of their withdrawal of funds, or changes in their own agendas.

   d) Role of Competing Interests: Sometimes policy changes do not occur either because there are strong opposing interests to that change (example: teachers’ unions opposing education reforms) or because politicians find some policies more politically profitable than others (they get more votes, more jobs, more rents, etc.), the interests of politicians
in the central government differ from politicians at the local level, or some bureaucracies are more powerful than others in pushing their agendas. Evaluate the role of:

- Opposing interests: Are there interests against nutrition policies? What is their rationale for opposing nutrition?
- Politicians: How are nutrition policies in the interest of politicians? If they are not, explain why?
- Central vs. Local: Do the interests of local governments/politicians differ from the interests of politicians at the central level, in regards to nutrition policies? Do the local politicians influence the agenda-setting process?
- Differential power of bureaucracies: Is nutrition advocated by one of the government’s agencies in particular? How powerful is this agency with respect to others? How are the nutritionist seen within these bureaucracies?

e) Role of Strategies: Examine what strategies pursued by the different actors seemed to be particularly successful in putting nutrition in the agenda; and which ones were not effective. Actors can improve their chances of success by making institutions and circumstances work in their favor. It is important to identify these strategies.

f) Role of Timing/Context: Identify the role that context could have had in putting nutrition in the agenda. For example, the role of other economic/social reforms under way, economic crisis, elections, food crisis, draughts, international conferences, etcetera.

g) Role of Beneficiaries (bottom up pressures) Are the beneficiaries (direct and indirect) of nutrition policies having an impact in shaping the agenda? Which means are they using? Is nutrition a priority for potential beneficiaries?

- Design: The design of a policy can have an impact on its likelihood of adoption, implementation and sustainability. From a political economy standpoint, the design reveals who is “in” and who is “out”, so it can be used strategically to increase its changes of adoption.

In your analysis of this phase, please pay attention to the following aspects:

a) Who gets to participate during this stage? What are their interests? How that affects the policy design?

b) Are there competing solutions, approaches to the problem of nutrition, represented by different actors? How do these solutions relate to the narratives (see agenda-setting)?

c) How do the agents for policy change (see agenda-setting) participate in this stage?

d) What is the role of donors during this stage?

e) Are actors strategic in the design of this policy? Do they include or exclude certain actors/agencies to increase chances of success? Do they include features that could be more appealing to politicians? Do they include rewards and sanctions to create constituencies and/or lower resistance? Explain the strategies adopted.
• Adoption: The adoption of a policy may require the involvement of different political institutions, and therefore new actors and rules of the game. Some policies can be obstructed during this stage, as opposition may use Parliament in their favor. Again, actors can behave strategically to play institutions in their favor.

In your analysis of this phase, please pay attention to the following aspects:

a) What are the key nodes (Parliament, Executive, etc.) during the adoption, the key actors, and the main constraints and opportunities?
b) Are the original proposals modified? What are the main modifications?
c) What are the roles of agents for policy change (in particular champions and advocacy coalitions) during this stage? What is the role of donors? Competing interests?
d) Main strategies adopted. What worked and what didn’t?

a. Implementation Adoption of a policy does not guarantee implementation, and policies can be derailed or modified during this stage. Often, new actors, new agencies, and new rules of the game appear on the scene of the politics of implementation.

In your analysis of this phase, please pay attention to the following aspects:

a) What are the key public agencies and actors that get involved in this stage? What is the role of local governments at this stage? To what extent this relates to the decentralization policy in your country? To what extent is the Executive able to maneuver at this point in the policy process?
b) Does the original policy suffer some modifications at this stage? Which ones? Who made them? Why?
c) How are decisions made on who does what and how? What are the competing interests at this point? What is the role of donors?
d) If there is a need for a coordinating agency for nutrition, what are the politics of this decision? What are the advantages and disadvantages of the location of that agency in your country? How is the funding of this agency decided? How does it work?
e) Are there competing implementation strategies? Who are the main actors that present these implementation strategies? How is the final decision made?
f) What is the role of the agents of policy change during this stage? Are members of the Advocacy Coalition able to intervene during this stage? How and in what decisions? What strategies were successful and which ones did not work?
g) What are the strategies that seem to work for keeping the implementation of nutrition policies/programs on the right track? What strategies did not work?
h) Did the beneficiaries have a role to play in the implementation strategy adopted, or in keeping the programs/policies alive?
i) How did timing issues or the context affect the politics of implementation?
j) Are the results of these policies recorded and conveyed to politicians/public/media?
Sustainability: Adopting a policy and implementing it is not enough to sustain it over time. For malnutrition to be reduced a long-term strategy needs to be adopted and sustained over time. It is important to understand how to keep nutrition on the government’s agenda. The overall question is how do we keep the interest of politicians, public officials, and the public in general on this issue, and adequate policies running?

a) Identify the main factors and strategies that made policies and programs in nutrition sustainable over time. How did they survive political changes in the Executive, in specific public agencies (Ministries of Health, Agriculture, Education, etc.)? How did they manage to adapt to new environments: political and economic, and to new ideas in the donor community, nutrition?

b) Identify the main obstacles in making nutrition sustainable over time? What were the least successful strategies?

c) What was the role of agents of change (Coalition, Nutritionists Core Group, Champions) in the sustainability of these policies? What was the role of donors and their specific contribution?

d) What are the characteristics of organizations (administrative capacity, personnel, leadership, accountability relationships) that tend to make nutrition policies more sustainable over time?

5. Understanding Sequence (and Inter-Relation). Unpacking Key Factors Identifying and Strategies

In understanding the factors that seem to make a difference in bringing about success in putting nutrition in the government agenda and some level of institutionalization over time, we are not only interested in identifying the factors (presence or absence) but also in understanding: a) what is the sequence in which they tend to work (for example, projects in nutrition start to have impacts and get noticed by politicians and then advocacy coalitions become more effective), their inter-relations (advocacy coalitions work only if there is also a “champion” in government sponsoring nutrition). So, it is very important that you pay attention to the order in which these factors tend to appear (the factors mentioned or the ones we might find relevant in your cases), and the way they interact with each other.

As the ultimate outcome of the study is to develop a tool that can assist the World Bank, governments and nutrition-minded reformists to bolster commitment and capacity in fighting malnutrition, it is very important to unpack how each of the factors identified work and its characteristics. For example, if an “advocacy coalition” exists in your country (either if it has been successful or not), identify its main characteristics: composition (who are the people that participate in it, mix of skills, networks, and communities of reference), its origins, how it stays together, how it functions, what it does, etc.

Another important aspect that we need to unravel through this study is the strategies, as they are mentioned several times throughout this guide. We need to know not just that we
need to have an advocacy coalition in place (and how to form it and make it work), we also want to know what the strategies that the coalition used to get nutrition in the government’s agenda and follow up the implementation of policies that were effective (or ineffective).