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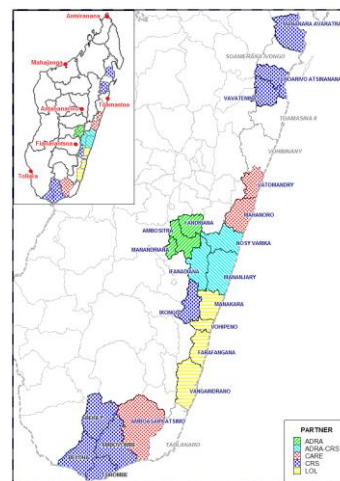
ADRA MADAGASCAR



Implementing the Essential Nutrition Action Framework 2009-2014

1. Background

The *Strengthening and Accessing Livelihood Opportunities for Household Impact* (SALOHI) Program was implemented in partnership with Catholic Relief Services (CRS), Cooperative for Assistance and Relief Everywhere, Inc. (CARE), and Land O'Lakes International Development Division (LOL). The goal of this five-year food aid program (July 2009 – June 2014) is to **reduce food insecurity and vulnerability** through three integrated Strategic Objectives: improve health and nutritional status of children under five; improve livelihoods of food-insecure households; and increase community resilience to shocks. Four cross-cutting themes reinforce these three objectives: gender, environment, good governance and sustainability. The SALOHI program originally targeted seven regions, 21 districts, 120 communes and 544 *fokontany* (an administrative unit composed of one or more communities) for a total of 630,000 beneficiaries in five geographical zones and seven regions. The primary target area for ADRA was Amoron'i Mania and Vatovavy Fitovinany covering the districts of Ambositra, Fandriana, Manandrina, Mananjary, Nosy Varika which cover 38 Communes and 234 Fokontany.



2. Nutrition Context

Globally, Madagascar has the 15th highest stunting rate at 50 percent and up to 25 percent of the national population is undernourished. Nearly five percent of children under five suffer annually from severe wasting or severe acute malnutrition (SAM), which is a principal cause of child mortality in Madagascar. There are also relatively high rates of anemia among both women (35 percent) and children (50 percent).¹ The 2009 DHS showed that 27 percent of women of child-bearing age suffer from under-nutrition. ADRA's Local Determinants of Malnutrition (LDM) study indicated that children who were perceived as small at birth by their mothers were six times more likely to be malnourished; 24 percent of babies under six months of age are already stunted (USAID-FSCF, 2013). Additionally, the median duration of exclusive breastfeeding is only three months for girls and two months for boys; only 29.8 percent for four- and five-month olds continue to be exclusively breastfed. The impact of this is that approximately 20 percent of babies under six months of age are already stunted and that boy children have higher malnutrition rates. Only 12.3 percent of children 6 – 23 months of age receive the minimum acceptable diet.²

3. ENA Strategy

Promoting ENA was the responsibility of several groups: SALOHI field agents; the community volunteers for each sector and committee members; and local leaders and authorities in SALOHI communities. SALOHI emphasized: breastfeeding (immediate breastfeeding within one hour of birth and exclusive

¹ (UNICEF, Global Nutrition Report, 2013; CFSVA+N, 2011).

² (USAID, FSCF, 2013; DHS, 2009)

breastfeeding for children 0-6 months); complementary feeding for children 6-23 months with continued breastfeeding; appropriate nutritional care for sick or severely malnourished children; and prevention of micronutrient deficiencies and anemia. The ENA were utilized through several different platforms including: **training and support of Community Health Volunteers (CHVs) in ENA**; counseling mothers during **Growth Monitoring and Promotion (GMP)** sessions; **PD/Hearth** where deviant mothers, “Model Mothers” were chosen to work with CHVs to promote ENA to caretakers of moderately malnourished children; and **support groups for pregnant and lactating women (SAMBAIKA)**. These support groups, composed of pregnant, lactating women and Model Mothers, used participatory capacity building techniques to promote healthy pregnancies, reduce low birth weights, and ensure that children had an excellent start in life.

4. Successes

During Qualitative Study Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs), women routinely discussed the importance of immediate breastfeeding (IBF), exclusive breastfeeding (EBF), and an adequate and diverse diet for young children starting at six months of age. They recited recipes, knew which foods were high in micronutrients such as Vitamin A and iron, and described the positive physical changes they had seen in their children as a result of the SALOHI program. Quantitative examples include: exclusive breastfeeding (EBF) increased from 26% in the baseline to 75% at the time of the final evaluation. Women whose children participated in GMP said they received advice on hand washing with soap (67%), complimentary feeding (66%), food conservation and processing (54%), conservation and treatment of drinking water (46%) and care of the sick child (40%), as well malaria prevention (31%) and foods rich in iron and vitamin A (24%). Stunting decreased from 41 % to 36 % and underweight decreased from 34% to 26%.



5. Challenges

Mothers did not always produce the necessary ingredients suggested in the recipes or have the money to buy them to practice some of the essential nutrition actions for complementary feeding. Another major challenge was the CHV motivation including capacity of the individual and the system, motivation and incentivization. As a solution to this challenge, this activity was decentralized to the hamlet level so parents and children didn't have to travel so far to participate in nutrition activities. Although the national standard is to have at least two CHVs per Fokontany, the SALOHI program trained up to 10 CHVs per Fokontany, to facilitate access to essential services in nutrition in remote locations, and in widely dispersed communities.



Another challenge worth noting is the gender disparity noted most frequently was the lack of special consideration for pregnant/lactating women due to their status, and particularly their nutritional requirements. The second disparity was the lack of interest on the part of men in the health of their children and wives. As a solution to this challenge, SALOHI trained both men and women CHVs, to facilitate communication with both parents.

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