UNDP Spain MDG Achievement Fund for Children, Food Security and Nutrition

Country: Ethiopia

Program Title: National Nutrition Program / MDG-F JOINT PROGRAM

JOINT PROGRAM Outcomes:

1. Improved management of children with acute malnutrition at community level
2. Improved caring and feeding behavior and practices of children and mothers
3. Improved quality and utilization of locally available complementary and supplementary foods
4. Improved nutrition information system, monitoring and evaluation of the project

Program Duration (start/end dates): 36 months starting from final approval of JOINT PROGRAM by MDG-F Steering Committee

Fund Management Option(s): pass through

Managing or Administrative Agent: UNDP

Total estimated budget: USD 6,999,884

UNICEF USD 6,373, 292
WFP USD 626,592

Out of which:

1. Funded Budget: USD 6,999,884

2. Unfunded budget:

Sources of funded budget:

- Government _____
- UN Org.... _____
- UN Org... _____
- Donor ... _____
- Donor ... _____
- NGO... _____

Names and signatures of (sub) national counterparts and participating UN organizations

UN organizations	National Coordinating Authorities
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List of Acronyms

AEW	Agricultural Extension Worker
BCR	Benefit Cost Ratio
BF	Breast Feeding
BoFED	Bureau of Finance and Economic Development
CF	Complementary Feeding
CHD	Community Health Days
C-IMCI	Community - Integrated Management of Childhood Illness
CPAP	Country Program Action Plan
DHS	Demographic and Health Survey
DMFSS	Disaster Management and Food Security Sector
DPPB	Disaster Prevention and Preparedness Bureau
ENA	Essential Nutrition Action
EOS	Enhanced Outreach Strategy
EWS	Early Warning System
FDA	Food Distribution Agents
FMOH	Federal Ministry of Health
GMP	Growth Monitoring and Promotion
JP	Joint Program
JCCC	Joint Core Coordinating Committee
HEP	Health Extension Program
HEW	Health Extension Worker
HSDP	Health Sector Development Program
IDA	Iron Deficiency Anemia
IDD	Iodine Deficiency Disorder
IYCF	Infant and Young Child Feeding
NNC	National Nutrition Coordination Body
NNP	National Nutrition Program
NNS	National Nutrition Strategy
NSC	National Steering Committee
MDG	Millennium Development Goal
MDG-F	Millennium Development Goal Achievement Fund
MI	Micronutrient Initiative
MOARD	Ministry of Agriculture and Rural Development
MOFED	Ministry of Finance and Economic Development
MOU	Memorandum of Understanding
OTP	Outpatient Therapeutic Program
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
PMT	Program Management Team
PMC	Program Management Committee
PSNP	Productive Safety Net Program
RC	Resident Coordinator
RHB	Regional Health Bureau
RUTF	Ready-To-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SNNPR	Southern Nations Nationalities and Peoples Region
TFP	Therapeutic Feeding Program
TSF	Targeted Supplementary Food
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistant Framework
USAID	United States Agency for International Development
USI	Universal Salt Iodization
VCHW	Volunteer Community Health Workers
VAD	Vitamin A Deficiency
WASH	Water Sanitation and Hygiene
WFP	World Food Program
WHO	World Health Organization
WoFED	Woreda Office of Finance and Economic Development
WoHo	Woreda Health Office

1. Executive Summary

Malnutrition is one of the main public health problems of children and women in Ethiopia. While there have been some improvements in the indicators of malnutrition among children under five, the country has to improve the rate of progress to achieve the target 2 of MDG 1, a reduction of underweight among children under five. Cognizant of the magnitude, causes and consequences of malnutrition and lessons learned from previous and current efforts to address malnutrition, the government, in cooperation with partners, has developed the National Nutrition Strategy (NNS) and its program, the National Nutrition Program (NNP) (2008-2012/13), to reduce the burden of malnutrition and its consequences in a harmonized and comprehensive manner, and through large scale national efforts so as to contribute to the achievement of MDG 1 and MDG4.

The NNS and NNP form the overall framework for the development and implementation of activities envisaged in this joint program, named NNP/MDG-F Joint Program, hereafter called Joint Program (JP). The JP supports the efforts of the Ethiopian Government by filling the existing NNP financial and implementation gaps, especially in the community management of acute malnutrition (OTP), prevention of malnutrition through Community Based Nutrition (CBN), local production of complementary/supplementary foods and nutrition information system of the NNP. It also facilitates the implementation of different nutrition interventions of the NNP with an integrated approach in the targeted Woredas. The JP contributes to achieving the NNP target of reducing underweight from 38% to 30% by 2013, and the non-income Target 2 of MDG 1 i.e. halving underweight by 2015. The JP targets the following highly vulnerable groups in 16 rural drought-prone Woredas: (i) 156,000 under two children and 14,640 under five children with severe acute malnutrition; (ii) 96,500 pregnant and lactating women (PLW) and 10,360 malnourished PLW; (iii) identified households coping with acute food insecurity in two Woredas and (iv) 40 women groups.

The Joint Program has four result areas which are well aligned with the Health Sector Development Program III (HSDP III), NNP and UNDAF outcomes.

1) Improved management of children with acute malnutrition at the health post and community level. This result is also directly related to the outcome area one of MDG-F which includes implementing community based therapeutic feeding programs.
2) Improved caring and feeding behaviors/practices of children and mothers. This will help to achieve the outcome of MDG-F which is scaling up of programs that improve the caring and feeding practices, reduction of micronutrient deficiencies, and growth of children.
3) Improved quality and utilization of locally available complementary and supplementary foods. By addressing promotion of local food security and empowering women which is one of the outcomes of the MDG-F, it will contribute to the reduction of underweight and wasting.
4) Improved nutrition information system. This will provide reliable and timely data for inputs into the nutrition project management decisions, planning and policy development.

The JP has four main components for achieving its results: 1) Rollout and sustainability of Out Patient Treatment (OTP) services for severe acute malnutrition at community level: this will improve the screening, awareness and treatment of acute malnutrition at the primary health care and community level; 2) Community Based Nutrition (CBN) interventions: this will build community capacity for assessment, analysis and action to improve the behavior practices in child care and feeding, provide integrated and preventive nutrition services as part of the Health Extension Program (HEP) and link with Agricultural Extension Workers (AEWs) and food security interventions; 3) Pilot/operational research on local production and utilization of complementary food: this will build the capacity of women to use and process local cereals/foods intended for the prevention of growth faltering/malnutrition at the most critical age and 4) Strengthening the nutrition information system and M&E mechanism: this will redefine the information needs and mechanisms for community based nutrition data collection, analysis, dissemination and utilization.

The implementation of the JP will use the strengthened capacity of the established NNP system, instead of creating a parallel one. It will depend particularly upon the HEP service delivery under the Federal Ministry of Health (FMOH), who is mandated to host and manage the NNP. The JP will be implemented by the Health Sector as the main national implementing partner, the FMOH at federal level, the Regional Health Bureaus (RHB) at the regional level and the Woreda Health Office (WoHo) at the Woreda level. The Disaster Management and Food Security Sector (DMFSS) is the second government implementing partner related to the provision of targeted supplementary food at the regional level. The two participating UN Agencies, UNICEF as the lead and WFP as the partner, will provide technical assistance according to their corporate priorities and based on the Joint Program Results Framework.

2. Situation Analysis

2.1. General profile of Ethiopia

Ethiopia is located in the North Eastern part of Africa, also known as the Horn of Africa, and it is around 1.1 million square kilometers (*Annex 1*). The country has a Federal Government structure composed of two city administrations (Addis Ababa and Dire Dawa) and nine regional states: Tigray, Afar, Amhara, Oromia, Somali, Benishangul Gumuz, Southern Nations Nationalities and Peoples Region (SNNPR), Gambella and Harrari. The regional states are further divided administratively into 78 zones and 700 Woredas. The Woreda is the basic decentralized administrative unit and the 700 Woredas are further divided into roughly 15,000 Kebeles (it is the lowest administrative unit, covering a population of approximately 5,000) organized under peasant associations in rural areas (10,000 Kebeles) and urban dwellers associations in towns (5,000 Kebeles).

The population has been growing rapidly. According to the projection for 2008 based on the 2007 census, the total population is 76.9 million, of which nearly half (49.5%) is female and 84% living in rural areas. Children under five constitute 15% of the population[1]. The four most populous regions: Oromia, Amhara, SNNPR and Tigray host about 86% of the total population. Rapid population growth has exacerbated critical gaps in food and nutrition insecurity resulting in increase malnutrition prevalence. Details of the population covered by the JOINT PROGRAM are summarized in *Annex 2*.

The Government has been implementing a national poverty reduction strategy known as Plan for Accelerated and Sustained Development to End Poverty (PASDEP) which is in its second five-year phase (PASDEP 2005-2010). It is instrumental in addressing poverty and geared towards reaching the MDGs. PASDEP has called for the implementation of the third Health Sector Development Plan (HSDP III) and the National Nutrition Strategy (NNS). The country has achieved 11.6% of real GDP growth rate. Since 2008, Ethiopia has been directly and indirectly affected by the global economic crisis and food price inflation. The national inflation rate in February 2009 was 46.1%, with food inflation at 61.1% and non-food inflation at 24.2%. The food security of households that spend a significant proportion of their income on food will continue to be negatively affected due to the high and rising staple food prices.

The Federal Ministry of Health has been implementing a twenty-year Health Sector Development Program (HSDP) since 1997/1998 which is the centerpiece of the health policy. The HSDP is the health chapter of the national poverty reduction strategy (PASDEP). It is the aimed at aligning the national health priorities with Millennium Development Goals (MDGs). The third phase of the HSDP (HSDPIII 2005 to 2010) incorporates strategies, objectives, targets and key activities, prioritized for five years, and are a result of substantial and extensive consultations with key stakeholders. The main vehicle to implement the HSDP is the Health Extension Programme (HEP) which is an innovative program designed to deliver door to door services of preventive, promotive, and a limited number of high impact basic curative services for the community.

The HEP is a community based health care delivery system aimed at creating a healthy environment as well as healthy living. It increases access and utilization of essential promotive, preventive and basic curative services by reaching the people at the grassroots level especially in rural areas. The core of the HEP is the construction of one health post in all of Ethiopia's 15,000 Kebeles, and the deployment of two salaried women called Health Extension Workers (HEWs) in each health post. All 30,000 HEWs have been trained and deployed amounting to 100% coverage of rural Kebeles in the country. The HEP model also includes establishing networks of Volunteer Community Health Workers (VCHWs) under the HEWs. The aim is to have one VCHW per 50 households. Thus, in an averaged-sized Kebele of 5,000 people (1,000 households), there would be one health post with 2 HEWs and 20 VCHWs, each managing 50 families. Nutrition is one of the HEP packages that focuses on changing the behavior of the community in child feeding, child care and maternal nutrition; promotion of the growth of children; screening for malnutrition and Vitamin A supplementation. Therefore, HEP is the most important institutional framework for the implementation of both the NNP and the Joint Program for the achievement of the MDGs.

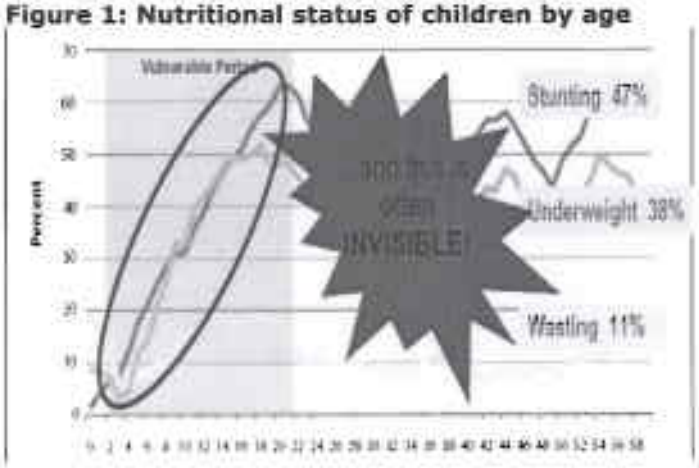
2.2. Nutritional status

Malnutrition continues to be a major public health problem in Ethiopia. Acute and Chronic Malnutrition are the most prevalent with half of Ethiopian children chronically malnourished and one in ten wasted (47%, 38% and 11% of children under five are stunted, wasted and underweight respectively)[2]. As shown in Figure 1, all typologies of child malnutrition increase with the age of the child, and the peak age is between 6 and 24 months of age. Among children, gender-based disparities are relatively small for chronic malnutrition but males (11.4%) are more affected than females (9.4%) by acute malnutrition. Rural children are more

[1] Summary and Statistical report of the 2007 Population and Housing Census. Population and Census Commission, 2008
[2] DHS 2005

stunted (48% vs. 30%), underweight (40% vs. 23%), and wasted (11% vs. 6%) than urban children. Regional variation in nutritional status of children is substantial; for example stunting levels are above the national average in Amhara and SNNPR. Regarding women, 27% are chronically malnourished and three in ten women aged 15-19 are undernourished. Variation between urban and rural women is also marked with more women being malnourished in rural areas (28%) than in urban areas (19%)[3].

Figure 1: Nutritional status of children by age



Micronutrient deficiencies are also a public health problem. Sub-clinical Vitamin A Deficiency (VAD) affects 37.7% of children of 6 to 59 months of age, which is extremely high; and 32% of childhood deaths are attributed to VAD. The prevalence of maternal night blindness is 1.8% which is also high[4]. With regard to Iodine Deficiency Disorders (IDD), the 2005 national IDD Survey indicates that the total goiter rate is 38% (39.9% of the children and 35.8% of women), which is extremely high; and only 4.6% of Ethiopian households consume iodized salt[5]. Iron Deficiency Anemia (IDA) is also prevalent with 54% of children age 6-59 months and 27% of women age 15-49 being anemic, mainly due to iron deficiency[6].

In Ethiopia, most undernutrition occurs during pregnancy and the first 2 years of life (Figure 1). This early damage is irreversible after the child reaches 24 months and thus it is a critical period in the lifecycle approach for interventions.

2.3. Consequences of malnutrition

The consequences of malnutrition for Ethiopia will be enormous if no action is taken. The greatest functional consequences of malnutrition for children are illness and death; and for those who survive, mental impairment and reduced capacity to produce and contribute to the economy of the country. In Ethiopia, half of all deaths in children under five are attributed to malnutrition; one third result from severe malnutrition and the majority (i.e. three-quarters) of these deaths result from mild to moderate malnutrition, which is not visible to health providers and families (Figure 2). Growth Monitoring and Promotion (GMP) visualizes the malnutrition of children to the families and communities. Some interventions, e.g. Vitamin A, Targeted Food Supplementation for the moderately malnourished and management of Severe Acute Malnutrition (SAM) have Benefit Cost Ratios (BCRs) that are high, and have a very large impact on child mortality when scaled up.

Figure 2: Causes of mortality in children under five[7]

Beyond the individual human suffering, malnutrition reduces cognitive development and thus, slows down learning throughout life. About 685,000 babies who are born to mothers with IDD suffer from some degree of mental retardation. Malnutrition also reduces work productivity as stunted, less educated and mentally impaired adults are less productive. It has been estimated that the annual productivity loss due to malnutrition (stunting, IDD and IDA) is 144 billion Birr[8], an estimated 10% of the GDP[9] , for the period of 2006-2015. When aggregated, the effects on illness, education and productivity have an enormous impact on the economic growth and poverty reduction efforts of the country.

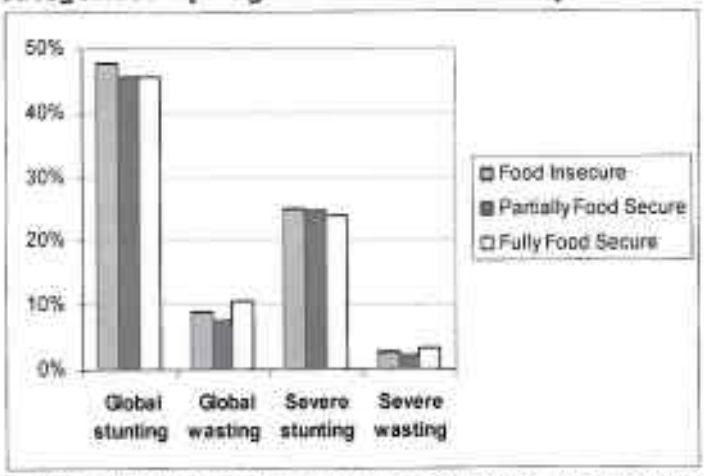
[3] Source for the above figures: DHS 2005
[4] National Vitamin A Survey report-EHNRI-FMoH-UNICEF,2008
[5] National IDD Survey report-EHNRI-FMoH-UNICEF,2006
[6] DHS 2005
[7] Source: Macro international Inc. 2008. Nutrition of young children and women, Ethiopia 2005
[8] US$ 12,984,670,870 at the UN exchange rate of 11.09 at 1st April 2009
[9] Ethiopia profile 2005

2.4. Determinants of malnutrition

There are many basic and underlying causes or determinants of malnutrition in children and women in Ethiopia that must be taken into account. Food insecurity, frequent disease, poor hygiene and environment and improper infant and child caring and feeding practices are all major determinants of child malnutrition.

Food insecurity is only one factor affecting nutritional status, as demonstrated in the 2007 World Bank's Economic and Sector Work (ESW), which found that the "Food Insecure" Woredas indeed had higher stunting rates than the food secure Woredas, but the difference is not very large. In addition, the "Food Insecure" Woredas did not appear to have higher wasting rates than the food secure Woredas (Figure 3). This shows Ethiopia's high malnutrition rates are also attributable to a range of other non-food factors; including appropriate breastfeeding (BF), complementary feeding (CF) and child care practices, hygiene, health status and health interventions, as well as the perceived status of women in society and adequate water and sanitation.

Figure 3: Malnutrition Rates of Woredas Categorized by Degree of Food Insecurity



Source: AFTH3 Human Development Department, Africa Region. Malnutrition in Ethiopia: Current Interventions, Successes, Cost-Benefit Analysis, and the Way Forward. June 2007.

In Ethiopia, inappropriate infant and child caring and feeding practices are also an important determinant of malnutrition. Breastfeeding is nearly universal in the country; with 96% of children having breastfed. However, a very large proportion of women do not practice appropriate BF and CF behavior. Only one out of three infants is exclusively breastfed for the first 6 months and the median duration of Exclusive Breast Feeding is 2.1 months rather than 6 months as is recommended[10].

There are also serious problems in the timing and quality of complementary food introduction, which is equally important. Based on the WHO guiding principles for feeding breastfed and non-breasted children, complementary feeding of children aged 6-23 months is reflected by the three Infant and Young Child Feeding (IYCF) practices indicators: continued breastfeeding; feeding solid or semi-solid food for a minimum number of times per day according to age and breastfeeding status; and including foods from a minimum number of food groups per day according to breastfeeding status. Based on these indicators, Complementary Feeding status is also suboptimal with only 23% of breastfed children aged 6-23 months fed according to the IYCF recommended practices[11]. That is why malnutrition peaks between 6-24 months of age. Much of inappropriate BF and CF behaviors are due to lack of knowledge rather than practical or financial constraints. For this reason, community based programs where community health workers impart knowledge on optimal BF and complementary feeding have proved very successful in changing child feeding behaviors and practices.

There is a strong relationship between the prevalence of diarrhea and being stunted or underweight. Both acute and chronic malnutrition rates rise concurrently from age 2 months to 16-18 months. Thereafter, the prevalence of diarrhea declines but the proportion of stunting and underweight does not.

The most important determinants of nutritional status among Ethiopian women are: place of residence (urban-rural) – i.e. the risk of being malnourished is 1.4 times higher for rural women than their urban counterparts; household economic status; employment status of women; age (adolescents are at a greater risk) and; marital status were found to be the most important determinants. In addtion, women with their own income and decision making autonomy on expenditure of their cash income have better nutritional status. Most of the socioeconomic variables affecting the nutritional status of women (mothers) also affect the nutritional status of their children. Malnourished mothers deliver low birth weight babies which results in stunting and high infant mortality in later life. This strong association between maternal and child nutritional status indicates that actions towards improving women's and child nutrition should always be integrated for effective utilization of scarce resources and to break the intergenerational link (mother-child) of undernutrition.

[10] DHS 2005
[11] Macro International Inc. 2008. Nutrition of young children and women, Ethiopia 2005

The existing nutrition information/surveillance structure in the country does not enable proper monitoring and evaluation of nutrition programs. Thus, the country needs a comprehensive nutrition surveillance system. This is a key recommendation of the NNS and one major subcomponent of the NNP. Such a system would be able to track localized nutritional indicators at all levels, so that the nutritional status of households in different localities could be tracked over time at the Woreda and even the Kebele levels.

These findings underline the vital importance of a multi-sectoral approach in addressing malnutrition, including not just interventions to address food, but also interventions that ensure nutrition security, like BF and CF, child care practices, hygiene, the perceived status of women in society and adequate water and sanitation. Interventions should target both women and children to have the maximum impact on women and child undernutrition and to break the intergenerational cycle of malnutrition. Stunting and even wasting rates can often be substantially improved by community based interventions that empower families, especially women and communities to assess, analyze and take action, and address appropriate feeding and childcare behavior, immunizations, and improved water and sanitation. Finally, interventions that prevent or reduce the consequences of undernutrition are essential to achieving most of the MDGs because improved nutritional status of children and women reduces child and maternal mortality, contributes to improving poverty by enhancing productivity and improves primary education enrollment by improving the learning capacity and school performance of children.

Despite some progress especially in reducing underweight and stunting (about 0.5 percentage points per year between 2000 and 2005), chronic malnutrition remains high and wasting (acute malnutrition) has remained unchanged at 11%[12]. Achieving Target 2 of MDG 1, i.e. a reduction of underweight among children under five from the current 38% to 19% by 2015, would require an annual reduction of over 2 percentage points. Based on current trends, however, there will be a higher absolute number of malnourished children in 2015 than there are today. The country also lags behind in achieving its HSDP III objective of reducing stunting and wasting by half. Moreover, the country under five mortality rate (U5MR), at 123 per 1000 live births, has declined by 1.8% per year since 1990, but the country still lags far behind in the achievement of the target level of MDG 4 (child mortality reduction), which would require an annual reduction of 7.9%.

Cognizant of the magnitude, causes and consequences of malnutrition, as well as lessons learned from previous and current efforts to address the problem, the Government of Ethiopia, in cooperation with partners[13], has developed the National Nutrition Strategy (NNS) and its program, the National Nutrition Program (NNP 2008-2012/13), to reduce the burden of malnutrition and its consequences in a harmonized and comprehensive manner, and through large-scale national efforts to hasten the achievement of MDGs, especially MDGs 1,4, and 5.

3. Strategies, including lessons learned and the proposed Joint Program

3.1 Background/context

3.1.1 Policy and Program Framework

Recently, nutrition has received attention as a national development priority and is being integrated into the strategies of relevant development sectors. The policy and program frameworks that are conducive for nutrition program include:

PASDEP (2005-2010) explicitly calls for the implementation of the NNS and Action Plan to achieve the MDG for halving poverty and hunger by 2015. Moreover, the strategy contributes to the improvement of the nutritional status of population especially children and women by addressing poverty.

Health Sector Development Program III (2005/2006-2009/2010): It is a health sector strategy which is in its third phase of implementation. It takes into account the time horizon of the MDGs, calling for further improving of health service delivery, capacity building and development of preventive health care and equal access to health services. Efforts are also being intensified to move services from health facilities to the village and household levels by institutionalizing community health services through the HEP. These strategies are conducive facilitating the implementation of the community based preventive nutrition interventions of the NNP. It also recognizes nutrition as a service that cuts across different sectors as well as the components of HSDP like child and maternal health. HSDP III has set nutritional objectives which are also objectives of the NNP as described below.

[12] DHS 2005
[13] UNICEF, WHO, WFP, CIDA, WB, EC, MI, USAID, FAO, JICA, Italian Cooperation and NGOs

National Nutrition Strategy: The FMOH in collaboration with partners, civil society and private sectors prepared and launched the NNS in February 2008.The strategy outlines how the country will address its nutritional problems in a timely comprehensive and sustainable manner. The goal of the Strategy is to ensure that all Ethiopians benefit from a secure and adequate nutritional status in a sustainable manner. The strategy gives priority to children under two years of age, pregnant and lactating women, adolescents, and food insecure households. The key implementation principles of NNS are: i) giving priority to vulnerable groups; ii) improving nutrition knowledge and skills; iii) ensuring community participation to address nutrition problems locally, and; iv) establishing and strengthening community based nutrition programs. These are also the major Principles of the NNP and of the JOINT PROGRAM. The strategy has 11 components/interventions to which the Joint Program outcomes contribute. Community Based Nutrition (GMP, Promotion of Essential Nutrition Action (ENA), women nutrition and building knowledge, attitudes, and practices for improved nutrition), Micronutrient Supplementation and Fortification, Strengthening Food Security Activities, Strengthening Nutrition in Emergencies and Strengthening Nutrition Information System.

National Nutrition Program (2008/2009-2012/2013): The first action to facilitate the implementation of NNS and achieve its aforementioned objectives is developing the national nutrition plan of action. Thus, the FMOH in collaboration with relevant government sectors and partners[14] has prepared the NNP to guide the implementation of the NNS. The NNP for the first five years (2008-2013) intends to scale-up existing nutrition interventions increasing the focus on community-based and high impact interventions, and harmonizing Government strategies as well as various donors' programs. The program has a primary impact, outcomes and intermediate objectives, which are reflected in this Joint Program Results Framework.

The NNP, as the NNS, targets the most vulnerable i.e. children under five years, particularly those under two years, pregnant and lactating women, and adolescents. It also gives priority to rural populations while recognizing that significant malnutrition exists in low income urban areas.

The NNP has two main components with four strategies under each component: Component 1, the Nutrition Service Delivery includes: i) Enhanced Outreach Strategy (EOS) with Targeted Supplementary Food (TSF) and transitioning of EOS into HEP as Community Health Days (CHD): it provides Vitamin A supplementation and deworming for children nationwide; and screening for malnutrition of children and pregnant and lactating women; ii) Health Facility Nutrition Services: Management of severe malnutrition, nutrition and HIV, counseling of infant and young child feeding and maternal nutrition; iii) Preventive CBN: it empowers the community to assess, analyze and take action to improve their children's and women's nutritional status through community conversation and individual counseling using the GMP as tool and; iv) Micronutrient Interventions: Universal Salt Iodization (USI), Iron/folate supplementation and deworming for pregnant women, Zinc supplementation for children with diarrhea, sprinkles and food fortification, and food based approaches. Vitamin A and deworming of children is provided through EOS/CHDs.

Component 2, Institutional Strengthening for Nutrition Policy and Program Implementation includes: i) Strengthening Human Resources and Capacity Building: endorse policies and procedures like enforcing the IDD legislation, registration of Zinc and code of marketing of breast milk substitute; improve the implementation capacity of the FMOH at all levels through supportive supervision, pre-service and in-service nutrition training and technical assistance; ii) Advocacy, Social Mobilization and Program Communication; iii) Nutrition Information System/ Surveillance, Monitoring and Evaluation, and operation research and; iv) Multi-sectoral Nutrition Linkages.

The FMOH is the lead government ministry for coordinating and implementing main components of the NNS and NNP. The main arrangement for implementing the NNP is the HEP so as to reach the population in need and increase the coverage to access these services. Thus, the NNP would facilitate the country's effort to achieve the HSDP III and MDG 1 objectives of reducing stunting and wasting by half, and MDG 4 objective of reducing childe mortality by two thirds by 2015.

3.1.2 Current efforts to address malnutrition in the NNP:

Management of acute malnutrition: The treatment capacity for SAM has increased from nearly nil in 2003 to over 78,000 at any time of the year. A sharp increase in the treatment capacity has been witnessed particularly in 2008 as a result of the decentralization of the management of severe malnutrition to the community level using the health posts. There is still a huge gap as there are 250, 000-300,000 acutely malnourished children at any one time in the country. Through EOS 7 million children and 1.5 million pregnant and lactating women are being screened for malnutrition every six months and referred to TSF and Therapeutic Feeding Program (TFP) if needed.

[14] UNICEF, WHO, WFP, CIDA, WB, EC, MI, USAID, FAO, JICA, Italian Cooperation and NGOs

Community Based Nutrition: UNICEF, under the Country Program Action Plan (CPAP), plans to support the Government to scale up CBN to 150 Woredas by 2011. Currently, about 103 Woredas (14% of all Woredas) have either started to implement or have secured funding to implement CBN. Other partners are JICA[15] and the World Bank.

Micronutrient interventions

Control and Prevention of Vitamin A Deficiency: By the end of 2008, the country achieved 94% coverage of children who receive twice-yearly Vitamin A supplementation through the EOS services. It was implemented as an interim strategy until the HEP is fully operational. An effort has been initiated to move from this campaign modality of delivering Vitamin A, deworming, and nutritional screening to CHD maintaining the high coverage achieved with EOS. CHD is locally organized and executed by HEWs and supported by VCHWs as one package/intervention of CBN. As a learning strategy, the implementation of CHD started in the 39 CBN Woredas supported by UNICEF in late 2008. This joint program supports the scale up of CHD.

Control and prevention of IDD: The objective of NNP is to increase the proportion of households that consume adequately iodized salt from the current 4.2% to 90% by 2013. The necessary financial and technical resources are contributed by the Government of Japan, UNICEF and Micronutrient Initiative (MI). Salt iodization was launched in April 11 at Afdera, Afar which will facilitate the achievement of USI. As an interim intervention, iodine oil capsules were distributed to 1.2 million under five children and 300,000 pregnant and lactating mothers in May 2008.

Control and prevention of IDA: There has been limited achievement to implement this intervention. Some resources are secured for procurement of iron/folate tablets and the plan is to scale up the supplementation of pregnant women through Community Based Nutrition with the objective of increasing proportion of pregnant women receiving iron/folate supplementation from 10% to 50% by 2013. This is one of the interventions to which the joint program contributes under the CBN component.

Food Security: Ethiopia has a large Food Security Project and a Productive Safety Net Program (PSNP) under the Ministry of Agriculture and Rural Development (MOARD) to address the longstanding food insecurity in the country. The Food Security Project benefits 8 million food insecure people; and 7.5 million people are covered under the PSNP. One of the major gaps is the utilization component of food security concept reflected by the fact that children from food secure families have also a high rate of malnutrition. This joint program supports the food utilization interventions through the Community Based Nutrition and the immediate food insecurity need through providing TSF for moderately malnourished and the innovative component that tries out and later scales up the production and preparation of complementary and supplementary foods from locally available products.

3.1.3 Joint Program and other Donor support/interventions

The total financing requirement for the NNP over the next five years is estimated to be USD 365 million. This excludes the Government's contribution of an estimated USD 96 million, which covers salary and operational costs and pre-service training of health workers, especially of the HEWs involved in the implementation of the NNP. There is already commitment from development partners like the World Bank, UNICEF, MI, CIDA[16], Embassy of Japan and JICA, to support part of the total financial requirement.

The MDG-F contribution of USD 7 million for this joint program will support efforts in meeting the existing financial and implementation gaps, especially in the community management of acute malnutrition (OTP), prevention of malnutrition through CBN, local production of complementary/supplementary foods and nutrition information system of the NNP. It also facilitates the implementation of different nutrition interventions of the NNP with an integrated approach in the targeted Woredas.

The JOINT PROGRAM is well aligned with the HSDP III, NNP and UNDAF outcomes, results and strategies. It will contribute to achieving the NNP target of reducing underweight from 38% to 30% by 2013, and the non-income Target 2 of MDG 1 i.e. halving malnutrition from 1990 levels (underweight in under five children) by 2015. It will also greatly increase the chance of achieving all other MDGs: (i) reduce poverty by boosting productivity; (ii) Ensure that all boys and girls complete a full course of primary schooling (MDG 2) by improving the children educational capacity; (iii) reduce by two thirds the mortality rate among children under five (MDG 4) by reducing 57% of malnutrition related under five deaths and; (iv) Reduce by three quarters the maternal mortality ratio (MDG 5) by empowering women, improving maternal nutrition, and reducing maternal deaths associated with malnutrition. The JP is also aligned with Ethiopia's UNDAF (2007-2011); and especially with two of the five Outcome areas: (i) Humanitarian Response, Recovery and Food Security and (ii) Basic Social Services and human resources i.e. support improved and equitable access and utilization of decentralized social services, including those for health, nutrition, education, water, sanitation

[15] Japan International Cooperation Agency
[16] Canadian International Development Agency

and hygiene. UNICEF, FAO, WFP, and WHO are already supporting the country in implementing the NNP through their country plans of action. Therefore, they are in a better position to support the country's effort to scale up the implementation of the NNP through this JP under the principle of a collective, coherent and integrated joint UN program.

3.2 Lessons Learned

The major lessons learned during the preparation, development and implementation of the NNS and the NNP are:

1. *Until recently, the broad multi-sectoral factors contributing to malnutrition have been insufficiently emphasized, with the focus placed on addressing food security as the primary and sufficient means of addressing nutritional insecurity.* Traditionally, there has been a food-biased approach towards combating malnutrition in Ethiopia, but there has recently been a growing understanding that programs that improve both food security and nutrition security are important as they are complementary.

2. *Scaling up the geographical coverage of community based programs; especially Community Based Nutrition and community management of severe malnutrition, to reach those who are really in need and contribute to the burden of malnutrition to the country.* This improves the access and increases the impact. Large-scale community based programs combating malnutrition, when implemented country-wide as in Bangladesh and Thailand, will have a large impact on nutrition status in Ethiopia with dramatic reductions in the percentage of the population that is underweight and stunted. The JP supports the country's effort to scale up these interventions.

3. *Community Based Nutrition should, in particular, target children below two years of age and pregnant women*; this is critical since they contribute to the bulk of the malnutrition burden; the major damage caused by malnutrition takes place in the womb and during the first two years of life; and the consequences of malnutrition are huge and after this period most of the damage is irreversible. That is why the NNP, as well as the JP, targets children under two years and pregnant and lactating women for this preventive program.

4. *Having comprehensive CBN information system:* It is currently impossible to obtain localized information on nutritional indicators at the Kebele or even the Woreda levels for decision making and action, except on a sporadic basis. A strong orientation towards management for results strengthens the sense of ownership and performance of all stakeholders involved in program implementation. Well-designed nutritional surveillance and monitoring and evaluation frameworks are critical for achieving outcomes, planning and following up on the quality of intervention, and taking action. The major gap area is in the information generated at community level and utilized by the community for action. That is why both the NNP and JP are designed to improve CBN information for monitoring and utilization for planning and actions.

5. *Activities need to be sufficiently broad and to have sufficient intensity*, including adequate ratios of community volunteers to households in the case of CBN, and sufficient length and intensity of initial and periodic refresher trainings which should be periodic. The JP uses the HEP implementation arrangement of two HEWs per 1000 households who are supported by one VCHW per 50 Households. Both the HEWs and VCHWs receive an initial training and refresher trainings every 6 months thereafter.

6. *Continuous capacity building at all levels especially at the district, Kebele, and community level is crucial for the success of malnutrition reduction efforts.*

7. *Development of inter-sectoral coordination and collaboration is very important for the establishment of a coherent national program, as well as coordinated efforts of community-based programs implemented by different partners and the UN.*

3.3 The Joint Program

The NNP/MDG-F JOINT PROGRAM enhances and scales up NNP implementation by filling its existing gaps and giving priority to community based nutrition interventions. It is a joint program implemented by one national lead Ministry, the FMOH, and two participating UN organizations: UNICEF and WFP. The JP has four complementary and interlinked outcome areas:

1. Improved management of children with acute malnutrition at the health post and community level.
2. Improved caring and feeding behaviors/practices of children and mothers.
3. Improved quality and utilization of locally available complementary and supplementary foods.

4. Improved nutrition information: This will provide a reliable and timely data/information for inputs into nutrition project management decisions, planning and policy development of short and long term corrective actions.

The JOINT PROGRAM has four main components which are subcomponents of the NNP, which will be used to achieve the JP outcomes:

1. Rollout and sustainability of Out Patient Treatment (OTP) services for severe acute malnutrition: This will improve the screening, awareness and treatment of acute malnutrition in the primary health care facilities and at community level.
2. Community Based Nutrition (CBN) interventions: This will build community capacity for assessment, analysis and action to improve child care and feeding behavior and practices, which is essential to prevent malnutrition. It will also provide integrated and preventive nutrition services as part of HEP; and link with agricultural extension workers and food security interventions.
3. Pilot on local production and utilization of complementary food: This innovative component consists of a pilot/operational research on local production and utilization of complementary food using local cereals/foods intended for the prevention of growth faltering/malnutrition at the most critical age. This will also demystify the management of malnutrition by families at community level.
4. Strengthening the nutrition information system and M&E mechanism: This will improve the current nutrition information system that in turn will redefine the information needs and mechanisms for data collection, analysis, dissemination and utilization. It will also include the monitoring mechanisms and the baseline, midline, and end line evaluation of the Joint Program.

All the JOINT PROGRAM components except the pilot on local production and utilization of locally available complementary foods will be implemented in a total of 16 rural Woredas in four region: Oromia (5 Woredas), Amhara (4 Woredas), SNNPR (5 Woredas) and Tigray (2 Woredas). Component 3 will be piloted in four Kebeles of two selected Woredas of the targeted 16 Woredas and later scaled up under CBN for the prevention of growth faltering in children. The Woredas are selected by the regions in consultation with FMOH and UNICEF/WFP based on the following criteria: i) Woreda with two HEWs in all rural Kebeles; ii) PSNP Woreda; iii) EOS and TSF Woredas; iv) Integration with WASH and C-IMCI programs and v) Commitment to implement CBN at all level.

The JOINT PROGRAM targets the following highly vulnerable groups in 16 rural drought-prone Woredas: (i) 156,000 under two children and 14,640 under five children with severe acute malnutrition; (ii) 96,500 pregnant and lactating women (PLW) and 10,360 malnourished PLW; (iii) identified households coping with acute food insecurity in two Woredas and (iv) 40 women groups.

The JOINT PROGRAM will use the strengthened capacity of the locally and nationally established NNP system, instead of creating a parallel system. The JP implementation will be coordinated by the FMOH and the RHBS, while in the field level implementation is through the existing decentralized Woreda Health Office (WoHo) and HEP service delivery supported by the local VCHWs. The local production component will be implemented through the AEWs and women's group in the community. UNICEF and WFP are already providing technical and financial support to implement the NNP (see their capability statement in *Annex 3*); and will continue to provide technical assistance and build the community capacity within the JP.

The JOINT PROGRAM will serve as a catalytic initiative, building on the comparative technical advantage of all the partnering UN agencies, as well as on the existing local and international nutrition interventions. Hence, by increasing the impact of the already existing support the UNCT provides to the NNP, the JOINT PROGRAM will further boost ongoing government efforts in the fight against malnutrition and provide an opportunity for the UNCT to demonstrate its capacity to function in a joint UN program. It will also help to deliver integrated community level nutrition interventions of government, UN and local NGOs and will be a good learning ground for later scale ups in NNP and other joint programs.

Key Cross Cutting Issues in the JOINT PROGRAM

JOINT PROGRAM and Gender: The JOINT PROGRAM addresses gender issues as?:

- Pregnant and lactating women are the direct beneficiaries of the targeted supplementary food and iron/folate supplementation. Women groups and women from food insecure households and with malnourished children are the direct beneficiaries of the local production income generating activities.
- Most of the participants of the monthly community conversation within the CBN component of the JOINT PROGRAM are women, who will be empowered as they assess and analyze the causes and consequences of their children's and their own nutrition and take collective action to address them.
- The capacity building activities within the JOINT PROGRAM target 960 HEWs who are all young women, and 9600 VCHW and Food Distribution Agents (FDAs) who are mostly women.

- The community based data like GMP participation rate, percentage of underweight, etc. is broken down by gender, and analyzed and used at the community and all levels disaggregated by gender.
- Analysis by gender will be part of the JOINT PROGRAM baseline and endline evaluations studies.

JOINT PROGRAM and Private sector: UNICEF has been building the capacity of a national private food factory that produces RUTF which is used to treat severely malnourished children in the country. The JOINT PROGRAM benefits this factory by enhancing the market for the RUTF, and continuing the technical support in maintaining quality of the production. There are also other private companies that produce and supply the supplementary food for moderately malnourished children and pregnant women. Thus, the JOINT PROGRAM will expand the existing market for their product.

JOINT PROGRAM and NGOs: In areas where NGOs run OTP programs, WFP with DMFSS will use a collaboration model (tripartite) agreement, and the NGO will take the responsibility for distributing discharge ration to beneficiaries. The aim is also to provide support for the OTP component by providing technical assistance like training and supportive supervision to the Woredas and HEWs.

3.4 Sustainability of results

The results achieved and the national and local capacities strengthened through the JOINT PROGRAM will continue even when it phases out because:

- The JOINT PROGRAM interventions focus on mothers/women, households and community lasting behavior and practice changes, and on local production of complementary foods that will generate income to sustain the program;
- The OTP component will use the decentralized service delivery of the government i.e. the community and health posts, which will ensure the strengthening of the existing health system and demystifying the management of acute malnutrition to the community;
- The community based nutrition and the innovative components built into this project use the existing HEWs and AEWs, offering the opportunity for linkages between the health and agriculture sectors;
- It will build the human resources capacity existing at community level and improve community capacity and involvement through community participation in their nutritional problem assessment, analysis and action. This will create the necessary capacity, responsibilities and ownership by the community and frontline service providers;
- The JOINT PROGRAM will be mainstreamed into the on-going NNP and implemented using the existing Government structure of the HEP and Agricultural Extension Program, of which both the Government and development partners have strong ownership.

4. Results Framework

4.1. National Nutrition Program Impacts and the Joint Program

The NNP impacts are:

1. Reduce the prevalence of underweight (W/A <-2) from 38% to 30% by 2013;
2. Reduce the prevalence of stunting (H/A <-2) from 46% to 40% by 2013;
3. Reduce the prevalence of wasting (W/H <-2) from 11% to 5% by 2013

The NNP Outcomes that are related to the JOINT PROGRAM outcomes include:

1. Improve child and pregnancy feeding and caring behaviors
   - By 2013, increase the proportion of infants 0-6 months exclusively breast fed from 32 % to 60%;
   - By 2013, increase the proportion of infants 6-9 months introduced to complementary food from 25% to 50%;

2. Acutely malnourished individuals have access to and utilize adequate and well organized TFP services (OTP and Inpatient)
   - By 2013, to increase % of functional TFP in health centers and hospitals from 31% to 50%;
   - Roll out community management of acute malnutrition to health post and community;

3. Strengthening Institutions for nutrition implementation and policy
   - Strengthening human and physical and community capacity in support of the NNP;
   - Strengthen the capacity of HEWs and VCHWs to achieve behavioral change objectives, and utilize media to promote appropriate caring practices at community level;
   - Support the development, management and monitoring of nutrition programs

4.2. UNDAF Strategic Areas and Outcomes and the Joint Program

The UNDAF Areas and Outcomes to which the JOINT PROGRAM contributes are:

Strategic Area 1: Humanitarian Response Recovery and Food Security: By 2011, significantly strengthened capacities of the Government, communities and other relevant stakeholders to respond to situations that threaten the lives and well being of a significant proportion of a population, which require rapid and appropriate action to ensure their survival, care, protection and recovery while enhancing their resilience to shocks and leading to food security and sustainable livelihoods.

Outcome 1: By 2011, the implementation of policies, strategies and coordination mechanisms are fully developed leading to: (a) Food and nutrition security and sustainable livelihood and (b) Protection of vulnerable populations and enhancement of their physical, human and social assets ensuring a smooth transition between humanitarian responses and longer-term development.

Outcome 2: By 2011, significantly increase capacity to deliver and provide access to essential commodities and services in emergency situations, cases of food, nutrition and livelihood insecurity, with direct linkages between humanitarian and longer-term development initiatives.

Strategic Area 2: Basic Social Services and Human Resources: By 2011, UN agencies will have significantly supported national efforts to achieve MDGs relating to improved and equitable access and utilization of decentralized social services, including those for health, nutrition, education, water, sanitation and hygiene, by developing capacities of both those responsible for service delivery, and those who demand and use such services, while giving special focus to the most vulnerable and marginalized groups:

Outcome 1: Improved access to and utilization of quality preventative, promotive, rehabilitative and curative health services at facility, community and household level.

Output 1.19: As per the National Nutrition Strategy, community-based nutrition activities scaled-up, families and communities strengthened to take action.

4.3. Joint Program Outcomes

By 2012, the JOINT PROGRAM shall achieve the four outcomes in the targeted 16 Woredas. The specific targets are summarized in the Joint Program Results Framework in *Annex 4*.

1. Improved management of children with acute malnutrition at the health post and community level. This will reduce the mortality and morbidity associated with acute malnutrition contributing to the MDG 4 target. It will enhance children's recovery from acute, moderate and severe malnutrition. This in turn will contribute to the NNP impact of reducing the prevalence of wasting from 11% to 5% by 2013 and Outcome 1 i.e. rolling out OTP to the community and health post. This result directly contributes to UNDAF strategic area 1 Outcome 2 of increasing capacity to deliver and provide access to essential commodities and services, and strategic area 2 Outcome 1 of increasing the access to nutrition services at facility, community, and household level.

2. Improved caring and feeding behaviors/practices of children and mothers. This will also contribute to the achievement of NNP outcomes, which entails improving caring and feeding practices, reducing micronutrient deficiencies and contributing to the growth of children (NNP outcome 1 and 3). This in turn contributes to achieving the NNP objective of reducing the prevalence of underweight from 38% to 30% and stunting from 46% to 40%, by 2013. It relates with the UNDAF strategic area 2 Outcome 1 of improved access to and utilization of quality preventative, promotive, rehabilitative and curative health services at community and household level and transitioning programs into long term development programs; and Output 1.19 which is community-based nutrition activities scaled-up, families and communities strengthened to take action.

3. Improved quality and utilization of locally available complementary and supplementary foods. This will improve the availability and utilization of complementary foods for young children, especially by food insecure households. By promoting local food security and empowering women, this project will contribute to the reduction of underweight and wasting.

4. Improved nutrition information: This will provide a reliable and timely data/information for inputs into the nutrition project management decisions, planning and policy development of short and long term corrective actions. Thus, it contributes to the NNP outcome of improving management and monitoring of nutrition programs.

The following subsections describe the JOINT PROGRAM outcomes, outputs and activities for the different components of the JP and the specific targets of the outcome and outputs are summarized in the Joint Program Results Framework in *Annex 4*.

1. Rollout and sustainability of OTP services

The overall objective is to enhance survival by reducing mortality and morbidity in children and women affected by acute malnutrition. The specific objectives are:

- Integrate and scale up the in and out-patient treatment (OTP) of severe acute malnutrition management (TFP) in existing health facilities;
- Increase access of the community to treatment of severe malnutrition by decentralizing OTP to the community level/the health post level (HEP);
- Provision of Targeted Supplementary Food to moderately malnourished children and PLW.

JOINT PROGRAM Outcome 1: Improved management of children with acute malnutrition at the health post and community level.

Ministry of Health is the implementer and UNICEF is the lead participating UN agency supported by WFP and WHO.

This outcome has three JOINT PROGRAM Outputs:

1.1 Under five children with severe acute malnutrition screened and provided quality care;
1.2. Moderately and severely malnourished children and pregnant and lactating women received TSF;
1.3. Enhanced health post capacity to provide quality out patient treatment for severe acute malnutrition.

Activities:

- Put in place OTP services in 320 health posts and inpatient treatment services in 50% of the health centers;
- Training of HEWs and health workers on the national protocol for the management SAM to enable them to provide quality services;
- Conduct community mobilization and community-based screening every 3 month through CHD;
- Provision of logistics support both for training and nutritional care inputs for health centers/health posts viz. F-75, F-100 milk, Plumpy'Nut, corn-soy-milk blend (CSMB), micronutrients, equipment (weighing and height measuring scale, and length measurement board), and drugs;
- Treat those children with severe acute malnutrition and without complication as OTP and refer those with complication or failure to respond to OTP for inpatient care to health centers with TFU. Discharge ration (FAMIX and vegetable oil) is given to those recovering from severe acute malnutrition;
- Food Distribution Agents (FDAs) provide Targeted Supplementary Food (FAMIX and vegetable oil) to moderately malnourished pregnant women, moderately malnourished under five children and under two children with persistent growth faltering. The FDAs also deliver key nutrition messages on complementary feeding, breast feeding and preparation of the ration;
- At community level, VCHWs and HEWs implement active case finding and defaulter tracing through home visits;
- Ensure proper supervision and service quality of TFP;
- Undertake Post-Distribution Monitoring to assess the utilization of TSF and problem encountered;
- WFP food monitors conduct beneficiary interviews to monitor food utilization.

2. Community Based Nutrition

The overall objective is to develop and strengthen communities' capacity to assess and analyze the causes of their malnutrition problems and to take action by making better use of family, community and external resources to improve the nutritional status of women and children.

JOINT PROGRAM Outcome 2: Improved caring and feeding behaviors/practices of children and mothers.

Ministry of Health is the implementer and UNICEF is the lead participating UN agency supported by WHO.

This outcome has two JOINT PROGRAM Outputs:

2.1 Improved growth of under two children
2.2 Build Community Capacity for Assessment-Analysis-Action to prevent Child Malnutrition

Activities:

i) Build community capacity for Assessment-Analysis-Action specific to preventing child malnutrition (Community Mobilization for Triple-A)

CBN activities are centered on the Triple-A approach which helps parents/caretakers, community members, service providers and local government authorities to assess the situation of children and women, analyze causes of the problems, take doable actions at family and community levels, and re-assess the situation regularly. The primary purpose of this approach is to bring about sustainable behavioral changes in child care practices and health-seeking behaviors in families and communities by making nutrition as an agenda for families and communities and mobilizing necessary support and services. The sub activities are:

- **Sensitization at Woreda, Kebele and Gotte levels** before the initiation of the program. This ensures full involvement and creates the potential support mechanisms and local resources.
- **Community (50 household) visioning and establishment of baseline through Household Register and community mapping**: The CHW with the help of the community key allies calls a community meeting; The CHW leads the community in visioning – a simple exercise on what positive changes the community wants to see for its children. She uses metaphors to explain the invisibility of malnutrition and helps the community understand that GMP can help them visualize and prevent malnutrition in their children. The community agrees to support CHWs in organizing and conducting monthly GMP sessions in their communities. The community members to create a map of the community and to identify factors that positively and negatively affect child growth and health, and they also identify the households with children under two or pregnant/lactating women. The CHW does a household inventory of the 50 households in her community to learn about key household practices that influence child health and growth. She compiles this information so that the community uses it for individual and community conversation/ assessment, analysis and action.
- **Conducting Community conversation at 50-household level and review meeting**: the CHW and HEW will conduct the first weighing GMP session for all children under two and the data from the GMP sessions are compiled into a community growth chart for presentation during community conversation or analysis and action that will be held monthly.
- Based on data from the community growth chart, community mapping, and household inventory, the CHW leads community members in assessing the nutrition situation in the community, analyzing the causes, and deciding on actions to take. The community also decides how it will monitor the progress in the actions and whether the actions are having the desired effect.

ii) Promote improved caring practices for children and women to prevent malnutrition

Child growth monitoring and promotion is the key tool to make malnutrition visible to caretakers, community members and other stakeholders, and enable them to make informed decisions on caring practices through behavioral change communication. The sub activities include:

- **Child Growth Monitoring and Promotion** Monthly growth monitoring and promotion will be conducted by a group of caretakers, led by Community Health Worker and supported by a Health Extension Worker. The target is all children under two years, which is the most vulnerable period when most of the malnutrition occurs. Participation of all children in the target group is a critical factor in preventing them from falling into malnutrition at an early stage of life.
- **Essential Nutrition Action through interpersonal and group communications**: A package of behavioral change communication messages on infant and young child and maternal nutrition, called Essential Nutrition Action (ENA), will be used for individual counseling during GMP and for community conversation. This will result in behavior change and improve child feeding and caring practices.

iii) Promotion of maternal care and nutrition through interpersonal and group communications

It is important for a mother herself, her family/community members and health workers to discuss issues related to pregnancy, causes of maternal malnutrition, and seek doable solutions at family and community level. ENA includes some key messages on maternal nutrition, and other BCC tools/materials that will be used during community conversation and individual counseling. HEWs provide basic nutrition services for pregnant and lactating women. The key services include monthly pregnancy weight gain monitoring, community conversation and individual counseling on maternal nutrition, and iron/folate supplementation and deworming during pregnancy. These services can be provided through an outreach mechanism by HEWs and follow-up promotion/support by CHWs.

iv) Referral and linkages

The VCHW refer to the HEWs those under two children identified as severely underweight through monthly growth promotion and those children growth faltering more than two consecutive months despite monthly counseling and home support for assessment and enrolling them in TSF or OTP (component of the JOINT PROGRAM) based on the severity of the malnutrition. Those children with health problems identified through community-IMNCI will be referred to the HEW and Health Workers for better evaluation and treatment.

CBN will also explore the integration with WASH (e.g. safe water supply and capacity building for sanitation activities), PSNP (e.g. income generation) and food security programs to better respond to communities' demands to be created through Triple-A process. For example those households with severe food insecurity will be linked to the existing Food Security and Productive Safety Net Program (PSNP) and others.

v) Reporting and feedback for effective follow-up actions

Based on the concept of community-based participatory monitoring, a minimum set of information will be generated by community members themselves and for themselves, facilitated by a VCHW (being a community member herself) and HEWs (providing technical support). In order for HEWs and CHWs to effectively support family/community actions and respond to their demand for better services, monthly review meetings will be conducted between Woreda and Kebele levels and between Kebele/HEWs and VCHWs for reporting, feedback and follow-up actions. Periodic micro-planning will be done as a built-in review and planning activity.

vi) Training for frontline workers

The training component of CBN aims to build the capacity of WoHo and frontline workers (HEWs and their supervisors and VCHWs) in program Woredas to improve their skills for implementing CBN. Training of Woreda health officers, HEWs supervisors, HEWs and VCHWs will be conducted at a Woreda level by a regional pool of nutrition and community dialogue experts from the region.

3. Local production and utilization of complementary/supplementary food

This innovative component will serve as a pilot or operations research. This aims at building the capacity of women to identify nutritionally suitable food products available locally, process them as easy-to-use complementary/supplementary foods, use the Community Based Nutrition structure to provide them to the neediest children and also make the system sustainable by selling some production in the local market. In turn, this will improve communities' efforts to prevent child malnutrition and growth faltering. If this pilot project works, it will be scaled up to more woredas of Community Based Nutrition and other regions and woredas.

JOINT PROGRAM Outcome 3: Improved quality and utilization of locally available complementary and supplementary foods

Ministry of Health is the implementer and UNICEF is the lead participating UN agency supported by FAO.

This outcome has two JOINT PROGRAM Output:

3.1. Quality complementary food prepared
3.2. Improved capacity of community women's groups

Activities:

- Develop the recipe: gather information of locally available products for complementary food preparation and perform a quality and nutrient content analysis;
- Select in a participative manner the women that are part of the group, taking into account their participation in the CBN program;
- Training of women's groups on complementary food preparation, quality control and utilization, mill (machine) basic maintenance and basic business management and accounting concepts to support the income generation side of the component. Further promotion of caring practices will be address by the CBN component. The training will be supported by AEWs;
- Establish production equipments in the community and start production;
- Establish a quality control system for production and final product;
- Supervise the production and income generation of complementary food, and give technical assistance, for which the program will use FAO technical expertise in the field.

4. Strengthening the nutrition information system and M&E mechanism

This component will redefine the information needs and mechanisms for data collection, analysis, dissemination and utilization of the NNP as well as the JOINT PROGRAM.

JOINT PROGRAM Outcome 4: Improved nutrition information

Ministry of Health is the implementer and UNICEF is the lead participating UN agency supported by WFP, FAO and WHO.

This outcome has three JOINT PROGRAM Outputs:

4.1. Community capacity in utilizing data for action improved;
4.2. Capacity of implementers on data reporting, analysis, and management improved;
4.3. Effective NNP and JOINT PROGRAM monitoring and evaluation system established.

Activities:

- Sustain the coordination of therapeutic feeding/emergency nutrition data that include collection, management, analysis and preparation of reports based on the information system databases;
- HEWs, VCHWs, HEW supervisors and WoHo will be trained on community based nutrition and OTP data collection, analysis and utilization to take appropriate action at the community, Kebele, and Woreda level. HEW supervisors and WoHo will be trained on supportive supervision;
- Conduct monthly review meetings at Kebele level and quarterly review meetings at Woreda level in order to assess the progress of the implementation and efficient utilization of the resources at the field level. There will be quarterly review meeting at the regional level involving the Woredas and Zones and annually at the national level involving FMOH, RHBS, RC, participating UN organizations and NGOs;
- Develop and establish a database for the different data sources;
- Routine data collection through existing nutrition programs such as HMIS/CBN, EOS, TFP and EWS;
- Conduct baseline survey and Midline, and Endline evaluations of the JOINT PROGRAM;
- Regular and triangulated data analysis to provide information for monitoring, review meetings, and supervision of the JOINT PROGRAM;
- Conduct biannual joint supervision/ field trip of the implementing partner and participating UN organizations.

The four components are interrelated: the Out Patient Therapeutic (OTP) service component will be supported by the Community Based Nutrition (CBN) component through community level identification, referral and follow-up of severely malnourished children; and the community based nutrition component will be a channel to promote the utilization of the locally produced complementary and supplementary foods. The nutrition information component uses the data generated through the three components for monitoring the progress and achievement of the outputs and outcomes of each component and for community level action.

5. Management and Coordination Arrangements

5.1. Joint Program Implementation Arrangement

Since the JP is part of the National Nutrition Program (NNP), the implementation arrangement for the JP will follow the same arrangement for NNP, using the existing government structures rather than establishing parallel ones. The FMOH is mandated, to host and manage the organizational and managerial structure of NNP. In order to have viable linkages and harmonization with the relevant sectors and donors, the NNP implementation and coordination framework has a multi-sectoral implementation and coordination arrangement at the policy and implementation level in all the decentralized (federal, regional, Woreda and Kebele) administration and community level. The National Nutrition Coordination Body (NNC) of the NNP at the Federal level will ensure effective multi-sectoral coordination and linkages at the national level. It draws members from relevant government sectors (education, agriculture, water, women affairs and finance and economic development), UNICEF and academia. Hence, the NNC will be instrumental also in the coordination of the JP. The same arrangement will apply for the coordination of the JP at the regional level, with some adaptation. Since the existing administrative arrangements at Woreda and Kebele levels are multi-sectoral, the JP nutrition interventions at Woreda and Kebele level will be under the leadership of the Woreda health offices.

The organizational and management structure for the JP will be housed in the MOH. Thus, the JP will be implemented by the MOH which is the national implementing partner, the FMOH at federal level, the Regional Health Bureaus (RHB) at the regional states level and the Woreda Health Office (WoHo) at the Woreda level. The HEP is the main service deliver arrangement at the field level for the JP. The Disaster Management and Food Security Sector (DMFSS) is the other government implementing partner pertaining to targeted supplementary food at the regional level. The two participating UN Agencies (UNICEF and WFP) provide technical assistance according to their corporate priorities and based on the Joint Program Results Framework. UNICEF is the lead UN agency. UNICEF has been performing the role of Lead Agency in nutrition as it is the country's UN nutrition cluster leader. UNICEF will provide support for program oversight and coordination among participating UN organizations.

In order to attain aid effectiveness and strengthen the move towards one plan, one budget, and one report the ministry and partners will strive for the principles of ownership, harmonization, alignment and mutual accountability so that transaction cost of having multiple channels of budgeting and reporting is minimized.

5.2. Joint Program Coordination Mechanism

The UNCT has a common joint program UNDAF (2007-2011), which is in its third year cycle, to support national priorities in order to achieve all MDGs. This JP is based on the Common Country Assessment, UNDAF and NNP. In addition to the overall coordination mechanism of the NNP, the JP uses the existing Resident Coordinator, National Steering Committee (NSC) and a Joint Core Coordinating Committee (JCCC) which will act as Program Management Committee (PMC) under the leadership of the FMOH and RC. Moreover, in order to ensure effective implementation capability of MOH a Program Management Team (PMT) will be established. Annex 5 summarizes the coordination and reporting arrangement.

5.2.1. Resident Coordinator (RC)

The RC's role is to facilitate collaboration between Participating UN Organizations to ensure that the program is on track and that promised results are being delivered. He or she will also be the main interface between the Secretariat and the MDTF Office on one hand and the UNCT on the other. The RC will exercise his/her authority over the program by being entrusted with leadership of the overall program design and ongoing programmatic oversight of the Fund's activities by co-chairing the National Steering Committee meetings. The UN Resident Coordinator reports to UNDP/Spanish MDG Achievement Fund Office on behalf of the Program.

5.2.2. National Steering Committee (NSC)

The National MDG Steering Committee comprises: a) the UN Resident Coordinator b) government of Ethiopia represented by State Minister of MOFED and c) a local representative from the Government of Spain represented by the Ambassador of the Kingdom of Spain. The Co-chairs are the UN Resident Coordinator and the state Minister of MOFED. The NSC will have a key oversight role throughout the life of this and the other joint programs. It is responsible for overall coordination of the joint program and provides guidance to project implementation through its bi-annual meetings. It will provide strategic guidance and oversight and approve the PROGRAM Document including subsequent revisions, Annual Work Plans and Budgets. The NSC meets biannually and the co-chairs can invite UNICEF, WFP and MoH as observers. Decisions of the NSC will be made through consensus. The primary responsibilities of the NSC include the following:

- Provide oversight and strategic guidance.
- Review and adopt the Terms of Reference and Rules of Procedures of the NSC and/or modify them, as necessary.
- Approve the JP document before submission to the Fund Steering Committee
- Approve the strategic direction for the implementation of the JP within the operational framework authorized by the MDG-F Steering Committee.
- Provide recommendations for attaining the anticipated outcomes as necessary.
- Approve the annual work plans and budgets submitted by MoH to ensure their conformity with the requirements of the Fund as well as ensuring the quality of the PROGRAM documents.
- Review the Consolidated Joint Program Report from the MDTF secretariat office and provide strategic comments and decisions as well as communicate it to key stakeholders and participating UN agencies.
- Offer remedial action for emerging strategic and implementation problems.
- Ensure proper consultation with key stakeholders and other donors working on related programs on the country level to avoid duplication of efforts.
- Approve the communication and public information plan prepared by the JCCCs.
- Ensure alignment of the MDG-F funded activities with the UN Strategic Framework or UNDAF approved strategic priorities.

5.2.3. Program Management Committee (PMC)

The Joint Core Coordinating Committee (JCCC) is an existing joint program coordination body composed of representatives from donors (UNICEF is also a member) and FMOH is the coordinating body. It is responsible for joint oversight of health sector program operational issues, review of quarterly financial and activity reporting, discussion of procurement plans and other operational issues as necessary. Rather than creating another coordination structure, JCCC will act as the PMC to carry out its duties and responsibilities stated below.

The JCCC, under the leadership of the NSC, will assume responsibility for the operational implementation and coordination of the Joint Programme. The Resident Coordinator will appoint a Co-Chair for the JCCC to facilitate the FMOH and UN Agency coordination and integration envisioned in this proposal. The JCCC membership for this purpose will consist of UNICEF, WFP, WHO, FAO, FMOH and MOFED as appropriate. Joint program managers, experts and private sector/civil society representatives can be invited to JCCC meetings as needed. The JCCC will meet on a quarterly basis and will hold additional meetings where it is needed to address issues directly related to management and implementation of the Joint program. The JCCC has overall control of the Program Management team and reports to the NSC. Its primary responsibilities with regard to this Joint Program are to:

- Ensure operational coordination
- Appoint a Program Manager or equivalent thereof

- Agree on re-allocations and budget revisions and make recommendations to the RC as appropriate
- Establish communication and public information plans
- Follow up on the implementation of the program
- Ensure resources are used to achieve outcomes and output defined in the program,
- Ensure alignment of the MDG-F funded activities with the UNDAF approved strategic priorities and national priorities,
- Establish the program baseline to enable sound monitoring and evaluation,
- Establish adequate reporting mechanisms in the program,
- Ensure integration of works plans, budgets, reports, and other PROGRAM related documents,
- Ensure that budget overlaps or gaps are addressed,
- Provide technical substantive leadership regarding the activities envisaged in the Annual Work Plan and provide technical advice to the NSC,
- Review and endorse progress report before it is submitted to the MDTF secretariat office on the 31st of March of each year,
- Address emerging management and implementation problems, and
- Identify emerging lessons learned

5.2.4. Program Management Team

One fulltime Program Coordinator will be assigned from MOH at Federal level and resides in the FMOH premises. He/she is responsible for daily management of the Joint Program such as developing action plans, monitoring activities, and producing reports. He/she will be accountable to FMOH who is the co-chair of the JCCC. UNICEF, as the lead agency, also assigns or recruits one program coordinator to coordinate the daily implementation of the JP with in the UN agencies. He/she will be accountable to UNICEF and work closely with the program coordinator at the FMOH.

The two program coordinators, Agrarian Nutrition of FMOH, UNICEF, and WFP will form the program Management team. They will meet monthly and report to the Chair of the JCCC. The team is expected to provide quick start up assistance, oversight the coordination of joint implementation more frequently/closely than the JCCC and prepare the quarterly and annual integrated narrative progress reports. A detailed job description will be prepared.

At implementing level, the Regional Health Bureau Nutrition Focal Persons and the WoHo, CBN or HEP focal persons take overall responsibility and accountability for each output, as detailed below (see also page 22 under the reporting section).

6. Fund Management Arrangements

6.1. Fund management

The MDG fund Management Board has decided to have a Pass-Through Fund Management arrangement and UNDP MDTF OFFICE will serve as the Administrative Agent (AA) for all country level activities. The UNDP MDTF OFFICE will release funds to UNICEF and WFP HQs, which will in turn transfer the fund to their respective country offices to finance their activities in annual allocations according to the agreed annual work plans and budgets. The release of the second year advances (and beyond) will be in accordance with Annual Work Plans approved by the NSC. The release of funds is subject to meeting a minimum commitment threshold of 70% of the previous fund release to the Participating UN Organizations combined (Commitments are defined as legally binding contracts signed, including multi-year commitments which may be disbursed in future years). If the 70% threshold is not met for the programme as a whole, funds will not be released to any organization, regardless of the individual organization's performance. On the other hand, the following year's advance can be requested at any point after the combined commitment against the current advance has exceeded 70% and the work plan requirements have been met. If the overall commitment of the programme reaches 70% before the end of the twelve-month period, the participating UN Organizations may upon endorsement by the NSC request the MDTF to release the next instalment ahead of schedule. The RC will make the request to the MDTF Office on NSC's behalf. Any fund transfer is subject to submission of an approved Annual Work Plan and Budget to the MDTF Office.

UNICEF and WFP establish a separate ledger account for the receipt and administration of the funds disbursed to it by UNDP MDTF OFFICE. Both UNICEF and WFP are requested to provide certified financial reporting according to the budget template. Participating UN Organization are entitled to deduct their indirect costs on contribution received according to their own rules and regulations. Periodic reviews of program management and finances will be undertaken by the NSC.

UNICEF and WFP are responsible for timely disbursement of funds, supplies and technical assistance to implementing partners. UNICEF and WFP assume complete Programmatic and Financial responsibilities for the funds disbursed to it by the administrative agent and can decide on the

execution process with its national partners and counterparts following the organization's own regulations. The program will be subject to an annual audit – each agency.

6.2. Cash Transfer

UNICEF and WFP will transfer the received cash to the national implementing partners. In cases where other UN agencies participating in the JP carryout some activities; UNICEF and WFP may release cash to the agencies up on the authorization of the FMoH. However, the MoU for such activities will be between FMoH, UNICEF and the Agencies. Pursuant to the UN General Assembly Resolution 56/201 on the triennial policy review of operational activities for development of the United Nations system, UNDP, UNICEF, WFP, other UN and UNDG ExCom Agencies adopted a common operational framework for transferring cash to government and civil society Implementing Partners. The national coordinating bodies that assume ultimate responsibility for overall management and coordination of UN programming are Ministry of Finance and Economic Development (MOFED) and Bureau of Finance Economic Development (BoFED) at national and regional level respectively. According to this common operational framework and signed CPAP document, UNICEF and WFP transfer all cash to regional implementing partners through public financial institutions (BoFED). Based on Harmonized Cash Transfer systems (HACT), JP funds will be channeled at Federal and Regional levels.

UNICEF and WFP will channel JP funds to FMOH for federal level activities and to Regions for regional level implementation based on AWP to BoFED, who will then disburse funds to Regional Health Bureaus (RHBs) and DPPB for regional level activities and Woreda Office of Finance and Economic Development (WoFED) for Woreda level activities. The WoFED in turn channels the fund to the Woreda Health Office based on the AWP. BoFED and WoFED are responsible for channeling funds to implementing partners and coordinating and reporting on fund flow whereas the FMOH and its respective Regional Health Bureaus and district (Woreda) health offices, as the national implementing partners assume full responsibility and accountability for preparing their JP AWP and for the effective use of JP fund and the effective management and delivery of outputs as outlined in JP annual work plans.

UNICEF and WFP transfer Cash to implementing partners using the following modalities:

i) Cash transferred directly to the Implementing Partner. It can be prior to the start of activities (direct cash transfer), or after activities have been completed (reimbursement);

ii) Direct payment modality upon request of government implementing partners. This includes:
Direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner; or
Direct payments to vendors or third parties for obligations incurred by UN agencies in support of activities agreed with Implementing Partners.

Direct cash transfers shall be requested and released for program implementation periods not exceeding three months. Reimbursements of previously authorized expenditures shall be requested and released quarterly or after the completion of activities. UNICEF and WFP shall not be obligated to reimburse expenditure made by the Implementing Partner over and above the authorized amounts. UNICEF will transfer funds to other implementing UN organization, US$ 374,000 to FAO and US$ 244,935 to WHO, as per a tripartite Memorandum of Understanding (MOU) signed by the three agencies and FMOH. The detailed budget is provided in annex 8, page 48.

7. Monitoring, Evaluation and Reporting

7.1. Monitoring and Evaluation

The monitoring and evaluation plan of the JOINT PROGRAM is summarized in the three-year Joint Program Monitoring Framework (*annex 6*) which will be the basis for the overall JOINT PROGRAM monitoring and evaluation. The Program Management Team (PMT) will be responsible for the overall coordination of the monitoring and evaluation activities. UNICEF, WFP, and MOH are responsible for the monitoring and evaluation for their respective activities. The monitoring and evaluation activities include: AWP and Annual Review Meetings; quarterly progress report, annual JOINT PROGRAM report, financial report, joint field visits of NSC members and JCCC; and JOINT PROGRAM baseline survey and mid-term, and endline evaluations.

MOH, RHBs, DPPB, MOFED/BoFED, RC and participating UN Agencies jointly conduct annual review and work planning meetings during the last quarter of each year. Joint Program review meetings include the achievements (in terms of activity implementation and fund utilization), challenges or risks, and lessons learned. Based on the lessons learned, a work plan and budget will be prepared for the next year which will

be approved by the JCCC. The program management coordinators and participating UN agencies make quarterly field visits. Moreover, the NSC and JCCC conduct a joint field visit, which will be organized by the JCCC, to selected JOINT PROGRAM Woredas twice per year.

The JOINT PROGRAM will be subject to baseline survey to assess the baseline status of the outcome and output indicators of the JOINT PROGRAM and to a mid-term review and a final evaluation to assess the relevance and effectiveness of the intervention and to measure the results, on the basis of the indicators of achievement by comparing with the baseline. The MOH, UNICEF and WFP are responsible for the baseline survey and endline evaluation and the costs are included in the JP budget whereas the mid-term review will be organized and funded by the MDG-F Secretariat. The JCCC will provide the necessary support to the MDG-F secretariat.

7.2. Reporting

The PMT will prepare and submit the quarterly progress and annual reports to the Program Management Committee which will prepare one annual Joint Program narrative report according to the MDG-F reporting template. The JCCC reports annually to the NSC and the final clearance stands with the NSC. Table 1 summarizes the reporting, monitoring and evaluation plan.

The MDTF office is responsible for producing the annual Consolidated Joint Program Progress Report, which will consist of three parts:

1. **Management Brief**: The Management brief consists of analysis of the certified financial report and the narrative report. The management brief will identify key management and administrative issues, if any, to be considered by the NSC;
2. **Narrative Joint Program Progress Report**: This report is produced according to the integrated JOINT PROGRAM reporting arrangement. It will be reviewed and endorsed by the NSC before it is submitted to the MDTF office on March 31 of each year;
3. **Financial Progress Report**: Each Participating UN Organization HQ will submit to the MDTF Office a financial report stating expenditures incurred during the reporting period. The deadline for this report is April 30 of each year.

Table 1: Reporting, Monitoring and Evaluation Plan

Activity	Responsible for consolidating/organizing	Approving Authority	Timeline
Baseline survey	UNICEF, WFP and MOH		Within three months after the JP is signed
AWP and Review meetings	MOH/RHBs	JCCC	Last quarter of each year
JOINT PROGRAM semi annual Field visits	JCCC	JCCC	Second and fourth quarter of each year
Quarterly progress report	PMT	JCCC	Within one week after the end of each quarter
Annual JOINT PROGRAM Narrative report	JCCC	NSC	March 31
Financial Progress report	UNICEF and WFP HQs	UNICEF and WFP HQs Financial Officer	April 30
AWP and Review meetings	MOH/RHBs	JCCC	
Annual Consolidated JOINT PROGRAM Progress report	MDTF Office	MDTF Executive Coordinator	May 31
Midline evaluation	MDG-F Secretariat		By the end of 2010
Endline evaluation	UNICEF, WFP and MOH		By the end of 2011

With regard to reporting, implementing partners at different levels will undertake the following responsibilities:

a) BoFED will be responsible to provide quarterly financial and physical reports to UNICEF, WFP, MOFED and FMOH (Program Management Team), which will be the basis for releasing subsequent advances/funds;
b) FMOH (PMT) will provide quarterly reports to UNICEF, and MOFED, while RHBs at regional level are responsible to prepare similar quarterly reports and submit to BoFED.
c) At Woreda level, WoFED is responsible to provide quarterly financial and physical reports to BoFED whereas WoHo is responsible to prepare similar quarterly reports and submit to WoFED and RHBs.

d) Regional DPPB will be responsible to provide financial and physical reports to BOFED and WFP, which will be the basis for releasing subsequent advances/funds.

8. Legal Context or Basis of Relationship

NNP/MDG-F JOINT PROGRAM is an MOH-led and UN-harmonized program including 2 participating agencies (UNICEF and WFP). Each agency brings special area of expertise given its mandate. The basis of operation in Ethiopia are governing documents such as the UNDAF (jointly signed between the UNCT and MOFED) and the respective Country Program documents (CPAP) of the respective agencies for the five years of implementation (2007-11), also signed with the MOFED. An agreement will be signed between the Administrative Agent (AA) and the implementing UN Partners to formalize the legal framework of the Spanish MDG Fund.

The following table summarizes additional information on the AA and participating UN Agencies basis of relationship with the government.

Table 4: Basis of Relationship

Participating UN organization	Agreement
UNICEF	UNICEF started working in Ethiopia in 1952. The Basic Cooperation Agreement between the Government of Ethiopia and UNICEF was signed in April 1963, which provides the basis of the relationship between the Government and UNICEF. The agreement was renewed and signed on 2007 as the Country Program Action Plan for the period 2007-2011 for the fulfillment of the Convention on the Rights of the Child, the commitments of the United Nations General Assembly Special Session on Children, the Millennium Development Goals (MDGs) and the Millennium Declaration.
WFP	WFP in Ethiopia was established in 1968 with aim of supporting the country in emergency intervention in an agreement with the Ethiopian government. Basic Agreement between the Government of the Federal Democratic Republic of Ethiopia and WFP was renewed and signed on 29 September 2005. Currently UNICEF, WFP, MOH and DPPB are working under an agreement in implementing the EOS/TSF Program which is in support of the government child survival initiative (CSI). UNICEF in collaboration with MOH is responsible for the screening for malnutrition, vitamin A supplementation, deworming and bed net distribution. WFP on the other hand in collaboration with DPPB is implementing the Targeted Supplementary Food Program (TSF) through the provision of blended food and fortified vegetable oil for malnourished children and pregnant and lactating women with the objectives of: Rehabilitating moderately malnourished children through the provision of blended food and vegetable oil Delivering key nutrition messages to beneficiary women WFP has been operating in Ethiopia since 1965. The agreement recognizes the humanitarian and developmental character of the activities of WFP and its important role in fighting hunger and poverty.

9. Work plans and budgets

Work Plan for: MDG-F/NNP Joint Program **Period: July 2009-August 2010**

JP Outcomes:
1. Improved management of children with acute malnutrition at the community level
2. Improved the caring and feeding behaviors/practices of children and mothers and under 2 children growing normally
3. Improved quality and utilization of locally available complementary and supplementary foods
4. Improved nutrition information and monitoring and evaluation of the project

UN organization-specific Annual targets	UN organization	Activities	TIME FRAME				Implementing Partner	PLANNED BUDGET		
			Q1	Q2	Q3	Q4		Source of Funds	Budget Description	Amount
JP Output 1.1: Under five children with severe acute malnutrition screened and provided quality care										
Targets 80% of under five children screened for malnutrition every 3 months 40 % (5,760) children with SAM access OTP services at the health post and community by 2009	UNICEF	Community mobilization and Screening for malnutrition			X	X	MOH	CIDA	Operational cost	6,400
		Treat as an outpatient with RUTF and routine drugs and Referral for those with complication			X	X	MOH	MDG-F	Supplies and commodities	688,876
JP Output 1.2: Severely malnourished children and malnourished PLW received TSF										
40 % (5,760) malnourished children received discharged TSF by 2009 2,360 malnourished pregnant and lactating women received TSF	WFP	Provision of TSF ration to malnourished children		X	X	X	DMFSS	MDG-F	Supplies and commodities	172,800
		Provision of TSF ration to malnourished PLW			X	X	DMFSS	MDG-F	Supplies and commodities	57,600
		Community mobilization			X	X	DMFSS	MDG-F	CIDA	See comm. mobilization in output 1.1
		Conduct CHDs			X	X	DMFSS	MDG-F	CIDA	See comm. mobilization in output 1.1
JP Output 1.3: Enhanced Health posts capacity to provide quality out patient treatment for severe acute malnutrition										
102 HEWs and 30 health workers trained on management of acute severe malnutrition 4,300 VCHW trained OTP services capacity established at 102 health post and community	UNICEF	Training of HEWs, VCHW, and health workers	X	X	X	X	MOH	MDG-F	Training	96,930
		Establishing OTP services at the health post community-level		X	X	X	MOH	MDG-F	Equipment	21,960
		Distribute OTP supplies (RUTF and routine drugs)		X	X	X	MOH	MDG-F	Transport	15,709
		Supportive supervision		X		X	MOH	MDG-F	Supervision / Travel	57,710
JP Output 2.1: Build Community Capacity for Assessment-Analysis-Action Specific to Preventing Child Malnutrition										
60 % of communities conduct Community conversation 960 HEWs and 9,600 VCHW trained on community	UNICEF	Conduct sensitization at woreda, kebele and gotte (sub kebele) levels	X				MOH	MDG-F	Training	31,538
		Conduct micro-planning (to identify target population and supply needs)	X				MOH	MDG-F		Included in Sensitization cost above (CBN)

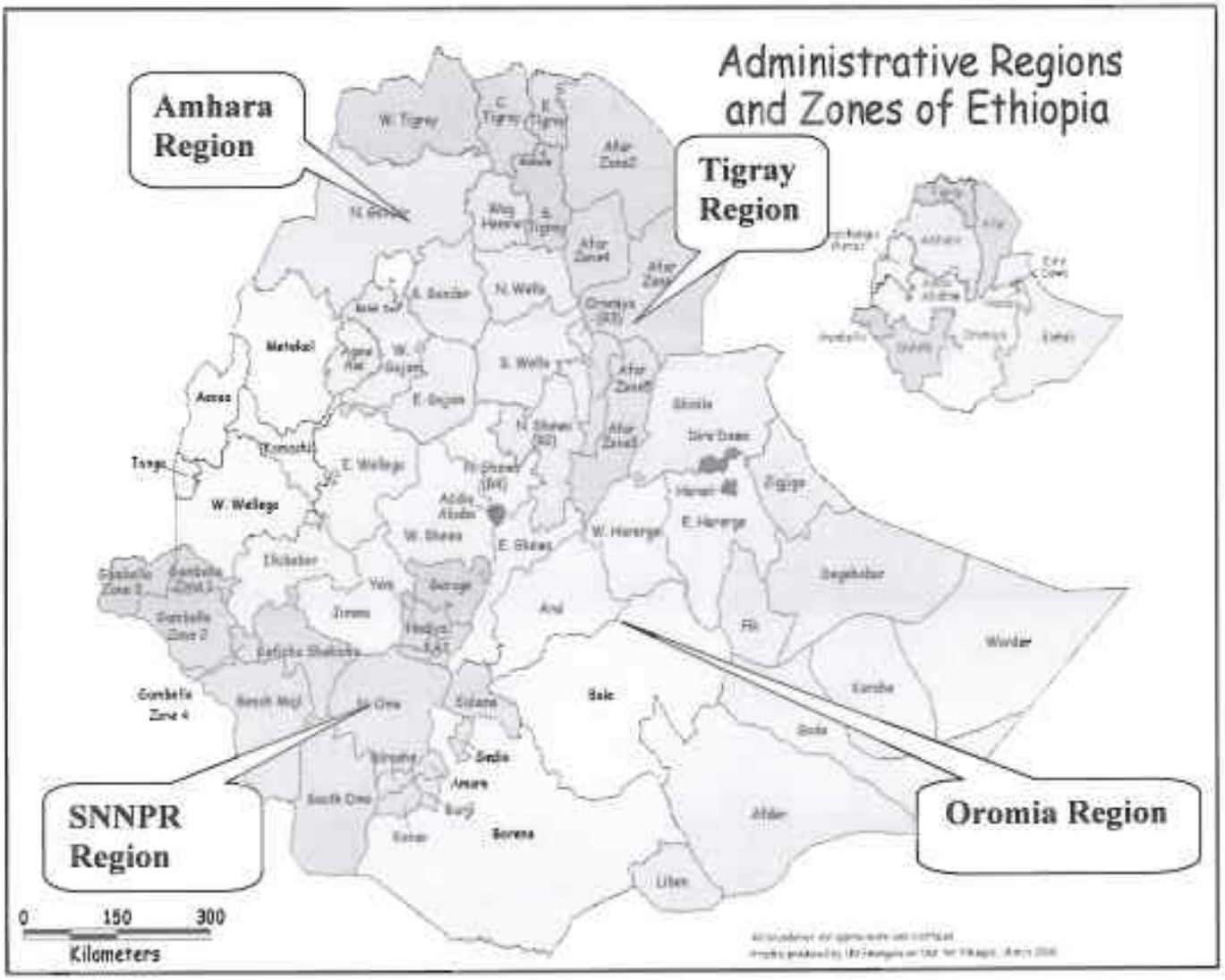
based nutrition		Conduct monthly community conversation (Triple-A)			X	X	MOH	MDG-F		
		Conduct training of HEW and VCHW on CBN	X	X	X		MOH	MDG-F	Training	378,227
		Technical assistance for the regions	X	X	X	X	MOH	MDG-F	Personnel	44,000
		Program manger for FMOH to manage the joint program	X	X	X	X	MOH	MDG-F	Personnel	29,000
JP Output 2.2: Under 2 Children growth improved (See also the outcome indicators 2.1 above										
60% (93,600) of targeted under 2 children participated in GMP 90 % of children access - Vitamin A supplementation (6-59 months) every six months); - Deworming (24-59 months) every six months)	UNICEF	Print and distribute CBN Job aids	X	X	X	X	MOH	MDG-F	Supplies and commodities	16,000
		Procure and distribute Salter Scales, iron tablets and other supplies	X	X	X		MOH	MDG-F	Supplies and commodities	261,426
		Conduct Supportive supervision		X		X	MOH	MDG-F	Supervision / Travel	63,840
		Conduct quarterly review		X		X	MOH	MDG-F	Training	See output 4.1
		Organize quarterly Community Health Days (CHD) for the delivery of child survival nutrition			X		MOH	CIDA		
		Conduct annual workshops on multi sectoral linkages			X		MOH	MDG-F	Training	1,600
JP Output 3.1: Quality complementary food produced										
Four types of complementary foods produced in the targeted four kebeles Four production sites established in the four targeted kebeles	UNICEF	Develop recipe and food analysis		X	X		MOH	MDG-F	Contract	155,500
		Establish the production equipments in the community and Pilot production of the food (including start up supply and operational costs)			X	X	MOH	MDG-F	Equipment	181,333
JP Output 3.2: Built Capacity of community women groups										
20 women group and 10 agricultural extension workers trained 20 women group start to generate income	UNICEF	Establish the production equipments in the community			X	X	MOH	MDG-F		See in out put 3.1
		Train Women groups in the four kebeles			X		MOH	MDG-F	Training	7,000
		Supervision and technical assistance for women group			X	X	MOH	MDG-F	Supervision / Travel	10,188
JP Output 4.1: Community capacity data utilization for action improved										
960 HEWs and 9,600 VCHW trained on community based nutrition information	UNICEF	Conduct monthly review meeting at kebele and quarterly at Woreda level			X	X	MOH	MDG-F	Operational costs	71,808

60 % of communities utilizing CBN monthly data 50 % of Kebeles conduct review meeting		Training of HEWs and VCHWs on data CBN information	X	X	X		MOH	MDG-F	Training	See training in output 2.1
JP Output 4.2: Capacity of implementers on data reporting, analysis and management improved										
30 Federal, Regional and Woreda health managers and ENCU staff trained on CBN and OTP data management CBN and OTP data reporting system established in 16 woredas and four RHBs	UNICEF	Develop and establish database for different data sources at Federal level				X	MOH	MDG-F	Contract	17,000
		Establish database and training at regional level in four regions		X			MOH	MDG-F	Training	1,400
		Train data managers CBN and OTP data management			X		MOH	MDG-F	Training	11,775
		Provide technical and administrative support	X	X	X	X	MOH	MDG-F	Contract	155,248
		Train 20 health providers at woreda level on data collect, management, analysis, interpretation and transfer			X		MOH	MDG-F	Training	50,240
JP Output 4.3: Effective NNP and JP monitoring and evaluation system established										
Baseline surveys conducted	UNICEF	Conduct baseline survey	X				MOH	MDG-F	Contract	100,000
Annual review meeting conducted		Conduct semiannual Joint supervision/field visit		X		X	MOH	MDG-F		Cost included in each output supervision cost
		Conduct annual joint review meeting				X	MOH	MDG-F	Training	24,900
		Share the result with relevant stakeholders				X	MOH	MDG-F		Included in the baseline survey cost under output 4.3
Total Planned Budget (including indirect support costs)										**2'914,261**
Total UN organization 1: UNICEF										**2'667,735**
Total UN organization 2: WFP										**246,528**

Description	**UNICEF**	**WFP**
1.1 Supplies, commodities, equipment and transport	1,185,304	230,400
1.2 Personnel (staff, consultants, travel and training)	204,737	0
1.3 Training of counterparts	675,419	0
1.4 Contracts	427,748	0
1.5 Other Direct Costs	0	0
Total Direct Costs	**2,493,208**	**230,400**
2.0 UN Agency Indirect Cost	174,525	16,128
Grand Total	**2,667,733**	**246,528**

Annexes

Annex 1: Map of the Ethiopia and Joint Program Target Regions



Annex 2: Population size of target regions by sex and place of residence

For 2008 based on 2007 Ethiopia census preliminary report

Sex	Urban + Rural		Urban		Rural	
	No.	%	No.	%	No.	%
TIGRAY Region						
Both Sexes	4,422,317	100	862,352	100	3,559,966	100
Male	2,177,991	49.25	424,708	47.24	1,681,728	49.74
Female	2,244,326	50.75	437,644	52.76	1,878,238	50.26
AMHARA Region						
Both Sexes	17,506,695	100	2,205,844	100	15,300,851	100
Male	8,783,109	50.17	1,106,672	48.49	7,419,383	50.41
Female	8,723,586	49.83	1,099,172	51.51	7,881,469	49.59
OROMIA Region						
Both Sexes	27,946,067	100	3,409,420	100	24,536,647	100
Male	14,073,639	50.36	1,716,984	50.6	12,415,543	50.32
Female	13,872,427	49.64	1,692,436	49.4	12,121,103	49.68
SNNP Region						
Both Sexes	15,478,764	100	1,547,876	100	13,930,888	100
Male	7,699,137	49.74	769,914	51.61	7,189,731	49.52
Female	7,779,627	50.26	777,963	48.39	6,741,157	50.48

National Population characteristics profile of the target children for the Joint Program (2008)

	Number total	%	Male	%	Female	%
COUNTRY Total*	73,918,505	100%	37,296,657	50.5	36,621,848	49.5
Under five children	10,785,103	15%	5,477,291	50.7	5,307,812	49.3
under two children	3,711,614	5%	1,883,688	51	1,827,926	49

Annex 3: Capabilities statement by UN Participating Organizations

Participating agencies:

1. The United Nations Children's Fund (UNICEF) is the UN agency that helps build a world where the rights of every child are realized. UNICEF Ethiopia country office works closely with the Government of Ethiopia and other partners in the realization of the rights of the children and women in Ethiopia based on the programs and projects developed and agreed upon by the Government and UNICEF under the CPAP 2007-2011. The CPAP was developed based on the Country Program Development (2007-2011) within the framework of the Basic Cooperation Agreement (1994) with the Government and the UNDAF II (2007-2011). The UNICEF supported PROGRAM and projects operating nationally and/or in the regions fall under the following areas: Health, Nutrition, Education, Gender and Child Protection, Water, Environmental Sanitation and Hygiene, Emergency Preparedness & Response, Capacity Building in Planning and Monitoring and Evaluation. UNICEF has a Country Team and Area Program Support teams under the Field Support Coordination Unit in most part of the country. The Nutrition and Food Security Section consist of 21 nutritional professionals and two support staff. In addition the Section comprises another 14 nutrition professional staff including an International Team Leader for the Emergency Nutrition Coordination Units (ENCUs) at Federal and five regional offices. The presence of UNICEF through its decentralized Area Program Support Teams, including professional nutrition staffs, in most part of the country brings a unique opportunity and strength to support the partners in the field for implementing and monitoring the programs in order to make them effective and efficient.

2. World Food Program (WFP) is the food aid agency of the United Nations and works on food assistance programs to reduce hunger, poverty and malnutrition. WFP Ethiopia has a Country Office and eight Sub-Offices around the country. WFP Ethiopia specifically has a Targeted Supplementary Food (TSF) Team, working under the Nutrition and Education Section in the PROGRAM Unit, staffed by an International Nutritionist, a National Nutritionist, a Junior PROGRAM Officer with Nutrition background and 3 PROGRAM Assistants with field nutrition emergency experience. This team supports the sub-offices, which all have TSF focal points.

Supporting agencies:

1. **World Health Organization (WHO)** is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. The WHO country office for Ethiopia (WCO-Ethiopia) has a strategic objective to improve nutrition, food safety and food security throughout the life-course. The WCO has two EHA Technical Officers and one Nutritionist. The unit has gotten support from other programs mainly EPI, Disease Prevention and Control, Inter-Country Supporting Team, AFRO and Head Quarter.

2. **Food and Agriculture Organization (FAO)** of the United Nations leads international effort to defeat hunger. FAO/BSF (FAO/Belgium Survival Fund) is the exit phase of the project 060 which aims at improving nutrition and household food security in Amhara and Tigray Regions. The project is working with the Ministry of Agriculture and Rural Development and other partners with the objectives of Community Empowerment, Nutrition and Health Promotion, Marketing and Enterprise, Agriculture and Natural Resource Development and Monitoring and Evaluation. The project staff includes a project manager, a national health and nutrition expert, an agriculture expert, 4 Woreda coordinators, 2 program assistants and 6 drivers.

Annex 4: Joint Program Results Framework

National Nutrition Program outcomes

1. Improve child and pregnancy feeding and caring behaviors
   - By 2013, increase the proportion of infants 0-6 months exclusively breast fed from 32 % to 60%;
   - By 2013, increase the proportion of infants 6-9 months introduced to complementary food at 6-7 months from 25% to 50%;
2. Acutely malnourished individuals have access and utilization to adequate and well organized Therapeutic Feeding Program services (OTP and Inpatient)
   - By 2013, to increase % of functional TFP in health centers and hospitals from 31% to 50%;
   - Roll out community management of acute malnutrition to health post and community;
3. Strengthening Institutions for nutrition implementation and policy
   - Strengthening human and physical capacity in support of the NNP;
   - Strengthen the capacity of HEWs and VCHWs to achieve behavioral change objectives, and utilize media to promote appropriate caring practices at community level;
   - Support the development, management and monitoring of nutrition Programs.

UNDAF Outcomes

Strategic area 1. Humanitarian Response Recovery and Food Security

Outcome 1: By 2011, the implementation of policies, strategies and coordination mechanisms are fully developed leading to: (a) Food and nutrition security and sustainable livelihood and (b) Protection of vulnerable populations and enhancement of their physical, human and social assets ensuring a smooth transition between humanitarian responses and longer-term development.

Indicators:1.10 Number of people who attain food security in 262 Woredas of Oromia, Amhara, SNNPR and Tigray through the Productive Safety Net and other Food Security Programs (Baseline: 7 million; Target: 15 million)

Outcome 2: By 2011, significantly increase capacity to deliver and provide access to essential commodities and services in emergency situations, cases of food, nutrition and livelihood insecurity, with direct linkages between humanitarian and longer-term development initiatives.

Indicators: 2.3. Number of under five children receiving child survival interventions (measles, vitamin A, deworming and malaria prevention) twice a year in 300 drought-prone Woredas, screened for malnutrition and referred to nutrition Programs (Baseline: 4 million; Target: 7 million)

Strategic area 2. Basic Social Services and Human Resources

By 2011, UN agencies will have significantly supported national efforts to achieve MDGs relating to improved and equitable access and utilization of decentralized social services, including those for health, nutrition, education, water, sanitation and hygiene, by developing capacities of both those responsible for service delivery, and those who demand and use such services, while giving special focus to the most vulnerable and marginalized groups.

Indicators relevant to the JOINT PROGRAM: i) Prevalence of underweight children (under-5 years of age) [MDG 1]: (Baseline: 38.4;arget: decrease by 50% (HSDPIII)); 2) Under-5 mortality rate [MDG 4]: (Baseline 140.1/1,000 (2005, HSDPIII); Target: 91/1,000 (2010, HSDPIII)); and Maternal mortality ratio [MDG 5]: (Baseline: 871/100,000 (2005, HSDPIII) ; Target: 590/100,000 (2010, HSDPIII))

Outcome 1. Improved access to and utilization of quality preventative, promotive, rehabilitative and curative health services at facility, community and household level.

Output 1.19 As per the National Nutrition Strategy, community-based nutrition activities scaled-up, families and communities strengthened to take action.

Indicator: 1.28) % of children exclusively breastfed up to 6 months (Baseline: 38% (HSDPIII) ; Target: 63% (HSDPIII))

1.29) % of children with diarrhea receiving ORT and continued feeding (Baseline: 13% (HSDPIII));Target: 68% (HSDPIII)

Joint Program Outcome 1: Improved management of children with acute malnutrition at the community level (UNDAF 1.2.3; NNP outcome 2) Indicators 1.1) % of Health posts in the 16 targeted woredas provide quality OTP services (Cure Rate of > 75%; Default rate of <15%; and mortality rate of <5%) to severely malnourished children. Baseline: TBD Target: 80% of the 320 health posts by 2012 1.2) % of children with acute malnutrition access OTP services in the 16 targeted woredas Baseline: TBD for the target Woredas Target: 80 % of the 18,300 SAM children by 2012										
Joint Program Outputs	Participating UN organization-specific Outputs	Participating UN organization	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Resource allocation and indicative time frame*				
						Y1	Y2	Y3	Y4	Total
1.1 under five children with severe acute malnutrition are screened and provided quality care Indicator: 80 % of under five children with severe acute malnutrition screened and provided quality care by 2012 Baseline: - Targeted Woredas: TBD - Target: 80% (14,640)	90% of under five children screened for malnutrition every 3 months 80 % (14,640) children with SAM access OTP services at the health post and community by 2012	*UNICEF*	*CPAP result area 5.1-5.6 (Enhanced Out reach strategy)*	*MOH*	- Community mobilization and Screening for malnutrition - Treat as an outpatient with RUTF and routine drugs and Referral for those with complication	688,876	602,766	459,251	NA	1,750,893
1.2. Severely malnourished children and malnourished PLW received TSF	80 % (14,640) malnourished children out of those screened received discharge TSF by 2012	*WFP*		*DMFSS*	- Procure Famix and Vegetable oils and distribute to the Woredas	230,400	201,600	153,600	NA	585,600

Baseline: Targeted Woredas: 60% for both Children and PLW Target: - 80 % (14,640) of children with severe malnutrition received TSF by 2012 - 80% (10,360) of malnourished PLW received TSF by 2012	10,360 malnourished pregnant and lactating women (out of those screened) received TSF									
1.3. Enhanced Health posts capacity to provide quality out patient treatment for severe acute malnutrition Baseline: Targeted Woredas: TBD Target: 80% (256) of health posts providing quality OTP services for SAM (Cure Rate of > 75%; Default rate of <15%; and mortality rate of <5%) in 16 targeted woredas	OTP services capacity established for 320 health post and community in the targeted woredas by 2012 320 HEWs and 30 health workers trained on management of acute severe malnutrition by 2012 9,600 VCHW trained on Community mobilization and screening for malnutrition by 2012	*UNICEF*	*CPAP result area 5.1-5.6 (Enhanced Out reach strategy)*	*MOH*	- Training of HEWs, VCHW, and Health Workers - Distribute OTP supplies(RUTF and routine drugs) - Establishing OTP services at the health post community-level - Supportive supervision	192,309	192,309	57,710	NA	442,328

Joint Program Outcome 2: Improved the caring and feeding behaviors/practices of children and mothers and under two children growing normally (UNDAF strategic area 2 indicators, UNDAF 2.1.19; NNP outcome 1&3) Indicators: 2.1) Proportion of underweight in under five years children in the 16 target woredas Baseline: national 38% , not established for the target Woredas (TBD) Target: Reduced by 6% from the baseline by 2012 2.2) Proportion of infants 0-6 months exclusively breast fed in 16 targeted woredas Baseline (national): 32% , not established for the target Woredas (TBD) Target: increase by 15 % from baseline by 2012										
2.1. Build Community Capacity for Assessment-Analysis-Action Specific to Preventing Child Malnutrition	60 % of communities in the 16 target woredas conduct Community conversation by 2012 960 HEWs and 9,600 VCHW trained on community based nutrition by 2011	*UNICEF*	*CPAP Result 7.1-7.4 (community based Nutrition)*	*MOH*	- Conduct Sensitization efforts at region, Woreda, and Kebele levels - Conduct micro-planning - Conduct Community mapping and inventory - Conduct monthly community conversation - Conduct training of HEW and VCHW on CBN - Technical assistance for the regions - Program manger for FMOH to manage the joint program	482,765	351,632	351,632	NA	1'186,030
2.2. Under two Children growth improved See also the outcome indicators 2.1	- 80% (124,800) of targeted under two children in the 16 target woredas participated in GMP by 2012	*UNICEF*	*Same as CPAP Result 7.1-7.4*	*MOH*	- Conduct monthly community-based Growth Monitoring and Promotion (individual counseling of	342,866	437,181	200,704	NA	980,751

and 2.2 above plus: Indicator: The proportion of infants 6-9 months introduced to complementary food at 6-7 months Baseline: TBD Target: Increase by 10 % from baseline by 2012	- 90 % of children 6-59 months receive Vitamin A supplementation every six months - 80 % of children 24-59 months receive deworming every six months				mothers and community conversation) - Print and distribute CBN Job aids - Procure and distribute Salter Scales, iron tablets and other supplies - Conduct Supportive supervision and quarterly review - Organize quarterly Community Health Days (CHD) for the delivery of child survival nutrition -Conduct annual workshops on multi sectoral linkages					
Joint Program outcome 3. Improved quality and utilization of locally available complementary and supplementary foods (UNDAF strategic area 2 (UNDAF 2.1.19; NNP outcome 1) Indicators: % of 6-24 months growth faltering children with improved growth after consuming the locally produced foods in the target Kebeles by 2012 Baseline: 0 Target: 60 %										
3.1. Quality complementary food produced Indicator: four types of complementary	- Four types of complementary foods produced in the targeted four Kebele by 2012 s	*UNICEF*	*CPAP Result 7.1-7.4 (community based Nutrition)*	*MOH*	- Identification of local food and testing of its food value - Develop recipe and food analysis	336,833	169,333	9,333	NA	515,500

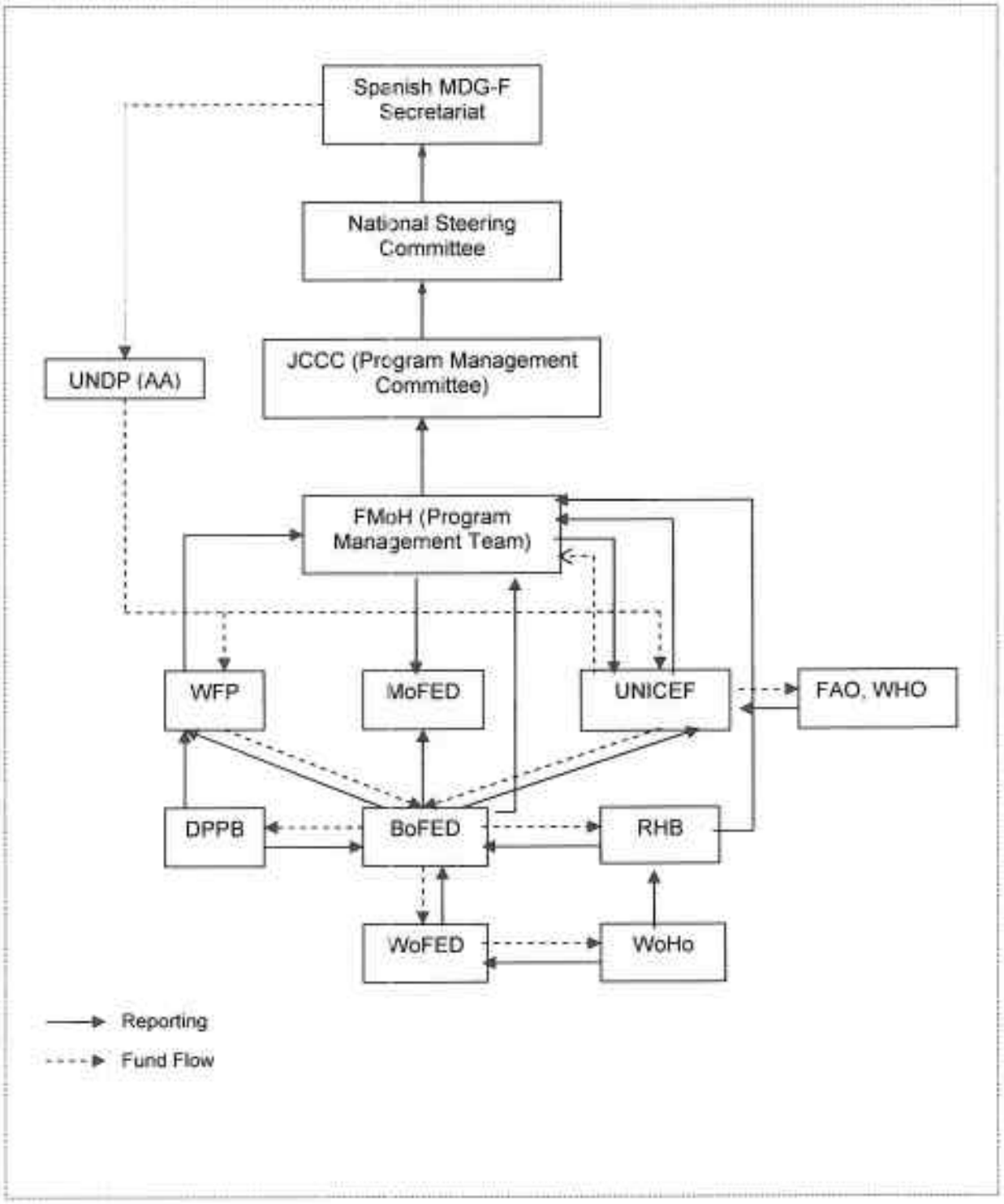
foods produced by 2012 Baseline: 0 Target: 4	- Eight production site established in the four targeted Kebeles by 2012				- Pilot production and test the food - Establish the production equipments in the community and start production - Develop communication materials - Train Women groups in the new Kebeles - Establish the production sites in the new Kebeles					
3.2. Built Capacity of community women group Indicator: No. of women groups producing complementary foods Baseline: 0 Target: 40	- 40 Women's group and 20 agricultural extension workers trained by 2011 - 20 women group start to generate income by 2012	*UNICEF*	*CPAP Result 7.1-7.4 (community based Nutrition)*	*MOH*	- Training of women group and agricultural extension workers - Establish the production equipments in the community - Supervision and technical assistance for women group	17,188	17,188	10,188	NA	44,563
JOINT PROGRAM Outcome 4: Improved nutrition information and monitoring and evaluation of the program in 16 target woredas by 2012 (NNP Outcome 3, UNDAF 1.3.3., 1.3.2)										
4.1. Community capacity data utilization for action improved	- 960 HEWs and 9,600 VCHW trained on community based nutrition information by 2011	*UNICEF*	*CPAP result area 6.1-6.7(Policy Coordination and information system)*	*MOH*	- Conduct training of HEWs and VCHWs - Conduct monthly review meeting at	122,048	71,808	71,808	NA	265,664

	- 60 % of communities utilizing CBN monthly data by 2012 - 70 % of Kebeles conduct review meeting by 2011				Kebele and quarterly at Woreda level - Conduct community conversation					
4.2.capacity of implementers on data reporting, analysis, and management improved	- 30 federal, Regional and Woreda health managers and ENCU staffs trained on CBN and OTP data management by 2010 - CBN and OTP data reporting system established in 16 Woredas and four RHBs by 2012	*UNICEF*	*Same as CPAP 6.1-6.7*	*MOH*	- Organize training on community based nutrition data reporting and management - Establish data at the Woreda, and regional level - Provide technical support and undertake supportive supervision - Conduct quarterly review meeting - Train 20 health providers at woreda level on data collect, management, analysis, interpretation and transfer	185,423	155,248	155,248	NA	495,919

4.3. Effective NNP and Joint Program monitoring and evaluation system established	- One baseline surveys conducted in 16 targeted woredas in 2009 - One endline evaluation Conducted in 2012 - Three Annual review meeting conducted by 2012	*UNICEF*	*Same as 6.1-6.7*	*MOH*	- Undertake Joint annual review meeting - Conduct semiannual Joint supervision/field visit - Conduct baseline survey and endline evaluation - Share the result with relevant stakeholders	124,900	24,900	124,900	NA	274,700
UNICEF	PROGRAM Cost **					2'493,208	2'022,366	1'440,774	NA	5'956,348
	Indirect Support Cost**					174,525	141,566	100,854		416,944
WFP	PROGRAM Cost **					230,400	201,600	153,600		585,600
	Indirect Support Cost**					16,128	14,112	10,752		40,992
Total	PROGRAM Cost **					2'723,608	2'223,966	1'594,374	NA	6'541,948
	Indirect Support Cost**					190,653	155,678	111,606		457,936

Description	**UNICEF**	**WFP**
1.1 Supplies, commodities, equipment and transport	2,862,970	585,600
1.2 Personnel (staff, consultants, travel and training)	614,212	0
1.3 Training of counterparts	1,640,923	0
1.4 Contracts	838,244	0
1.5 Other Direct Costs	0	0
Total Direct Costs	**5,956,348**	**585,600**
2.0 UN Agency Indirect Cost	416,944	40,992
Grand Total	**6,373,292**	**626,592**

Annex 5: Coordination and Reporting Arrangements



Annex 6: Joint Program Monitoring Framework

Expected Results (Outcomes & outputs)	Indicators (with baselines & indicative timeframe)	Means of verification	Collection methods (with indicative time frame & frequency)	Responsibilities	Risks & assumptions
JP Outcome 1: Improved management of children with acute malnutrition at the community level	Indicators 1.1. % of Health posts in the 16 targeted woredas providing quality OTP services (Cure Rate of > 75%; Default rate of <15%; and mortality rate of <5%) to severely malnourished children. . Baseline: TBD Target: 80% of the 320 health posts by 2012 1.2. % of children with acute malnutrition access OTP services in the 16 targeted woredas Baseline: TBD for the targeted Woredas Target: 80 % of the 18,300 SAM children by 2012	Monthly OTP reporting format (2009-2012) Baseline survey report (2009) Endline evaluation report (2012)	Review of Monthly OTP reporting format (2009-2012) Review Baseline survey report (2009) Review Endline evaluation report (2012)	UNICEF /MOH/RHBs	The major risk is drought that will increase the Sam case load Mitigation: mobilize and utilize emergency resources to manage the case load Assumptions: the price of PlumpyNut and TSF price remain the same. If increased it will affect the coverage of the program. The other assumption is there will not be significant turnover of staffs Measures: Training of new staffs during refresher training
Output 1.1 under five children with severe acute malnutrition screened and provided quality care	Indicators 1.1.1. % of under five children screened for malnutrition every 3 months Baseline: 80 % Target: 90% 1.1.2. % of children with SAM access OTP services at the health post and community by 2012 Baseline: TBD Target: 80% (14,640)	CHD reporting format (2009-2012) OTP reporting format (2009-2012) Baseline survey report (2009)	Review of quarterly CHD report (2009-2012) Record Review of the monthly OTP report format (2009-2012) Review of the Baseline report (2009)	UNICEF/MOH/RHBs	
Output 1.2					

Severely malnourished children and malnourished PLW received TSF	Indicators 1.2..1 % of children with severe malnutrition in the 16 targeted woredas received TSF by 2012 Baseline: Targeted Woredas: 60% Target: 80 % (14,640) 1.2.2. % of malnourished PLW out of the total screened who received TSF by 2012 Baseline: 60% Target: 80% (10,360)	Post CHD coverage survey report (2009-2012) Quarterly post distribution monitoring report (2009-2012) TSF annual outcome evaluation (2010,2011,20120) Post CHD coverage survey report (2009-2012) Quarterly post distribution monitoring report (2009-2012) TSF annual outcome evaluation (2010,2011,20120)	Review of quarterly CHD and post CHD coverage survey reports (2009-2012) Record review quarterly post distribution monitoring report (2009-2012) Review of TSF annual outcome evaluation report (2010,2011,2012) Review of regional TSF database	WFP/DMFSS/DPPB	

Output 1.3 Enhanced Health posts capacity to provide quality out patient treatment for severe acute malnutrition	Indicator 1.3.1. % of health posts/OTP sites providing quality OTP services (Cure Rate of > 75%; Default rate of <15%; and mortality rate of <5%) in 16 targeted woredas Baseline: TBD Target: 80% (256 health posts) 1.3.2. Number of health post and community with OTP services capacity established Baseline: TBD Target: 320 1.3.3.Number of HEWs and health workers whose capacity to screen and treat acute malnutrition improved Baseline: None Target: 320 HEWs and 30 HWs 1.3.4. Number of VCHW trained community mobilization and screening for malnutrition Baseline: none Target: 9600	Monthly OTP reporting format (2009-2012) Endline evaluation report (2012) Monthly OTP reporting format (2009-2012) Annual Joint Program progress reports form RHBs (2009-2010)	Review of Monthly OTP reporting format (2009-2012) Review Endline evaluation report (2012) Annual Joint Program progress reports form RHBs (2009-2010)	UNICEF/MOH/RHBs	

Joint program Outcome 2: Improved the caring and feeding behaviors/ practices of children and mothers and under two children growing normally	Indicators: 2.1) Proportion of underweight in under five years children in the 16 target woredas Baseline: national 38% , not established for the target Woredas (TBD) Target: Reduced by 6% from the baseline by 2012 2.2) Proportion of infants 0-6 months exclusively breast fed in 16 targeted woredas Baseline (national): 32% , not established for the target Woredas (TBD) Target: Increase by 15 % from baseline by 2012	Baseline survey report (2009) Endline evaluation report (2012) Baseline survey report (2009) Endline evaluation report (2012)	Review Baseline survey report (2009) Review Endline evaluation report (2012) Review Baseline survey report (2009) Review Endline evaluation report (2012)	UNICEF/MOH/RHBs	The major risks are drought ,political instability and epidemics Mitigation measure: Mobilize emergency resources and early detection of SAM cases and treat or refer Assumptions: there will be commitment of HEWs, VCHWs and Woreda Health office. There will not be significant drop out of VCHW
Output 2.1 Build Community Capacity for Assessment-Analysis-Action Specific to Preventing Child Malnutrition	Indicators 2.1.1. % of communities conducting Community conversation Baseline: 0 Target: 60 % 2.1.2. Number of HEWs and VCHWs trained on community based nutrition Baseline: 0 Target: HEWs-960 HEWs VCHWs- 9600 2.1.3. Perception of women and men with regarding intra-household time allocation for infant and child feeding	HMIS/Community based Nutrition quarterly report (2009-2012) CBN training RHBs report (2009-2011) Annual review meeting report (2010-2012) Baseline survey report (2009) Endline evaluation report (2012)	Review of Quarterly HMIS/CBN report from RHBs (2009-2012) Review of annual review meeting reports and annual CBN training reports from RHBs Time frame: 2009-2011 Review Baseline survey report (2009) Review Endline evaluation report (2012)	UNICEF/MOH/RHBs	Measures: Involvement of the managers during the planning and implementation, undertake regular review meetings and supervisions, provide continuous refresher training ; recognize their work; and provide them reasonable responsibility

Output 2.2. Under two Children growth improved See also the outcome indicators 2.1 and 2.2	Indicators 2.2.1. the proportion of infants 6-9 months introduced to complementary food at 6-7 months) Baseline: TBD Target: Increase by 10 % from baseline by 2012 2.2.2. % of under two children participated in GMP Baseline: 0% Target: 80% (124,800) 2.2.3. % of children 6-59 months who received vitamin A supplementation every six months Baseline: 90 % of children access Target: 95% 2.2.4. % of children 24-59 months who are Dewormed every six months Baseline: 80 % of children access Target: 90%	Baseline survey report (2009) Endline evaluation report (2012) HMIS/Community based Nutrition quarterly report (2009-2012) For 2.2.3. and 2.2.4. Quarterly CHD report (2009-2012) Post CHD coverage survey (2009-2012)	Review Baseline survey report (2009) Review Endline evaluation report (2012) Review of Quarterly HMIS/CBN report from RHBs (2009-2012) Review of quarterly CHD report (2009-2012) and post CHD coverage report		
Joint Program Outcome 3: **Improved quality and utilization of locally available complementary**	Indicators 3.1. % of 6-24 months growth faltering children with improved growth after consuming the locally produced foods in the target Kebeles by 2012 Baseline: 0 Target: 60 %	Research project report (2010-2012)	Review the annual Research project reports Quarterly HMIS/CBN report from RHBs 2009-2011	UNICEF/MOH	

Output 3.1 Quality complementary food produced	Indicator 3.1.1 Types of complementary foods produced in the targeted four Kebele by 2012 Baseline: 0 Target: 4 3.1.2. Number of production site established in the eight targeted Kebeles by 2012 Baseline: 0 Target: 8	Research report (2009-2010) Quarterly and Annual progress reports (2010-2012)	Review of the annual Research report , Review Quarterly and Annual progress reports (2010-2012)	UNICEF/MOH/RHBs	
Output 3.2 Build Capacity of community women group to produce local complementary/supplementary foods	Indicator 3.2.1. Number of women groups producing complementary foods Baseline: 0 Target: 40 3.2.2. Number of women group who start to generate income Baseline: 0 Target: 20 3.2.3 Perception of the womens group and the community regarding local complementary food production benefits and contribution to improving child nutritional status	Quarterly progress report and Annual review meeting and progress report 2009-2012 Baseline survey report (2009) Endline evaluation report (2012)	Review of the annual Research, Quarterly progress report and Annual review meeting and progress report Time frame 2009-2012 Review Baseline survey report (2009) Review Endline evaluation report (2012)	UNICEF/MOH	
Joint Program Outcome 4: Improved nutrition information and monitoring and evaluation of the project					

Output 4.1. Community capacity data utilization for action improved	4.1.1. 960 HEWs and 9,600 VCHW trained on community based nutrition information by 2010 4.1.2. 60 % of communities utilizing CBN monthly data by 2011 4.1.3. 70 % of Kebeles conduct review meeting	Annual Joint Program progress reports form RHBs (2009-2010) HMIS/Community based Nutrition quarterly report (2009-2012)	Review of the annual and Quarterly progress report (2009-2010) Review of Quarterly HMIS/CBN report from RHBs (2009-2012)	UNICEF/MOH/RHBs	
Output 4.2. Capacity of implementers on data reporting, analysis, and management improved	4.2.1. 30 federal, WoHo and RHBs and DMFSS staffs trained on CBN and OTP data management 4.2.2. CBN and OTP data reporting system established in 16 Woredas and four RHBs by 2012	Training Report (2010) Annual Joint Program progress reports form RHBs (2010)	Review of training report (2010) Review of the annual and Quarterly progress report (2010)		
Output 4.3. Effective NNP and Joint Program monitoring and evaluation system established	4.3.1.One baseline surveys conducted in the four regions in 2009 4.3.2. One endline evaluation Conducted in 2012 4.3.3. Three Annual review meeting conducted by 2012	Baseline evaluation report (2009) Endline Evaluation report 2012 Annual review meeting report form RHBs (2009-2012)	Review of Baseline survey and endline evaluations report Review of the Quarterly progress report and Annual review meeting and progress report		

Annex 7: Consultation process summary

UNDP Spain MDG Achievement Fund for Children, Food Security and Nutrition

Programme Title: National Nutrition Programme / MDG-F Joint Programme (NNP/MDG-F), Ethiopia

Date	Organization(s) consulted	Topic
March 13th, 2009	Ministry of Finance and Economic Development (MOFED)	Agree on the next steps, coordination mechanisms and response times in the development and endorsement of the Joint Program document.
March 31st, 2009	Regional Health Bureaus (RHB) from Amhara, Oromia, SNNP and Tigray	Presentation on the MDG-F and the concept note and the JP. The criteria and the number of woredas per region were discussed and agreed on, and the representatives were asked to discussed at the regional level and suggest the specific woredas to be covered by the Joint Program.
April 2nd, 2009	Save the Children UK, Save the Children US, Integrated Family Health Program (IFHP), Alive and Thrive, CONCERN Last 10 kilometers (L10K)	Briefing on the MDG-F and the concept note and the JP. Conversation on what are the roles or potential roles of the participants in the implementation arrangements of the JP.

Annex 8: Budget for the NNP/MDG-F Joint Programme for three years per agency

CATEGORY	AGENCY	ITEM	Comp.	Output No	UNIT COST ($) per year	NUMBER OF UNITS per 3 years	TOTAL COST per 3 years
1. Personnel (by agency)	UNICEF	National Coordination (Program Manager)	CBN	2.1	29,000	3	87,000
	UNICEF	Technical Assistance Regional Coordination (2)	CBN	2.1	22,000	6	132,000
2. Contracts (by agency)	UNICEF	Develop and establish data base for the different data sources within the NNF-NIS framework at federal level	NIS	4.2	17,000	1	17,000
	UNICEF	Research on locally available products and production including product analysis and quality control system	FNS	3.1	155,500	1	155,500
	UNICEF	Conduct baseline and end-line evaluation of the joint programme (50/50)	NIS	4.3	200,000	1	200,000
	UNICEF	Technical Support (2) to establish NIS	NIS	4.2	27,000	6	162,000
	UNICEF	Administrative Support	NIS	4.2	13,248	3	39,744
	UNICEF	Regional Technical Support (4)	NIS	4.2	22,000	12	264,000
3. Training (by agency)	UNICEF	Training of Health Workers and HEWs on outpatient management of SAM (2 days)	OTP	1.3	42	2,880	122,056
	UNICEF	Training of Health Workers and HEWs on TFU/SC management of SAM (3 days)	OTP	1.3	51	960	49,342
	UNICEF	Training of HEWs supervisors on OTP and supervisory skills (4days)	OTP	1.3	78	288	22,464
	UNICEF	Training of HEWs and community volunteers (year1) for CBN and on data management at community level	CBN	2.1	23,639	16	378,227
	UNICEF	Refresher training of HEWs and community volunteers (years 2 and 3)	CBN	2.1	7,722	64	494,188
	UNICEF	Biannual review meetings (years 2 and 3)	CBN	2.2	1,683	64	107,692
	UNICEF	Quarterly Review Meeting (only two because two meetings happen during CBN training) at Kebele and Woreda Levels (2 in year 1)	NIS	4.1	1,683	128	215,424
		Annual Joint Program Review Meeting (3 years)	NIS	4.3	24,900	3	74,700
	UNICEF	Sensitization / orientation workshops at district and sub-district level	CBN	2.1	1,971	48	94,615
	UNICEF	Annual workshops on multi-sectoral linkages with food security and other programmes	CBN	2.2	100	48	4,800
	UNICEF	Establish data base and training at regional level in four regions	NIS	4.2	350	4	1,400
	UNICEF	Train 20 health providers at woreda level on data collect, management, analysis, interpretation and transfer (in OTP and CBN woredas)	NIS	4.1	157	320	50,240
	UNICEF	Train 30 data managers at regional and federal level in four regions	NIS	4.2	157	75	11,775
	WFP	Training of community producers and other relevant actors	FNS	3.2	7,000	2	14,000
4. Transport (by agency)	UNICEF	Delivery of supplies to woreda	OTP	1.3	384	48	18,433
	UNICEF	Fuel cost for delivery of supplies from woreda to Health Post	OTP	1.3	9	1,440	12,985
5. Supplies and commodities (by agency)	UNICEF	RUTF	OTP	1.1	5,200	293	1,522,560
	UNICEF	F75	OTP	1.1	2,650	41	108,629
	UNICEF	F100	OTP	1.1	2,700	34	92,486
	UNICEF	ReSoMal	OTP	1.1	4,250	0.615	2,613
	UNICEF	Drugs for TFP	OTP	1.1	0.84	29,280	24,595
	WFP	Discharge SF ration	OTP	1.2	20	29,280	585,600
	UNICEF	Salter scales	CBN	2.2	19.55	7,680	150,144
	UNICEF	Family health cards with growth charts	CBN	2.2	0.70	262,080	183,456
	UNICEF	Adult scale for pregnancy weight gain	CBN	2.2	117.30	2,016	236,477
	UNICEF	Iron / folate supplements for pregnant women	CBN	2.2	2.83	20,736	58,662
	UNICEF	Printing of materials (pack of GMP registers, HH inventories, Comm Growth Chart and reporting forms)	CBN	2.2	1,000	48	48,000
	UNICEF	Initial (for start up) supply of raw and packing material for production	FNS	3.1	6,000	2	12,000
	UNICEF	Supplies for operation and other operational costs	FNS	3.1	14,000	2	28,000

CATEGORY	AGENCY	ITEM	Comp.	Output No	UNIT COST ($) per year	NUMBER OF UNITS per 3 years	TOTAL COST per 3 years
6. Equipment (by agency)	UNICEF	Equipment for TFP	OTP	1.3	1.5	29,280	43,920
	UNICEF	Full equipment to set one small scale production factory (average 4 kebeles)	FNS	3.2	40,000	8	320,000
7. Travel (by agency)	UNICEF	Supervision at regional, district and sub-district levels	CBN	2.1	2,080	48	99,831
	UNICEF	Technical Assistance visits (1 NC and 2 RC = 3 for 6 times to regional level)	CBN	2.1	1,598	54	91,669
	UNICEF	Supervision and technical assistance to local producers during production (3 visits per year per woreda)	FNS	3.2	1,598	18	30,563
	UNICEF	Supervision per woreda by Health Sector (6 supervisors, 1 time/month, for 2 months)	OTP	1.3	301	576	173,129
8. Miscellaneous (by agency)							0.0
9. Agency Management Support (based on rules and regulations by agency)	UNICEF	UNICEF Agency Management Support					416,944
	WFP	WFP Management Support					40,992
TOTAL BUDGET BY AGENCY	UNICEF						6,373,292
	WFP						626,592
GRAND TOTAL*							**6,999,884**

Transfer of resources from UNICEF to FAO and WHO:

CATEGORY	AGENCY	ITEM	Comp.	Output No	UNIT COST ($) per year	NUMBER OF UNITS per 3 years	TOTAL COST per 3 years
Training	FAO	Training of community producers and other relevant actors	FNS	3.2	7,000	2	14,000
Training	FAO	Initial (for start up) supply of raw and packing material for production	FNS	3.1	6,000	2	12,000
Supplies and commodities	FAO	Supplies for operation and other operational costs	FNS	3.1	14,000	2	28,000
Equipment	FAO	Full equipment to set one small scale production factory (average 4 kebeles)	FNS	3.2	40,000	8	320,000
	TOTAL FAO US$						**374,000**
Training	WHO	Training of Health Workers and HEWs on TFU/SC management of SAM (3 days)	OTP	1.3	51	960	49,342
Training	WHO	Training of HEWs supervisors on OTP and supervisory skills (4days)	OTP	1.3	78	288	22,464
Travel	WHO	Supervision per woreda by Health Sector (6 supervisors, 1 time/month, for 2 months)	OTP	1.3	301	576	173,129
	TOTAL WHO US$						**244,935**