ALTHOUGH ETHIOPIA IS MAKING STEADY PROGRESS IN REDUCING HUNGER, MALNUTRITION AND CHILD MORTALITY, 44% OF CHILDREN ARE STUNTED.

MDG 4 – TO REDUCE CHILD MORTALITY BY TWO-THIRDS – CANNOT BE ACHIEVED WITHOUT FASTER PROGRESS IN TACKLING MALNUTRITION.

The government of Ethiopia has introduced several measures, such as the National Nutrition Programme (NNP) which aims to reduce stunting from 44.4% to 40% by 2013. An accelerated Stunting Reduction Strategy and a Food Fortification Initiative complement these initiatives. The Productive Safety Net Programme (PSNP) that, which offers cash-based support to vulnerable families, has also been linked to the NNP.

At community level, the Health Extension Programme contributes to the goal of universal access to healthcare with the help of health extension workers, and a new social protection policy is being validated. Together these are helping the government towards achieving the Millennium Development Goal (MDG) 1 target of cutting hunger and malnutrition by half by 2015.

The mortality rate of children under five years has been reduced by half – from 202 per 1,000 in 1990 to 88 per 1,000 in 2011, and the infant mortality rate has been reduced from 124 per 1,000 live births in 1990 to 59 per 1,000 live births in 2011. Overall, Ethiopia is steadily moving up from its 174th ranking in the United Nations Development Programme Human Development Index of
Food insecurity is a complex issue. An estimated 38.5% of rural households live below the poverty line. Urban/rural disparity is stark. The traditional livelihoods of over 80% of the rural population – such as farming and cattle rearing – are under threat from poor land management, erosion, overgrazing, urbanisation, drought, market pressures, small landholdings, low yields, a lack of land use/ownership security, and climate change.

At the same time, lack of market access and limited skill-sets make earning difficult for many small farmers. Milk production is declining, or limited to the rainy season. Job opportunities are limited outside farms. Rural households spend 57% of their income on food, almost half of it on staples. Most pastoralists subsist mainly on cereals bought with the proceeds of livestock sales. Food prices have gone up dramatically. Seasonal shortages and sudden illness come as shocks that threaten household food security. A recent drought has affected large parts of the country.

Undernutrition increases the burden of disease and, in turn, poverty. Stunting could cause an estimated loss of 44 billion Ethiopian Birr during 2005 to 2015. Low levels of education and inadequate water supply and sanitation facilities, along with gender inequality and poor governance, contribute to undernutrition.
 Poor Infant and Child Caring Practices

The most sustained and intense period of a child’s growth is during the first 1,000 days following inception – the time to provide sufficient energy and nutrients. However, breastfeeding and complementary feeding of infants is sub-optimal in many parts of Ethiopia. Only 52% of infants below six months are exclusively breastfed.11 Poor food habits such as delayed introduction of complementary food and non-diversified diets lead to high rates of chronic malnutrition and risk of wasting and underweight. Micronutrient deficiency affects physical and mental growth. Over 80% of Ethiopian children suffer from iodine deficiency disorder, leading to increased dropout rates in primary schools.12 Vitamin A deficiency damages the immune system and lowers resistance to common infections. It affects 61% of children aged 6–59 months and is the number one cause of preventable blindness. It also leads to about 80,000 deaths a year.13 Mothers who are away from their infants for more than two hours a day are less likely to breastfeed them exclusively than those who spend less time at work.14 Poor mothers often have to be away at work soon after childbirth, and are often too weak to feed or have insufficient milk.15 Food taboos, lack of diet diversity, and food distribution that favours men deny nutritious food to many pregnant women and breastfeeding mothers.16

The Solutions

- Target interventions for the first 1,000 days of a child’s life – from conception to two years.
- Introduce specific, measurable, achievable, relevant / realistic, time-bound (SMART) targets for assessing the impact of nutrition interventions.
- Promote childcare practices – covering breastfeeding, legislation on the International Code of Marketing of Breast-milk Substitutes, vitamin A supplements, access to healthcare and micronutrient supplementation.
- Full implementation of the government’s Accelerated Stunting Reduction Strategy.

High Rates of Maternal and Adolescent Malnutrition

Maternal education and nutrition, along with the interval between births, a child’s birth weight, wealth quintile and illnesses influence nutrition status. Malnutrition among women means sick mothers and malnourished, underweight children. Official studies show that 17% of women aged 15–49 years and 44% of children aged six months to five years are anaemic.17 One of the most common causes of anaemia is iron deficiency. Poor households sell nutritious food to buy enough cheaper but less nutritious food.18 Pastoralist households cannot get animal milk during certain seasons.19 Young children depend a lot on milk, but the availability is often limited.20 Women often get to eat last and least. Education can make a change. Mothers who went to high school are three times less likely to have underweight children than those who had less or no education.21

The Solutions

- Cover pregnant and lactating mothers under the 1,000-day nutrition intervention for children.
- Review the progress of nutrition interventions and ensure a minimum package with adequate resources.
- Ensure household food security, taking into account seasonal shortages, need for diet diversity, and cultural practices.
- Introduce a multisector coordination mechanism covering food production and markets as well as health promotion and care.
Poor access to health services and low rates of health facility usage persist due to costs, distances, and perceived poor quality of the facilities. Coverage is therefore limited in villages. For instance, immunisation against measles in rural areas is less than half of the urban coverage of 64%. Limited access to clean water and sanitation also contributes to illnesses.

The HIV prevalence rate of 2.3% and the possibility of mother-to-child transmission are high with limited coverage among HIV-positive pregnant women. AIDS leaves many children orphans and vulnerable. Malaria is a major public health menace too, responsible for a fifth of under-five deaths. Out of about nine million people who get malaria annually only four to five million are treated in a health facility; and only a fifth of children under five get treated. Climatic fluctuations and drought-related malnutrition, poor health and no sanitation expose the immune system to malaria attacks. In turn, malaria further worsens the effects of malnutrition through diarrhoea and anaemia.

Our goal is that Millennium Development Goal 4 – a two-thirds reduction in child mortality rates by 2015 – is achieved. Improving child nutrition is key to achieving this goal. It will save many lives and give all children the chance of a good start in life so they can grow up to fulfil their potential.

• Infectious disease control, including safe water and sanitation, vaccinations and rapid response to diarrhoea diseases.
• Implement integrated management of newborn and childhood illnesses.
• Improve the availability of and access to primary healthcare.
• Enhance coverage of HIV-prevention measures and the scope of prevention of mother-to-child transmission. Mainstream them into maternal and child health service coverage.
• Ensure care and support to orphans and vulnerable children.
• Malaria prevention and control programmes should consider nutrition interventions, especially to prevent anaemia.
“We have enough food to survive”

“We have enough food to survive before the safety net programme was introduced, if a drought came we had to sell all of our animals,” says Mujahid. “When you have no food you do whatever you can to feed your family. We would sell all of our cattle or our goats. There would be nothing left. There would be nothing to breed after nothing to milk or sell. Drought has affected us this year. The rivers have dried. Animals are dying in other places. The programme has meant that we did not have to sell our last animals – they will give us milk all through this drought. And they will breed again next year. We have enough food to survive without selling everything. We will be well in this drought. We have enough to eat and sell.”

In return for five days’ work a month, doing jobs like repairing schools and health centres, and building public water facilities, Mujahid, his wife, Zahar, and their son (pictured here) receive food rations as part of the government’s safety net programme.
This briefing is part of a set of eight country briefings produced by Save the Children and the Institute of Development Studies to accompany Save the Children’s report, A Life Free from Hunger: Tackling child malnutrition.

To see the full report, visit everyone.org

17 CSA (2011) p. 21
18 LIU (2010)
21 B Fenn (2011) Research for Save the Children’s report, A Life Free From Hunger: Tackling child malnutrition