



Knowledge, attitudes, and practices in nutrition in Oromia and SNNP regions of Ethiopia

Introduction

Ethiopia has made progress in the last two decades in addressing malnutrition among its citizens, and specifically, in reducing child stunting and maternal undernutrition. However, micronutrient deficiencies remain a significant public health concern across populations in the country, with the most common being vitamin A, iodine, iron, and zinc deficiencies. IGNITE supports the Sasakawa Africa Association (SAA) to develop content and messaging for a nutrition awareness campaign that also integrates gender. This study was conducted to establish nutrition-related knowledge, attitudes, and practices in the SAA intervention areas within the Oromia and SNNP regions of Ethiopia, and to observe how gender influences household food-related decision-making processes. The findings will inform the development of nutrition messages for a social behaviour change (SBC) campaign in the two regions.

Research methods

- This was a mixed methods study. It collected qualitative data through focus group discussions with 126 participants in 21 groups, and key informant interviews (KIIs) with 14 respondents. Quantitative data was collected from 311 respondents in a household survey..
- The study was conducted in three woredas in Oromia and SNNP regions of Ethiopia: Angecha woreda in the SNNP region; and Anna Sora and Negele Arsi woredas in the Oromia region. Fair & Sustainable Ethiopia supported the execution of this study.

What the findings show

1. While communities in the two regions are aware of the importance of a balanced diet rich in micronutrients, lack of money and variety affects food choice

- The findings show that a majority of the respondents are aware and supportive of the need for a balanced diet and can tell when someone in the family is malnourished. There is equally high awareness in the two regions of the need for families to consume foods enriched with micronutrients, such as iron and vitamin A, to prevent malnutrition. About 83 percent of respondents had heard about vitamin A deficiency or related diseases and knew the common foods that contain the vitamin. More than half of the survey respondents (52 percent) reported that it is a serious issue to have vitamin A deficiency. However, over 80 percent of the respondents cited lack of enough money to buy food as the most common reason why families may not have a balanced diet. Difficulty in

obtaining diverse foods (unavailability) was cited as the second most common reason for poor family food choices.

2. Awareness and deliberate choice of bio-fortified and fortified foods is poor.

- While over half of the household survey respondents reported that their households use biofortified and fortified foods, participants in the FGDs suggested differently. For instance, there is a lack of knowledge on the health benefits of fortified oil, including what nutrients have been added to it. In the SNNP, FGDs showed that fortified wheat flour is not known by the community, and the community uses locally ground flour; when they do purchase packed flour from the shops, they do not care if it is fortified or not. Across the two regions, only 40% of respondents in the household survey were aware of the health benefits of eating orange-fleshed sweet potato (OFSP).

3. Although respondents are aware of the benefits of eating fruits and vegetables, few plan to grow them:

- All survey respondents knew about the benefits of producing fruits and vegetables and reported that their household members were aware of how to produce fruits and vegetables in home gardens. Nearly half (47 percent) think it is very serious if a household is not producing fruits and vegetables for home consumption, but 54 percent of the respondents did not think it was likely that their household would do so. There were no significant cultural rules or taboos identified that were against production and consumption of fruits and vegetables.

4. Women make decisions around food distribution in the household, preservation, and storage.

- Study participants reported that men have more power and control over women on decisions regarding the proportion of family-produced food to be consumed by the household and the proportion to be sold in the market. On the other hand, women independently make decisions around the production and consumption of fruits and vegetables. Women also mainly make household decisions on food preparation and allocation to household members; storage of cooked and fresh foods; buying foods rich in micronutrients. Women also make decisions on the type of food to be eaten by children and women in the household.

5. A high proportion of women have inadequate micronutrients intake:

The findings show that the diets of 72 percent of women in the study area do not meet the minimum dietary diversity for women (MDD-W), which is an indicator of the adequacy of micronutrient intake. The mean dietary diversity score for the women was 3.8, indicating that, in the previous day, most consumed 3 to 4 food groups out of the 10 food groups.

Only 15 percent of women in the two regions reported having eaten any eggs, meat/poultry, and fish the previous day. Participants in the FGDs and KIs also noted that community members in the study area mostly consume starchy foods (maize, kocho, enset), with some opting to sell some nutritious foods in exchange for other foods, such as coffee and sugar.

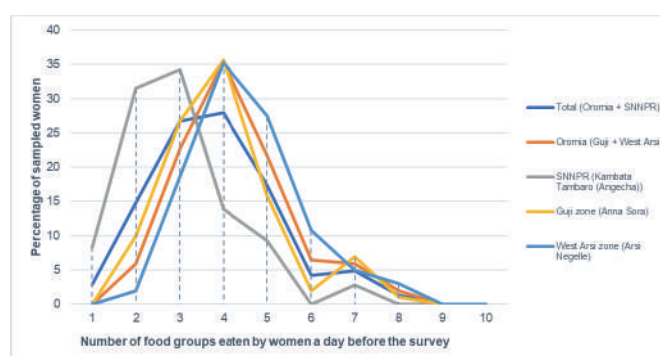


Figure 1: Distribution of dietary diversity scores for women

Conclusions and recommendations

This study established that communities in the study area face the risk of malnutrition and especially micronutrient deficiencies due to their dietary choices, and that the benefits of biofortified and fortified foods are still largely unknown. SAA and partners should implement the following recommendations to address these and other challenges.

- Sensitize community members to use locally available food sources to improve their dietary quality.** Results show that the community consumes a diet that is not diverse, mainly consisting of starchy foods, with some opting to sell some nutritious foods (protein rich foods like eggs, milk, and milk products) to raise cash. The results also show that there is significant variation in minimum dietary diversity for women across the two regions. SAA and partners should aim to sensitize households on how to better use local resources for a more nutritious and diverse diet for their members, especially women.
- Encourage communities to choose and consume more nutritious foods.** SAA and partners should aim to increase awareness in the research communities on the benefits of producing and consuming bio-fortified and fortified foods, including vitamin A and iron-rich foods, iodized salt, and encourage the communities to choose these foods, as well as to grow more fruits and vegetables for home consumption.
- Empower women in household decision-making and strengthen the link between gender and nutrition throughout production, distribution, and other reproductive activities.** The results show that women make household decisions on food distribution, preservation, and storage, and are also more involved in decisions around the production and consumption of fruits and vegetables. They are also aware of nutrition-rich foods, such as eggs, meat, milk, and milk products and their benefits. However, they are still eating insufficient amounts of such foods. Empowering them has the potential to improve both their own diet and their household's, and in adoption of improved food varieties.
- To further improve women's nutrition, agricultural extension and gender experts should consult and advise men in the community on how to support women** and to recognize their contributions in household food production and distribution, and to improve the nutrition status of all family members within households.