# Understanding the Essential Nutrition Actions (ENA) Framework


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## Current Context

The landmark Lancet Series on Maternal and Child Undernutrition published in 2008 and updated in 2013 estimates that maternal and child undernutrition is the cause of 45 percent of under-five deaths.1 These series identified effective, targeted nutrition-specific and nutrition-sensitive interventions which, if implemented at scale during the window of opportunity (from conception to 24 months of age), could significantly reduce mortality and related morbidity and disability.2 In 2013, the World Health Organization (WHO) released a guide on Essential Nutrition Actions: improving maternal, newborn, infant and young child health and nutrition that summarizes those recommendations which, following systematic review, reflect proven actions that need to be taken to scale within the health sector.

## Background on Essential Nutrition Actions (ENA) Framework


The **Essential Nutrition Actions (ENA) framework** was originally developed with the support of USAID, WHO and UNICEF, and has been implemented across Africa and Asia since 1997.[3] **The full ENA framework** is an approach for managing the **advocacy, planning and delivery** of an integrated package of interventions to **reach near universal coverage** (>90%) in order to achieve public health impact. It promotes a "nutrition through the life cycle" approach to deliver the right services and messages **to the right person at the right time** using all relevant program platforms. It provides an **operational framework** for reducing "missed opportunities" both within[4] and outside the health system for delivering nutrition messages and services. Its proven interventions and partnership strategies are also the foundation for Scaling Up Nutrition and the REACH Partnership.

The recommended practices are multiple and potentially complex. However, over years of experience the program has evolved to distill the most important and practical aspects, and to **organize delivery mechanisms** that refresh and reinforce the knowledge of implementers. In addition, in each setting users can select priority elements from the full package for their context, and/or phase in components over time to avoid overloading health agents, community volunteers and other cadres helping to roll out nutrition strategies.

Tools and guidance have been developed to support implementation of the ENA framework, including key message booklets, training programs, and assessment tools, which are open-source for use wherever they are needed. A selection of these are described below.

# The Essential Nutrition Actions

Among the training tools available is a module designed for managers, the "ENA State of the Art Training." This module is targeted for decision makers and designed to persuade them of the enormous impact nutrition interventions can have on national health and economic development. It also seeks to build consensus among participants about the high returns to investments in nutrition and the further gains from scaling up such programs. The curriculum also reviews tested approaches for delivering the specific ENA as an integrated package. There is also a trilogy of materials to guide the implementation of this package within the health system and at community level. The trilogy includes a key messages booklet and two practical training guides, one designed for health workers and a second designed for community volunteers. The integrated package as the Essential Nutrition Actions includes:

1. **Womens' Nutrition**
    - **For adolescents and women:** the importance of the healthy timing and spacing of pregnancy, consumption of diversified diet and/or of fortified foods (commercial and/or in-home fortification).
    - **During pregnancy and lactation:** increased protein, caloric and micronutrients (Vitamin A, Iron, Zinc) intake, dietary change to increase iron absorption, rest during pregnancy, and the lactation amenorrhea method (LAM) of contraception..
2. **Breastfeeding** during the first 6 months of life: early initiation of breastfeeding (immediately after birth) and exclusive breastfeeding for the first 6 months, and infant feeding in the context of HIV.
3. **Complementary feeding** from 6 months (appropriate quality, frequency, diversity) with continued breastfeeding for up to two years and beyond, consumption of fortified foods (commercial and/or in-home fortification), responsive feeding, food hygiene, and recommendations for HIV positive children and children of HIV positive mothers who are unable to breastfeed;
4. **Nutritional care of sick and malnourished children:** kangaroo mother care for low birth weight infants, feeding more during and after illness, provision of vitamin A and treatment of diarrhea with low-osmolarity ORS and zinc supplements, integration of all aspects of the community-based management of acute malnutrition (CMAM) for treatment of moderate and severe acute malnutrition.
5. **Prevention and control of anemia:**
    - **Among women:** increased dietary intake of iron-rich or enhancing foods, iron-folic acid supplementation during pregnancy, post-partum and more routinely by women of childbearing age, intermittent preventive treatment (IPT) for malaria and de-worming treatment during pregnancy, use of insecticide-treated bed nets (ITNs), and delayed cord clamping at birth.
    - **Among children:** delayed cord clamping at birth, implementation of the Integrated Management of Childhood Illness (IMCI) algorithm and integrated Community Case Management (iCCM) of malaria, diarrhea, pneumonia, anemia and acute malnutrition, use of ITNs, de-worming from age 12 months, increased dietary intake of iron-rich or enhancing foods from age 6 months, and iron supplementation where indicated.
6. **Prevention and control of vitamin A deficiency** through breastfeeding, high dose supplementation of children ages 6-59 months and of women post-partum where appropriate, low dose supplementation during pregnancy where indicated.
7. **Prevention and control of iodine deficiency** through promotion of iodized salt or through supplementation in the absence of scaled up iodized salt program.

In addition, mounting evidence suggests it is necessary to give more separate attention to the **Essential Hygiene Actions**, which were previously embedded within complementary feeding and feeding the sick child. These actions include: promotion of safe drinking water (such as chlorine dispensers at water points), hand washing at five critical occasions (after defecation; after cleaning child who has defecated; before preparing food; before feeding child; before eating), safe disposal of feces, safe storage and handling of food, use of latrines and promotion of open defecation free communities, and creating barriers between toddlers and soiled environments and animal feces.

# The framework to integrate, communicate and harmonize

The ENA Framework includes ensuring that priority messages and services from this comprehensive list are integrated into all existing health sector programs, in particular those that reach mothers and children at critical contact points in the life cycle: maternal health and prenatal care; delivery and neonatal care; postpartum care; family planning; immunizations; well child visits (including growth monitoring, promotion and counseling); sick child visits (including facility and community IMCI and CCM); and CMAM treatment.

The appropriate messages and services are also integrated to the greatest extent possible into programs **outside the health sector**: agriculture and food security contacts; education (pre-service for health, primary and secondary schools for general education) and literacy programs; microcredit and livelihoods enhancement. ENA messages and behavior change communications are also delivered by **community groups.**

Implementing the ENA framework entails building the widest possible network of partnerships across sectors so that interventions, practices and messages are harmonized and all groups use similar materials and jobs aids. Ideally, ministries and partners are brought together at the regional and/or national levels to agree on these harmonized approaches. Such fora can also serve as a platform for **advocacy** with policy leaders on the importance of nutrition to the nation's economic as well as social development.

**Multi-channel social and behavior change communication** (SBCC) techniques are used to promote adoption of "small do-able" actions. Special emphasis is given to **interpersonal counseling** (supporting individual mothers, especially in the context of their daily routines, to adopt optimal practices) reinforced by mass media, community festivals and other social mobilization events. Health agents, other agents, and community volunteers are trained to employ "negotiations for behavior change," with volunteers visiting mothers in their households or community meeting places (markets, chores, women groups meetings, etc.) and helping them anticipate and overcome barriers to carrying out new practices.

While the content of the messages and modules remains generally fixed, the approach for communicating the rationale and benefits of the practices may need to be adapted through **formative research or testing of the messages** to ensure they fit specific country and regional cultures and contexts. Such research will identify key behavioral determinants to be addressed, local terms and social norms to be taken into account, and other strategies to tailor the general training modules and communications strategies to the specific needs of each unique area.

The capacity of health agents and community volunteers for promoting the essential nutrition actions using negotiations for behavior change is strengthened by using) the "generic" **training modules**, appropriately adapted, as part of the trilogy, which incorporate sessions to introduce, role play and then employ these skills with actual mothers.

Once materials have been adapted, cascade training is most often used to introduce the ENA framework into a new setting. In summary, one or two seasoned trainers conduct an initial training of trainers (of approximately 10 days) to teach both the content of ENA and adult training techniques. Next these master trainers, with some supervision by the original trainer(s), train all relevant health workers (with each training session approximately 5 days in length). Health workers supervised by the master trainers then train community volunteers (over at least 3 days). All training includes considerable role plays as well as field visits to practice the techniques in counseling and negotiating for behavior change. Refresher trainings and supportive supervision are often needed to reinforce both new knowledge and skills.

# Reference Documents

Broad scale ENA programs were successfully implemented by the USAID-funded LINKAGES Project (1996-2006). Documents from that project can still be found on the project website. In the years since the project ended, ENA has been adapted in many countries often as part of an integrated child health and/or multisectoral strategies. In addition, the following resources may be useful.

**Lancet References (2008 -2013)**
Lancet Series on Maternal and Child Undernutrition (2008)
Lancet Series on Maternal and Child Nutrition (2013)

**WHO References (2013)**
WHO Essential Nutrition Actions Guide

**Adaptable Versions of Trilogy of ENA Training Materials (English & French, 2011)**
ENA Trilogy
I. ENA Key Messages
II A. ENA Framework Training Guide for Health Workers
II B. ENA Framework Health Worker Handout
III. ENA Framework Training Guide for Community Volunteers

**ENA State of the Art Training for Managers (English & French, 2006)**
Includes nine modules on rational for the essential nutrition actions and large scale implementation

**Technical Capacity Assessment tools (JSI, 2013)**
These tools are designed to help an organization assess its ability to implement various nutrition programs, looking holistically at personnel, documents, and systems in place at the organizational and implementing partner levels.
Nutrition: Essential Nutrition Actions Framework within the Health system
Nutrition: Community-based Management of Acute Malnutrition
Nutrition: Essential Nutrition Actions Framework within the context of HIV & AIDS

**Quality Assessment of Nutrition Services (HKI)**
Surveying Nutrition-Related Services Offered to Pregnant Women, Postpartum Women, and Caregivers of Children Under Five in Health Facilities

**Supportive Supervision tools**
Quality Improvement Verification Checklists
Partnership Defined Quality (Save the Children)
Integrated MNCH Supportive Supervision (JSI)
Supportive Supervision at key health contact points (JSI)

**Care Group Guidance for Community**
Care Group Difference: Guide to Mobilizing Community-Based Volunteer Health Educators (World Relief/CORE Group, 2004)
Training Manual for Program Design and Implementation (Food for the Hungry, 2013)

**Formative Research Tools**
ProPAN 2.0 (PAHO, CDC, 2013)/Optifoods
Focused Ethnographic Study Guide (GAIN, 2012)
Designing for Behavior Change (CORE Group & Food Security & Nutrition Network, 2013)

## References

1. Black, R. E., C. G. Victora, et al. (2013). "Maternal and child undernutrition and overweight in low-income and middle-income countries." The Lancet

2. Bhutta, Z. A., J. K. Das, et al. (2013). "Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?" Lancet.

3. Guyon AB, Quinn VQ, Hainsworth M, Ravonimanantsoa P, Ravelojoana V, Rambeloson Z, and Martin L. (2009) Implementing an integrated nutrition package at large scale in Madagascar: The Essential Nutrition Actions Framework. Food Nutr Bull 30(3):233-44.

4. Hampshire, R. D., V. M. Aguayo, et al. (2004). "Delivery of nutrition services in health systems in sub-Saharan Africa: opportunities in Burkina Faso, Mozambique and Niger." Public Health Nutr 7(8): 1047-1053.

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