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INTERNATIONAL FOOD POLICY
RESEARCH INSTITUTE
sustainable solutions for ending hunger and poverty
Supported by the CGIAR

Case Study

Implementing the ENA framework with Homestead Food Production: Experience from Burkina Faso 2009-2012

1. Background

Helen Keller International has implemented its Homestead Food Production (HFP) program across Asia since the 1990s to increase household production of micronutrient-rich foods and improve diet quality for vulnerable households. Village model farms are established to demonstrate gardening techniques that support diversified, year-round production of micronutrient-rich crops and small animal husbandry, and to train community members to replicate these techniques at the household level. This agricultural training is integrated with the Essential Nutrition Actions (ENA) framework to ensure that HFP contributes to improved nutrition practices in participating households. ENA uses social & behavior change (SBC) communications to encourage adoption of those practices that most benefit individuals in the “1,000 day” critical growth window from conception through the first two years of life, including the consumption of the nutrient-rich garden and animal products by women and young children 6-23 months of age. This approach has increased the quantity, quality and diversity of produce in home gardens, the consumption of this produce, the income of program participants and, in some cases, reduced anemia among women and/or young children¹.



In Burkina Faso with funding from USAID Office of Foreign Disaster Assistance, HKI introduced an adapted version of this “Enhanced HFP” (E-HFP) model in the Fada district. The International Food Policy Research Institute (IFPRI) collaborated to evaluate the impact of this package of interventions on a range of outcomes, including knowledge and adoption of key ENA practices using a randomized cluster design.

2. Nutrition Context

The baseline survey, which examined children between 3-12 months of age revealed some alarming facts about nutritional status and ENA practices. Growth faltering was evident even among the youngest children in the sample. On average across treatment and control communities, 25.3% were stunted (HAZ <-2 SD), 25.6% were wasted (WHZ <-2SD), and 88% suffered from anemia (Hb concentration <11.0 g/L). Key practices were extremely low: 40% of children were breastfed within one hour of birth; 20.8% were exclusively breastfed in the previous 24 hour period; 13% were introduced to complementary foods at the

¹ Iannotti L., et al. (2009) Diversifying into healthy diets: homestead food production in Bangladesh, in: Millions Fed: Proven successes in agricultural development. IFPRI Discussion Paper. Washington D.C.: International Food Policy Research Institute.

appropriate time; 9% were fed an iron-rich food in the previous 24 hours; 16% were fed with minimum acceptable frequency according to WHO and only 1.6% received the minimum dietary diversity.

3. ENA Strategy

The SBC strategy for nutrition was shaped by a series of participatory workshops in each treatment community comprised of 20-25 members including mothers and fathers of children <2, elder women, and community leaders. Over the course of these three-day workshops the participants were introduced to ENA, explored gaps between recommended and actual practices, and identified relevant beliefs and taboos. The project team then used these data to inform messages and strategies for supporting positive change.



While women beneficiaries (mothers of children < 12 months) were selected to be village farm leaders and train other mothers in the food production techniques, a separate set of volunteers were trained to promote knowledge and practice of ENA among these same households. In one subset of villages these ENA change agents were elder women (grandmothers), who are known to be highly respected in West African cultures; in another subset of villages these were health committee members, or volunteers selected and trained by the Ministry of Health to expand the reach of health services. For both sets, six volunteers served in each community, and organized monthly ENA discussion sessions with women participating in homestead food production, occasional cooking demonstrations, and home visits to support each woman's adoption of the best practices most relevant to her circumstances.

4. Evaluation

At approximately mid-term in the project, IFPRI undertook a process evaluation to examine the quality of implementation to date. Among areas identified as needing improvement were: regularity of home visits; training of beneficiary mothers and their attendance at training sessions; knowledge related to feeding children during illness and the prevention of anemia; and the adoption of the practices of feeding children 6-23 months and including eggs. In addition, there was indication that improvements could be made in the motivation and recognition of nutrition volunteers and reinforcing their mastery of certain ENAs. The project team worked to address these weaknesses during the remainder of the project. The impact evaluation indicated that beneficiary women were significantly more knowledgeable about a number of optimal IYCF practices as compared to those living in control villages, indicating that the BCC strategy had indeed been successful. The research also found some evidence that women in treatment villages as compared to control villages were more likely to report practicing these optimal IYCF practices such as initiating breastfeeding within the first year of hour, giving their children iron-rich foods and giving their children at least four out of seven types of foods, as recommended to meet the minimum requirements for a diverse diet. However change in practices was less than hoped, indicating the need to hone the SBC strategy and sustain the effort into the future. The Canadian government has granted support to continue and expand the program for an additional three years, and rigorous evaluation of delivery and impact is also ongoing.

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