Ethiopian Public Health Institute

ጤና ሚኒስቴር - ኢትዮጵያ
MINISTRY OF HEALTH-ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!
HEALTHIER CITIZENS FOR PROSPEROUS NATION!

Ethiopia Food and Nutrition Strategy Baseline Survey

Key Findings Report
February 2025

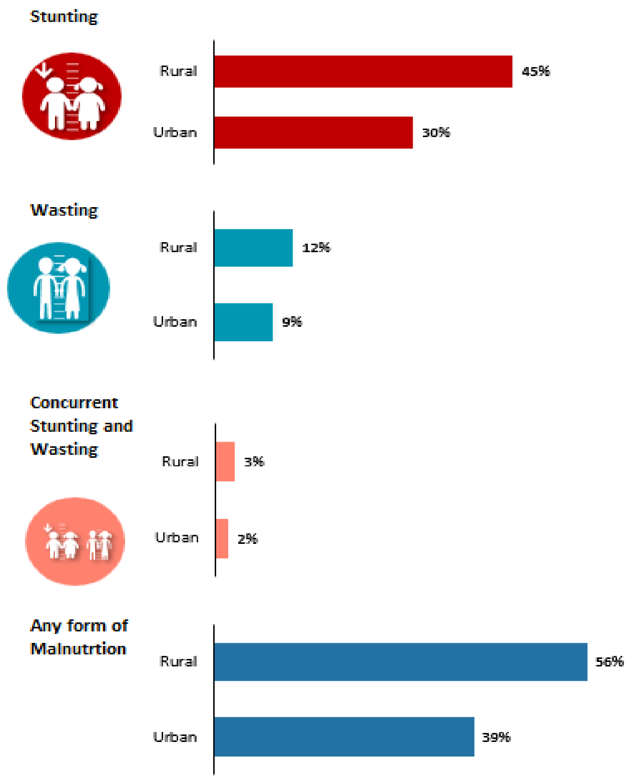
1. Prevalence of malnutrition among children under five

41% stunted	Despite progress in reducing malnutrition in Ethiopia over the past two decades, stunting remains a major public health concern. Findings from the Food and Nutrition Strategy Baseline Survey (FNSBS) showed that, nationally, 41% of children under five were stunted (height-for-age below -2SD).
11% wasted	The national prevalence of wasting (weight-for-height below -2 SD) was 11%.
23% underweight	The national prevalence of underweight (weight-for-age below -2SD) in children under five was 23%.
4% overweight	The national prevalence of overweight (weight-for-height above +2SD) among children under five was 4%. Among the regions, prevalence was highest in Addis Ababa (7%) and lowest in the Afar (2%).

1.1 Urban-rural differences in malnutrition

Nationally, more than half of children under five years were affected by some form of malnutrition. The proportion of stunted children was higher in rural areas (45%) than in urban areas (30%). Similarly, wasting was more prevalent in rural areas (12%) than in urban areas (9%) (see **Figure 1**).

Figure 1. Prevalence of undernutrition by place of residence



1.2. Regional differences in the prevalence of child malnutrition

The prevalence of undernutrition varied across regions, with the highest stunting rates observed in Tigray (48%), Afar (44%), Benishangul-Gumuz (44%), and Oromia (42%) (**Figure 2A**). Oromia and Amhara had the largest absolute number of stunted children. Regionally, the prevalence of wasting ranged from 4% in Addis Ababa to 26% in Afar (**Figure 2B**).

Figure 2A. Geographic distribution of stunting among children under five

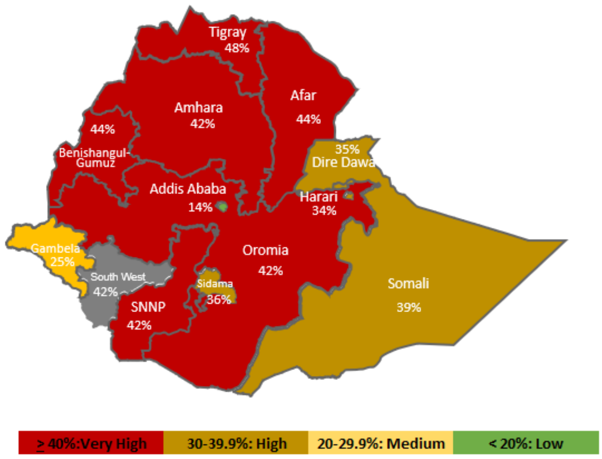
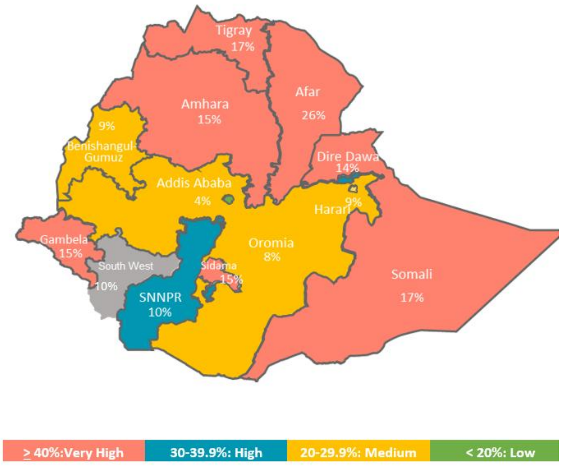


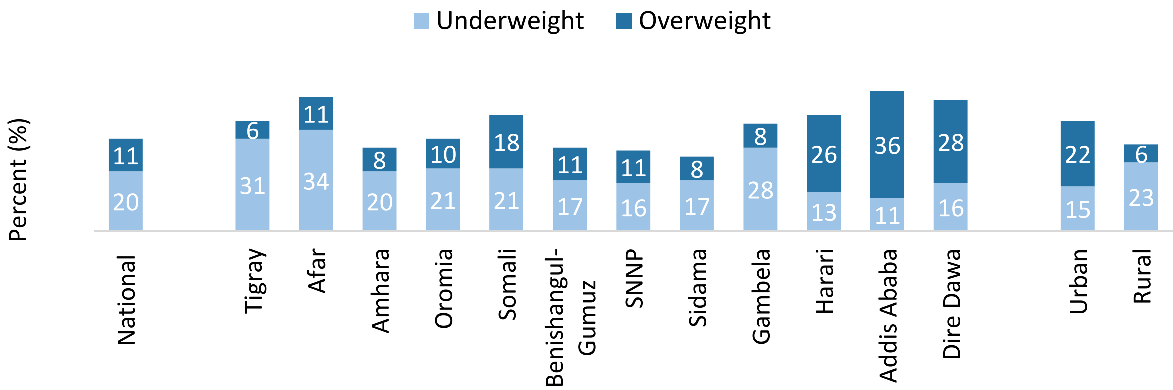
Figure 2B. Geographic distribution of wasting among children under five



2. Malnutrition in Women

Overall, 20% of women of reproductive age were underweight (BMI < 18.5 kg/m2). The prevalence of underweight was higher among rural women (23%) compared to urban women (15%). In contrast, about 11% of women were overweight or obese. Overweight or obesity were four times more prevalent in the urban areas (22%) than in rural areas (6%), with the highest rates observed in Addis Ababa (36%) and Dire Dawa (28%) (**Figure 3**).

Figure 3. Prevalence of malnutrition among women of reproductive age by region and place of residence

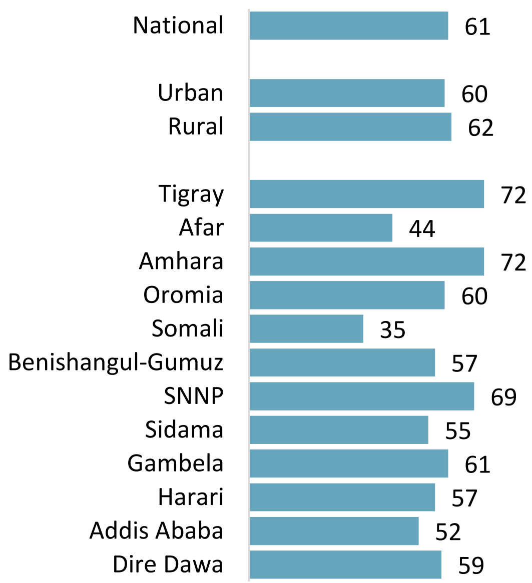


3. Infant and Young Child Feeding Practices

3.1. Exclusive breastfeeding for six months

Overall, 61% of children aged 0–6 months were exclusively breastfed. As shown in **Figure 4**, rates were slightly higher in rural areas (62%) than in urban areas (60%). Regionally, the highest exclusive breastfeeding rates were in Amhara and Tigray (both at 72%), followed by the Southern Nations, Nationalities, and Peoples' (SNNP) region (69%). The lowest rates were recorded in Somali (35%) (**Figure 4**).

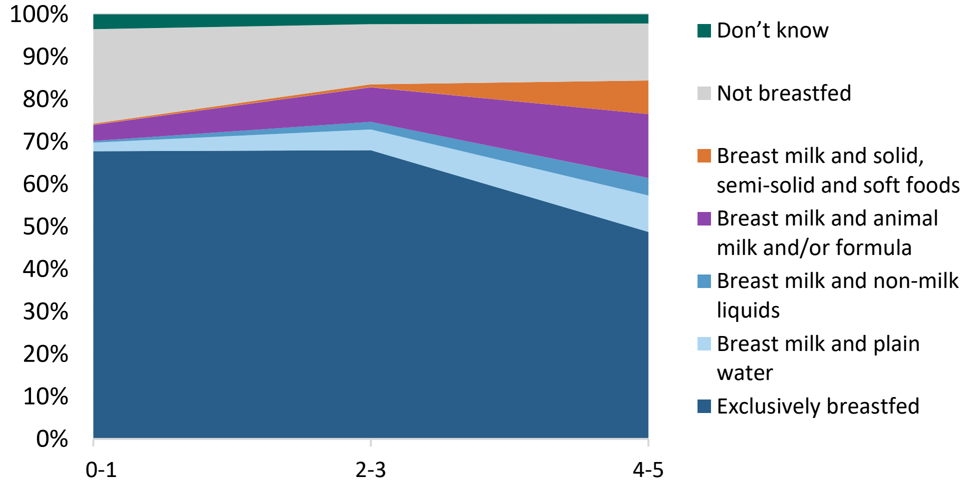
Figure 4. Exclusive breastfeeding rates among children aged 0–6 months by region and place of residence



3.2. Breastfeeding patterns

Although, 61% of children were exclusively breastfed, a significant proportion received other liquids early on. Among children aged 0–1 month, 7% were given plain water, animal milk, or other non-milk liquids. This proportion increased to 16% among those aged 2–3 months and 36% among those aged 4–5 months. Additionally, 22% of children aged 0–1 month, 14% aged 2–3 months, and 13% aged 4–5 months were not breastfed at all (**Figure 5**).

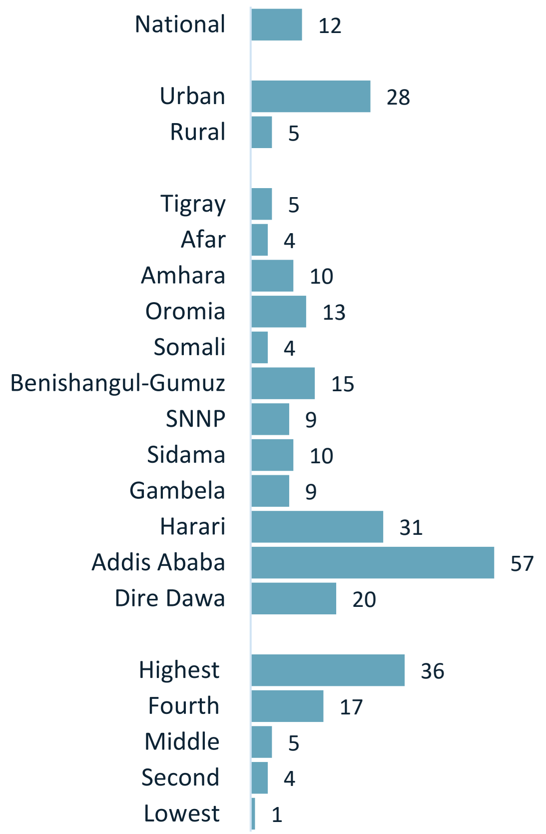
Figure 5. Breastfeeding patterns by age group



3.3 Exposure to breast-milk substitutes (BMS)

In Ethiopia, 12% of caregivers reported seeing or hearing advertisements for infant formula or other baby milk products . Exposure to BMS promotions varied by region, with the highest proportions recorded in Addis Ababa (57%), Harari (31%), and Dire Dawa (20%). Urban caregivers were six times more likely to be exposed (28%) than their rural counterparts (5%). Exposure also varied by household wealth, with 36% of caregivers from the wealthiest households reporting exposure, compared to just 1% from the poorest households (see **Figure 6**).

Figure 6. Exposure to the promotion of BMS among children 0–23 months by region, residence, and wealth quintile



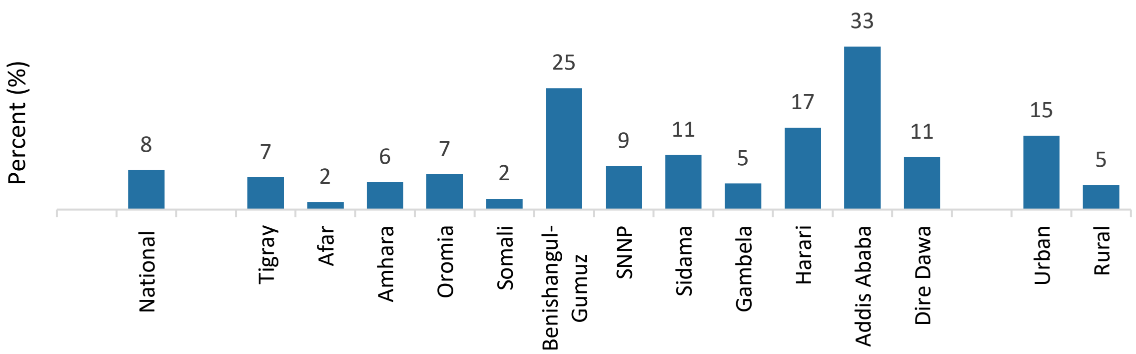
4. Complementary Feeding Practices

4.1. Dietary diversity

Only 8% of children aged 6–23 months consumed the minimum recommended number of 5 out of 8 food groups. Regional variations were evident, with Addis Ababa recording the highest proportion of children (33%) meeting the dietary diversity recommendations, while Afar and Somali recorded the lowest (both at 2%).

Dietary diversity was three times higher in the urban areas (15%) compared to rural areas (5%) (**Figure 7**).

Figure 7. Dietary diversity among children aged 6–23 months by region and place of residence

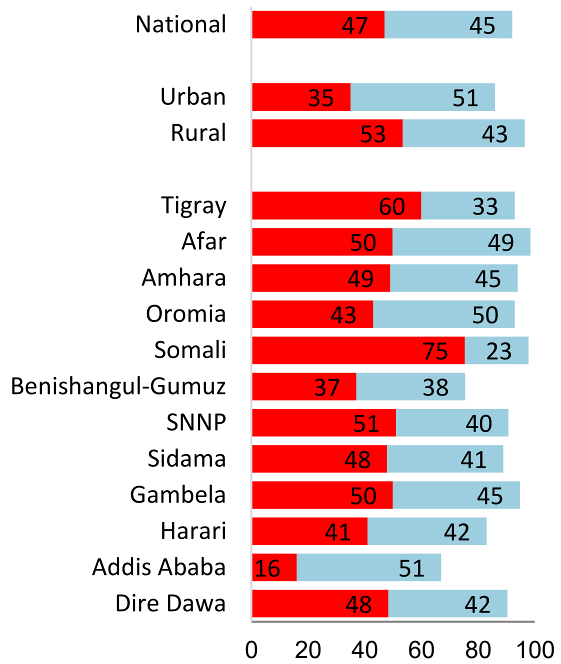


4.2. Child food poverty

Nationally, 47% of children aged 6–23 months experienced severe food poverty, consuming fewer than two food groups per day. Regionally, the highest proportion of children facing severe food poverty were in Somali (75%), SNNP (51%), and Gambella (50%). Children in rural areas were more likely to experience severe food poverty (53%) compared to 35% in urban areas.

Nearly half (45%) of the children aged 6–23 months experienced moderate food poverty, consuming 3-4 food groups per day. Similar levels of moderate food poverty were seen in Addis Ababa (51%) and Oromia (50%). In the urban areas, 51% of children consumed 3-4 food groups daily, compared to those in rural areas (43%) (**Figure 8**).

Figure 8 Food poverty among children aged 6–23 months by region and place or residence



5. Unhealthy feeding

5.1. Unhealthy food consumption

Nationally, 16% of children aged 6–23 months consumed unhealthy foods. Among the regions, Addis Ababa (36%) and Sidama (30%) recorded the highest intake of unhealthy foods, while Afar (2%), Dire Dawa (8%), and Somali (9%) had less than 10% consumption. In urban areas, 23% of young children consume unhealthy foods—twice the 12% observed in rural areas (**Figure 9**).

5.2 Sweet beverage consumption

About one in three children (31%) aged 6–23 months consumed sweet beverages. Regionally, the highest consumption was recorded in Addis Ababa (70%), while the lowest was in SNNP (22%). Nearly half of the children in urban areas (49%) consumed sweet beverages, compared to 23% in rural areas (**Figure 9**). Consumption also varied by household wealth, with 55% of children from the wealthiest households consuming sweet beverages, compared to 19% from the poorest households.

5.3 Zero fruit or vegetable consumption

Nationally, 75% of children aged 6–23 months did not consume any vegetables or fruits, with a notable gap observed between rural areas (79%) and urban areas (66%). Among the regions, Afar (94%) reported the highest proportion of children consuming no vegetables or fruits, followed by Somali (91%), while Addis Ababa reported the lowest (42%) (**Figure 9**).

Figure 9. Sweet beverages, unhealthy food, and zero fruit/vegetable consumption among children aged 6–23 months by region and place of residence

6. MICRONUTRIENT DEFICIENCIES

6.1 Micronutrient status of women of reproductive age (WRA)

Micronutrient deficiencies were widespread among women of reproductive age (WRA) in Ethiopia. Zinc deficiency was the most prevalent, affecting 64% of women. Regionally, the highest prevalence was in Oromia (78%) and the lowest in Dire Dawa, Gambela, and Sidama (47% each). Women in rural areas were slightly more affected (65%) than those in urban areas (62%) (**Table 1**).

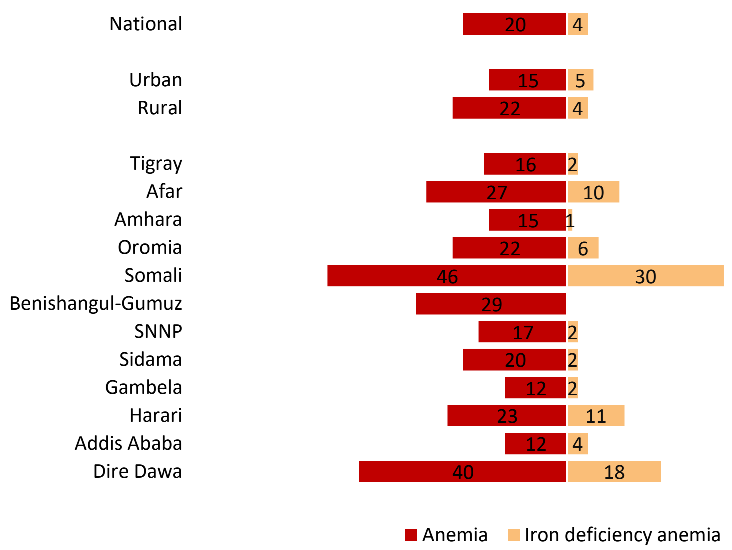
RBC folate insufficiency affected 63% of WRA, placing 59% at risk of having a pregnancy affected by neural tube defects (NTDs). Vitamin D deficiency affected 32% of women, while 39% had insufficient levels. Among the regions, the highest prevalence of vitamin D deficiency was reported in Addis Ababa (60%) and Amhara (44%), while the lowest was observed in Somali (1%), followed by Gambela (10%). Vitamin A deficiency affected 11% of WRA, with the highest prevalence in Dire Dawa (18%), Afar (16%), and Somali (15%), and the lowest in Addis Ababa (2%). Vitamin B12 insufficiency affected 35% of women, with 11% classified as deficient — more prevalent in rural areas (12%) than urban (9%). Nationally, 19% of WRA were iodine deficient, with the highest prevalence in SNNPR (35%) and the lowest in Harari (6%). Rural women (23%) were more affected than urban women (11%) (**Table 1**).

Table 1. Micronutrient deficiencies among women of reproductive age by region and place of residence

Region	Iron Deficiency (%)	Folate insufficiency (%)	Folate deficiency (%)	Risk of Neural Tube Defects (%)	Vitamin A insufficiency (%)	Vitamin A deficiency (%)	Vitamin B12 deficiency (%)	Vitamin B12 insufficiency (%)	Zinc deficiency (%)	Urinary iodine deficiency (%)	Vitamin D deficiency (%)
National	8	63	8	59	37	11	11	35	64	19	32
Tigray	3	65	32	91	33	8	10	27	60	29	25
Afar	19	68	29	91	52	16	4	23	60	12	16
Amhara	3	74	8	68	38	10	8	35	50	14	44
Oromia	10	64	7	59	41	13	16	45	78	16	31
Somali	45	74	11	75	51	15	3	17	53	27	1
SNNP	6	51	2	33	29	6	8	26	67	35	22
Sidama	4	24	1	13	40	12	1	6	47	11	21
Gambela	7	73	17	83	42	10	3	18	47	20	10
Harari	16	74	15	81	48	18	13	45	55	6	32
Addis Ab-aba	8	72	10	78	23	2	10	38	58	8	60
Dire Dawa	24	77	17	86	52	18	22	60	47	29	11
Urban	9	74	10	72	35	9	9	34	62	11	33
Rural	7	57	7	51	39	12	12	35	65	23	32

The prevalence of anemia among WRA in Ethiopia was 20%. Marked regional differences were observed: anemia remained a severe public health problem in Somali, where 40% of women were affected. It was considered moderate in Dire Dawa (18%) and mild in all other regions. The overall prevalence of iron deficiency anemia was 4%, with the highest regional prevalence in Somali (30%) and the lowest in Amhara (1%) (**Figure 10**).

Figure 10. Anemia and iron deficiency anemia among women of reproductive age by region and place of residence



6.2 Micronutrient status of children under five

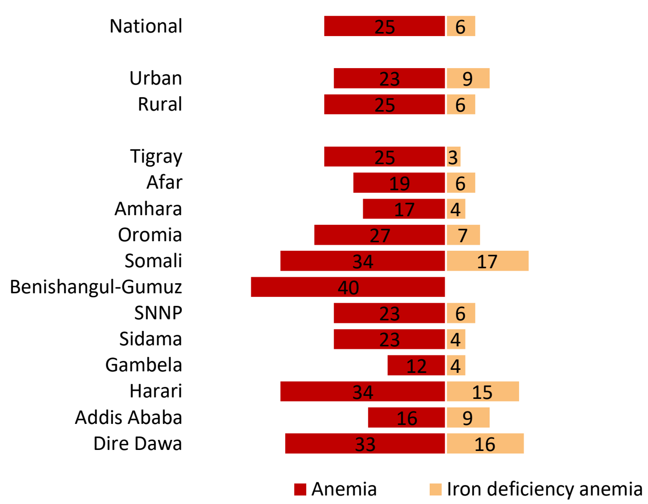
Micronutrient deficiencies were also widespread among children aged 6–59 months. Nationally, zinc deficiency was alarmingly high, affecting 50% of children. Among the regions, the highest prevalence was recorded in Harari (71%) and the lowest in Sidama (32%). The national prevalence of iron and folate deficiency was 13% and 5%, respectively. Regional variations were notable: iron deficiency was highest in Somali (35%) and lowest in Amhara (9%). Vitamin A deficiency affected 32% of children, with the highest rates observed in Harari (66%), Oromia (41%), and Somali (40%), and the lowest in Amhara (13%) (**Table 2**).

Table 2. Micronutrient deficiencies among children aged 6–59 months by region and place of residence

Region	Iron deficiency (%)	Folate possible deficiency (%)	Folate deficiency (%)	Vit A insufficiency (%)	Vit A deficiency (%)	Zinc Deficiency (%)
National	13	16	5	68	32	50
Tigray	5	29	22	46	9	53
Afar	16	31	43	70	27	51
Amhara	9	20	5	52	13	49
Oromia	13	12	2	75	41	53
Somali	35	39	26	74	40	51
SNNP	15	7	0	78	39	46
Sidama	15	3	1	66	28	32
Gambela	16	34	16	68	24	54
Harari	24	35	5	96	66	71
Addis Ababa	17	17	1	71	18	53
Dire Dawa	24	38	20	74	31	43
Urban	17	22	7	66	28	50
Rural	12	13	4	69	33	50

The prevalence of anemia among children aged 6–59 months was 25%, with minimal variation between urban (23%) and rural (25%) areas. Anemia among children remained a significant public health concern in the Benishangul-Gumuz (40%), Somali (34%), and Harari (34%) regions. Iron deficiency anemia affected 6% of children nationally, with Somali region reporting nearly three times this prevalence (**Figure 11**).

Figure 11. Anemia and iron deficiency anemia among children aged 6–59 months by region and place of residence



6.3 Micronutrient status of school-aged children

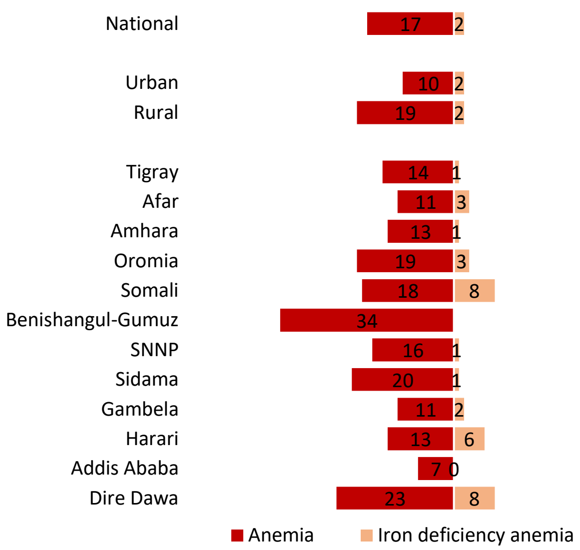
Among school-aged children (6–12 years), zinc deficiency was high, affecting 59% of school-aged children. Regionally, the highest prevalence was observed in Afar (68%) and Amhara (67%), while the lowest was in Sidama (34%). Vitamin A insufficiency remained widespread, affecting 75% of children, with 38% classified as deficient. The highest prevalence of vitamin A deficiency was recorded in Dire Dawa (61%), Harari (60%), and Oromia (47%) regions, with the lowest in Addis Ababa (18%) (**Table 3**).

Table 3. Micronutrient deficiencies among school-aged children by region and place of residence

Regions	Iron deficiency (%)	Vitamin A insufficiency (%)	Vitamin A deficiency (%)	Zinc deficiency (%)	Iodine deficiency (%)
National	5	75	38	59	17
Tigray	3	72	25	56	16
Afar	12	77	35	68	4
Amhara	2	76	32	67	9
Oromia	6	79	47	60	16
Somali	18	79	42	49	20
SNNP	4	70	30	57	31
Sidama	4	68	32	34	13
Gambela	5	88	41	48	18
Harari	11	90	60	53	11
Addis Ababa	4	55	18	61	5
Dire Dawa	15	90	61	50	10
Urban	6	75	36	55	15
Rural	5	75	39	60	18

The prevalence of anemia among school-aged children was 17%, with the highest rates in Benishangul-Gumuz (34%) and Dire Dawa (23%) regions (Figure 13). Nationally, 2% of school-aged children had iron deficiency anemia. The highest prevalence of iron deficiency anemia was found in Somali region and Dire Dawa, both at 8% (**Figure 12**).

Figure 12. Anemia and iron deficiency anemia among school-aged children by region and place of residence



6.4 Micronutrient status of adolescent girls

Nationally, 7% of adolescent girls were folate deficient, and 64% had insufficient folate levels. The prevalence of folate insufficiency was higher in urban areas (71%) compared to rural areas (60%). Regionally, the highest rates of folate deficiency were observed in Afar (21%), and Dire Dawa (29%) (**Table 4**).

Vitamin D deficiency was also widespread, with 72% of adolescent girls having insufficient or deficient levels. Zinc deficiency affected 62% of girls, with the highest prevalence reported in Oromia (67%) and Amhara (66%), and the lowest in Sidama (43%).

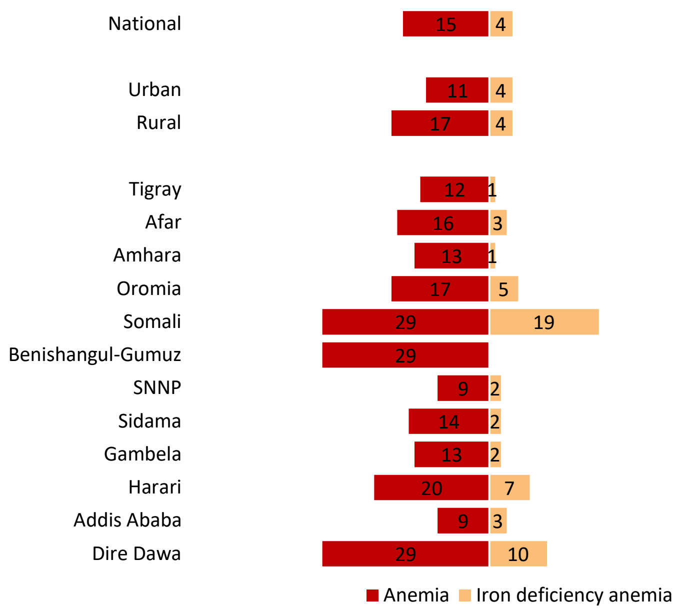
One in ten adolescent girls were vitamin A deficient. The highest prevalence was found in Harari (23%), Afar (26%), and Somali (27%), while the lowest was in Amhara (11%).

Table 4. Micronutrient deficiencies among adolescent girls by region and place of residence

Regions	Iron Deficiency (%)	Folate insufficiency (%)	Folate deficiency (%)	Vitamin A insufficiency (%)	Vitamin A deficiency (%)	Vit B12 deficiency (%)	Vit B12 insufficiency (%)	Zinc deficiency (%)	Vitamin D deficiency (%)
National	8	64	7	51	13	30	8	62	72
Tigray	4	79	13	59	15	15	3	62	70
Afar	12	76	21	66	26	16	2	58	63
Amhara	3	68	3	52	11	29	6	66	80
Oromia	12	67	8	48	11	41	13	67	71
Somali	32	71	15	75	27	12	2	46	13
SNNP	6	52	2	49	17	25	9	59	79
Sidama	3	15	1	43	13	3	1	43	58
Gambela	10	68	16	58	15	12	3	47	38
Harari	13	80	13	67	23	50	20	55	67
Addis Ababa	8	70	13	36	5	31	6	47	92
Dire Dawa	15	69	29	52	15	60	24	46	60
Urban	11	71	9	50	11	27	6	60	79
Rural	7	60	6	51	14	32	9	63	69

Anemia affected 15% of adolescent girls, with the highest prevalence reported in the Somali (29%) and Benishangul-Gumuz (29%) regions (**Figure 13**). Nationally, 10% of girls had iron deficiency, and 4% had iron deficiency anemia. The Somali region recorded the highest prevalence of iron deficiency anemia at 19%, nearly three times the national average (**Figure 13**).

Figure 13. Anemia and iron deficiency anemia among adolescent girls by region and place of residence

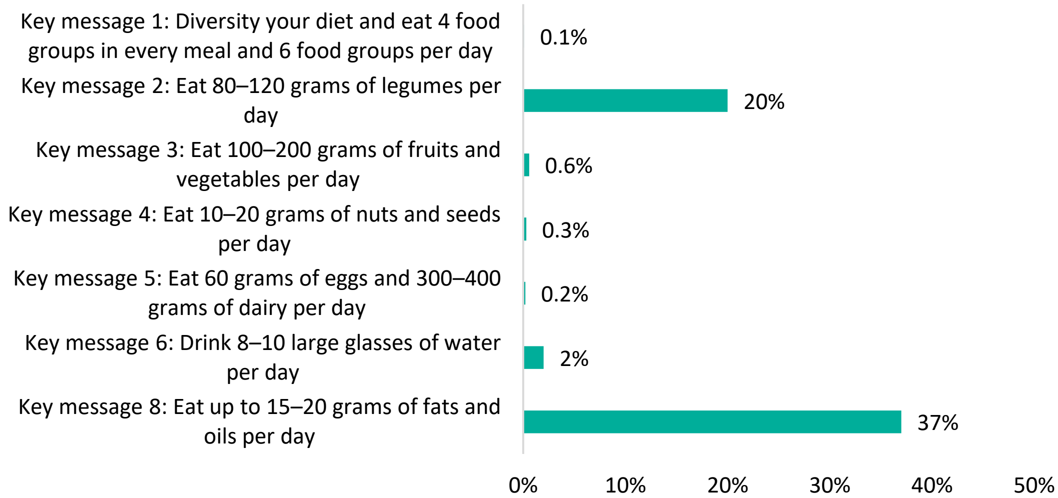


7. DIETARY INTAKES

7.1. Adherence to the Ethiopian Food-Based Dietary Guidelines (FBDG)

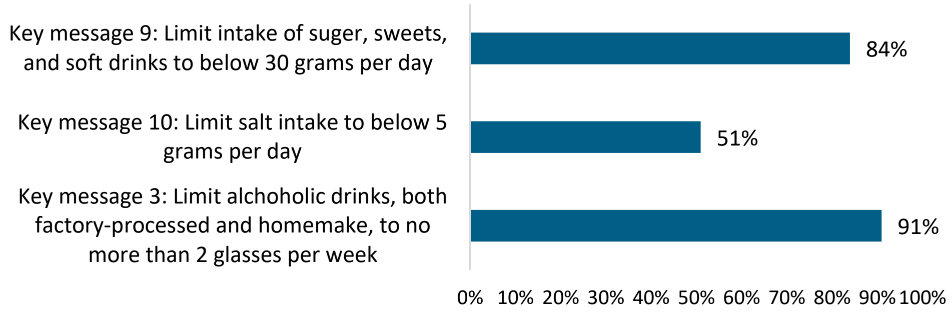
Nationally, fewer than 1% of women adhered to the FBDG recommendation of consuming at least four food groups per meal and six food groups per day to ensure dietary variety (Key Message 1, **Figure 14**). Although very few women met the recommendation of consuming six food groups per day, 12% consumed five food groups, and 52% consumed at least three. Adherence to specific food group recommendations was also low. Only a small proportion of women met the daily recommended servings of fruits and vegetables (1%), nuts and seeds (under 1%), and animal-source foods (less than 1%). In contrast, 20% of women met the suggested daily intake of legumes (80–100 grams), and 37% consumed the recommended 15–20 grams of fats and oils per day (**Figure 14**).

Figure 14. Percentage of WRA who adhere to selected messages in the FBDG



Most women in Ethiopia (91%) limited alcohol intake to no more than two glasses per week, and 84% consumed less than 30 grams of sugar per day, with a higher proportion of rural women (89%) adhering to this recommendation compared to their urban counterparts (75%). However, 50% of women exceeded the recommended daily salt intake of 5 grams (**Figure 15**).

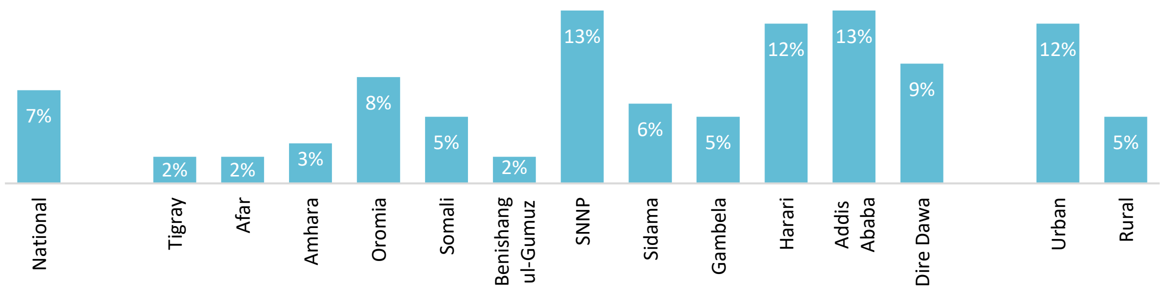
Figure 15. Percentage of WRA who adhere to the FBDG recommendations that promote limited consumption of selected food groups



7.2. Women dietary diversity

Nationally, only 7% of women consumed the minimum recommended number food groups. A higher proportion of women in urban areas (12%) met this recommendation than those in rural areas (5%). Regionally, the highest proportions were recorded in Addis Ababa (13%), SNNP (13%), and Harari (12%) (**Figure 16**). Women from the wealthiest households were more likely to meet the recommendation (15%) than those from the poorest households (4%).

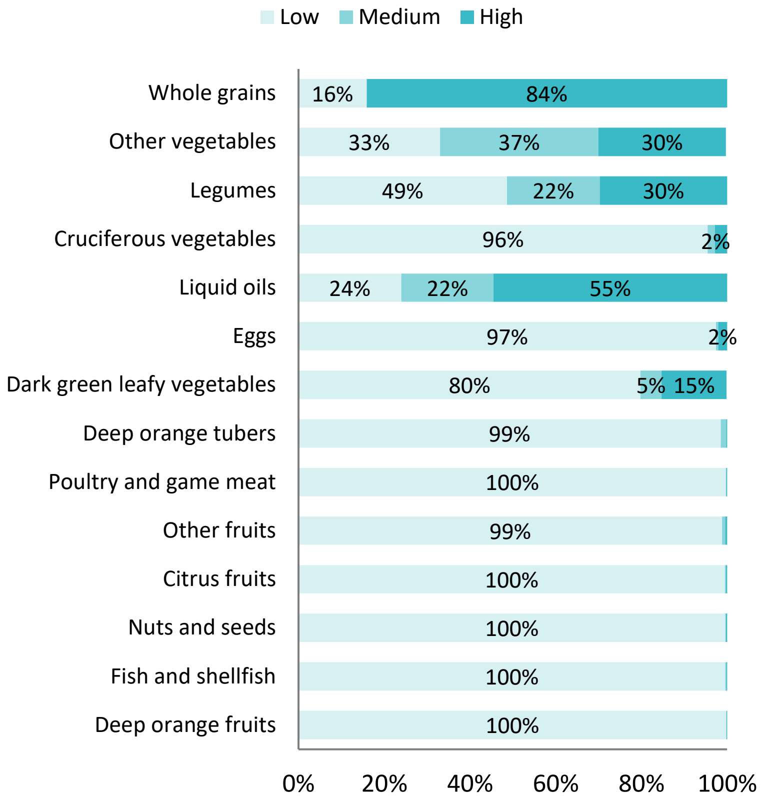
Figure 16. Dietary diversity among women aged 15-49 years by region and place of residence



7.3. The Global Diet Quality Score (GDQS)

Diet quality was assessed using the GDQS, which captures both the quality and quantity of foods consumed. The mean overall GDQS score for women was 18. The GDQS consists of two components: a positive sub-metric (16 healthy food groups) and a negative sub-metric (7 unhealthy food groups). A high positive score reflects greater consumption of healthy foods, while a high negative score indicates lower consumption of unhealthy foods.

Figure 17. Ranges of intake of healthy GDQS food groups

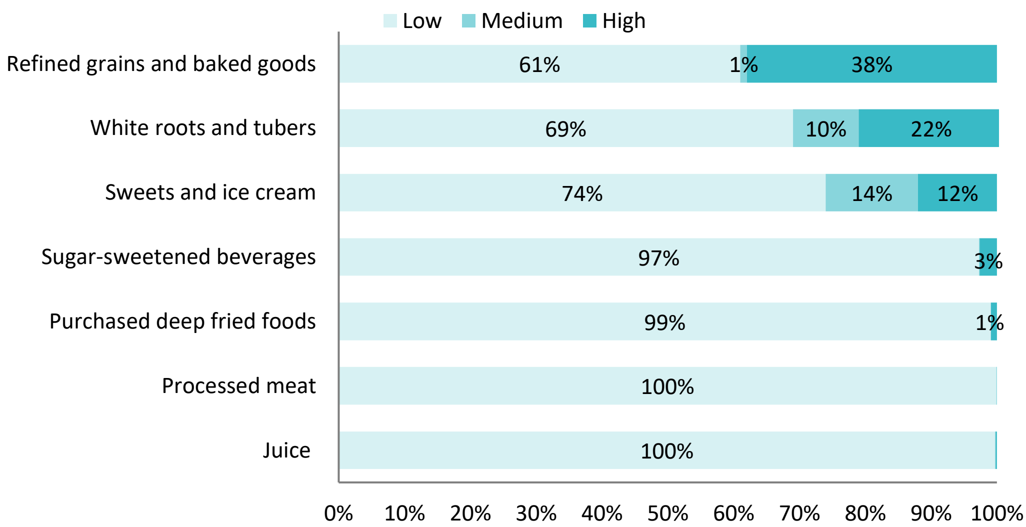


Ethiopian women had a mean GDQS positive score of 6 out of 32, indicating low intake of healthy foods, and a mean GDQS negative score of 12 out of 17, suggesting relatively low consumption of unhealthy foods. Food group consumption was categorized as low, medium, or high, based on the amount of food consumed in the past 24 hours.

Among the healthy food groups, the most frequently consumed at high levels were whole grains (84%), liquid oils (55%), other vegetables (30%), legumes (30%), and dark green leafy vegetables (15%). However, for 11 out of the 16 healthy food groups, at least 97% of women had low consumption (**Figure 17**).

Among the seven GDQS unhealthy food groups, refined grains were the most frequently consumed, with 38% of women reporting high intake (**Figure 18**).

Figure 18. Ranges of intake of unhealthy GDQS food groups

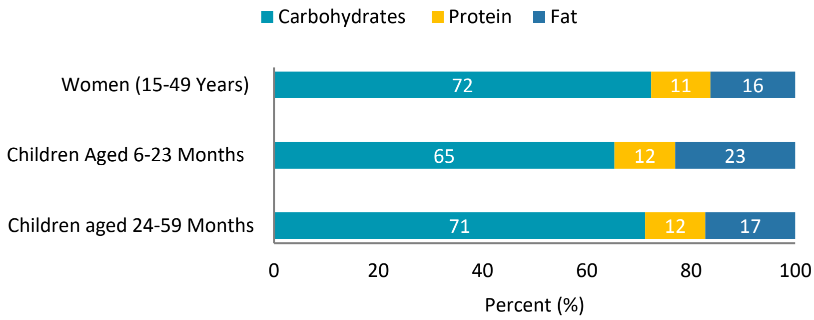


7.4. Macronutrient intakes

Nationally, the median usual energy intake was 1,656 kcal for women, 498 kcal for children aged 6–23 months (excluding breast milk), and 960 kcal for children aged 24–59 months. Cereals were the primary source of energy, followed by fats and oils, starchy roots and tubers, legumes, and sugary products (**Figure 19**).

For women, the main sources of energy were *injera* (39%), bread (12%), and oil (8%). Among children aged 6–23 months, energy intake came primarily from *injera* (29%), milk (15%), grain flours (10%), bread (9%), and oil (7%). For children aged 24–59 months, the main contributors were *injera* (29%), bread (14%), grain flours (8%), and oil (7%).

Figure 19. Contribution of macronutrients to energy intake



The macronutrient breakdown of energy intake varied by group. Women derived 72% of their energy from carbohydrates, 11% from protein, and 16% from fats. Children aged 6–23 months received 65% of their energy from carbohydrates, 23% from protein, and 12% from fats. Among children aged 24–59 months, the distribution was 71% carbohydrates, 17% protein, and 12% fats. These macronutrient intake ranges align with the WHO recommendations for a healthy diet, which suggest that daily energy intake should consist of 10-15% protein, 15-30% fat, and 45-75% carbohydrates.

7.5. Dietary nutrient inadequacy

Women (15–49 years)

Nationally, 35% of women had inadequate protein intake, with the highest prevalence observed in Somali (76%) region and the lowest in Benishangul-Gumuz (14%) and Amhara (18%) regions. Calcium inadequacy was widespread, exceeding 90% across all regions and types of residence.

Overall, 20% of women had inadequate iron intake, with higher rates in rural areas than in urban areas (21% versus 17%). Among the regions, the highest prevalence of iron inadequacy was found in Somali (75%), while the lowest was in Amhara (3%).

For zinc, 45% of women had inadequate intake nationally, with Somali (82%), Harari (72%), SNNP (68%), and Gambela (65%) regions showing the highest prevalence (**Table 5**).

Vitamin A inadequacy affected 86% of women nationwide, with higher prevalence in rural (89%) than urban areas (79%). Tigray region had the highest inadequacy (97%), while Addis Ababa had the lowest (70%). Over half of women (57%) had inadequate folate intake, with rural areas showing a higher prevalence (61%) than urban areas (48%). The highest folate inadequacy as recorded in Somali region (83%), followed by Sidama (80%), Harari (74%), SNNP (73%), and Tigray (71%) regions (**Table 5**).

Table 5. Prevalence of protein and micronutrient dietary inadequacy among women (15-49 years) by region and place of residence

	Protein	Calcium	Iron	Zinc	Vitamin A	Folate
National	35%	95%	20%	45%	86%	57%
Tigray	39%	98%	9%	41%	97%	71%
Afar	21%	94%	43%	54%	78%	40%
Amhara	18%	92%	3%	21%	84%	36%
Oromia	32%	95%	20%	45%	85%	58%
Somali	76%	99%	75%	82%	99%	83%
Benishangul-Gumuz	14%	95%	18%	40%	92%	44%
SNNP	56%	97%	36%	68%	88%	73%
Sidama	59%	90%	20%	56%	78%	80%
Gambela	25%	97%	41%	65%	89%	66%
Harari	42%	98%	40%	72%	83%	74%
Addis Ababa	35%	97%	13%	58%	70%	49%
Dire Dawa	36%	97%	38%	58%	91%	60%
Urban	33%	93%	17%	50%	79%	48%
Rural	37%	93%	21%	43%	89%	61%

Children aged 24–59 months

Among children aged 24–59 months, 6% had inadequate protein intake, with the highest prevalence in SNNP (15%), Sidama (13%), and Somali (12%) regions. Inadequacy was slightly higher in rural areas (6%) than urban areas (4%). Nationally, 82% had inadequate calcium intake, with the highest prevalence observed in Tigray (90%), SNNP (90%), and Benishangul-Gumuz (89%) regions. Almost one in five children (18%) had inadequate iron intake, with the highest prevalence in Gambella (46%), Somali (45%), and Afar (44%) regions (**Table 6**).

Zinc inadequacy affected 12% of children aged 24–59 months, with the highest regional prevalence in SNNP (26%) and Somali (20%), and the lowest in Amhara (5%). Based on food sources alone, 92% of children had inadequate vitamin A intake, with rates exceeding 90% in all regions except Addis Ababa (76%), and Afar (85%). When accounting for supplementation, the national prevalence of inadequate vitamin A intake dropped to 86% (**Table 6**).

Table 6. Prevalence of protein and micronutrient dietary inadequacy among children aged 24–59 months by region and place of residence

	Protein	Calcium	Iron	Zinc	Vitamin A : Food	Vitamin A:Food and vitamin A supplements	Folate
National	6%	82%	18%	12%	92%	86%	43%
Tigray	4%	90%	7%	6%	98%	97%	48%
Afar	2%	76%	44%	12%	85%	78%	27%
Amhara	3%	83%	4%	5%	91%	84%	28%
Oromia	3%	80%	16%	10%	91%	85%	42%
Somali	12%	82%	45%	20%	99%	99%	54%
Benishangul-Gumuz	2%	89%	18%	7%	97%	92%	26%
SNNP	15%	90%	33%	26%	96%	88%	60%
Sidama	13%	71%	18%	16%	93%	78%	61%
Gambela	3%	83%	46%	19%	95%	89%	46%
Harari	6%	86%	29%	20%	94%	83%	56%
Addis Ababa	2%	72%	13%	10%	76%	70%	29%
Dire Dawa	3%	79%	23%	7%	93%	91%	34%
Urban	4%	81%	17%	11%	88%	79%	37%
Rural	6%	82%	18%	12%	94%	89%	45%

8. Coverage of direct and indirect nutrition interventions

8.1. Vitamin A supplementation coverage in the past six months among children

Vitamin A supplementation coverage among children aged 6–59 months in Ethiopia was 20%. Coverage was notably higher in urban areas (30%) than in rural areas (15%) (**Figure 20**). Regional differences were evident: the highest coverage was in Benishangul-Gumuz (56%), and Addis Ababa (52%), while the lowest was in Somali (5%).

8.2. Children received deworming tablets in the past six months

Nationally, 22% of children aged 6–59 months received deworming tablets in the past six months. Coverage was higher in urban areas (29%) than in rural areas (20%). Regionally, Addis Ababa reported the highest coverage (46%), while the Somali had the lowest (6%) (**Figure 21**).

Figure 20. Vitamin A Supplementation Among Children Aged 6-59 Months

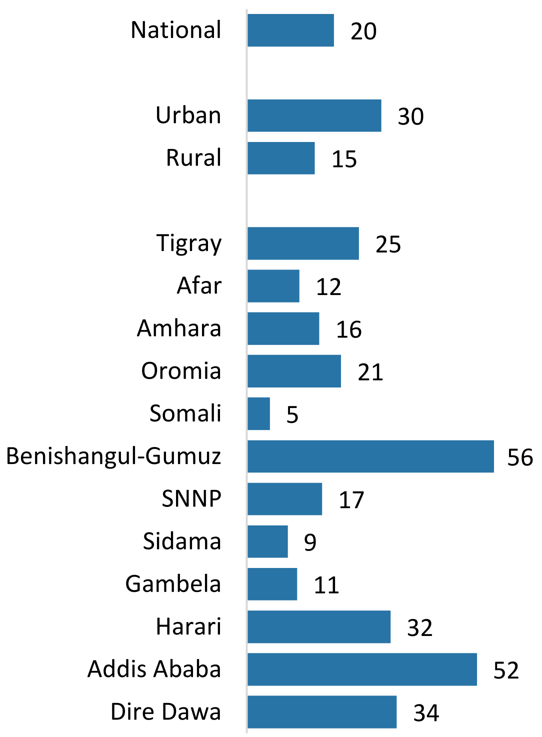
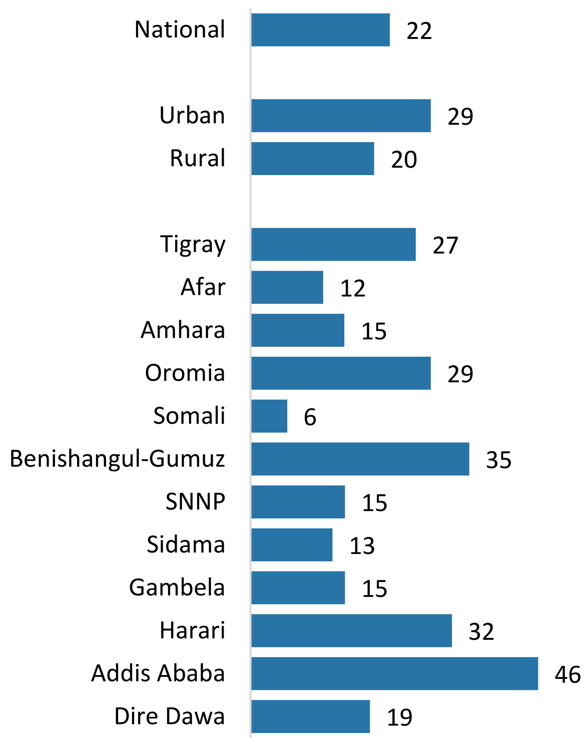


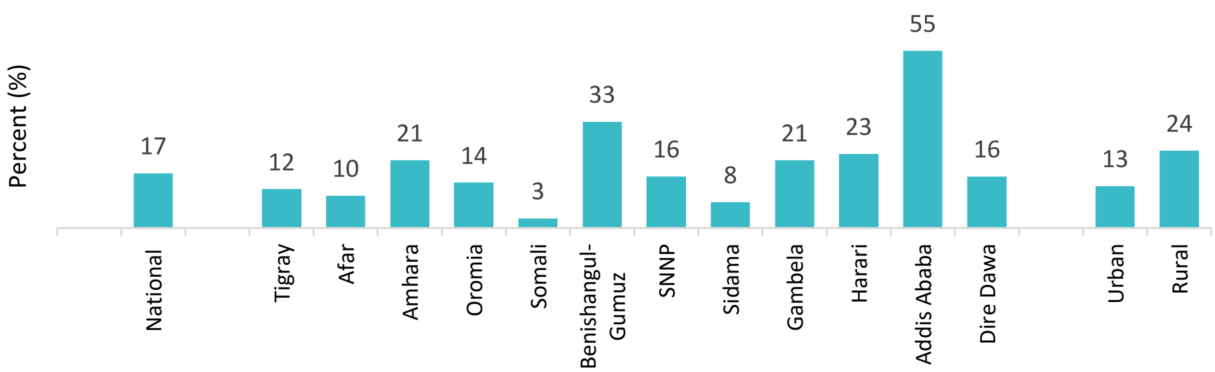
Figure 21. Deworming coverage among children aged 6–59 months by region and place of residence



8.3. Coverage of growth monitoring services

The growth monitoring program provided in the health facilities is a vital intervention to address all forms of malnutrition. Nationally, only 17% of children had their weight measured in the past three months preceding the survey. The highest coverage of weight measurement was reported in Addis Ababa (55%) and the lowest was in the Somali region (3%) (**Figure 22**).

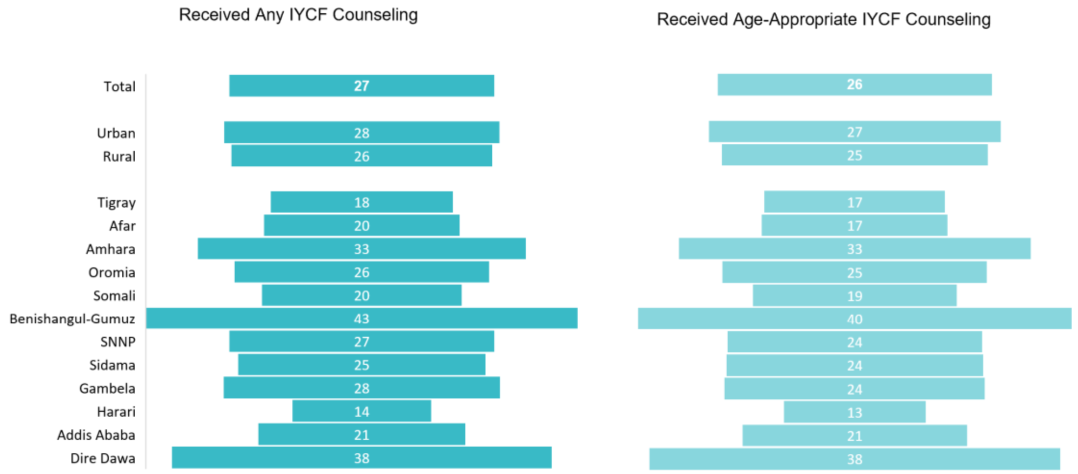
Figure 22. Coverage of growth monitoring service (weight measurement) in the last three months by region and place of residence



8.4. Infant and young child feeding (IYCF) counseling

Nationally, coverage of age-appropriate IYCF counseling and any IYCF counseling was low at 26% and 27%, respectively (**Figure 23**).

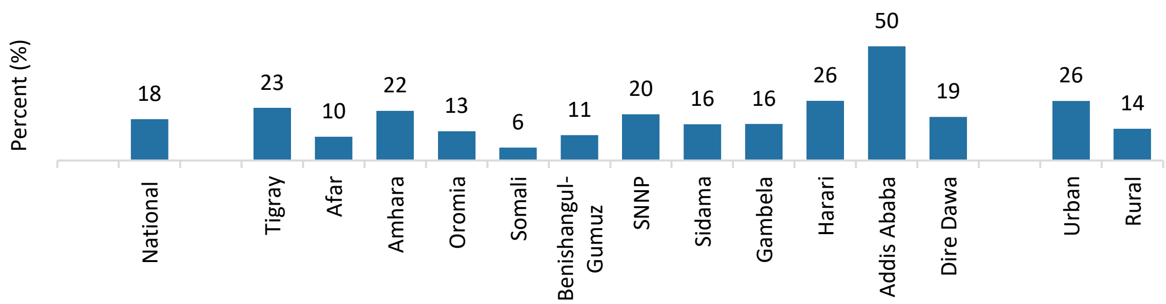
Figure 23. Age-appropriate IYCF counseling by region and type of residence



8.5. Iron and folic acid (IFA) supplementation during pregnancy

Overall, only 18% of pregnant women took IFA tablets for 90 days or more . Coverage was highest among pregnant women in urban areas (26%) and those from the wealthiest households (30%). Regional variation was substantial, ranging from just 6% in the Somali region to 50% in Addis Ababa (**Figure 24**).

Figure 24. Iron and folic acid supplementation during pregnancy by region and type of residence



8.6. Breastfeeding counseling during pregnancy and postnatal care

Nearly half of women (46%) reported receiving counseling on the importance of delivering in a healthcare facility. Regional variations were observed, with the highest coverage in Addis Ababa (88%) and the lowest in Somali (17%).

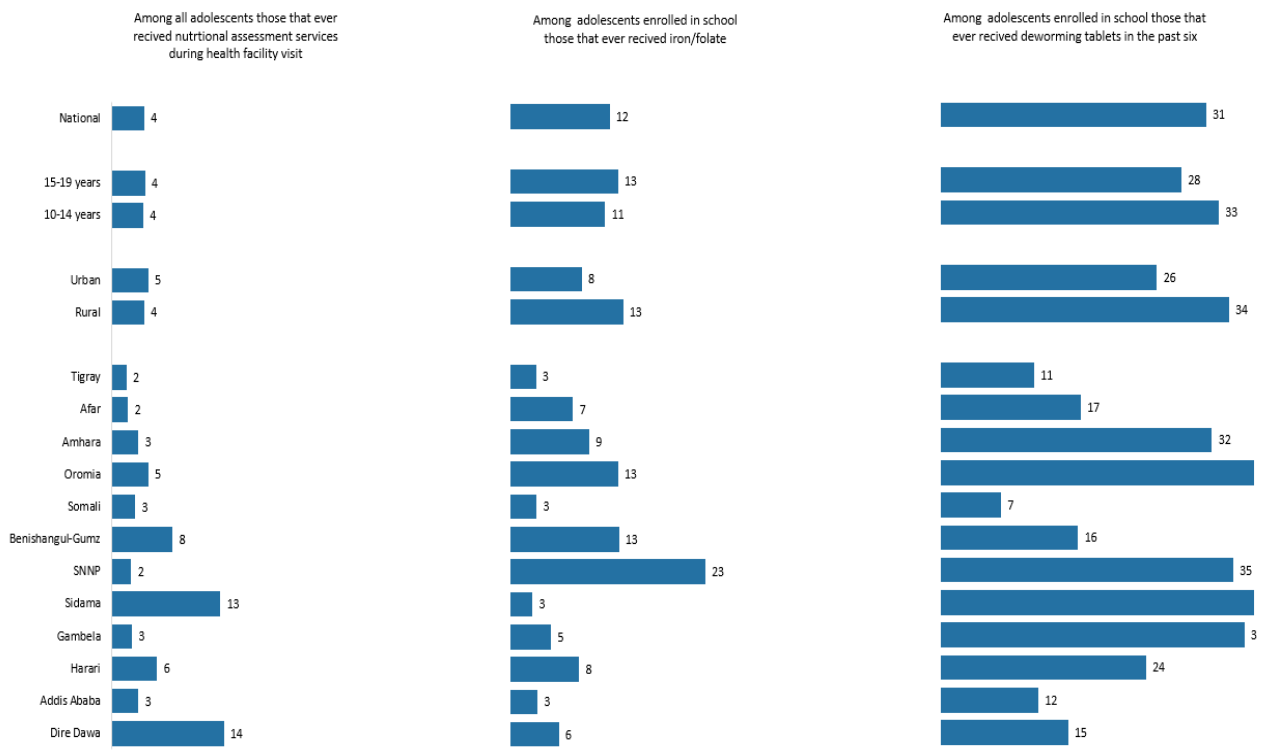
Nationally, 33% of mothers received breastfeeding counseling the first month after birth. Additionally, 31% received breastfeeding counseling in the first two days postpartum, whilst 34% received breastfeeding observation during the same period.

8.7. Coverage of direct and indirect nutrition interventions for adolescent girls

Nationally, 9% of adolescent girls received nutritional counseling, and 4% received nutritional assessment services. Among the regions, Dire Dawa reported the highest proportion of adolescent girls receiving nutritional assessments (14%), while Tigray, SNNP, and Afar reported the lowest (all at 2%). Coverage varied only slightly between urban (5%) and rural areas (4%) (**Figure 25)**.

Among school-attending girls, 12% received iron/folate supplementation and 31% received deworming tablets. Regionally, iron/folate supplementation was highest in SNNP (23%) and lowest in Tigray, Sidama, and Addis Ababa (all at 3%). Deworming coverage was highest in Sidama and Oromia (both at 37%) and was lowest in Somali (7%). In general, rural areas had higher coverage than urban areas for these interventions, and coverage increased with higher levels of education and household wealth (**Figure 25**).

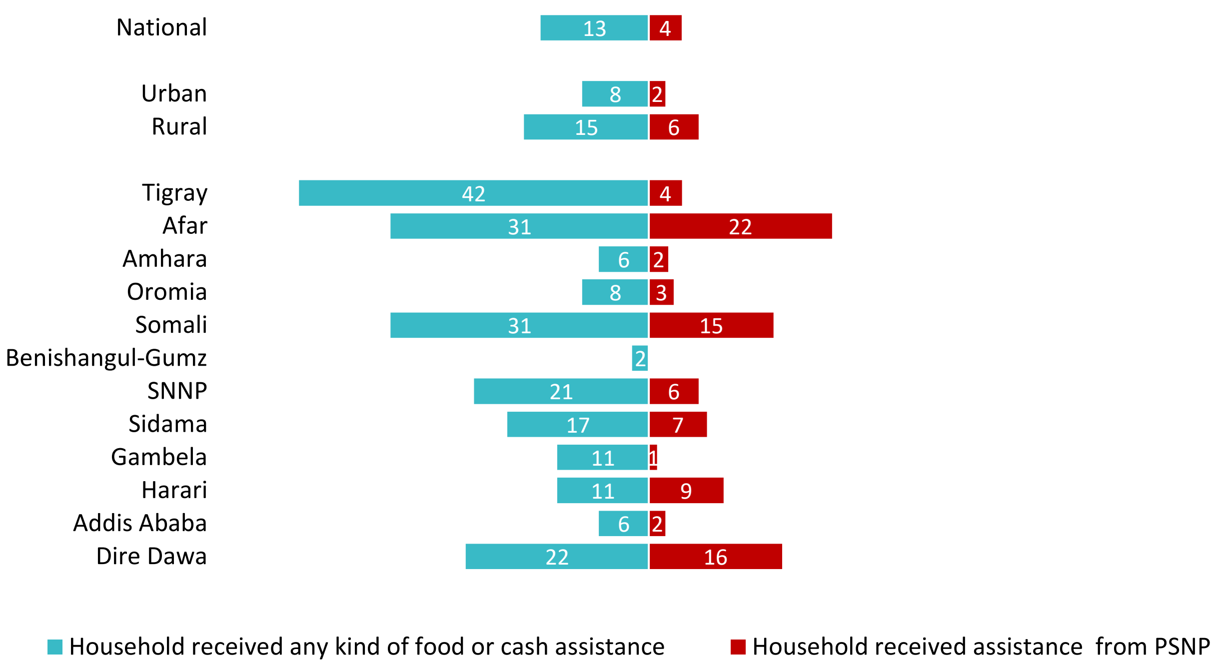
Figure 25. Coverage of nutrition interventions for adolescent girls



8.8. Coverage of social protection programs

Nationally, 13% of households reported receiving cash or food assistance. Among them, 4% received support through the Productive Safety Net Program (PSNP) (**Figure 26**).

Figure 26. Coverage of social protection programs



8.9 Household consumption of fortifiable foods

In Ethiopia, most households reported consuming fortifiable edible oil (90%) and salt (98%), while coverage of fortifiable wheat flour was considerably lower at 31%. Urban households generally had higher access to these foods than rural households. Regionally, Addis Ababa had the highest consumption of fortifiable oil (97%) and salt (100%), while Dire Dawa reported the lowest oil consumption (79%) and Tigray the lowest salt coverage (91%). The highest consumption of fortifiable wheat flour was in Somali (71%), and the lowest in Amhara (17%). Awareness of fortified foods was limited, with only 11% of household heads familiar with them and their benefits (**Table 7**).

Table 7. Household access to fortifiable foods by region and place of residence

	Coverage of fortifiable edible oil (%)	Coverage of fortifiable wheat flour (%)	Coverage of fortifiable salt (%)
Tigray	81	26	89
Afar	81	45	97
Amhara	89	17	99
Oromia	93	31	99
Somali	83	71	90
Benishangul-Gumuz	90	39	98
SNNP	90	30	99
Sidama	93	33	99
Gambela	96	30	99
Harari	91	65	99
Addis Ababa	97	60	100
Dire Dawa	79	40	98
Urban	95	46	99
Rural	88	24	97
National	**90**	**31**	**98**

8.10. Household consumption of iodized salt

In Ethiopia, only 42% of households consumed adequately iodized salt, while 35% consumed inadequately iodized salt and 23% consumed salt with excessive iodine levels. Coverage varied by region and residence. Adequately iodized salt use was highest in Dire Dawa (59%) and lowest in Somali (9%), with urban households slightly more likely to consume it (44%) than rural households (41%). Inadequately iodized salt use was most prevalent in Somali (88%) and higher in rural areas (39%) than urban areas (25%). Excessive iodine intake was highest in Addis Ababa (43%) and more prevalent in urban than rural households (31% versus 20%) (**Table 8**).

Table 8. Coverage of iodized salt by region and place of residence

	Inadequately Iodized Salt (<20)	Adequately Iodized Salt (20-40)	Excessively Iodized Salt (>40)
Tigray	52	39	10
Afar	33	42	25
Amhara	24	48	28
Oromia	35	42	23
Somali	88	9	3
Benishangul-Gumz	23	58	20
SNNP	36	40	24
Sidama	48	35	17
Gambela	32	48	19
Harari	27	48	25
Addis Ababa	11	46	43
Dire Dawa	27	59	14
Urban	25	44	31
Rural	39	41	20
National	35	**42**	23

9. Underlying determinants of malnutrition

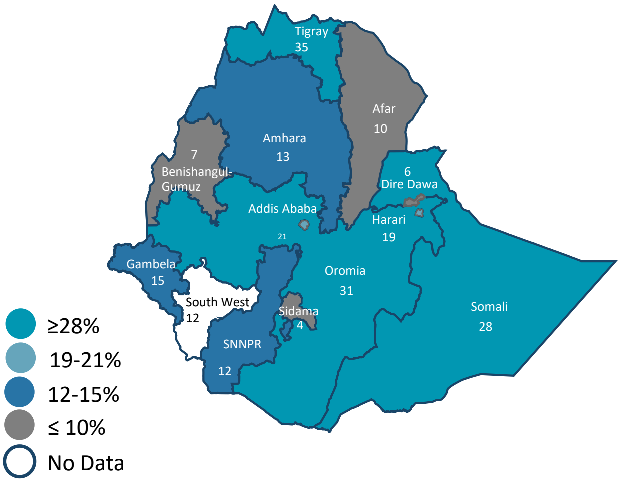
9.1. Children with reported weight at birth

Overall, only 30% of children had a reported birth weight. Urban children were more likely to have a reported birth weight (59%) compared to rural children (19%). Among children aged 0–59 months with recorded birth weights, the average was 3.3 kg. About 5% had a low birth weight (under 2.5 kg), with the highest proportions in Tigray (10%) and Afar (9%), and the lowest in Gambela (1%).

9.2. Prevalence of common mental disorders among women

In Ethiopia, 20% of women of reproductive age (WRA) experienced common mental health disorders. Regional differences were notable, with the highest prevalence in Tigray (35%), followed by Oromia (31%), Somali (28%) and Addis Ababa (21%) (**Figure 27**).

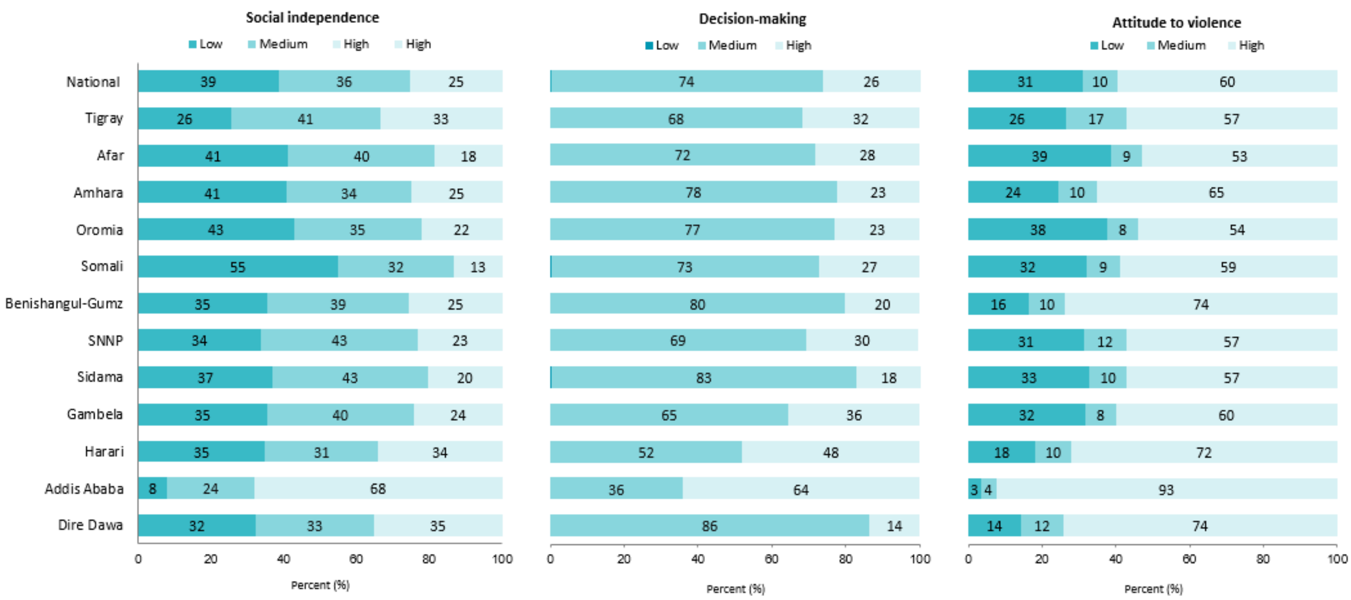
Figure 27. Prevalence of common mental health disorders among women of reproductive age by region



9.3. Women's empowerment

The survey assessed married women's empowerment using the SWPER index, which covers three domains: social independence, decision-making, and attitudes toward violence (**Figure 28**). Social independence, which reflects a woman's access to education and information, was high among 25% of WRA. Among the regions, the highest proportion was observed in Addis Ababa (68%), while the lowest was in Somali (13%). Decision-making, defined as a woman's participation in household decisions, was high among 26% of WRA. Nationally, about 6 in 10 women of reproductive age (WRA) had a high attitude-to-violence score, indicating low acceptance of violence. The highest proportion was observed in Addis Ababa (93%), while the lowest was in Afar (53%).

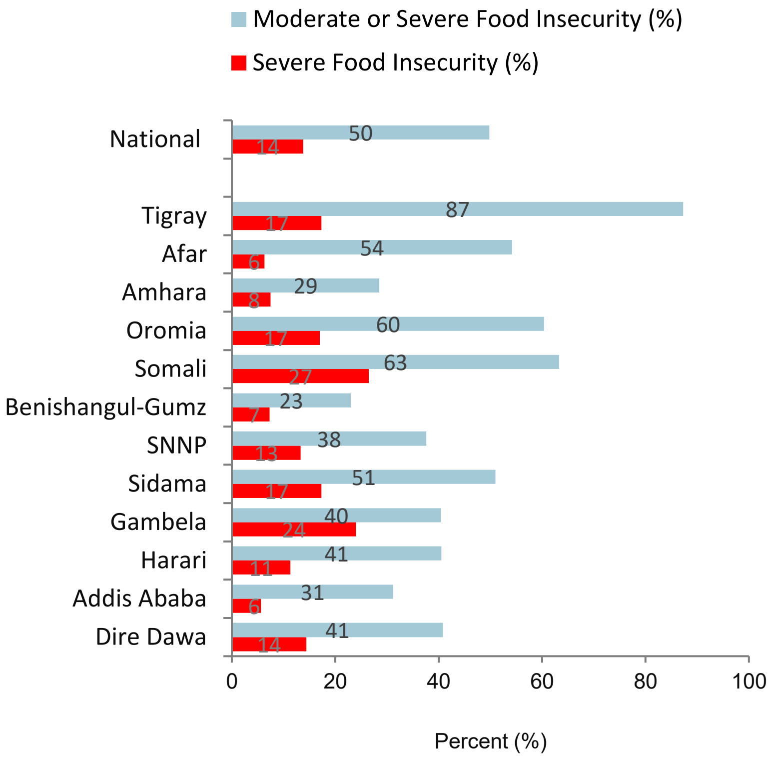
Figure 28. Women's empowerment by region



9.4. Household food insecurity

In Ethiopia, 50% of households experienced moderate or severe food insecurity, with 14% experiencing severe food insecurity. At the regional level, Tigray had the highest proportion of food-insecure households (87%), while Benishangul-Gumuz had the lowest (23%). Severe food insecurity was highest in Somali (27%) and lowest in Addis Ababa (6%) (**Figure 29**).

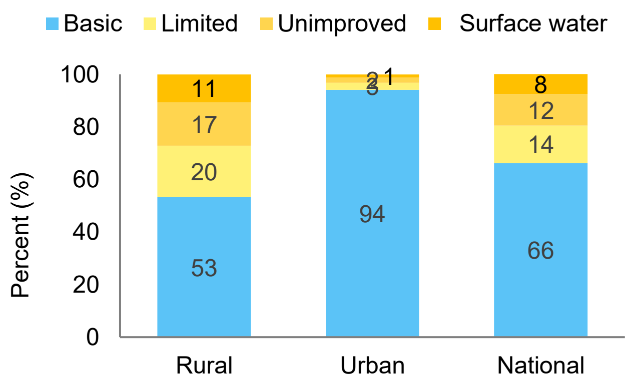
Figure 29. Percent distribution of household food insecurity



9.6. Coverage of household WASH facilities

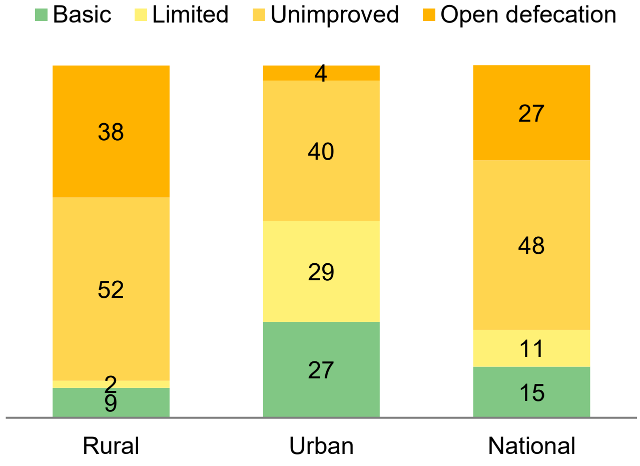
In Ethiopia, 80% households had access to improved drinking water, with urban households having a higher use of basic drinking water facilities (94%) than rural households (53%) (**Figure 30**).

Figure 30. Percent distribution of households by drinking water facilities



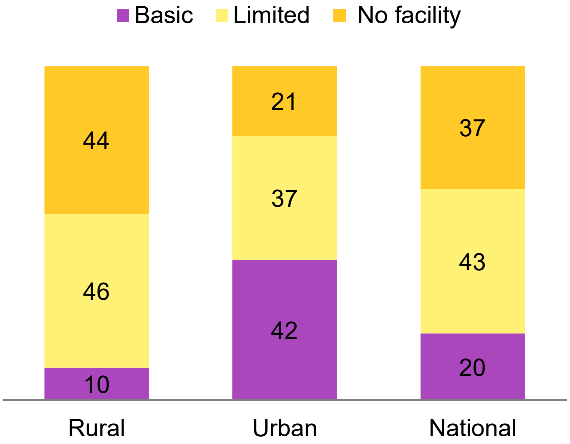
Nationally, 15% of households used a basic toilet facility, 11% used a limited sanitation facility, 48% an unimproved sanitation facility, and 27% still practiced open defecation. Open defecation was far more common in rural areas (38%) than in urban areas (4%) (**Figure 31**).

Figure 31. Percent distribution of households by sanitation facilities



Hand washing facilities were available in 56% of households, with urban households more likely to have access (79%) compared to rural households (53%) (**Figure 32**).

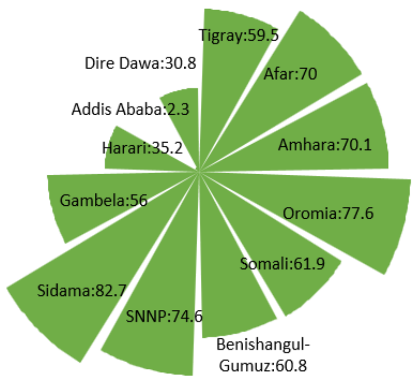
Figure 32. Percent distribution of households by handwashing facilities



10. HOUSEHOLD AGRICULTURAL ACTIVITIES

Nationally, 70% of households participated in some form of agricultural activity. Among these, 64% were engaged in crop farming, 56% in livestock production, and 51% in both activities. At the regional level, Sidama had the highest proportion of households engaged in agricultural activities (83%), followed by Oromia (78%), and SNNP (75%), while Addis Ababa had the lowest proportion (2%) (**Figure 33**).

Figure 33. Households involved in any agricultural



Cereals were the most produced crop, produced by 90% of households that own agricultural land (**Figure 34A**). Production diversity was low across all regions, with Sidama (3.8) and SNNP (2.8) and Sidama recording the highest average diversity (**Figure 34B**).

Figure 34A. Percentage of crop production among households who own agricultural land

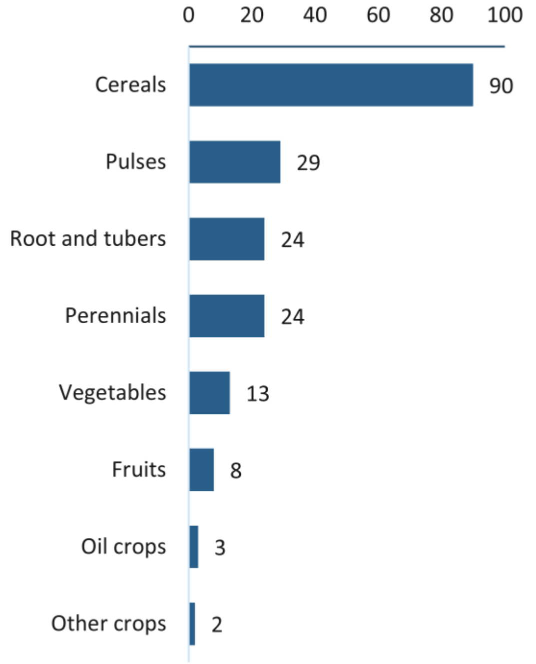
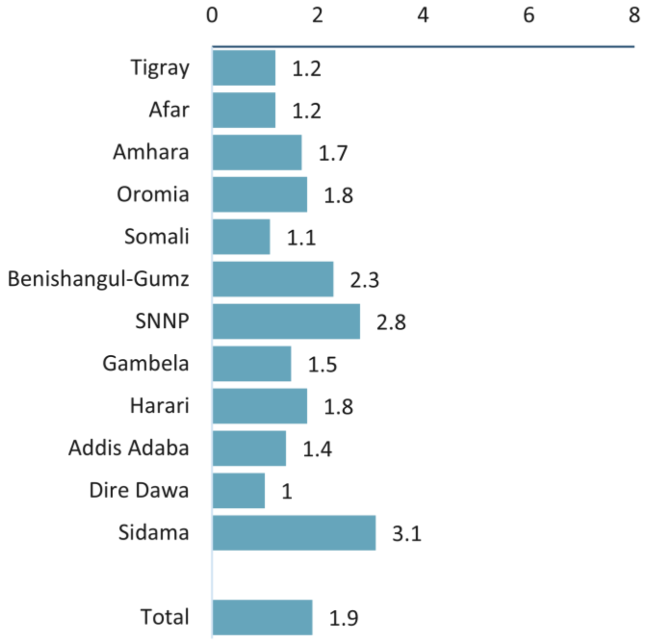
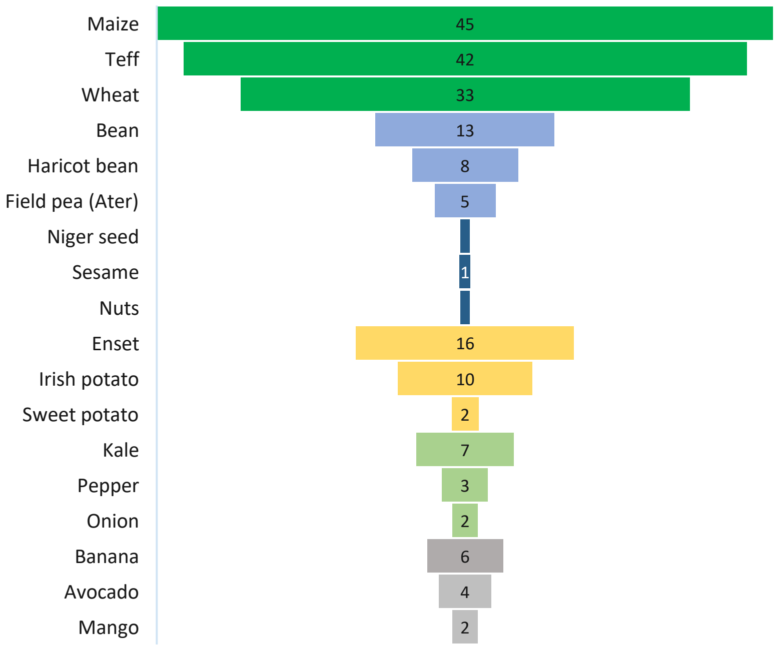


Figure 34B. Average number of crops cultivated by region



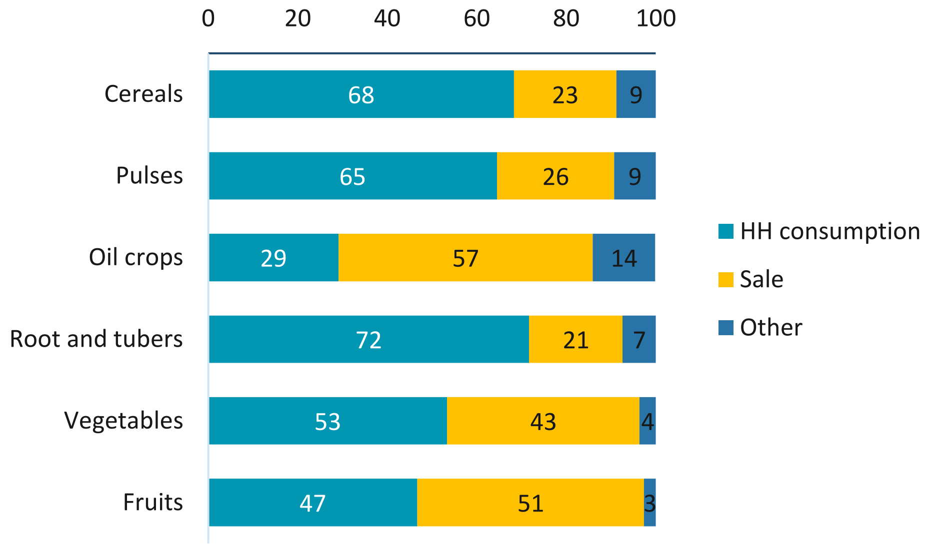
Maize, teff, and wheat were the most commonly produced crops, while fruits and vegetables were the least produced crops (**Figure 35**).

Figure 35: Most commonly produced crops



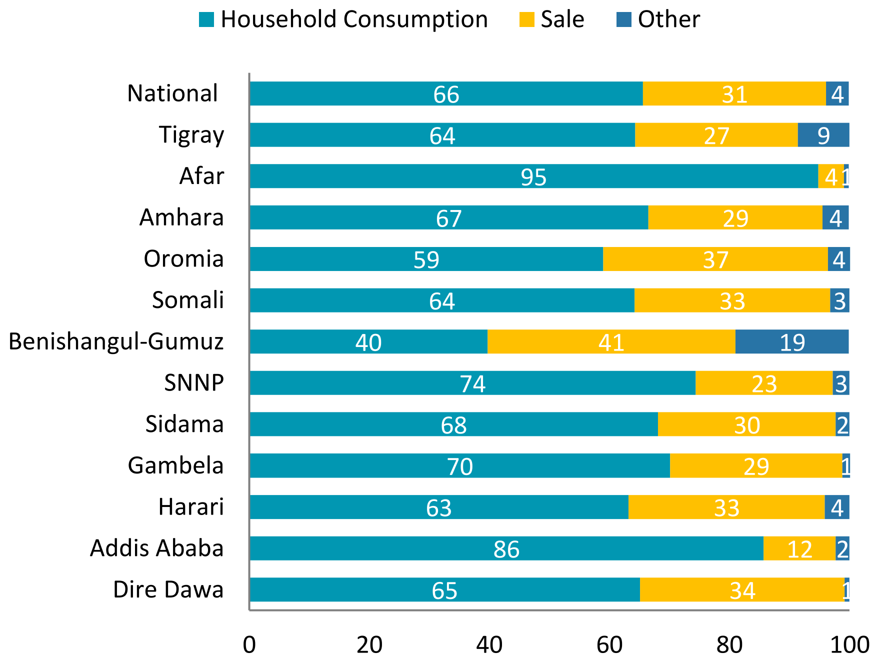
More than half (51%) of fruits produced in households and 43% of vegetables produced were sold. In contrast more than half cereals (68%), pulses (65%) and roots and tubers (73%) produced were utilized for own household consumption (**Figure 36**)

Figure 36. Consumption, sale, and other uses of food crops



Nationally, 25% of households reported producing at least one type of animal-source food (ASF), with slightly higher participation in urban areas (28%) than in rural areas (25%). Among ASF-producing households, 66% consumed their produce and 31% sold it. Among the regions, Afar (95%) and Addis Ababa (86%) had the highest proportions of households consuming their ASF, while Benishangul-Gumuz (40%) had the lowest but the highest proportion selling ASF (41%) (**Figure 37**).

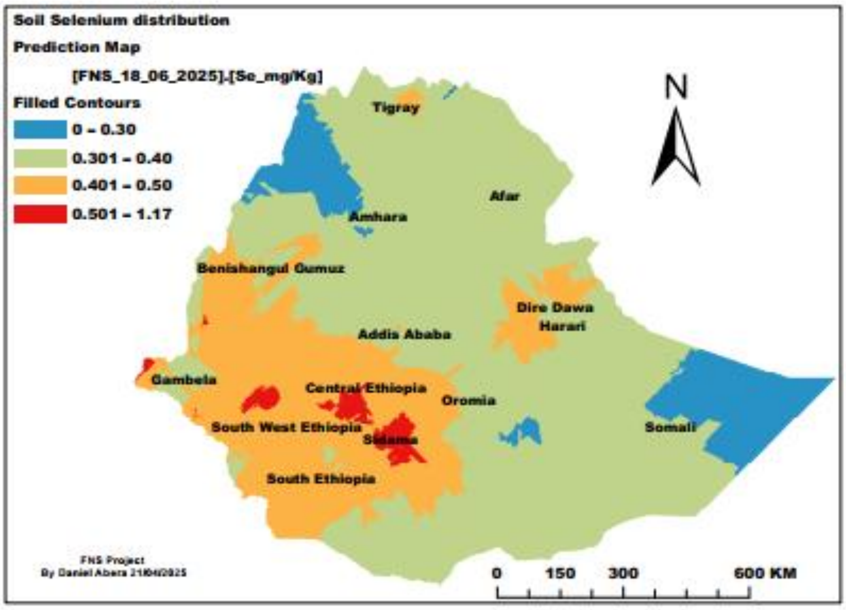
Figure 37. Consumption, sale, and other uses of animal-source foods



11. SOIL MICRONUTRIENTS

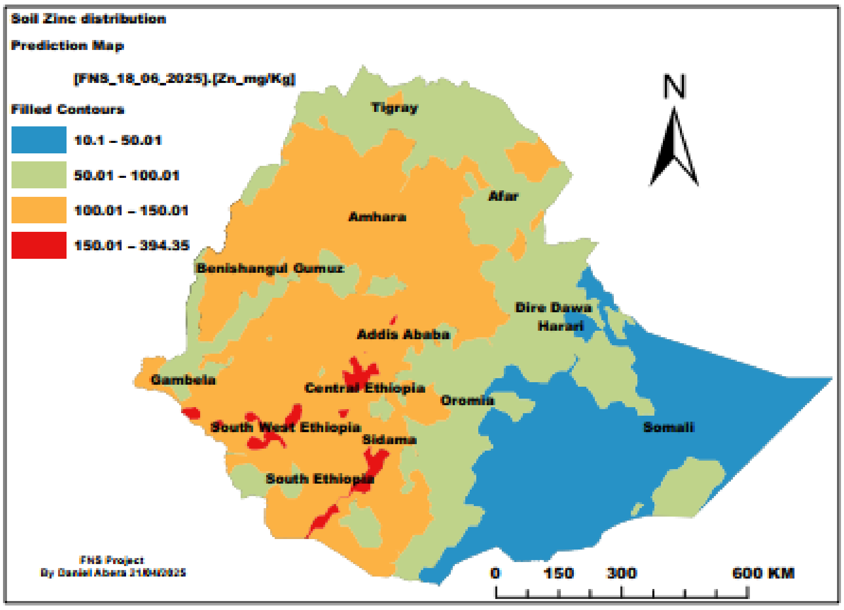
In Ethiopia, total selenium (Se) concentrations in smallholder agricultural soils ranged from 0.002 to 1.174 mg/kg, with a median of 0.26 mg/kg (**Figure 38**). Total Se levels below 0.5 mg/kg are generally considered as deficient, and 84% of samples in this survey fell below this threshold.

Figure 38. Distribution of selenium in agricultural soil across Ethiopia



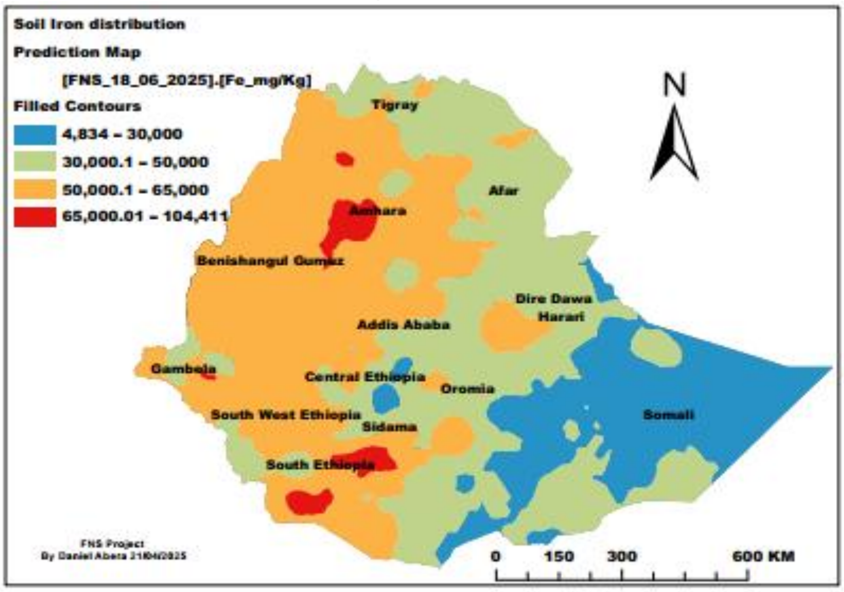
In nearly all soil samples fell within the natural range of total zinc concentrations (up to 300 mg/kg), with a median of 102 mg/kg. Exceptions included samples from Sidama (394 mg/kg) and Somali (367 mg/kg) regions. Beyond these exceptions, 11% of the samples exceeded 150 mg/kg, surpassing the optimal range for plant growth. Elevated zinc levels were particularly concentrated in Sidama, Central Ethiopia and South West Ethiopia regions (**Figure 39**).

Figure 39. Distribution of zinc in agricultural soil across Ethiopia



In this survey, total iron concentrations in the topsoil samples ranged from 4,834 mg/kg to 104,411 mg/kg, with a median of 46,090 mg/kg. Total iron levels were adequate to moderately high in the western parts of Ethiopia, while lower concentrations were observed in the eastern regions (**Figure 40**).

Figure 40. Distribution of iron in agricultural soil across Ethiopia



12. IMPLICATIONS OF FINDINGS

Progress in reducing child and maternal malnutrition in Ethiopia has been uneven. **Table 9** summarizes the country's progress toward the World Health Assembly (WHA) targets.

Table 9. Progress towards the WHA targets

Target	FNSBS 2025	EDHS 2016
Child stunting: 40% reduction in number of stunted children	41	38
Anemia in women: 50% reduction	20	24
Low birth weight: 30% reduction	5	13
Childhood overweight: No increase	4	3
Exclusive breastfeeding: At least 50%	61	58
Wasting: Less than 5%	11	10

Some of the possible reasons for the limited progress seen are listed below.

1. COVID-19 pandemic and other public health emergencies
2. Food prices, inflation, crop failure, and desert locust infestation
3. Climate change (droughts, floods), conflict, and internal displacement (*Loss of livestock and agricultural production)*
4. Imbalance between humanitarian response and development efforts
5. Suboptimal investment in nutrition-related programs
6. Challenges in multisector nutrition coordination across all levels (*Issues with coordination structures, budgeting, and human resources)*

13. A CALL TO ACTION

The change needed is significant—but not impossible. The following actions are essential to improve nutrition in Ethiopia:

1. Promote dietary approach and dietary diversity
2. Enhance innovation of food fortification programs
3. Scale up evidence based micronutrient supplementation
4. Strengthen nutrition-sensitive health services
5. Implement comprehensive nutrition education
6. Increase production of healthy foods in the food system.
7. Strengthen food supply chains
8. Address underlying determinants of malnutrition
9. Strengthen multisectoral collaboration and coordination
10. Create supportive and healthy food environments
11. Targeted interventions to address disparities

14. KEY LIMITATIONS OF THE FNSBS

- Conflict-related access challenges restricted survey coverage in certain regions.
- In Tigray, delayed data collection may have affected comparability with other regions.
- In Benishangul-Gumuz, the absence of biological sample collection limited assessment of micronutrient deficiencies.
- Data could not be generated for newly established Southern regions, as they were not yet formed at the time of the survey.

Despite these constraints, the survey provides regionally representative data for the areas successfully assessed, offering valuable insights into Ethiopia's food and nutrition landscape.

Further Information

Detailed information on the methodology and additional findings is available in the full technical report. For more information, please visit the survey EPHI website.

Acknowledgments

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