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Multi-Sectoral Nutrition Policy and Programme Design, Coordination and Implementation in Ethiopia

Seife Ayele, Elias Asfaw Zegeye and Nicholas Nisbett

The strategic partnership between Irish Aid and Institute of Development Studies focuses on social protection, food security and nutrition. The collaboration brings together research and capacity development with policy, programmatic and influencing know-how to support action that more effectively reduces poverty and injustice. The aim of the partnership is to combine cutting edge evidence and learning to support implementation of Ireland’s policy for international development, A Better World.

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Summary

Multi-sectoral nutrition governance has been hailed as an effective mechanism to reduce undernutrition. Ethiopia has adopted the approach and has been implementing nutrition programmes with some success, but undernutrition remains high for a range of reasons. This study explores political economy challenges facing Ethiopia in nutrition programme design, coordination and implementation, and looks at root causes that remain less understood. Using reviews of literature, qualitative interviews and a deep-dive study of two interventions, the study finds that the policy narrative has shifted in Ethiopia from the historically dominant narrative of 'food and production security' to 'food and nutrition security'. The former *ad hoc* and reactive responses to droughts and famines have given way to an understanding of the complexity of undernutrition, its causes and consequences. However, in several critical areas, multi-sectoral nutrition coordination under the federal Ministry of Health, and regional bureaux of health, has been ineffective for many reasons, including lack of accountability mechanisms; perceived coordinator bias; inadequate staffing and resources; and low priority often given to programmes, which results in undernutrition – the 'silent problem' – being side-lined to 'competing priorities'. As envisaged in the Food and Nutrition Policy, the study recommends setting up a well-equipped, and independent, multi-sectoral governance structure, and offers several recommendations that can reinvigorate the process towards sustainably reducing undernutrition.

Keywords: multi-sectoral nutrition coordination, nutrition governance, nutrition implementation, political economy analysis of nutrition, nutrition politics, policy processes, Ethiopia

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The authors remain responsible for any errors and omissions.

Acronyms

BMI	body mass index
CAADP	Comprehensive African Agriculture Development Programme
CBN	community-based nutrition
CSA	Central Statistics Agency
DFID	Department for International Development
EDHS	Ethiopian Demographic Health Survey
EPHI	Ethiopian Public Health Institute
EPRDF	Ethiopian People's Revolutionary Democratic Front
EU	European Union
FAO	Food and Agricultural Organization
FDRE	Federal Democratic Republic of Ethiopia
GTP	Growth and Transformation Plan
IDS	Institute of Development Studies
M&E	monitoring and evaluation
MoAL	Ministry of Agriculture (and Livestock)
MoF	Ministry of Finance
MoH	Ministry of Health
MoI	Ministry of Industry
NNCB	National Nutrition Coordination Body
NNP	National Nutrition Programme
NNTC	National Nutrition Technical Committee
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
RNCB	Regional Nutrition Coordination Body
RNTC	Regional Nutrition Technical Committee
RRC	Relief and Rehabilitation Commission
SDGs	Sustainable Development Goals
SNNPR	Southern Nations, Nationalities, and Peoples' Region
SUN	Scaling Up Nutrition
SURE	Sustainable Undernutrition Reduction in Ethiopia
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WHO	World Health Organization

1 Introduction

1.1 Background to the study

Ethiopia has made a high-level commitment in the past decade to reduce undernutrition[1] and its associated socioeconomic costs. This commitment has been manifested in many ways, including the design of a national nutrition strategy and programmes. Its second – and comprehensive – National Nutrition Programme (2016–20, NNP-II) aims to end hunger by 2030 (FDRE 2016c). A significant component of Ethiopia's nutrition programme is what has become known as the Seqota Declaration, which was launched in 2015 (FDRE 2016b; FDRE 2018b). In the past decade, the institutional landscape for nutrition policy and practice has also been changing. One example has been the adoption of the national Food And Nutrition Policy (FDRE 2018a) and the formation of a multi-sectoral nutrition governance structure to coordinate programme design and implementation (FDRE 2013a; FDRE 2016c):

- The National Nutrition Coordination Body (NNCB) was set up and has been operating since 2008. NNCB is 'homed' under the auspices of the Ministry of Health (MoH) and chaired by the deputy prime minster. It comprises both state and non-state actors.
- A National Nutrition Technical Committee (NNTC) was also set up to support NNCB, which draws members from both state and non-state actors.

Despite faltering over the past four years, Ethiopia has demonstrated robust economic growth over the past 15 years; and over the past two years, its economy has continued to grow at a respectable average rate of 9.9 per cent (World Bank 2019a; 2019b). Some progress has also been achieved in reducing undernutrition. For example, stunting in children under five years of age (under-fives) fell from 58 per cent in 2000 to 38 per cent in 2016; and the percentage of women with anaemia fell from 27 per cent in 2005 to 23 per cent in 2016 (CSA 2016). Despite these improvements, however, undernutrition remains unacceptably high; for example, prevalence of stunting among children aged 6–59 months is 40 per cent, prevalence of wasting is 9 per cent and 27 per cent of children are underweight (FDRE 2016c). Also, some 67 per cent of the adult population in Ethiopia suffered from stunting as children (FDRE 2013b). Government sources show that the country ranks among the highest in sub-Saharan Africa and the world for undernutrition (FDRE 2016c). The Cost of Hunger in Ethiopia report shows that the cost of multiple forms of undernutrition to individuals, families and the country was estimated at over 55.5bn birr[2] per year (FDRE 2013b). This staggeringly high cost stands as a major impediment to Ethiopia achieving its ambitious goals of reaching lower middle-income country status by 2025, and meeting its many international commitments, such as the United Nations (UN) Sustainable Development Goals (SDGs) by 2030.

Since the launch of the first National Nutrition Strategy in 2008 (FDRE 2008), the government has recognised the value of a multi-sectoral approach to nutrition policy, and programme design and implementation. This also suggests that political leaders recognise that nutrition affects, and is affected by, diverse factors that interact in many ways. However, Ethiopia continues to face two major challenges: poor programme coordination and implementation, both of which have significantly hampered the translation of nutrition strategy and programmes into action and outcomes. Implementation, in particular, is

[1] While undernutrition and malnutrition are often used interchangeably, there is a clear difference between the two. The term malnutrition refers to both undernutrition and overnutrition (such as obesity). Undernutrition is the outcome of insufficient food intake and repeated infectious diseases. It also includes being underweight for one's age, too short for one's age (stunted), dangerously thin (wasted), and deficient in vitamins and micronutrient); see: www.unicef.org/progressforchildren/2006n4/index_undernutrition.html. In this report, we use undernutrition mainly as it applies to child undernutrition and define it as encompassing chronic (child stunting) and acute (child wasting) forms, as well as micronutrient deficiencies.

[2] Equivalent to US$4.7 million or 16.5 per cent of Ethiopia's gross domestic product in 2009.

fragmented, slow or excessively delayed. Such political economy obstacles are not unique to Ethiopia (Reich and Balarajan 2012; Balarajan and Reich 2016) but the root causes of the problems remain less well understood.

1.2 Aims and core research questions of the study

Cognisant of these political economy challenges in reducing undernutrition, Irish Aid commissioned a study entitled Political Economy Analysis of Nutrition Policy and Programme Design, Coordination and Implementation in Ethiopia, aimed at critically exploring the major challenges that Ethiopia faces in nutrition policy and programme design, coordination and implementation, the root causes of problems and how these may be addressed. Irish Aid and its partners thus aimed to gain an understanding of the processes, design, coordination and implementation of nutrition policy in Ethiopia and identify drivers and programmes. Based on the findings, the study also aimed to provide draft strategies, with the potential to improve coherence, coordination and alignment of nutrition actors.

Section 2 provides our approach to political economy analysis of nutrition. Section 3 presents the research methodology and tools of the study. Sections 4–6 present the findings. Section 4 provides a review and synthesis of literature-based evidence on Ethiopia's nutrition politics, policy and practice environment, and identifies the obstacles (and successes) in multi-sectoral coordination and implementation of nutrition programmes. Sections 5 and 6, respectively, present macro-level and case study-based empirical findings. Finally, section 7 presents a discussion about, and the conclusion and recommendations of the study.

2 Approach to political economy analysis of nutrition

Given its importance to the understanding of undernutrition and its relevance to this study (FDRE 2008),[3] we begin by discussing the UNICEF (United Nations International Children's Emergency Fund) conceptual framework (see Figure 2.1).[4] The UNICEF framework was hailed as a 'giant step forward', as it framed the key determinants of undernutrition (Nisbett *et al.* 2014: 423). First, the immediate determinants of undernutrition show us the importance of considering both nutrient intake and the body's health status and immune response (both determinant of and determined by adequate nutrient intake, appetite and absorption) (UNICEF 2015).

Second, fundamental to these immediate causes are access to sufficient quality food, and health-care services. Although not explicit in the framework, many sectors are critical here, including manufacturing that fortifies staple foods with micronutrients; adequate sanitation; and women's empowerment, education and maternal care services, all providing the requisite knowledge to improve care practices (Benson 2007; Nisbett *et al.* 2014).

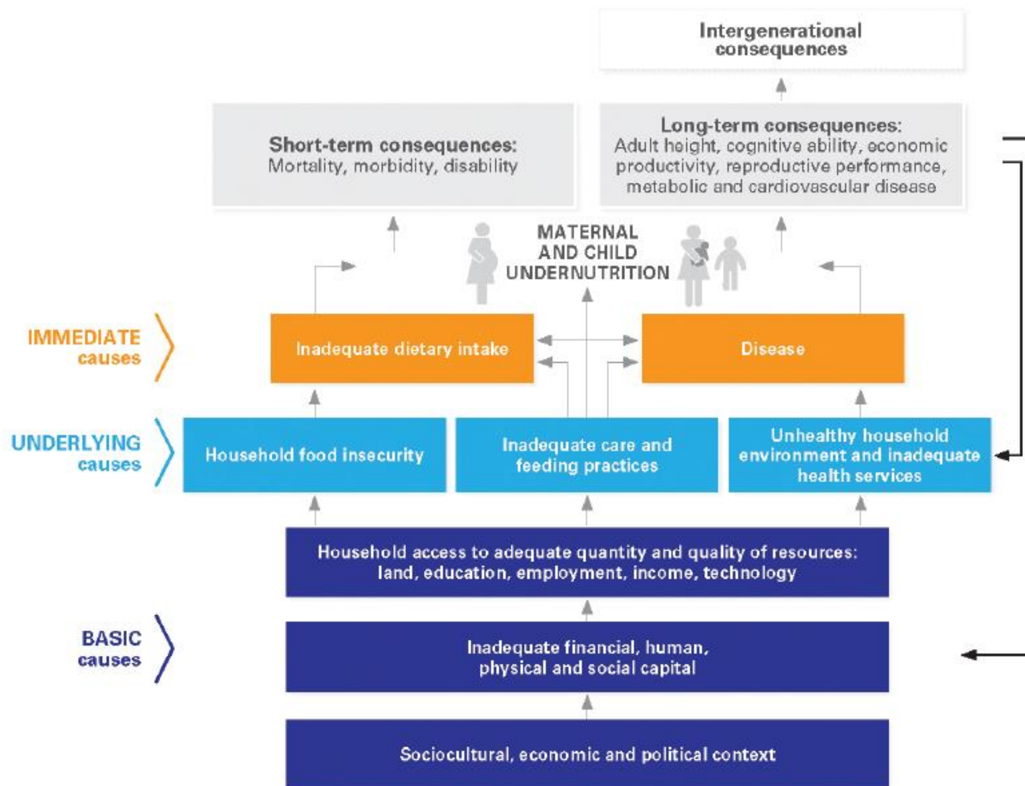
Finally, the framework notes how access to adequate food and health care, food and health environments at an underlying level are determined by basic resource inequities and political

[3] Ethiopia's national nutrition strategy is based on an understanding of the complex causes and consequences of undernutrition. It focuses on community participation and prioritisation of vulnerable segments of the population, most notably children, mothers and those vulnerable to HIV/AIDS.

[4] Originally developed by UNICEF in 1990, the framework has been revised and adapted by academics, practitioners, advocacy agencies and the like. Donor strategies (for example, USAID's 2014–25 multi-sector nutrition strategy) are very much in line with this complex understanding (USAID 2014a). Similarly, the European Union is implementing an initiative called 'EU + Joint Programming on Nutrition' in Ethiopia, an initiative very much built on the understanding of causes and consequences of undernutrition; see European Union Delegation to Ethiopia (2016).

economy structures. The framework has been helpful in highlighting often misconceived narratives that food security alone is enough to address undernutrition. The framework also clearly illuminates the 'life cycle' nature of the problem of nutrition; for example, a malnourished mother passing on her predicament to her children (UNICEF, 2015).

Figure 2.1 Conceptual framework of determinants of undernutrition



Source: UNICEF (2015)

Political economy work on undernutrition has used the framework's focus on underlying and basic factors to note that there is 'nothing natural in the causes of current high levels of global childhood undernutrition and their persistence in the face of economic growth' (Nisbett *et al.* 2014: 422). Political commitment and effective policy and implementation are necessary to ensure adequate levels of care, food and health at family and community levels. However, emphasising the multi-sectorality needed to ensure adequate nutritional environments, political economy analysis has noted that relevant sectors need to work in concert to tackle undernutrition, but often do not have nutrition improvement as their core interest. All of them have other prime interests; hence, they overlook undernutrition. The alignment of interests around nutrition improvement will therefore need to be achieved through negotiation, contestation and settlement (Balarajan and Reich 2016; Nisbett *et al.* 2014; Reich and Balarajan 2012).

Second, the political economy analysis we undertook situated nutrition interventions within the prevailing political and economic structures and institutions, processes and actors' interactions to address constraints to policy change to improve outcomes (DFID 2009; FAO 2017). In the same vein, Reich and Balarajan (2012) and Balarajan and Reich (2016) used processes that cover agenda setting and policy formulation, policy design and adoption, multi-sectoral coordination and implementation, and monitoring and evaluation (M&E). The Ethiopian nutrition policy and programme design, coordination and implementation system

(FDRE 2016c) resonates with this policy process and cycle but it is not clear how influential non-state actors are, particularly in agenda setting.

For the purposes of this study, we use a recent synthesis by Baker *et al.* (2018), which provides a systematic summary of earlier work and frameworks (including Gillespie *et al.* 2013:553).[5] First, Baker *et al.* identify five thematically organised factors that drive political commitment for nutrition: actors; institutions; political and social contexts; knowledge, evidence, and framing; and capacities and resources. They also identify five forms of political commitment: (1) rhetorical commitment – where statements are made by relevant high officials within and outside of government; (2) institutional commitment – where concrete institutions responsible for coordinating actions, resources, etc. are put in place; (3) operational commitment – where the requisite human, technical and financial resources are provided and there is effective coordination of all actors involved along national to subnational implementation pathways, and the commitment of local-level managers and implementation teams; (4) embedded commitment – where nutrition is embedded in wider socioeconomic development; and (5) system-wide commitment – where long-term policy and programme responses are built in. We thus use these two sets of frameworks to present and discuss the empirical evidence that emerged from the study. In the next section we outline the methodology of the study.

3 Research methods and tools

Our key research questions are: what are the core challenges that Ethiopia faces in nutrition policy and programme design, coordination and implementation? What are the root causes of the problems, and how may these be addressed? Based on the framework we adopted to understand and analyse political economy of nutrition, our methods included deskwork, key informant interviews and case studies of two nutrition programmes.

Deskwork: literature search, review and synthesis

The study widely reviewed grey and academic literature on the political economy of nutrition, and policy and practice in Ethiopia. It focused on the identification of obstacles to, and progress made in, nutrition policy design, multi-sectoral coordination and implementation.

Key informant interviews and case studies

The study aimed to generate reliable and unbiased data from informed federal-level representatives in Ethiopian nutrition politics, policy and practice. However, to capture issues and challenges at regional and project or programme levels, in consultation with our partners we studied a high-population region with significant nutrition challenges to the study, the Amhara region. We also explored the design and implementation of two nutrition interventions, one deemed successful and the other less successful. We chose, first, the Sustainable Undernutrition Reduction in Ethiopia (SURE) programme, which was hailed for integrating core nutrition activities of the health and agriculture sectors to improve child feeding and reduce stunting.[6] Second, we included the food fortification programme, as micronutrient deficiency is one of the priority areas of the NNPs, but despite some progress in improving iodine fortification, there was little or no progress in food fortification programmes (FANA Broadcasting Corp. 2018; Gashu, Tesfaye and Hagose (n.d.)).

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[5] In short, Gillespie and colleagues discuss political and policy processes that build and sustain momentum for effective implementation of actions that reduce undernutrition.

[6] See: https://ciff.org/grant-portfolio/ethiopia-perinatal/.

The key informants were individuals involved in and/or knowledgeable about nutrition politics, policy and practice. We ensured that they came from different segments of the nutrition policy process, including NNCB, NNTC, multilateral and bilateral donor communities, advocacy agencies, thinktanks and research agencies, the private sector, regional and subregional actors, and programme implementers. Table 3.1 summarises details of informants. There were 42 informants in total: 27 at federal level and 15 at regional and subregional levels.

Table 3.1 Interviewees: number, role and representation

Institution/level of representation	Number of interviewees	Interviewees' roles and representation
Federal level		
National Nutrition Coordination Body (NNCB), National Nutrition Technical Committee (NNTC)	11	Incl. members of the NNCB and NNTC, and representatives of donor and CSO communities and the private sector
CSOs/advocacy agencies	4	Incl. local and international advocacy agencies
Nutrition programme implementers	6	Incl. flagship project leaders and donor-funded project coordinators
Thinktanks/research agencies	3	Incl. senior researchers and monitoring and evaluation experts
Department heads	3	Incl. federal-level budget heads and donor programme coordinators
Regional level – Amhara		
Regional Nutrition Coordination Body/Regional Nutrition Technical Committee (RNTC)	4	Incl. RNTC members/bureaux heads and regional government nutrition advisor
Nutrition project implementers	4	Incl. SURE/Seqota Project Implementers
Yelmana Densa *woreda* nutrition coordinators and tech teams	7	Incl. heads of offices for health and agriculture, *kebele* administrator, extension workers and community leaders
Total	**42**	

Source: Authors' own

Tailored to the specific roles of informants, data collection instruments and checklists were developed. The instruments were used to collect data from the major nutrition policy cycle components: obstacles and progress in nutrition policy and programme design, coordination and implementation, and M&E. A series of main – and probing – questions were asked, including around: (1) nutrition agenda setting, and policy and programme design; (2) multi-sectoral coordination and implementation; and (3) mechanisms put in place to monitor, and evaluate programme implementation and outcomes. Finally, interviews were transcribed and recurring themes were coded, followed by analysis and synthesis.

4 Ethiopian nutrition politics, policy and practice

4.1 Nutrition political economy context

With a population of over 110 million people, Ethiopia is the second most-populous country in Africa, after Nigeria (World Bank 2019a). Its government is a federal parliamentary republic, with nine self-governing regions and two city administrations. Following the fall of the communist regime in 1991, until November 2019 (Endeshaw 2019)[7] the government was ruled by the Ethiopian People's Revolutionary Democratic Front (EPRDF). Shortly after it came to power, the EPRDF-led government implemented a series of policies, strategies and plans to develop Ethiopia's economy and society. One of the earliest of these was Agricultural Development-Led Industrialisation focused on smallholder agriculture development and food security (Ayele 2020; Ayele *et al.* 2020). The Plan for Accelerated and Sustained Development to End Poverty (PASDEP) (2005/06–09/10) (FDRE 2006) gave significant consideration to nutrition. While the narrative under the agriculture and productive safety net programmes sections continued to be around food security, concerted efforts were made in the health sector during the plan period to improve the nutritional status of under-fives in particular (*ibid.*).

In the 2000s, Ethiopia embraced the 'developmental state' approach, and the government went on to play an even more active role in the economy. The first Growth and Transformation Plan (2010/11–14/15, GTP-I) (FDRE 2010) and GTP-II (2015/16–2019/20) (FDRE 2016a) aimed to achieve high economic growth through rapid industrialisation and structural transformation, and thereby attain the vision of becoming a lower middle-income country by 2025. Nutrition is also mainstreamed in the GTPs, particularly in GTP-II (FDRE 2016a). The implementation of successive national plans led Ethiopia to register double-digit growth for over a decade (FDRE 2016). Ethiopia's gross national income per capita grew from US$120 in 2000 to US$660 in 2016. Average life expectancy increased from 49 years in 2000 to 65 in 2016, and the poverty headcount ratio fell from 44.2 per cent in 2000 to 29.6 per cent in 2016 (at US$1.90 per day).[8] Ethiopia's ambitious plan is to end hunger by 2030 (FDRE 2016b; World Bank 2017).

Ethiopia has made concerted efforts to reduce undernutrition (FDRE 2008; 2016c). It has also joined forces with global actors in the fight against undernutrition; for example, it joined the Scaling Up Nutrition (SUN) movement in 2012. It is also signatory to:

- The 2003 Maputo Declaration, also known as the Comprehensive African Agriculture Development Programme (CAADP), a framework that addresses food and nutrition security in the region;
- The 2014 Malabo Declaration on Accelerated Agriculture and Growth and Transformation for Shared Prosperity and Improved Livelihoods, which is under the CAADP framework;
- The 2013 Global Nutrition for Growth Compact;
- The SDGs, including SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture; and
- WHO global targets 2025.
  (FDRE 2016b; 2016c)

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[7] In November 2019, the EPRDF was dissolved and the new Prosperity Party was formed. Since taking power in 2018, Prime Minister Abiy Ahmed has embarked on radical political and economic reforms, including filling 50 per cent of his cabinet with women and appointing a female head of state in 2018 (see Endeshaw, 2019).

[8] See: https://data.worldbank.org/country/ethiopia (accessed 15 January 2020).

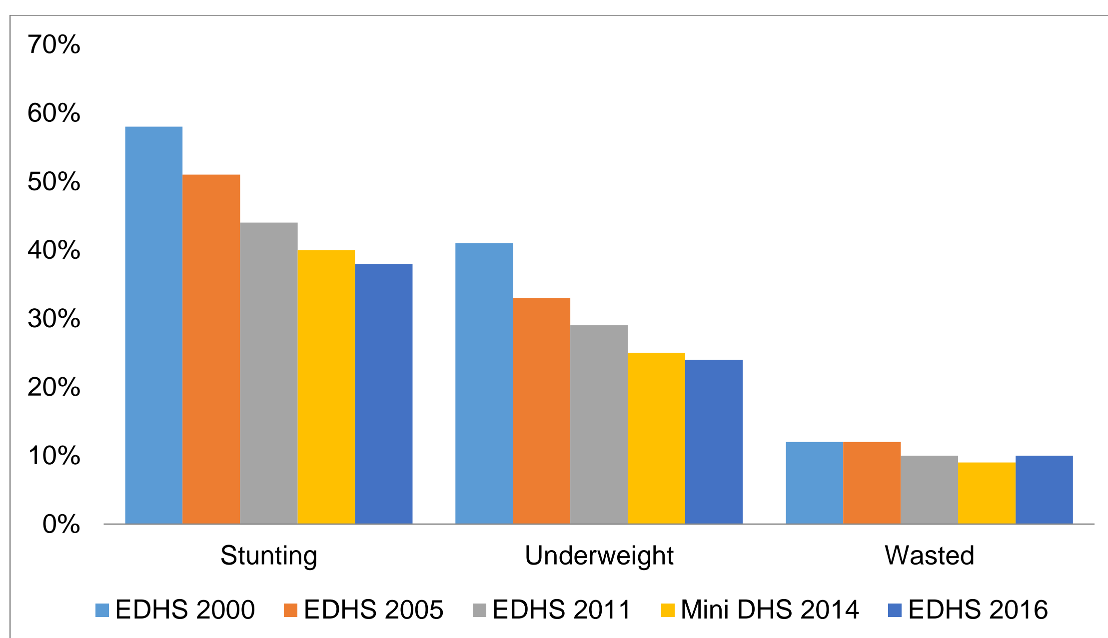
Most importantly, as discussed below, Ethiopia launched its own declaration – the Seqota Declaration – to end child undernutrition by 2030 (FDRE 2016b). As part of NNP-II, two key goals of the declaration are zero stunting in under-fives and 100 per cent access to adequate food all year round (FDRE 2016c).

4.2 Trend and status of nutrition

Ethiopia tracks its nutrition status through well-established indicators such as stunting, wasting, being underweight, and the proportion of women of reproductive age (15–49 years) with a body mass index (BMI) < 18.5. Based on these indicators, Ethiopia has made progress in reducing undernutrition (see Figures 4.1 and 4.2). Successive editions of the Ethiopian Demographic and Health Survey (EDHS) show that, over the period 2000–16:

- The prevalence of stunting reduced from 58 per cent to 38 per cent;[9]
- The proportion of under-fives who were underweight decreased from 41 per cent to 24 per cent; and
- The prevalence of wasting decreased from 12 per cent to 10 per cent (while the explanations are unclear, only a small rate of change was observed here).

Figure 4.1 Trend of nutrition status among Ethiopian children



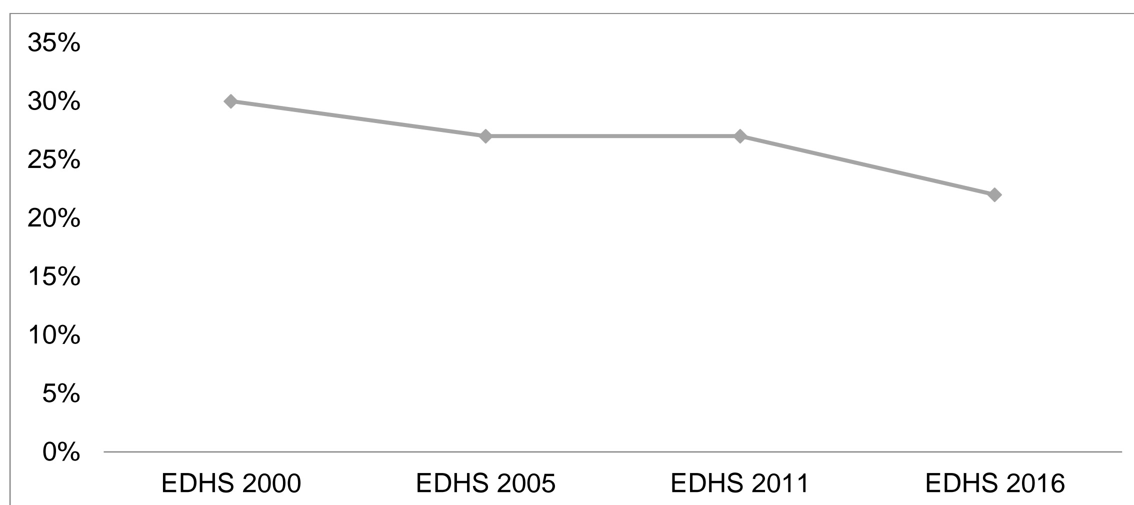
Source: Authors' own, based on data from CSA (2001, 2006, 2012 and 2017)

4.2.1 Proportion of women of reproductive age (15–49 years) with BMI < 18.5

Undernutrition of women aged 15–49 year is measured by BMI less than 18.5. Based on this criterion, the proportion decreased during 2010–16, but 22 per cent remained thin (Figure 4.2). Figure 4.2 also shows that, while there was almost no change during 2005–11, there was an overall decline between 2000 and 2016.

[9] Indeed, some projects and programmes show major successes in reducing undernutrition in areas. For example, the EGINE Ethiopia programme led to a reduction in stunting BY 20 per cent in Amhara, by 14 per cent in Southern Nations, Nationalities and Peoples Region, and by 12 per cent in Oromia. Underweight prevalence declined in 25 of 26 *woredas* (districts) assessed. The programme was well coordinated and multi-sectoral, involving health, agriculture and WASH; and involved non-state actors, notably the private sector, in programme implementation (Save the Children 2016).

Figure 4.2 Trend of nutrition status women of reproductive age (15–49 years) with BMI < 18.



Source: *ibid.*

While these figures are showing improvements, first, it is worth noting that they are still poor by global standards: by the government's own admission, Ethiopia's undernutrition records are unacceptable and among the highest in sub-Saharan Africa and the world (FDRE 2016c). Up to 70 per cent of children in Ethiopia are at risk of stunting, and 38 per cent are actually affected (CSA 2017). Second, the spatial distribution of undernutrition is significantly uneven and a source of major concern. While 38 per cent of under-fives are stunted across the country, Amhara, Benishangul-Gumuz, Affar, and Dire Dawa are the regions most highly affected by child stunting, with proportions ranging from 41 per cent to 46 per cent. Similarly, wasting imposes the heaviest burden in Somali, Affar, and Gambela, with rates of 23 per cent, 18 per cent and 14 per cent, respectively (CSA 2017). Finally, research shows that the cost of undernutrition (health, education, productivity, etc.) is very high – as much as 55.5bn birr per year (FDRE 2013b) – and stands as a major impediment to Ethiopia achieving its ambitious goals of reaching middle-income country status by 2025 and meeting commitments such as the SDGs by 2030 (FDRE 2016c; 2018).

Recognising the magnitude of the challenge, NNP-II (2016–20) (FDRE 2016c) came up with a list of nutrition-specific and nutrition-sensitive interventions (Table 4.1). Nutrition-specific interventions, such as those that enhance access to micronutrients, are set to be delivered within existing health service delivery platforms and health tiers, namely community health extension programmes and health facilities; whereas nutrition-sensitive interventions are meant to deal with the different underlying determinants and causes of undernutrition, such as access to adequate food and sufficient health services. After two years' consultation, the Ministry of Agriculture and Natural Resources and Ministry of Livestock and Fisheries also produced a joint national nutrition-sensitive strategy in 2017 (FDRE 2017a). Likewise, the National Food Fortification Program Plan of Action (FDRE 2017b), National School Health and Nutrition Strategy (FDRE 2012) and many other programmes are being undertaken by the government, donors and CSOs around water, sanitation and hygiene (WASH), health and nutrition programmes all over the country. These interventions recognise that undernutrition manifests itself in different multi-sector arenas, and multi-stakeholder interventions are required to address them. For example, nutrition-sensitive agricultural interventions are now said to be essential components of the Productive Safety Net Programme and the Agriculture Growth Programme (FDRE 2016c).

Table 4.1 Nutrition-specific and nutrition-sensitive interventions

Nutrition-specific interventions
• Maternal, infant and young child nutrition promotions • Micronutrient interventions • Community management of acute malnutrition • Management of moderate acute malnutrition • Promotion of breastfeeding • Preventative zinc supplementation; and vitamin A supplementation and deworming • Pre-conceptual folic acid supplementation or fortifications • Maternal balanced energy protein supplementation • Maternal calcium supplementation • Maternal micronutrient supplementation • Appropriate complementary feedings
Nutrition-sensitive interventions
• Mainstreaming Nutrition into Agriculture (nutrition-sensitive agriculture initiatives) • School Feeding Program • Food safety and food processing; and Food Fortification • Family planning: healthy timing and spacing of pregnancy • Water, sanitation and hygiene (WASH) • Early childhood care and development • Girls' and women's education, economic strengthening • Livelihoods and social protection.

Source: FDRE (2016c)

An embodiment of the government's commitment to end stunting in children under the age of two (under-twos) is the ambitious Seqota Declaration, which aims to bring stunting of under-twos to zero by 2030. The name and the focus area of the initiative are not accidental: Seqota (the town and the *woreda* or district) is located in the northeast of Ethiopia. It was the epicentre of the 1984 famine – over 4.3 million people in Seqota and its environs still suffer from stunting levels ranging from 60 per cent to 80 per cent, and food insecurity (FDRE 2018b). Although it started in Seqota, and the surrounding Tekeze valley, the Seqota Declaration is to be implemented over 15 years in three phases, aimed at reaching the country at large (FDRE 2016b; 2018b):

- Phase 1: Innovation or community labs phase (2016–18) – high-impact interventions were piloted in 32 *woredas* in Amhara and Tigrai regions stretching along the Tekeze River Basin (FDRE 2018b).
- Phase 2: Expansion phase (2019–20) – best practices of high-impact interventions are being rolled out to reach the most vulnerable communities across the country.
- Phase 3: National scale-up (2020–30) – best practices will be scaled up to national level.

An estimated US$538.7 million was earmarked to implement phase 1 of the Seqota Declaration (FDRE 2018b). As with all three phases, the more elaborate pilot phase is anchored in a multi-sector and multi-actor approach to interventions. Three of these are (FDRE 2016b):

- The MoH is leading on an intervention that addresses 'nutrition through the life cycle' – tackling child undernutrition in the first 1,000 days (from the start of a woman's pregnancy until her child's second birthday).

- The Ministry of Agriculture is implementing a pilot intervention referred to as agricultural innovation and technology centres – the idea is to introduce innovations that lead to ending hunger and achieving food self-sufficiency.
- The Ministry of Water, Irrigation and Electricity's response is the most comprehensive (and also expensive) pilot intervention, whose implementation requires setting up river basins.

As the architect of the declaration, former minister of health Dr Kesetebirhan Admasu, noted; '[The] Seqota Declaration is a blueprint for multi-sector nutrition programmes development'. For Admasu, multi-sectoral coordination in Ethiopia has been 'a talking shop'. But, he argued, the Seqota Declaration has taken it to a different level: programme design and implementation avoids fragmentation at multiple levels as there is only 'one plan, one budget and one report'.[10] But, as with the implementation of many other nutrition programmes, it started slowly and is still in phase 1. It faces major funding gaps: in 2018, sources for 51.5 per cent of the US$538.7 million investment plan had not been identified (FDRE 2018b).

4.3 Nutrition governance and coordination

To understand how narratives, policy and practice around undernutrition have evolved and shaped current politics and policy and practice, in this subsection we review the literature on the evolution of nutrition policy, governance and multi-sectoral coordination.

4.3.1 Evolution of nutrition politics and policy and practice

We identify three eras of nutrition politics and policy and practice (Table 4.2). First, the history of modern nutrition politics and policy and practice goes back to the early 1960s. The Ethiopian Nutrition Institute was established in 1962 (Wu 2009). The 1960s and 1970s were characterised by events-led, *ad hoc* and reactive responses to recurrent droughts and famines, which were caused by the droughts and political conflicts, leading to the establishment in 1974 of the Relief and Rehabilitation Commission (RRC). In particular, the 1984–85 famine resulted in the loss of over a million lives and triggered the creation of the Early Warning System. The government (through the RRC), the Ethiopian Red Cross Society and donors were the primary agents in planning and implementing food and nutrition programmes (Keller 1992).

The second era roughly covers the 1980s and 1990s, which featured the emergence of community projects, one of which was the Sidama community project, which ran over 1984–92 (Wu 2009). An important development during this period was a conscious move towards multi-sectoral governance of nutrition, which in 1987 led the Derg regime to establish the Nutrition Unit within the Ministry of Planning and Economic Development (Taylor 2012). However, the EPRDF disbanded the unit in 1991 (*ibid.*). In 1995, the RRC was replaced by the Disaster Prevention and Preparedness Commission, which in 2004 became the Disaster Prevention and Preparedness Agency, the precursor to the present-day Productive Safety Net Programme. Moreover, in 1998 a series of health sector programmes (not nutrition *per se*, but including preventative healthcare) were introduced (Save the Children 2016; Taylor 2012).

[10] Speech by Admasu, speaking at a side event titled 'Seqota Declaration – An Innovative Government of Ethiopia Commitment to End Stunting in Children Under Two Years by 2030: Taking Stock of Progress' at a meeting of the UN General Assembly in 2019.

Table 4.2 Three eras of nutrition politics and policy and practice in Ethiopia

Era 1: 1960s and 1970s – *ad hoc* and reactive responses to disasters	Era 2: 1980s and 1990s – emergence of community projects	Era 3: 2000+ move towards multi-sector nutrition policy design and implementation
1962: Ethiopian Nutrition Institute formed (Wu 2009) 1970s: responses to recurrent droughts and famines (Taylor 2012)	1984–92: Sidama community project (Wu 2009) 1980s: responses to recurrent droughts and famines (Taylor 2012) 1987: Nutrition Unit formed in Ministry of Planning (Taylor 2012)	2000+: a series of EDHS published 2005–10: PASDEP 2008: National Nutrition Strategy 2013–15: NNP-I 2016–20: NNP-II 2015: Seqota Declaration 2016: Seqota Implementation Plan (FDRE 2016d) 2019: Food and Nutrition Policy
Main actors: RRC, Ethiopian Red Cross Society and donors	Main actors: RRC, Ethiopian Red Cross Society and donors	National actors: NNCB, NNTC, ministries Regional/subregional actors Global actors: UN, bilateral and multilateral actors Non-state actors (non-governmental organisations and private sector)
Main narrative: food security	Main narrative: food security	Main narrative: food security and nutrition security

Source: Authors' own

The third era started from roughly 2000 and has continued to run up to the present day. This period is characterised by efforts to set up multi-sectoral governance for nutrition policy design and implementation. Official documents such as NNP-II (FDRE 2016c) indicate that several developments influenced this move towards multi-sectoral coordination of nutrition, including EDHS findings, the *Lancet* series (2008; 2013), international commitments to Millennium Development Goals and SDGs, and the emergence of global actors, notably the SUN Movement.

Here, some key observations can be made. First, despite the prevalence of high levels of chronic malnutrition in food deficit and food surplus regions, historically, Ethiopia's nutrition policy has been around food production and food security (Pelletier *et al.* 1995). The fact that nutrition was not prioritised meant that the approach significantly undermined efforts to reduce undernutrition. Second, the narrative and framing of nutrition changed, particularly in the 2000s, leading Ethiopia to increasingly take steps to shift towards a more proactive approach to reducing undernutrition. Many of the current strategies and programmes came about due to this shift. Third, the institutional landscape also changed. Many players have become major players in fighting undernutrition, such as: SUN; major donors including the United States Agency for International Development (USAID) and the Department for International Development (DFID); UN agencies such as FAO; and research agencies and thinktanks such as the Ethiopian Public Health Institute (EPHI) and International Food Policy Research Institute. The policy narrative broadened to include nutrition security, although effective progress towards reducing undernutrition has either been slow or insufficient.

4.3.2 Ethiopia's multi-sectoral nutrition governance and coordination

Ethiopia set up its multi-sectoral nutrition governance and coordination in 2008 (FDRE 2008).[11] The governance structure clearly recognises that nutrition affects and is affected by many factors, including food production and access, health and education impact on individuals, families and communities. Core sectors and actors – members of the donor organisations and CSOs, and the private sector – are thus represented in the governance structure (Figure 4.3). Moreover, as a number of researchers note, including Kennedy *et al*. (2015) and Harris *et al*. (2017), the Ethiopian nutrition governance structure and its programmes mirror international movements such as SUN and/or priorities advocated by such agencies. The structure endorses evidence-based global practices. For example, the Seqota Declaration endorses the life cycle approach and is aligned with global nutrition agendas, and national and international goals – such as the GTP and Ethiopia's commitments to the SDGs. Second, NNP-I provides the framework for strategic objectives and interventions in all sectors including health, agriculture, education, water, labour and social affairs, women, children and youth affairs. It endorses a multi-sectoral governance approach and was developed with the support of –and in collaboration with – multiple actors, including national government actors and multilateral and bilateral donors (Kennedy *et al*. 2015).

Until 2016, the NNCB was led-by a senior minister of health; but since then, to enhance leadership and multi-sectoral coordination, it has been chaired by the deputy prime minister. The NNCB convenes 13 signatories:[12] ministries from relevant sectors[13] and representatives from UN agencies, donors and academia. The national nutrition governance structure is supported by the NNTC.[14]

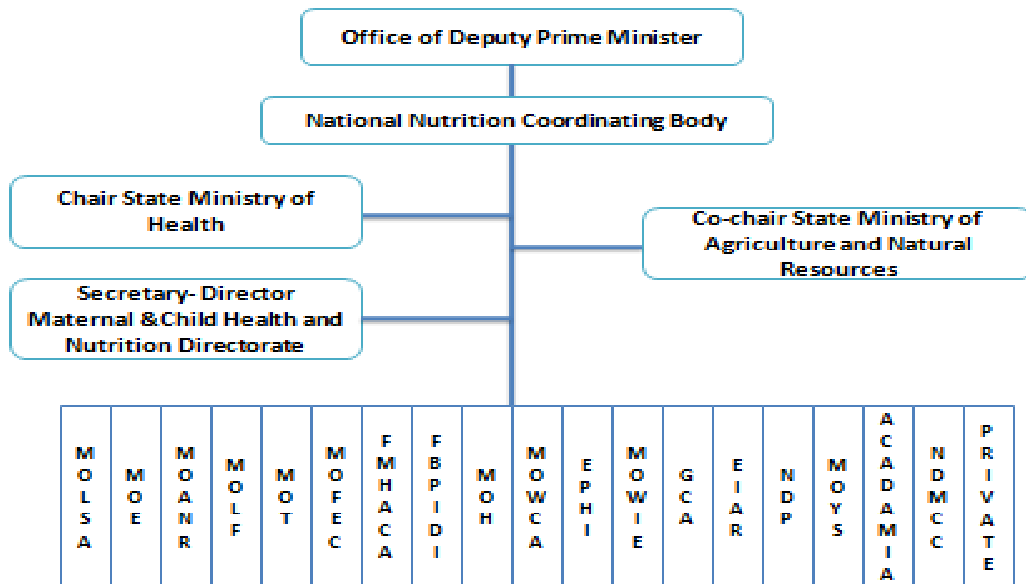
[11] Lack of coordination is endemic in this topic area (see Benson 2007; Reich and Balarajan, 2012; and Balarajan and Reich 2016), but it is claimed that a coordinated approach delivers better and stronger impact (FAO/WHO 2014).

[12] These include: the Office of Deputy Prime Minister; Ministry of Health; Ministry of Agriculture and Natural Resources; Ministry of Livestock and Fisheries; Ministry of Education; Ministry of Trade; Ministry of Labour and Social Affairs; Disaster Risk Management Coordination Commission; Ministry of Water, Irrigation and Electricity; Ministry of Finance and Economic Cooperation; Ministry of Women and Children's Affairs; Ministry of Environment, Forest Development and Climate Change; Ministry of Youth and Sport; and Government Communication Affairs Office. In addition, the Nutrition Development Partners Meeting; and the private sector (PRIVATE).

[13] At the time of writing, the number ministries was believed to be nine but no official list was available. This was because on 16 October 2018, the number of ministries in the country was reduced from 28 to 20 – some ministries that play key roles in nutrition such, as the ministries of industry and trade, have merged; see: www.independent.co.uk/news/world/politics/ethiopia-prime-minister-abiy-ahmed-cabinet-appointments-women-a8586876.html.

[14] SUN sources also indicate that Ethiopia has a Nutrition Development Partner Group, which engages UN agencies, donors and civil society. DFID and UNICEF act as donor conveners, and CSOs participate in the group and other relevant platforms. In 2013, the Ethiopian Civil Society Coalition was established to galvanise efforts to alleviate the burden of malnutrition. The business community has rallied support through the Ethiopian Chamber of Commerce. Also, the Multi-Stakeholder Food Fortification Working Group has been instrumental in setting quality standards for salt iodisation and flour and oil fortification see: http://scalingupnutrition.org/sun-countries/ethiopia/.

Figure 1.3 Structure of the National Nutrition Coordinating Body



Notes: MOLSA = Ministry of Labour and Social Affairs; MOE = Ministry of Education; MOANR = Ministry of Agriculture and Natural Resources; MOLF = Ministry of Livestock and Fisheries; MOT = Ministry of Trade; MOFEC = Ministry of Finance and Economic Cooperation; FMHACA = Food, Medicine and Health Care Administration; FBPIDI = Food, Beverage and Pharmaceutical Industry Development Institute; MOH = Ministry of Health; MOWCA = Ministry of Women and Children's Affairs; EPHI = Ethiopian Public Health Institute; MOWIE = Ministry of Water, Irrigation and Electricity; GCA = Government Communication Affairs; EIAR = Ethiopian Institute of Agricultural Research ; NDP = Nutrition Development Partners; MOYS = Ministry of Youth and Sports; NDMCC = National Disaster Management Coordination Council; PRIVATE = private sector.

Source: Authors' own, based on FDRE 2016c

Limited studies were conducted on Ethiopia's multi-sectoral nutrition programme coordination and implementation. An extensive study by Kennedy *et al.* (2015; 2016) identified key nutrition challenges as undernutrition, food security and deficiencies in micronutrients. Other challenges included low awareness levels, and issues of leadership, coordination, collaboration, advocacy, and the lack of dedicated budget lines. The study also shows that budgetary problems are most pronounced in Amhara, while low awareness levels about nutrition challenges are a major problem in Tigray. Kennedy *et al.* (2015) highlighted the poor level of nutrition governance at lower levels of administrations. They noted that 'most interviewees can see the benefit in collaboration and coordination but find it difficult to envisage a modus operandi that will be effective in accomplishing this end' (Kennedy *et al.* 2015: 542). As often was the case, where the MoH dominated the scene, respondents complained that it was not 'fair' to call the NNP multi-sectoral.

Woredas and *kebeles*[15] are arenas where interventions and programmes are implemented, and Warren and Frongillo's (2017) study shows how nutrition-sensitive programme implementation is affected at the subregional level by mid-level implementing actors. They found that nutrition programme implementation at the subregional level faces complex challenges. First, a top-down approach means that those at grass-roots level have no input and struggle with a top-down approach to information flow, often finding that higher-level decisions are not communicated until the last minute; unplanned assignments of tasks add to workloads and budgetary burdens. Second, there is a shortage of nutrition experts,

[15] A *kebele* is the smallest, localised administrative unit of Ethiopia; a *woreda* is made up of *kebeles* and is roughly equivalent to a district.

particularly in agriculture-related nutrition-sensitive programmes.[16] Third, turnover of mid-level staff was high due to low pay, poor working conditions, and, in some cases, an inability to take technical decisions. Finally, the party system dominates both the technical and administrative aspects of interventions, making it challenging for professionals to take decisions even on implementation. A related critical study of the Ethiopian health system (Ostebo, Cogburn and Mandani 2017) shows how often politics encourages a 'one-sided' or 'positive' outcome. They note that those who speak up and address real challenges often face adverse consequences, including job losses (*ibid.*: 7). While these studies are strong in identifying problems, they do not provide concrete solutions to complex challenges. This study aims to fill this gap.

5 Drivers of political commitments for nutrition: macro-level empirical data and findings

Key informants at the federal level, including programme coordinators, were asked a series of questions about the drivers of nutrition, how nutrition agendas were set and adopted, and whether these were evidence based and participatory. The ultimate objective was to understand whether there are sufficient drivers of political commitment for nutrition, including actors, networks and institutions that provide coordination and policy guidance; and the presence of capacities such as human and financial resources that could sustainably drive a reduction in undernutrition. The subsections below capture key responses and findings.

5.1 Nutrition actors and stakeholders

We found a range of state and non-state actors with common interests, working in loose networks –such as the Donors' Working Group on Nutrition and the Ethiopian Civil Society Coalition – making diverse contributions to reduce undernutrition. Informants noted that the national nutrition policy and programme design, coordinated under the auspices of the MoH, was highly participatory, in that many it involves relevant state and non-state actors. State actors, in particular, were keen to highlight that the process was 'open and participatory'; besides, the relevant government bodies, private sector, donors, CSOs and advocacy agencies, and academia were represented in the nutrition governance structure, and made a valuable contribution to policy and programme design (FI01).[17]

Non-state actors also confirmed their 'wider' participation in nutrition policy and programme design, which took different forms – some contributing to proceedings in working groups on programme development, others involved in consultation meetings or in forums where draft documents were presented and discussed. Actors' contributions also ranged from providing oral feedback at meetings to substantive written comments on draft documents. Actors' participation – particularly among representatives of donor and CSO communities – also extended to sectoral and regional nutrition programme designs. However, informants' responses to the effectiveness of their participation varied. Some – particularly UN agencies – appeared to be effectively engaged. An informant who represented a major UN agency noted that:

[16] In agriculture, nutrition-sensitive interventions are implemented through the government's flagship programmes, the Productive Safety Net Programme and Agricultural Growth Programme.

[17] Definitions of interviewee acronyms: AM = Amhara region; CS = civil society organisation; DC = donor community; FI = federal; PR = private sector; RT = research/thinktank.

> We have been involved in every step of policy and programme development. We have been part of the design of NNP-I and NNP-II, we are a member of NNCB, sit in NNCT and we also have a vibrant advocacy plan for nutrition. [In short] we have been at the heart of the nutrition programme development (DC07).

Government and some CSO actors underlined that while key actors participated and contributed to the proceedings, 'the government has been the main driver of the agendas' (CS12). However, while the donors and CSOs are generally supportive of the nutrition agenda and keep it going, they have not been proactively driving agendas. The donor community, in particular, lacks effective coordination within itself. An informant from the donor community noted that:

> We have a donor platform [Working Group on Nutrition] which focuses on key policy issues, we meet monthly and discuss topics such as food fortification and try to come up with advocacy points… but we have not been well coordinated among ourselves to influence outcomes (DC05).

The second critique that came from informants was that regional representatives were drawn into the design after an early programme draft had been developed:

> after a full draft was produced, regions were engaged from all the respective sectors to comment on and contextualise initiatives at the regional and sub-regional levels, and some of the regions came with their own perspective (FI01).

Informants also noted that a major impediment to regional staff involvement was a shortage of regional expertise in nutrition and that delayed engagement limited the inclusion of the diverse dietary needs in the regions in the national programme.

5.2 Knowledge, evidence and framing

Informants pointed out the understanding of the causes and consequences of undernutrition and the role that evidence plays in the design and implementation of programmes. Many informants stated that Ethiopia makes use of credible evidence to design its programmes. A member of the NNCT noted that:

> our approaches [to programme design] involve a systematic desk review of the available national and international evidence. As we did for the NNP-I, while designing NNP-II programmes, we distilled existing knowledge in scientific publications and experiences of countries on stunting, anaemia, maternal diet, communicable and non-communicable disease, etc. and related these to our own contexts. Many of our drafts, and finally approved interventions were based on these findings (FI01).

Likewise, many informants confirmed that Ethiopia makes 'efforts to bring global learning to its nutrition programme design and contexts' (DC05). EDHS survey findings and the *Lancet* series were frequently mentioned as sources of evidence. Ethiopia's own experience of implementing NNP-I was used 'as input' in the designing NNP-II. The nutrition governance structure endorses evidence-based global practices and informants noted that it has joined global actors, such as the SUN Movement, which has helped to tap into global knowledge and evidence. That said, some informants noted limitations; for example, the dietary diversity of Ethiopians has not been sufficiently looked at.

5.2.1 Framing issues

Here divergence was observed in perspectives, particularly among those who were involved in designing programmes. The first perspective is more in support of nutrition-sensitive or developmental nutrition, while the second one promotes health-specific programmes:

> As much as you focus on the broader nutrition agenda, [one] needs to allocate more resources to reducing problems such as diarrhoea and pneumonia. We need a narrative that directly links nutrition to health outcomes (DC06).

> I think what is missing most is coordination on the development of nutrition… emergencies seem coordinated better, but on the development side, not so much effort has been exerted (DC05).

Such differences, according to some of the informants, led to competing programmes and lack of direction on when and how to support programmes. Moreover, despite the fact that 'food and nutrition security' has become an official development narrative in Ethiopia, interviewees noted that bureaucrats in a significant number of ministries and bureaux hold the view that nutrition is a matter of 'cooking wot' (a sauce to eat injera with) or at best includes midwifery services – roles traditionally assigned to women. This unreformed perspective is a manifestation of poor understanding or lack of awareness about the causes and consequences of undernutrition.

However, with their increasing prominence in the health and agriculture extension systems and senior government positions, women are playing major roles in tackling undernutrition. Lack of awareness about undernutrition and divergences in perspectives are not openly visible, nonetheless both persist and adversely affect programme design and implementation. Yet, nutrition coordinators have not established clear lines of communication with core actors. Consequently, some donors continuously revise their positions and sometimes struggle to decide when and where to allocate funding, which means the flow of funding for implementation is adversely affected.

In terms of putting the nutrition agenda on the table, the common view was that many participated and everyone deserves credit:

> Neither us nor anyone else can claim the credit but we, along with many others, participate in policy discussion and intervention development. Nobody has all the answers to undernutrition but initiatives come from different angles, all stakeholders participate (DC07).

5.3 Institutions for multi-sectoral nutrition coordination

Invariably, informants noted that the government had made a high-level policy commitment to reduce undernutrition. A senior informant noted, 'as far as policy commitment goes, albeit the draft national policy came only in late 2018, the government has taken up nutrition as a major policy agenda' (FI03). Many of the interviewees noted that high-level political commitment has translated into a series of institutional commitments and nutrition programmes, including designing, launching and implementing successive NNPs; setting up the NNCB, NNTC and several steering committees, including a steering committee for food fortification; and designating the MoH to 'house' and manage the organisation and management of the NNCB and NNTC.

Key informants were also asked about how multi-sectoral nutrition has been horizontally and vertically coordinated, whether coordination works, and if not, what the main challenges are and how these may be addressed. Here, too, informants acknowledged the progress made over the past few years: nutrition has moved from being an *ad hoc* to a more organised activity of government and relevant actors. However, interviewees were critical of the status of multi-sectoral nutrition coordination. Some said there is no multi-sectoral nutrition coordination to speak of. Others, while acknowledging the problems, emphasised that Ethiopia is still learning how to coordinate multi-sectoral nutrition.

Some critical informants noted, 'The national coordination body, and technical committee members, act like volunteers who move in and out of the committees at will,' (RE11). A subtle point in the above response was that many members of the NNCB and NNTC hardly meet, so cannot proactively provide leadership. Moreover, some proactive members tend to move positions between ministries or relinquish their positions, and progress made in their earlier ministries and bureaux gets 'held up or goes backwards.

The opposite view was that, while it has been over a decade since Ethiopia adopted multi-sectoral nutrition, some say 'multi-sectoral is at a nascent stage' and 'we are still learning' (FI04). It was also noted:

> We've been progressing over the past 3–4 years on multi-sectoral nutrition coordination, but such coordination entails participation and ownership of multiple sectors and actors, and increasing participation and ownership has been a major problem … not all relevant sectors are at the same level and pull together. Some have not made a full commitment and taken the agenda on board; in many of the sectors there are gaps in budgeting and staffing.… Implementation is also low at all levels and commitment is not at the same level in all areas (FI02).

Coordination also varies by sector and region. As noted above, a notable area of weakness was 'coordination on the development nutrition side' (DC05). Compared to the national level, coordination at regional government level was referred to as 'even worse', as any work that federal-level actors do with regions is based on 'personal relationships, not institutionally backed up' (FI04). Regarding donor programme coordination, some critical responses were also made, including:

> we [donors] are not good at coordinating interventions… sometimes I hold donors accountable for that, I mean we've got the Donors' Platform or Working Group for Nutrition but I very much doubt if they actively coordinate interventions supported by themselves (PR09).

Informants mentioned a series of cases where donor-supported programme coordination had failed, including the production of several versions of behavioural change communication posters and leaflets. Supported by a number of donors, posters and leaflets were designed in different local languages. As one informant put it, posters were put up as if to 'decorate extension office walls in *kebeles*, and even walls of extension workers living quarters' (RT1). This duplication of effort – design, translation into local languages, copying and distribution – adds unnecessary costs to the system, and creates confusion in transmitting information to users.

Along the same line, a donor programme manager noted:

> we compete and secure funding, but [donors'] calls for proposals do not articulate how we work with others, programmes are often done without being coordinated with other complementary activities. For example, interventions on behavioural change or emergency food provision are typical here… a good part of it is nutrition or about nutrition but hardly coordinated with other nutrition-based activities (PR09).

Informants clearly noted failures of coordination, such as between ministries, regions and donors. In some sectors, such as agriculture, nutrition programme coordination was a problem. The crop and livestock segments were 'disconnected' until recently, as they were in different ministries. The lack of a dedicated team within the ministry was also a challenge in terms of coordinating internal and external actors, including donors, but this has now 'been addressed and we coordinate the sector as a whole' (FI04).

5.3.1 Causes of weak multi-sectoral coordination and possible solutions

Informants gave a number of reasons for weak multi-sectoral coordination. First, almost all informants identified lack of accountability as a major cause of coordination failure. An informant gave an elaborate description of the challenge they face time and again:

> To me, lack of coordination is to do with weak accountability mechanisms. At the heart of it is power relations – who has more power than others. Members of the NNCB and NNTC are at the same or parallel power level. It has been difficult for chairs of NNCB and NNTC to hold members to account for their inactions. Many members thus act as if they are volunteers, sometimes they turn up for meetings and other times they don't even show up (FI01).

Another key informant noted:

> The way I see it, representatives of sector ministries [who are at equal level] do not seem to accept the leadership from the MoH and the latter's power over them. Vertical coordination is even worse for the same reason – MoH has no power over the regions (DC06).

Second, many informants gave lack of effective coordination tools as a reason for coordination failure. However, those who lead on coordination were adamant that the NNCB and NNTC 'meet regularly': the NNCB meets twice a year and NNTC meets quarterly but, of late, meetings have been sporadic. Only a few members, such as those from the ministries of agriculture, water and education regularly participate. Many others do not even turn up.

Third, quite a number of informants noted that the MoH's leading coordination has been part of the problem, as the ministry suffers from perceived and/or real bias in dealing with nutrition matters:

> In my view, from the start, MoH should not have been assigned to lead on multi-sectoral nutrition coordination. On many occasions, it has shown clear cases of bias in favour of its programmes – it receives significant resources… and pumps [them] into its own programmes… but only a small amount of resources go to other sectors (FI04).

Fourth, informants noted the MoH's inability to coordinate complex tasks:

> although MoH makes credible efforts to drive the multi-sectoral nutrition agenda, multi-sectoral coordination remains a secondary task to its core programmes, it has no multi-sectoral perspective to create vertical and horizontal synergy between actors, its staff are more oriented towards health interventions, they are dependent on a few pro-health donors (FI05).

Finally, we asked informants for suggestions to address coordination failure: who should coordinate multi-sectoral nutrition and how. Informants' responses were mixed. Some favour current arrangements, but said they should be strengthened:

> The way I see it, MoH has the experience and institutional structure (albeit not sufficiently staffed) to coordinate multi-sectoral nutrition. Starting all over again or shifting to another ministry would mean loss of this experience (CS12).

Other informants suggested an entirely new model for coordination:

> In my view, MoH should not front multi-sectoral nutrition coordination. MoH is still about diagnostics of health issues, it hardly looks at preventative issues, production, etc. A truly multi-sectoral nutrition needs to be established. We need an independent agency, *the* agency dedicated to nutrition only. An agency that leads on policy and programme design, mobilises and fairly distributes resources to implementing bodies (CS10).

Informants are also divided over what shape the multi-sectoral coordinating body should take. However, many pointed to implementing the new nutrition policy, which includes a council or agency under the auspices of the prime minster that would have clear mandates and measurable deliverables.

5.4 Capabilities and resources for multi-sectoral nutrition implementation

We asked informants whether nutrition programmes have been implemented as intended and, if not, why not and what could be done to improve implementation. Questions focused on whether implementation strategies were developed and mainstreamed within the implementing sectors, and whether case teams had been set up and budget was allocated to implement programmes as stipulated in NNP-II effectively. Responses are detailed below.

First, informants noted what is now public knowledge: that only a few ministries had developed action plans (the ministries of health, agriculture, industry and education). Moreover, informants noted that while NNP-II runs from 2016 to 2020, implementation started at a slow pace. Only a few line ministries drew up action plans immediately after the signing of NNP-II. Some took time to start, while others have still not started.

Informants acknowledged the government's political commitment, but were invariably critical of the lack of or limited implementation:

> No doubt there is a commitment to nutrition verbally and on paper but something always drops off at the end of that commitment, in terms of leadership, accountability and planning for the eventual implementation and carrying out those responsibilities by stakeholders. If you were to ask me to define what it takes to make a commitment towards nutrition you need a yearly work plan, but also it does involve leadership, putting in place mechanisms to achieve the outcomes related to the commitment and organisational development and coordination. I don't think all that has been included when we see the commitment on behalf of many of the line ministries that have signed up to the national nutrition plan – that is what we have been struggling with (DC05).
> Yes, we have got NNP-II programmes and a number of flagship programmes… but, at the implementation level, you are lost… there is no or little priority accorded to implementation (DC06).

Second, among those ministries that have started, mainstreaming of nutrition within sector ministries has been a challenge. Some informants attribute this to the very nature of multi-sectoral coordination. It takes time to negotiate and agree on programmes, but many agree that the problem is fundamentally to do with lack of leadership. As one informant succinctly put it:

> Delays, I think, have to do with the work level in implementing ministers, having to wait for the go ahead, somebody to give them the green light… [there you have] any decision-making process getting stalled… clearances, mechanisms on the ground, any change has to start with a significant level of training that is heavy and often does not add value to implementation (DC05).

Third, problems in nutrition case team formation – and budget allocation – were another area that many of the informants noted. Table 5.1 provides details on case team establishment. Accordingly:

- Five line ministries set up teams of more than one person.
- Seven ministries, however, had only a focal person whose roles, according to our informants, are no more than to attend nutrition-related meetings, some not even regularly turning up.

As admitted by an NNTC member, staffing for nutrition has not been the priority of the Ministry of Finance (MoF). In fact, within the ministry 'neither staff nor budget matters is talked about' (FI07).

Table 5.1 Nutrition case teams by ministry

Line ministry	Case team/directorate (total number of staff)	Of which seconded staff	Year of establishment
Ministry of Health	13	4	2014
Ministry of Agriculture and Livestock	8	3	2016
Ministry of Industry	4	1	2018
Ministry of Water, Irrigation and Electricity	2	–	2014
Ministry of Education	3	2	2015

Source: Authors' own

There are two more points to note here. First, despite multi-sectoral nutrition planning and implementation having started some ten years ago, many case teams were set up during or after the launch of NNP-II in 2016. Second, ministries were 'dependent on seconded staff', including those ministries with relatively better performance records (MoH and MoA). Secondment is largely due to the inability to pay for better salaries in the public sector and a shortage of professionals in the market. Staff within the Ministry of Industry (MoI, now the Ministry of Trade and Industry) have not been effective either: apart from salt iodisation, no programmes led by the ministry have started.

Informants noted not only staff shortages as a major problem, but also staff turnover. It takes time to train and orient staff on the causes of nutrition, and retaining them has also been a problem.

5.4.1 Budget for and investment in nutrition

Albeit limited, investment in nutrition has been growing.[18] Informants noted multimillion-dollar investments going into flagship programmes such as the Seqota Declaration, and many other activities included health and agriculture programmes. However, the technical elite and leadership at powerful ministries such as the MoF have little knowledge of nutrition activities. The ministry has not developed an incentive for itself or others to tackle undernutrition, but MoF-based informants, rightly or otherwise, shifted the blame elsewhere:

> For the Ministry financial openness and accountability are key principles in our budgetary allocations. The Ministry allocates budget to an independent and accountable agency that can be monitored. Unfortunately, at least the way we see it, the existing multi-sectoral nutrition arrangement does not give defined owners of nutrition programmes (FI05).

[18] Our informants from the MoF explicitly admitted that the ministry barely tracks investment on nutrition across line ministries, regions and support agencies. However, evidence shows that expenditures to support NNP-II objectives nearly doubled from US$181 million in 2006/07 to US$330 million in 2007/08. By]2008/09, budget allocations were reported as US$455 million, split across nutrition-sensitive programmes (US$333 million; 73%), nutrition in emergency response programmes (US$68 million; 15%) and nutrition-specific programmes (US$54 million; 12 %) (FDRE n.d.).

According to our informants, the challenge for implementing ministries was allocating budget for staff and operating costs. An informant noted that they are able to budget for developing demonstration materials, publications, etc. However, budget for 'capacity development, per diems, travel costs and the like [are] the main bottleneck' (FI04). According to the same informant, the problem is due to 'high cost of living – staff cannot live on birr 174 or 124 as and when they travel to regions… hence, we did not budget for coordination for this year, for example' (FI04).

Preparation and training prior to launching programmes takes far too long. Lack of knowledgeable and skilled personnel in nutrition and allied fields were repeatedly mentioned. Consequently, every intervention, small or large, has to start with an elaborate capacity development programme. However, informants also noted that while such preparation, training, and manual development take a long time, they actually 'add less value to the overall effort' (DC05).

Moreover, priority accorded to nutrition implementation is low. As many informants forcefully stated, often nutrition does not 'compete fairly' with other priorities:

> In the face of other priorities and 'emergencies', it is often the case that policymakers postpone nutrition programmes, as it's not as urgent as tackling unemployment or drought-caused emergencies (DC05).

> Nutrition is a silent problem, those who are malnourished don't even know that they are malnourished so don't mount protests… this is different to cases like unemployed youth who come out and challenge policymakers (DC06).

The view seems to be that authorities can always come back to nutrition, but on the evidence thus far never do. It is clear that lack of agency – to push the agenda for the victim – is a central problem.

5.5 Political and social contexts

Again, informants were asked whether the nutrition agenda is supported through the political system from the higher echelons of political power to departments at multiple levels, and whether this is events based or sustained, etc. Informants noted cases where high-level government officials were on record making commitments for nutrition either orally and/or on paper.[19] For example, an advocacy speech was made by HE Roman Tesfaye, the former first lady of Ethiopia, and HE Demeke Mekonen, deputy prime minister of Ethiopia, at the official launch of the Seqota Declaration. Many ministers and regional presidents also spoke before, at or after the launch, signifying the importance of reducing undernutrition in Ethiopia. In September 2019, the president of Ethiopia[20] hosted an event at the UN General Assembly on the declaration. However, as noted before, there is still a lack of awareness among a section of political leaders, and society at large, as to what undernutrition constitutes, its causes and consequences.

A claim several informants repeated was the role that 'first-hand experience' drawn from visits to countries and/or successful sites within Ethiopia had in turning sectoral ministry and department heads into nutrition champions. For example, many referred to visits to Brazil, Israel and Uganda by teams of senior government officials who, on their return, mainstreamed NNP-II within their respective ministries, and continue to play an active role in

[19] One such key reference to this was the declaration by 13 state ministers as they signed up to NNP-II implementation: 'we, as a government, recognise that the high malnutrition rate in Ethiopia is completely unacceptable' (FDRE 2016c).

[20] Sahle-Work Zewde, who is also the first female president of Ethiopia, appointed on 25 October 2018. She hosted a side event titled 'Seqota Declaration – An Innovative Government of Ethiopia Commitment to End Stunting in Children Under Two Years by 2030: Taking Stock of progress' at the September 2019 meeting of the UN General Assembly.

policy and programme design at the federal or regional levels. It was noted that those who went on these international visits have become real champions of nutrition.

6 Political commitments for nutrition: case study-based findings

6.1 Multi-sectoral nutrition coordination and implementation in Amhara region

Located in the north-western and north-central part of Ethiopia, Amhara is one of nine self-governing regions and two city administrations in Ethiopia. It is the second most-populous regional state after Oromia. The region is believed to be home to some 23.3 per cent of the total population of 110 million people.

A large part of the region is highly productive and produces a large proportion of the country's food and livestock. However, progress towards eradicating poverty is below average. Across Ethiopia, 23.5 per cent of the total population (25.6% in rural and 14.8% in urban areas) were found to be living below the poverty line in 2015/16, whereas the same rate for Amhara was 26.1 per cent (CSA 2018). In terms of nutrition, the national rate of stunting for under-fives is 38 per cent, but the rate for Amhara is 46 per cent. Based on measures of dietary diversity and meal frequency, children in Amhara also receive the lowest minimum acceptable diet.[21] Implementation of multi-sectoral nutrition is all the more urgent to generate positive impacts on nutrition outcomes. The study explored how nutrition programmes are being designed, coordinated and implemented in the region.

6.1.1 Multi-sectoral nutrition governance structure

Mirroring the national structure, informants noted that in 2017 the Regional Nutrition Coordination Body (RNCB) and Regional Nutrition Technical Committee (RNTC) were set up. Thirteen bureaux and partner organisations are represented in the RNCB and RNTC. The latter also involves the Amhara Mass Media Agency and Bahir Dar University. Members of the RNTC reiterated that while the RNCB and RNTC are open to private sector participation, owing to its 'infant' stage of development in the region, the private sector is not represented in either the RNCB or RNTC (AM01).

By invitation, major programme-implementing donors in the region – such as Save the Children and UNICEF – are also represented in the governance structure. Many informants share the view that non-state actors involved in the governance of nutrition in particular have 'put the nutrition agenda upfront' and provided resources – in the form of budget and personnel – to keep multi-sectoral nutrition afloat. The governance body also developed terms of reference for implementing its mandate. According to these, interviewees noted, the RNCB is headed by the region's president and convenes twice a year. Chaired by the head of the Health Bureau, the RNCT is meant to meet monthly. In reality, however, the head of the Health Bureau has become head of the RNCB, as the president has 'little time to discharge his duty' (AM01; AM02).

6.1.2 Multi-sectoral nutrition programme design

Interviews with a number of bureaux heads and members of the RNTC made it clear that the region has developed a multi-sectoral nutrition action plan. The action plan consists of detailed nutrition-specific and nutrition-sensitive programme activities and modalities for coordination. The action plan is a 'direct' adaptation of NNP-II programmes, using 'indicators

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[21] With the highest level (27%) in the capital Addis Ababa and the lowest levels (2–3%) in Affar, Somali, and Amhara (CSA 2017:194).

from NNP-II to contextualise nutrition with the realities of the region' (AM01). While the development of the action plan is broadly considered as progress, some informants commented that the plan did not 'sufficiently use regional evidence to come up with regionally relevant programmes' (AM01). They noted that it lacks strong evidence, for example, on the dietary mix of communities, and social and religious constraints that affect behavioural change.

6.1.3 Multi-sectoral nutrition coordination

Informants stressed that the attention given to nutrition and development of an action plan at the regional level was a 'seismic change' (AM01), and that multi-sectoral coordination has started to work in the health and agriculture sectors at least. Focal persons – not case teams – are being allocated in the two sectors, but staff in other sectors are taking on nutrition as a supplementary role. In terms of awareness creation, progress has been made; for example, the region has made a good start on increasing the dietary mix of households:

> Our awareness creation work is paying off, for example, families are naming their prime assets such as calves/chicken/or fruit trees after their kids to create entitlement to the benefits. Before taking chickens to the market, they make sure that their children have enough eggs to consume… in recent years, children fed with eggs have increased, some anecdotal evidence shows growth from 6 to 66 per cent (AM01).

However, informants noted that multi-sectoral nutrition implementation has been problematic and barely effective, for many reasons. First, a problem noted repeatedly was lack of accountability:

> We plan along with the other sectors and partners, but our programme implementation is weak. Our budget is small, it often comes from donors. But when it comes to accountability, no one is held accountable for failing to deliver on the action plans (AM01).

Informants noted that the source of the problem is 'lack of legal mechanisms to make implementers accountable' (AM02). They also noted that nutrition is seen as a 'supplementary' activity and/or the 'job of Health Bureau', partly because the bureau leads the RNTC. Second, the regional leadership has not accorded priority to nutrition programme implementation. Informants gave many examples of and reasons for this, including failure to lead the RNCB, or to review and hold those who failed to deliver accountable.

Informants noted that other priorities – such as political positioning– prevail over nutrition. Even development partners inadvertently undermine the nutrition agenda, as they often respond to 'emergency nutrition' challenges at the expense of 'developmental nutrition'. The lack of priority is in part due to low levels of awareness. Individuals with a higher level of awareness – acquired through visits, seminars, personal efforts – seem to be performing better than others. These individuals, informants noted, often do not 'externalise challenges' but try to address them using their own capacity and in partnership with each other.

Third, mainstreaming nutrition within bureaux is done at a low level and inconsistent. Only a few bureaux assigned staff to look after nutrition. The Health Bureau has assigned five staff: two paid for by the government and three seconded staff paid for by donor or non-governmental organisation programmes. The Agriculture Bureau has made huge steps, designating focal persons for nutrition in 10 zones and over 50 *woredas*. There are similarly positive developments in the water sector, but many sectors have no proper case team for nutrition. Staff turnover is yet another challenge, particularly in places where nutrition seems to be working: either the leadership and/or experts seem to leave their posts. A related challenge raised was the shortage of staff with knowledge and expertise in nutrition. Even

when bureaux want to appoint staff, they lack people with the right skills, often resorting to seconded staff who are not sustainably paid for with short-term project funding.

Many informants stressed lack of progress, particularly in allocating budget to implement nutrition programmes. Any project implementation is also said to be dependent on donor funding. Examples of the regional government allocating budget tend to be few and far between. But according to one informant (AM01), the regional government allocated 30 million birr towards implanting the Seqota Declaration. A few *woredas* have also started to allocate budget for nutrition activities, including Laye Gaynt, which has allocated 100,000 birr, while North Achefer has allocated 50,000–60,000 birr for nutrition activities. However, such positive developments are led more by individuals rather than being institutionally motivated and driven.

6.1.4 Lack of synergy between horizontal and vertical coordination

Current efforts, though weak, mainly focus on building relationships and coordination among bureaux. Vertical coordination is rather weak and limited to the health and agriculture sectors. For many informants, their greatest concern was that as things stand, Amhara is a long way from reducing undernutrition and meeting the 2030 targets:

> As a region, we have a heavy burden of undernutrition, for example, stunting was 46.3 per cent a couple of years back but all indicators suggest that we are cutting it by no more than 1.5 [per cent] a year – this is not going to get us to zero level by 2030 unless we step up and more than double our efforts (AM01).

The frustration of many actors was that there were no significant signs of change on the horizon that would deliver satisfactory nutrition outcomes by 2030.

6.2 Sustainable Undernutrition Reduction in Ethiopia (SURE) programme

6.2.1 Background to the SURE programme

The SURE programme is a government-led multi-sectoral nutrition intervention that incorporates nutrition services in the health and agriculture sectors. Its aim is to improve child feeding and reduce stunting by up to 26 per cent by 2020 in four regions: Amhara; Oromia; Southern Nations, Nationalities, and Peoples' Region (SNNPR); and Tigray. SURE is being implemented in 150 *woredas* over 2016–19: 37 in Amhara, 75 in Oromia, 25 in SNNPR and 13 in Tigray (Moss *et al.* 2018). The implementation is in three phases. Phase one was launched in 2017 and by 2018 had reached an estimated 800,000 children aged under 24 months in 63 *woredas*. The remaining 87 *woredas* were to be reached over the second and third phases of programme implementation in 2018 and 2019 (*ibid.*). The project has three main components:[22]

- Enhancing community-based nutrition (CBN) to address inadequate complementary feeding and household dietary diversity through infant and young child feeding counselling and nutrition-sensitive agriculture.
- Systems strengthening, which focuses on integrating health and agriculture extension platforms by improving human resource capabilities, data management and information systems.
- Developing a sustainable multi-sectoral coordination mechanism to deliver nutrition services accountable to communities and government leadership.

SURE's service delivery is underpinned by actions to strengthen systems and to facilitate multi-sectoral coordination. Its components include: (1) monthly growth monitoring and promotion for children aged under 24 months; (2) vitamin A supplementation and

[22] See: https://ciff.org/grant-portfolio/ethiopia-perinatal/.

deworming; and (3) quarterly screening for acute malnutrition. SURE aims to enhance CBN by expanding services to improve complementary feeding and dietary diversity (*ibid.*).

Key actors in SURE are:

- The federal ministries of health and agriculture (implementers).
- The Children's Investment Fund Foundation – SURE has a total budget of US$29 million, 90 per cent of which is contributed by the foundation and the remaining 10 per cent by the Government of Ethiopia.
- The EPHI and the London School of Hygiene and Tropical Medicine are also key actors, and undertake baseline studies and research into the programme's impact (*ibid.*).

As SURE programme implementation is cascaded to the grass-roots level, regional and subregional government agencies (bureaux and offices) are also key implementing actors. Our fieldwork focused on the multi-sectoral nutrition coordination and implementation of SURE in Amhara. In consultation with partners, we visited Yilmana Densa *woreda* and a *kebele* near Adet town.

6.2.2 Multi-sectoral nutrition coordination and implementation of the SURE programme in Yilmana Densa woreda

Informants at the federal and regional levels underlined that SURE is 'the first government-run multi-sectoral nutrition programme' (FI03), which has several strengths, according to the informants (FI01; FI03; AM01), including that:

- It builds on lessons from a previous CBN, and uses health and agricultural platforms, as these sectors have extension systems stretching to the lowest grass-roots level.
- Its implementation was preceded by thorough preparation, in the form of training, manual and communication tools development, and monitoring and evaluation tools.
- Its core activities are well funded, relative to other projects – we have noted that Yilmana Densa *woreda* had 1.8 million birr in 2009/10, which was used in full on multi-sectoral nutrition activities.
- SURE programme implementation is actively monitored at all levels, including *woredas* and *kebeles*.

Moreover, informants credited the programme with developing an understanding that nutrition is not only for the health sector. SURE brought in agricultural activities and personnel as core elements and drivers of the programme. Consequently, informants noted an increase in awareness levels among the communities in *kebeles* where SURE has been implemented:

> in the past, agriculture actors were more about increasing production and productivity but due to SURE programme and the joint agriculture-health work, the community have started to understand and apply the importance of crop diversity, balanced diet, water management and land use management, joint household visits by health and agriculture workers (AM05).

SURE is also credited with demonstrating multi-sectoral nutrition coordination at the *kebele* level, which involves seven members of the Kebele Nutrition Technical Committee.[23] They noted that health and agriculture extension workers make joint house-to-house visits, conduct joint assessments of needs, and draw up and implement plans. For example, health extension workers lead on nutrition-specific interventions, such as provision of vitamin A

[23] *Kebele* administrator (chair.), a health extension worker, an agriculture health extension worker, four women and men drawn from members of the community (AM10).

supplementation to breastfeeding mothers. Agriculture extension workers, in turn, lead on the demonstration of increased dietary diversity from crops, fruit and vegetables, and animal and poultry farming, but awareness creation and work with community elders are joint activities. Extension workers use guidelines prepared at the federal level to engage local=level programme implementers, discussing nutrition problems and diagnosing root causes to develop solutions that lead to planning and implementation.

However, informants identified many challenges. First, the programme's slow start and implementation: SURE aims to reach 150 *woredas* by 2020 and reduce stunting by up to 26 per cent. However, at the time of our visit in Autumn 2018, it was still in phase one: 'two years gone, we are still in phase one… quickly generating lessons from pilot or Phase1 and rolling out to scale has been a problem' (SU01). Causes for the delay included extensive training and time taken to prepare guidelines for extension workers. Second, despite being hailed as a multi-sectoral nutrition programme, SURE remains focused on the health and agriculture sectors, while many other relevant sector activities such as in WASH are not included. Third, while coordination at the federal and regional levels appears to be working, at the grass-roots level coordination has been a struggle, as '*kebele* committees members barely meet' (AM11). Finally, finding and retaining qualified staff remains a challenge for SURE, despite efforts being made. There still exist skills gaps, particularly when trained personnel leave their positions. While a credible effort is being made to coordinate nutrition activities with the health and agriculture sectors, due to these challenges SURE's progress has been limited.

6.3 National Food Fortification Programme: a case of slow progress or no start

The National Food Fortification Programme was one of the areas that our core informants reported as a case where – until early 2019 – nutrition programmes had barely got off the ground or not started at all. The MoI was one of the ministries that developed the National Food Fortification Program Plan of Action (2017/18–2021/22), published in December 2017 (FDRE 2017b). Among other things, the action plan aimed to coordinate the National Food Fortification Programme: to reduce the deficit of micronutrients (vitamins and minerals), to develop and endorse national mandatory food fortification standards, and to support the production of quality fortified food (*ibid*). While a steering committee was set up to lead on the fortification programme, actual fortification was stalled for a number of interrelated reasons.

The major problem was technical: fortification includes iodising salt (which started prior to the launch of NNP-II in 2016), and adding vitamin B, iron and zinc to wheat flour and vitamin A to edible oil. However, according to our informants, many scientists challenged the decision to add iron to wheat flour:

> On one hand, given that many Ethiopians consume iron rich teff, it was thought that fortification is not a priority. But, on the other hand, anaemia is prevalent particularly among children and childbearing women – an aspect of anaemia deficiency in iron (FI01).

Resolving this technical matter took time and it was referred to a scientific committee, which after long deliberation came up with a voluntary fortification strategy. The position, it appears, is in part based on the fact that 'teff is not staple food to all Ethiopians' (CS13).

The second issue that interviewees raised relates to standards for fortification, which came late but as voluntary standards. According to some interviewees, voluntary fortification does not create a level playing field for business. Some informants also argued that voluntary fortification has further limitations:

> Flour millers, for example, need to change their production systems… small processors cannot afford it either. Voluntary fortification, thus, put those fortifying food in a disadvantaged position (CS13).

Clearly, the private sector needs a market and a level playing field. As things stand, the standard is voluntary and those fortifying food will lose out.

The third issue staff turnover and leadership. The state minister who oversaw the MoI's nutrition programme was seen as a champion of nutrition programmes; but, as informants noted, with the move of this person to another role, the fortification programme lost leadership and hence momentum. Consequently, more than half-way into the implementation of NNP-II, a significant part of the fortification programme in effect has not yet started.

7 Discussion, conclusion and recommendations

Ethiopia faces major undernutrition challenges. On a technical level, it faces limited dietary diversity, insufficient food and micronutrient intake, and poor health services. Notwithstanding these challenges, this study uncovered that political and institutional factors have been as constraining as technical ones in reducing undernutrition. What emerged as a multi-sectoral nutrition strategy in the late 1980s was abandoned as a matter of policy, relegating nutrition to a low-priority activity. Positive developments since 2008, in turn, have been beset by poor nutrition governance.

This section pulls together the primary and secondary evidence presented in the preceding sections, and systematically presents and discusses the main conclusions and recommendations. The recommendations aim to identify factors to create and sustain action for nutrition. We use Baker *et al.*'s (2018) five forms of political commitments and five thematic areas that drive political commitment for nutrition to summarise our findings and conclusions (Tables 7.1 and 7.2). Embedded in Baker *et al.*'s framework are the distinct, yet discrete stages of nutrition policymaking processes: agenda setting and policy design, multi-sectoral nutrition coordination, implementation and M&E, within which we identify major challenges, consider the causes thereof, and offer potential solutions.

7.1 Discussion of political commitments for nutrition

We mapped the forms of political commitment for nutrition, from the initial stage of making statements about undernutrition being unacceptable, to sustainably addressing it (Table 7.2).

7.1.1 Rhetorical commitment

Although few and far between, senior government and non-government actors have demonstrated commitments to reduce undernutrition. Since 2008, in particular, senior government officials at the federal and regional levels are on record as having made such commitments.

Table 7.1 Evaluative summary of forms of political commitment

Form of commitment	Description and evaluation of commitment
Rhetorical commitment [1]	*Medium-high level of commitment*: high-level government and non-governmental officials declared commitment to reduce undernutrition.
Institutional commitment [2]	*Medium level of commitment*: rhetorical commitments [1] above were turned into a series of actions, including launching the Nutrition Strategy in 2008 and formation of NNCB and NNTC. However, institutional commitments did not lead to effective multi-sectoral nutrition coordination and implementation.
Operational commitment [3]	*Low level of commitment*: programme implementers were not sufficiently provided with required human, technical and financial resources, leading to poor programme coordination and implementation on the ground.
Embedded commitment [4]	*Low-medium level of commitment* – nutrition agenda entered Ethiopia's wider social and economic development plans, but with limited finance going into such nutrition programmes.
System-wide commitment [5]	*Low level of commitment* – a few interventions reached the grass roots, but many have yet to be scaled up.

Source: Authors' own, based on framework by Baker *et al.* (2018)

7.1.2 Institutional commitment

Creating an enabling environment[24] was one of the key steps taken by the government. Among other things, without the need to create a new agency, the government designated a 'home' for coordinating nutrition programmes under the auspices of the MoH (and bureaux of health at the regional level). This was positive, but the lack of or delay in nutrition policy, and legal mechanisms, has meant that programme implementers have not been held to account for their action or inaction. However, the draft national nutrition policy produced in 2018 (FDRE 2018) was adopted in 2019.

7.1.3 Operational commitment

Despite the rhetoric, operational commitment has been low and did not lead to effective implementation of nutrition programmes for many reasons, including low staff numbers and quality, low budget and inability to mainstream and implement nutrition activities at the federal and regional levels.

7.1.4 Embedded and system-wide commitments

Ethiopia aims to reach low middle-income country status by 2025 and eliminate hunger by 2030, along with related undernutrition-related deficiencies. Nutrition targets are being built into GTP-II, but nutrition programme implementation lags far behind and efforts thus far are mainly dependent on donor investment.

7.2 Drivers of political commitments for nutrition

Key Ethiopian nutrition drivers constitute actors, institutions, the political and societal context, knowledge, evidence and framing, and capacities and resources (Table 7.2).

[24] This refers to 'political and policy processes that build and sustain momentum for effective implementation of actions that reduce undernutrition' (Gillespie *et al.* 2013; 2017).

Table 7.2 Factors driving political commitment for nutrition

Thematic factor area	Factor description
Actors	Networks of nutrition actors are involved but lack consensus on internal and external framing of food and nutrition security; consequently, actors' contribution to reduce undernutrition has been impeded.
Institutions	National and regional coordination bodies were set up, but have no effective power to coordinate and hold nutrition programme implementers accountable for their actions.
Political and societal context	There exists supportive leadership from the top, but the rhetoric has not translated into action, undermining commitments to nutrition.
Knowledge, evidence and framing	Strong use of national and global evidence in policy and programme design, and good understanding of causes and consequences of undernutrition among core nutrition actors. However, consensus is lacking among major actors on internal and external framing of food and nutrition security.
Capacities and resources	Nutrition programme implementers (ministers and bureaux) have insufficient skilled personnel and financial resources.

Source: *ibid.*

7.2.1 Nutrition actors and networks

Rallying behind the NNCB, state and non-state nutrition actors operate under a loosely organised network for reducing undernutrition. Leaders of the NNCB engaged the donor community, civil society actors, the private sector and academia; and, albeit marginally, regional actors. Operating under the umbrella of the Donors' Working Group on Nutrition, our evidence confirmed that donors provide significant support to nutrition programme design and implementation, but efforts are fragmented along their 'own' priority areas. Similarly, civil society and advocacy agencies positively contribute to reducing undernutrition; but compared to the need for awareness creation among bureaucrats and society, their efforts are very much limited.

The private sector is generally at a nascent stage of development and yet its contributions have been impeded by an inadequately defined regulatory environment for food fortification. The private sector thus far has in the main participated in NNCB and NNTC meetings; but, we argue, it could fruitfully contribute to the production, import and distribution of nutritious food. To enhance the role of the private sector in this area, emerging food and agro-processing businesses in the new industrial clusters also need to be in tune with the new food and nutrition policy.

Further, while being hailed for the participation of core nutrition actors, the participation of regions in strategy development and programme design was at best marginal, with regional perspectives and input only taken up after programmes had been fully drafted. While limited resources and regional expertise in nutrition were the main explanations for lack of participation, regional participation and ownership are clearly likely to bring diverse ideas in terms of choice of technical solutions, and political economy opportunities and constraints in implementing programmes. In a nutshell, national leaders have not managed to align diverse perspectives on nutrition and ensure effective participation of regional implementers in programme design, consequently undermining efforts towards reducing undernutrition.

7.2.2 Institutions

National and regional bodies have been created for the coordination of nutrition; however, multi-sectoral coordination of nutrition has largely been ineffective. We found many causal factors for this problem. First, lack of accountability: nutrition leaders, core actors and

implementers jointly develop programmes and action plans at federal and regional levels, but there was no legal mechanism to make implementers accountable. To enhance accountability, members of the national and regional nutrition coordination bodies at federal and regional levels are headed by the deputy prime minister at the federal level and regional presidents. But this has not worked either, as those who in effect lead the coordination bodies are the minister for health and heads of health bureaux who, in terms of political hierarchy, are at the same level as the other committee members. Second, many, including powerful members of the NNCB and NNTC still only regard nutrition as a supplementary activity, and hence do not fully engage in programme design, mainstreaming and implementation.

Third, the 'home' of the nutrition coordination body at both the federal and regional levels also suffers from perception problems. Many informants hold the view that the nutrition coordinator – in the MoH or bureaux of health – is biased in favour of its own interventions. Moreover, the secretariat of the coordinating body is not well equipped, either in terms of staff or budget, and it piggybacks on the Maternal and Child Health and Nutrition Directorate at the MoH. Finally, informants allege that the secretariat lacks the multi-sectoral perspective needed to create vertical and horizontal synergy between actors, its staff being more oriented towards health interventions, which are dependent on a few pro-health donors. Clearly, issues raised around the 'home' for multi-sectoral nutrition coordination call for urgent solutions. However, informants are divided over what shape the multi-sectoral coordinating body should take (see Table 7.3). That said, all agree that whether the coordinator remains within the MoH or not, coordination needs to be legally empowered to fully discharge its mandates. Many stated their preference for the establishment of an independent agency or council under the Prime Minister's Office (which is also in line with the Food and Nutrition Policy (FDRE 2018).[25]

Table 1.3 Summary of informants' views for and against the current 'home' of nutrition coordination

Case in favour of the status quo	Case against the status quo
Can build on existing institution rather than creating a new one from the scratch	It will be difficult to see a dynamic, nimble and responsive coordinator that creates and sustains change if the coordinator is to stay within the current bureaucracy
Can build on coordination experience, donor networks, knowledge and evidence sources, etc.	It had over a decade to learn and produce effective coordination, but has not done it
If well equipped with more, and diverse and qualified staff, the location or the 'home' of the unit does not matter	Current 'home' is perceived as biased towards health-specific interventions – its perspective is largely about health intervention; it is not best placed to create and sustain change in nutrition
If legally empowered, it could effectively lead on coordination	Will be difficult to see it command political power and lead

Source: Authors' own

7.2.3 Political and societal context

Again as noted above, government officials at the federal and regional levels express support for nutrition. The strategic approach being pursued has also focused on drought-

[25] The Food and Nutrition Policy was adopted in 2019, but the final version is not publicly available.

prone and vulnerable areas such as Seqota where flagship programmes were piloted for nationwide nutrition programme implementation. However, as discussed below, political commitment has not been sustained; consequently, nutrition consistently falls into a low-priority implementation area. Our evidence also showed that when leaders were exposed to successful national and international experiences, they became champions of nutrition and effective participants in the governance structure, as well as successful implementers of programmes within their respective ministries or bureaux.

7.2.4 Knowledge, evidence and framing

Food production and food security used be the dominant narrative in the field, particularly among state actors, but this has shifted to food and nutrition security to drive commitment for nutrition. In a similar vein, Ethiopia used credible evidence to develop its nutrition strategy, policy and programme. However, policy and programme design, coordination and implementation still suffer from uninformed narratives about the complexity of nutrition. Divergences in perspective and/or interest also prevail among major donors, further impeding commitment for nutrition.

7.2.5 Capacities and resources

Nutrition programme implementation has not been backed up by sufficient numbers or quality of personnel and financial resources. More than half of the implementing ministries – and bureaux – do not have case teams or directorates to lead nutrition programmes. While growing marginally, the amount of budget allocated to nutrition is limited and overly dependent on donor funding. This suggests that without adequate and sustained investment in nutrition, Ethiopia's commitment to targets, including the SDGs, will not be realised. Further, despite the adverse effect of hunger on Ethiopia's gross domestic product, the government's investment in nutrition is low and heavily dependent on donors. The country's apex institutions, including the MoF, barely monitor or incentivise investment in nutrition. Consequently, with a few exceptions – such as the ministries of health and agriculture – mainstreaming nutrition among all implementing ministries has not been completed.

These factors have put the brakes on many programmes and projects, including flagship ones. While a few flagship projects, such as SURE, have introduced and implemented rigorous data collection instruments on the implementation of programmes, and outcomes and impacts, efforts by a large number of implementing ministers and regions have been limited. Availability of information is also key to holding implementers accountable for results.

7.3 Recommendations of the study

Based on our findings and conclusions, below we propose a series of (interrelated and some nested) recommendations for nutrition actors to consider.[26]

1. **Create and empower an independent multi-sectoral nutrition coordination council** – the study clearly showed that multi-sectoral nutrition coordination was largely inefficient, and there were excessive delays in translating nutrition policy into action and outcomes. To overcome this challenge, we strongly recommend:
   - 1.1 Implementing the new national nutrition policy as a matter of urgency and creating an independent multi-sectoral nutrition coordination agency at the federal, regional and sub-regional levels, whose activities are legally binding for signatory ministries and regions.
   - 1.2 Assessing and equipping the coordination bodies at the federal, regional and subregional levels, employing staff with multi-disciplinary perspectives and increasing the budget for coordination.

[26] These recommendations were presented, discussed and refined at the end of a project stakeholders' workshop held in Addis Ababa in April 2019.

1.3 Establishing legal and data or information frameworks to monitor and ensure accountability.

2. **Enhance implementation priority** – the study showed that other 'competing priorities' prevail over nutrition and the undernourished themselves lack agency to make it a priority. To address this challenge, a series of actions need to be taken:
    2.1 Strengthen and/or create well-functioning nutrition case teams and allocate requisite budgets, office premises, etc. at the federal, regional and grass-roots levels.
    2.2 Ensure selected indicators are built into the national, sectoral and regional plans, and citizens' nutrition developments are regularly monitored.
    2.3 CSOs and media should increase awareness creation – or nutrition literacy – aimed at leaders, implementers and communities.
    2.4 The government should train enough personnel at higher education institutions to sustainably plan and implement nutrition programmes.

3. **Increase investment and funding for nutrition programme implementation and capacity development** – the government and its partners should increase funding for programme implementation and capacity development. The MoF in particular should closely monitor nutrition activities and provide investment incentives for nutrition, so that demonstrably adequate and sustained investment is put into nutrition programmes.

4. **Enable the private sector to contribute to nutrition programmes** – the analysis showed an inadequate enabling environment for the private sector to contribute to nutrition programmes. Hence, we recommend:
    4.1 Reviewing the current voluntary food fortification directives and creating a competitive, level playing field for businesses.
    4.2 Supporting the private sector to play a more proactive and effective role in processing and/or importing and distributing highly nutritious and affordable foods, using emerging agro-industrial infrastructure to stimulate local supply chains in reducing undernutrition.

5. **Increase funding and research on the social, political and financial constraints to, and opportunities for, reducing undernutrition** – currently, research on the political economy analysis of nutrition is inadequate, and M&E data are limited. Hence, we recommend:[27]
    5.1 Improving M&E data collection to inform and enhance programme design and implementation, and accountability.

6. **Engage with regional governments early and increase their participation in developing national nutrition policy, strategy and programmes.**

7. **Align different perspectives on nutrition and priorities to reduce undernutrition** – key action points are to:
    7.1 Establish basic facts of undernutrition's multi-sectoral causes across government, relevant sections of the private and the cooperation sector – including gender dimensions – so that all actors understand key, simple drivers by sector of undernutrition.

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[27] The authors of the report believe there are many pertinent questions to explore, including: what are the requisite human, financial and institutional capacities at the federal, regional and subregional levels to effectively plan and implement multi-sectoral nutrition? What are the nutrition literacy gaps and how may these be addressed to sustainably reduce undernutrition? And what enterprise capacities and capabilities are required to fortify food, and how may such capacity gaps be addressed?

7.2 Operating under the Donors' Working Group on Nutrition, donors should build consensus on reducing undernutrition, aligning priorities to focus on the most impactful interventions.

7.3 Improve donor-supported programme coordination – the Donors' Working Group on Nutrition should agree to prioritise and coordinate activities within its community, and between federal and regional state actors.

7.4 Identify and raise awareness levels of nutrition leaders at all levels – organise retreats, and domestic and international visits to improve awareness; and develop a virtual platform where leaders receive up-to-date information about nutrition and allied sectors.

8. **Ensure programmes and projects start and finish on time** – to address excessive delays in programme implementation, we recommend:

8.1 Improving or creating leadership to start, complete and scale up initiatives, programmes and projects.

8.2 Pilot projects should be of a reasonable size (e.g. implemented in fewer than ten *woredas* at a time), avoiding unnecessary preparation and only providing training to relevant personnel.

8.3 Selecting and building indicators into national, sectoral and regional plans where nutrition developments are regularly monitored.

If carefully considered, we believe these recommendations can reinvigorate the process of sustainably reducing undernutrition.

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