



MATERNAL, INFANT, AND YOUNG CHILD NUTRITION IN KENYA

FORMATIVE RESEARCH SUMMARY REPORT

ENRICH

ENHANCING NUTRITION SERVICES TO
IMPROVE MATERNAL AND CHILD HEALTH

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BACKGROUND

The Enhancing Nutrition Services to Improve Maternal and Child Health (ENRICH) initiative in Elgeyo Marakwet County, Kenya aims to improve overall maternal, infant, and young child nutrition (MIYCN) and health outcomes. ENRICH works through nutrition-specific and nutrition-sensitive interventions to reduce malnutrition in the first 1,000 days of life—from conception to 23 months of age. Promoting increased consumption of nutritious foods and micronutrient supplements are essential practices at the household level and central to ENRICH success.

Kenya has made considerable progress in the status of many health indicators, yet undernutrition remains a serious problem for women and children. In 2016, ENRICH conducted a baseline study¹ in Elgeyo

Marakwet County, which provided context for the formative research study. The baseline study yielded informative results, including:

- **Infants and children:** High levels of stunting and underweight, as well as sub-optimal feeding practices—particularly for aspects of complementary feeding; micronutrient powder (MNP) sachets had not yet reached the area (**Tables 1, 2**). Exclusive breastfeeding (EBF) of children under six months reached only 42.5% and requires continued attention.
- **Mothers of children <2 years:** Sub-optimal dietary practices and low iron and folic supplement (IFA) consumption during pregnancy (**Table 2**).

TABLE 1. NUTRITIONAL STATUS OF CHILDREN FROM THE BASELINE ENRICH SURVEY

CHILDREN < 5 YEARS	
33% Stunted (height for age)	17.8% Underweight (weight for age)

TABLE 2: SELECT FEEDING/DIETARY PRACTICES FROM THE BASELINE ENRICH SURVEY

CHILDREN 6 MONTHS – 2 YEARS OLD	MOTHERS OF CHILDREN < 2 YEARS OLD
Minimum dietary diversity = 27.2%	Minimum dietary diversity = 27.8%
Minimum meal frequency = 79.4%	Consumed >= 4 meals/day in last pregnancy = 18.2%
Minimum acceptable diet = 23%	>90 IFA consumption in last pregnancy = 4.3%

STUDY DESIGN AND PURPOSE

Formative research conducted in Elgeyo Marakwet County between December 2017 and January 2018 was designed to better understand the current MIYCN practices from multiple perspectives.

Specifically, the research explored:

- Current household IYC feeding and dietary practices of pregnant and lactating women with an emphasis on barriers and opportunities within households and communities;
- Current practices and counseling related to nutrition within the health system—including health facility workers (HFW) and community health volunteers (CHV); and
- Feasibility and acceptability of several practices in household trials (HHT).

The formative research aimed to identify priority behaviours and key messages aligned with improving consumption of nutritious foods and micronutrient supplements by women and IYC, as well as to identify opportunities within the local context to promote these behaviours. These results have informed the development of a behaviour change intervention (BCI) strategy for ENRICH.

Household trials (HHT), also known as trials of improved practices (TIPs), is a participatory research method used to pre-test practices or behaviors with a selected number of respondents before introducing it more widely. This provides insight into the barriers and enabling factors participants experience for adopting a new practice, allowing a potential intervention to be refined.

FIGURE 1. ELGEYO MARAKWET COUNTY, KENYA



Site selection for the formative research included eight villages across all four sub-counties of Elgeyo Marakwet County—Marakwet East, Marakwet West, North Keiyo and South Keiyo (ENRICH project areas), which represent the region’s three ecological zones and maximize sample diversity (**Figure 1**). A variety of qualitative methods engaged multiple respondents to explore topics and provided rich data to triangulate across methods and type of respondent (**Table 3**). After the initial analysis of the formative research results, HHT tested the feasibility and acceptability of several proposed behaviours for IYC.

TABLE 3. METHODS AND RESPONDENTS/DATA SOURCE

DATA COLLECTION METHOD	RESPONDENTS/DATA SOURCE
Free-listing of foods available and consumed locally	Community key informants
Market survey of local nutrient rich foods available and accessible	Community markets
Food attributes exercises of the perceptions of foods, barriers and opportunities for consumption	Pregnant women; Caregivers of IYC
In-depth interviews including photo-projective exercises* about healthy pregnancy/IYC, dietary/feeding practices, influential household members and interactions with health workers and home food stock	Pregnant women; Lactating women; Caregivers of IYC; Fathers
Qualitative dietary recall	Pregnant women; Lactating women; Caregivers of IYC
Home observation of feeding main meal	Caregivers of IYC
In-depth interviews about service provision and counseling, and nutritional problems encountered	Health facility workers; Community health volunteers
Health facility observations of the interactions between health facility workers and women/caregivers	Antenatal and IYC services
Exit interviews when leaving the health facility	Pregnant women; Caregivers of IYC
Household trials to test the feasibility and acceptability of identified behaviours/practices	Caregivers of IYC

*A caregiver selects a photo of a woman or child and provides a narrative on health, diet, feeding, care, etc.





FINDINGS

Results from the formative research highlight important insights obtained on access, availability and attributes of local nutritious foods, nutrition of pregnant and lactating women, and IYC nutrition. Dietary/feeding practices and micronutrient consumption are addressed, as well as the role of health services and family influences on maternal and IYC nutrition.

Availability, access and attributes of nutritious foods

A diverse selection of foods was available in the larger Elgeyo Marakwet County markets, which families visit on a weekly basis, and included animal source foods (ASF), vitamin A rich fruits and vegetables, pulses and other foods. Seasonality was found to affect the availability and price of a number of foods during the dry season, in particular, some of the fruits and vegetables. In addition to the wide availability of eggs in the markets, many community members rear chickens providing easy access to eggs. However, families often preferred to sell eggs for income versus consume them at home. Other ASF were available (beef, offal, chicken, fish), but were considered more costly—especially fish. The ENRICH project planned to introduce biofortified foods, including orange flesh sweet potatoes (OFSP) and iron fortified beans; however, these were not yet available in the markets.

Pregnant and lactating women and caregivers of IYC described mainly positive attributes for nutritious foods such as ASF, milk, fruits, vegetables and pulses. Eggs were the exception being associated with excessive fetal growth when consumed during pregnancy. Positive comments about foods for both women and children demonstrated use of “nutritional language” with mentions of vitamins, proteins and energy as well as strengthening blood (iron) and bones. Specific positive and negative attributes for eggs are provided in **Table 4**. Groundnuts, while considered a good “energy” food, were associated with excessive fetal growth if eaten in too large a quantity.

For children specifically, a few negative attributes of foods were mentioned, often associated with preparation. For example, milk needed boiling to avoid illness, foods required mashing to avoid choking, and groundnuts required children to chew. Feeding too much of certain foods could result in upsetting the child's digestion.

TABLE 4. PERCEIVED ATTRIBUTES OF EGGS FOR PREGNANT AND LACTATING WOMEN AND IYC

ANIMAL SOURCE FOOD	PERCEIVED POSITIVE ATTRIBUTES	PERCEIVED NEGATIVE ATTRIBUTES
Egg (chicken's egg)	<ul style="list-style-type: none"> • Body building food • Energy giving food • Strengthen bones (child) • Rich in protein (child) 	<ul style="list-style-type: none"> • Will increase the size of unborn child resulting in an abnormally large baby and c-section delivery • High levels of proteins, which may cause palpitations and fainting (pregnancy) • Child cannot consume a lot; can affect digestive system and cause constipation or diarrhoea (child)

Positive attributes were equated with the readily available vitamin A rich vegetables and fruits including their ability to affect health and appetite for both women and IYC (**Table 5**). Caregivers felt that it was appropriate to start feeding IYC these foods around four months of age. While seasonal availability was the only perceived negative attribute identified for women, several others were mentioned for children. This demonstrates the importance of careful selection, preparation and quantity of these foods for children.

TABLE 5. PERCEIVED ATTRIBUTES OF SELECT VITAMIN A RICH FOODS FOR PREGNANT AND LACTATING WOMEN, AND IYC

VITAMIN A RICH FOOD	PERCEIVED POSITIVE ATTRIBUTES	PERCEIVED NEGATIVE ATTRIBUTES
Leafy greens	<ul style="list-style-type: none"> • Body building foods • Increase the blood levels, rich in vitamin A • Give appetite • Vitamins boost immune system (child) 	<ul style="list-style-type: none"> • Only in "plenty" during rainy season • Some are bitter (child) • Some are acidic and rough (child) • Stomach aches if too much eaten (child)
Fruits/Vegetables (e.g. mango, papaya, pumpkin, butternut, carrot)	<ul style="list-style-type: none"> • Helps vision, enhances health • Rich in vitamins • Sweet • Filling (child) • Can eat raw (child); Carrots soothe irritable gums during teething (child) • Cleans the stomach (child) 	<ul style="list-style-type: none"> • Diarrhoea or constipation if too much consumed (child) • Fibre can stick on teeth (child)

Results from both the market survey and attributes exercise provide important local insights on foods—including local preparations—as well as words to emphasize and associate with these foods in BCI messaging, and they offer a range of possibilities to improve dietary diversity.

The WHO recommends introduction of complementary (solid) foods at 6 months together with continued breastfeeding up to 2 years of age or beyond.



Maternal diet during pregnancy

During pregnancy, women aspired to eat balanced meals, attend antenatal care (ANC) clinics as recommended, to rest and have peace of mind. Partners wanted to take good care of their wives until delivery. Several characteristics were associated with a healthy pregnant woman included good nutrition (IFA supplementation, balanced diet), hygiene (clean clothes and smooth complexion), social interactions (peer admiration, to be smartly dressed) and family support (feeding the child, household chores). Key concerns included stress caused by not eating well and feeling overworked.

Women demonstrated knowledge of a variety of healthy foods. In particular, ASF such as eggs, beef, fish, chicken were associated with positive comments such as “energy giving” and “body building” although some were also associated with high expense. However, actual practice demonstrated few women consumed ASF and none reported eating eggs in the previous day—likely influenced by the cultural taboo described earlier. Almost all women

consumed milk as it is readily available to most in the area; however, milk was usually mixed with caffeinated tea to drink. In contrast, vitamin A rich foods, mainly varieties of leafy green vegetables, were consumed by the majority although consistent consumption in the past week required improvement. Only half of the women consumed beans or pulses 2-3 times and most women did not consume fruit, yet those that did demonstrated the local availability of different fruits.

The majority of pregnant women consumed less than four meals per day, falling short of the recommended frequency. Yet, positive comments about consuming at least four daily meals during pregnancy included strength for the woman and benefits for the child. Barriers included financial constraints as well as the concern that consuming four or more meals in a day would result in becoming overweight, or that the recommended frequency only applied to women who were underweight in pregnancy. As one pregnant woman commented:



...a pregnant woman should eat about thrice or four times in a day because less would not benefit her and the child. Over eating would also lead to being overweight...

pregnant woman, Keiyo North

These concerns are informative in light of the existence of under- and overweight women and suggest a need to discuss practices that lead to healthy weight gain during pregnancy. Knowledge of nutritious foods and their link to good outcomes did not result in actual consumption of diverse nutritious foods. HFWs and CHVs agreed; they reported that lack of food diversity and poverty were the main problems encountered during pregnancy leading to “unbalanced meals.” Translating women’s knowledge/perceptions into doable home practices consistent with dietary diversity is needed.

Consumption of Iron and Folic Acid supplements

Consuming IFA supplements during pregnancy represents a known behaviour with generally positive attributes by pregnant women and their partners. IFA is perceived as a source of iron, which “increases blood,” enhances appetite and supports the healthy development of the unborn child. Nonetheless, about half of pregnant women interviewed had not consumed any IFA in the past week, consistent with the critically low percentage found in the ENRICH baseline survey. Women mentioned side effects from consuming IFA including stomach-aches and nausea. Inconsistent attendance or starting ANC visits late in pregnancy represented another barrier, as IFA was provided in increments throughout pregnancy. Observations at the health facility revealed that health workers gave IFA to women with encouragement to consume, but without specific comment on how to avoid side effects.

Daily oral iron and folic acid supplementation with 30-60 mg of elemental iron and 400 µg folic acid is recommended for pregnant women to prevent maternal anaemia, puerperal sepsis, low birth weight, preterm birth, and neural tube defects.³

These findings provide insights for promoting IFA consumption including discussion of side effects, promoting attendance at ANC clinics, and stressing positive attributes. Consumption during lactation needs renewed attention to follow the government’s recommended guidelines.

Maternal diet during lactation

During lactation, food restrictions no longer applied (e.g. limiting eggs and groundnuts). The importance of consuming nutritious foods 4-5 times daily was voiced and associated with “giving energy,” “building the body” and “increasing appetite”; all important for a healthy state to produce milk and breastfeed. ASF, milk and pulses were specific foods associated with breastmilk production and quality of milk. As one woman stated about ASF:



...it [ASF] is good because once you eat, the child will also get it through breastfeeding.

pregnant woman, Keiyo North

Nonetheless, qualitative recall data from interviews demonstrated limited consumption of diverse nutritious foods—including those linked to increased breastmilk production. Interestingly, mothers responded they would increase consumption of specific foods if advised by a health worker.

Compared to pregnant women, meal frequency (four or more meals) was better among the lactating women interviewed, yet often fell short. This represents an opportunity to build upon—to increase consumption of the diverse foods perceived as giving energy and helping milk production through an extra meal. As insufficient breastmilk is a frequent complaint and leads to early introduction of complementary foods, emphasis on the lactating mothers’ diet, which is perceived as vital for breastmilk production, remains essential. Support from family to reduce workload and allow mothers time to breastfeed is also needed.

Role of family

Grandmothers (mothers-in-law) were named as most influential during pregnancy, providing advice on the need to eat, frequency of meals, consuming balanced meals, and avoiding certain foods. Husbands also advise on diet, provide food and other necessities (e.g. clothing, mosquito nets) and accompany women to ANC visits. During lactation, the important role of family members continues although with some competing messages. Husbands were more aligned with providing advice on EBF, while grandmothers tended to provide advice on the use of traditional herbs to clean the baby's digestive tract and stomach—demonstrating how traditional and current practices are intertwined. Family members play an important role in supporting pregnancy and lactation; a role that is a useful target for intervention and education to improve MIYCN and health.

Nutrition for IYC

All parents expressed high aspirations for their child's future—equally for boys and girls—centered on educational achievement and professional employment, good health and a moral character. Essential elements to attain these aspirations included good health and a healthy diet for the child. Perceptions of healthy growth included descriptions of weight gain, a playful child (indicating physical, social/emotional health) and achieving developmental milestones. Behaviours associated with healthy growth included EBF and offering the child a balanced diet, as well as good hygiene.

Breastfeeding

EBF was challenged by beliefs that herbs help prevent colic in children younger than six months, often reinforced by influential grandmothers. As mentioned above, lactating mothers often perceive their breastmilk insufficient to satisfy the child, and introduce complementary foods early, typically around four months. Nonetheless, the message to exclusively breastfeed up to six months was known by parents, and consistent with

advice given by HFWs and most CHWs. In Keiyo North, alcohol consumption among breastfeeding mothers was problematic and hindered breastfeeding.

During observations, mothers appeared overwhelmed with household duties, such that many did not pay attention to the child during breastfeeding. This is at odds with the image described by mothers of a healthy breastfeeding mother—one that smiles, looks strong and has peace of mind. The perception of a good diet with diverse foods for lactating mothers to adequately breastfeed was not matched in practice.

Among those interviewed, almost all mothers continued breastfeeding after six months, which is consistent with the ENRICH baseline survey results. Nonetheless, HFWs expressed concerns about experiences with early weaning from breastfeeding.



Complementary feeding

Dietary diversity

While parents readily discuss the benefits of a nutritious and diverse diet for IYC and can list a number of nutritious foods equated with such a diet and their benefits (e.g. “rich in vitamins, “energy giving,” “body building”), actual feeding practices differed considerably. A monotonous diet was commonplace, with frequent feeding of staple foods such as maize porridge or ugali and limited diversity. Often, food was removed from the family pot and prepared by mashing or adding milk or broth. The consistency of the prepared cereals and tubers was most often thin (lacking density). Handwashing before meal preparation occurred in most households observed. Breastfeeding usually occurred after feeding, although in some cases before the meal began, likely reducing the child’s appetite.

The WHO recommends avoid giving IYC drinks with low nutrient value such as tea, coffee, and sugary drinks to avoid displacing more nutrient-rich foods.⁴

From the qualitative dietary recall, nutritious foods such as eggs, bananas, papayas, beans, and tomatoes were recorded, but infrequently and for only a few children. For some ASF, caregivers were more likely to feed children broth made from the ASF versus actual meat due to concerns about choking. Preparation techniques such as shredding meat to avert these concerns were not observed. The worry about choking extended to some fruits and tubers as well. Milk was commonly fed, alone or mixed with tea. While most foods were thought appropriate to feed from a young age, groundnuts were the exception, fed from 18 months due to “high levels of protein” and the need to chew them.

Meal practices and responsive feeding

Meal practices commonly included feeding the child first from their own plate and spoon (separate from others), before other family members although in some cases, children ate with the family. Caregivers assisted younger children in eating, but little supervision was given to older children who could feed themselves. Most mothers were overwhelmed

with household duties in addition to feeding. However, a few women were observed to pause their work and fully attend to the child, which resulted in completing the meal faster and contentment on behalf of the mother. Caregiver-child interactions ranged from singing and talking to encourage eating, to ignoring or force-feeding.

Among household members, fathers exerted the most influence in terms of feeding and caring for the child. They provided food for the family, money for health facility visits and played with the child. Grandmothers played a key role by providing advice on feeding IYC.

The WHO recommends practicing responsive feeding (feeding slowly and patiently, encouraging children eat but not forcing them, talking to the child, and maintaining eye contact).²

Use of micronutrient powders

None of the children had consumed MNPs, and according to health workers, MNP packets were not available in the health facilities.

Overall, complementary feeding practices demonstrate a number of opportunities for intervention to improve diet quality by building on parental knowledge and aspirations for their children. It is essential to identify doable actions defined for the home to improve dietary diversity through local foods, encourage responsive feeding, and to introduce MNPs successfully. Promoting EBF in the first six months requires careful attention to both the lactating mother and child.

Household trials for IYCs

Based on initial findings from the formative research analysis, three practices for IYC were identified to test using HHT over three days. Findings showed that all caregivers recalled the three practices (except one who did not remember MNPs), most complied with the practices (one was unable due to financial constraints) and all intended to continue them. Modifications to the practice were unnecessary. HHT provided encouraging results—practices were acceptable by caregivers and IYC, with immediate and long-term benefits voiced by caregivers, and feasible to implement. See **Table 6** for findings from each practice.

A healthy diet during pregnancy contains adequate energy, protein, vitamins and minerals, obtained through the consumption of a variety of foods, including green and orange vegetables, meat, fish, beans, nuts, pasteurized dairy products and fruit.⁶

TABLE 6. HHT FOR IYC FINDINGS

HHT PRACTICE	NUMBER OF CAREGIVERS WHO IMPLEMENTED	FINDINGS
Add ASF to your child's meal	10 of 11	<ul style="list-style-type: none"> HHT Practice Add ASF to your child's meal Feed vitamin A rich foods to your child Add MNPs to your child's food every 3 days
Feed vitamin A rich foods to your child	10 of 11	<ul style="list-style-type: none"> Caregivers varied in giving vegetables, fruits or both. Advice to cut vegetables in small pieces or mash fruits was useful. Many benefits were perceived and the practice was easy to implement.
Add MNPs to your child's food every 3 days	11 of 11	<ul style="list-style-type: none"> MNP packets were easy to add to food; caregivers mixed with different preparations: mashed banana, mashed potatoes, ugali and porridge. Caregivers informed husbands to gain their support, an important finding in line with the influence fathers had in the home. Immediate benefits such as "helps the child's appetite" and the "child was happy and played a lot" were voiced as well as the long-term positive effects for growth and intelligence. One caregiver noted the child's stool turned black. Discussing possible side effects of MNPs is essential with counseling.

Health services

The current practice of ANC visits amongst the majority of pregnant women includes a late start and making fewer visits than recommended. Lack of financial resources for transportation costs stands as the main barrier. The husband is a key influencer as he provides money for these visits.

The WHO recommends a minimum of eight antenatal care contacts to reduce perinatal mortality and improve women's experience of care.⁶

Pregnant women's satisfaction with ANC visits was primarily equated with short waiting times versus the content of the visit. Yet, health workers were considered trusted and important sources of information (Table 7).

During ANC visits, most pregnant women were weighed, although explanation of weight gain varied. Many women were provided with some counseling, often related to the types of foods to consume, for example, "foods rich in proteins," or "green leafy vegetables." Advice was inconsistent across HFWs and did not include information on breastfeeding. HFWs treated women with respect, although communication was generally one-directional, from HFW to the woman. Some pregnant women had received a home visit by a CHV, but the majority had not. For those who did, they appreciated the nutritional advice and tried to implement it.

TABLE 7. INFORMATION SOURCES AND INFLUENCE ON MIYCN

- **HFWs and CHVs were cited as the main, trusted source of MIYCN (particularly HFWs)**
- **Grandmothers, husbands and other family (aunties) are influential in the household**
- **Media platforms including TV and radio programs provide information**
- **Sensitization programs in schools provide information**

Observations of IYC health services revealed busy, under-resourced health workers providing care for illnesses and conducting well child visits. When interviewed, HFWs were knowledgeable about ideal practices, but did not mention nutrition counseling as part of their role. During visits, IYC were often weighed but length measurements were not taken. Some health facilities lacked anthropometry equipment. Nutrition advice was sometimes given to caregivers; the content varied from general statements on feeding to a list of specific foods to give IYC. While HFWs greeted caregivers and were respectful of them, counseling practices and communication were found to be sub-optimal. During exit interviews, one caregiver described the advice received from HFW, which captures the need for capacity building to make the most of these interactions:



...to give broth/porridge, proteins, mashed fruits

caregiver of IYC

The WHO recommends that weight and length measured and recorded whenever an infant or child visits a health care provider.⁷

CHVs provide outreach to the households in the communities they serve and are to provide counseling on breastfeeding and hygiene, vaccination and general advice on complementary feeding. However, in reality, CHV visits were infrequent. Yet HFWs and CHVs remain trusted sources of information. Capacity building to improve nutrition knowledge of CHVs and to strengthen context specific counseling with doable priority behaviours for both HFWs and CHVs has real potential to improve MIYCN. Emphasizing home visits by CHVs in addition to health facility visits reinforces counseling. Involving grandmothers and fathers in counseling can serve to leverage their influence on MIYCN in the home.

CONCLUSION AND KEY MESSAGES

Formative research and HHT led to a better understanding of the current MIYCN practices within the local context of Elgeyo Marakwet County and identified many opportunities for improving MIYCN at the household level. Engaging pregnant and lactating women, caregivers and families has great potential for influencing improved MIYCN. Healthcare workers require capacity building to take on a greater role in MIYCN counseling. Recommendations to improve MIYCN include the following behaviours/practices:

PREGNANT WOMEN

- Eat a diverse diet with balanced quantities of different food groups including ASF (e.g. eggs), green and orange vegetables, beans, nuts and fruits
- Eat at least 4 meals plus 1 snack daily
- Consume daily IFAs; attend ANC visits to obtain IFA

LACTATING MOTHERS

- Exclusive breastfeeding (EBF) until 6 months
- Give your attention to the child when breastfeeding
- Eat a diverse diet with balanced quantities of different food groups, including ASF, green and orange vegetables, beans, nuts and fruits
- Eat at least 4 meals plus 1 snack daily
- Consume IFAs daily for 6 weeks; attend postnatal care to obtain

INFANTS AND YOUNG CHILDREN

- Feed your baby a diverse diet with balanced quantities of different food groups including ASF, green and orange vegetables, beans, nuts and fruits for a balanced diet
- Fortify your child's food with MNPs
- Ensure your child's food is of the right consistency
- Handwash at critical moments

HUSBANDS/FATHERS

- Support your wife in attending clinic visits
- Reduce your wife's workload
- Feed children nutritious foods grown in the kitchen garden

To position these priority behaviours, the ENRICH research team identified important guiding principles reflective of the formative research findings as follows:

- Focus on the benefits to provide motivation for engaging in priority behaviours
- Husbands/fathers are key influencers in the home—recognize and support their involvement; grandmothers are also influential—garner their support for priority behaviours
- Identify key messages to focus and unify the BCI strategy, improve coverage and exposure
- Make BCI activities and learning enjoyable using songs, dance, games and engagement
- Build practical skills such as how to prepare food for IYC to promote priority behaviours
- Promote accessible foods—local, affordable, already in homes, and consider seasonality
- MNPs are new—build trust with caregivers and health workers to facilitate IYC consumption; encourage mothers, HFWs and CHVs to taste MNPs mixed with mashed banana
- Optimize use of HFWs and CHVs, as they are trusted sources of information on MIYCN

REFERENCES

- University of Toronto. (2017). Enhancing Nutrition Services to Improve Maternal and Child Health in Africa and Asia (ENRICH) Baseline Study Report KENYA.
- World Health Organization. (2020). Infant and Young Child Feeding. Available at: <https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding>
- World Health Organization e-Library of Evidence for Nutrition Actions (eLENA). Daily iron and folic acid supplementation during pregnancy. Available at https://www.who.int/elena/titles/guidance_summaries/daily_iron_pregnancy/en/
- Pan American Health Organization and World Health Organization. (2003). Guiding principles for complementary feeding of the breastfed child. Available at: https://www.who.int/nutrition/publications/guiding_principles_compfeeding_breastfed.pdf
- World Health Organization e-Library of Evidence for Nutrition Actions (eLENA). Nutrition Counseling during pregnancy. Available at: https://www.who.int/elena/titles/nutrition_counselling_pregnancy/en/
- The WHO Reproductive Health Library; Geneva: World Health Organization. World Health Organization. (2018). Available at: <https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-antenatal-care-contact-schedules>
- World Health Organization. Training Course on Child Growth Assessment. Geneva, WHO, 2008. Available at: https://www.who.int/childgrowth/training/module_b_measuring_growth.pdf?ua=1