



MATERNAL, INFANT, AND YOUNG CHILD NUTRITION IN PAKISTAN

FORMATIVE RESEARCH SUMMARY REPORT

ENRICH

ENHANCING NUTRITION SERVICES TO
IMPROVE MATERNAL AND CHILD HEALTH

2019/20



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BACKGROUND

Pakistan aims to improve overall maternal, infant, and young child nutrition (MIYCN) and health outcomes in the Sukkur District, Sindh Province. Implementing nutrition-specific and nutrition-sensitive interventions to reduce malnutrition in the first 1,000 days of life—from conception to 23 months of age—remain central to this objective. Promoting increased consumption of nutritious foods and micronutrient supplements are essential practices at the household level.

The country has made slow progress in the status of national health indicators and undernutrition remains a serious public health problem for women and children. In 2017, the Enhancing Nutrition Services to Improve Maternal and Child Health (ENRICH) initiative conducted a baseline survey¹ in the Sukkur District of Sindh

Province to provide context for a formative research study. The baseline survey yielded informative results, including:

- **Infants and children:** High levels of stunting, underweight and wasting among IYC¹ and sub-optimal feeding practices—particularly for aspects of complementary feeding; micronutrient powder (MNP) sachets had not yet reached the area. Exclusive breastfeeding (EBF) of children under six months reached only 62.5% and requires continued attention. (**Tables 1, 2**).
- **Women:** Sub-optimal dietary practices and low iron and folic acid (IFA) supplement consumption during pregnancy (**Table 2**).

TABLE 1. NUTRITIONAL STATUS FROM THE BASELINE ENRICH SURVEY

CHILDREN <5 YEARS		
44.6% Stunted (height for age)	29.7% Underweight (weight for age)	10.2% Wasted (weight for height)

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

CHILDREN 6 MONTHS – 2 YEARS OLD	MOTHERS OF CHILDREN < 2 YEARS OLD
Dietary diversity = 19.2%	Minimum dietary diversity = 14.2%
Minimum meal frequency = 44.3%	Consumed ≥ 4 meals/day in last pregnancy = 83.6%
Minimum acceptable diet = 10.1%	>90 IFA consumption in last pregnancy = 0.8%

¹ Infants and young children (ages 0-23.9 months)

STUDY DESIGN AND PURPOSE

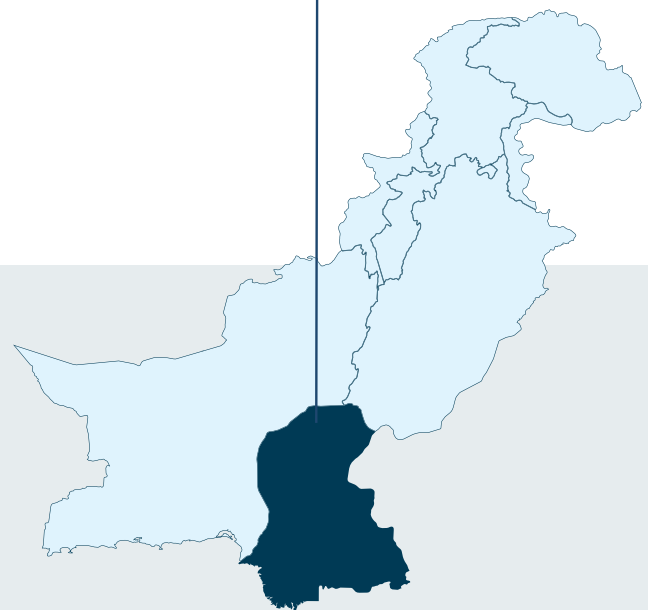
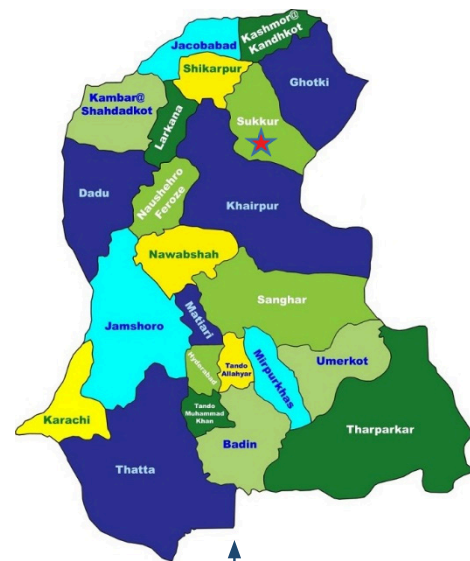
Formative research, conducted in the Sukkur district, Sindh Province in December 2017 was designed to better understand the current MIYCN practices from multiple perspectives. Specifically, the research explored:

- Current household IYC feeding and dietary practices of pregnant and lactating women with an emphasis on barriers and opportunities within households and communities;
- Current routines and counseling related to nutrition within the health system—including health facility workers (HFW) and community health workers (CHW); 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 the district.

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.

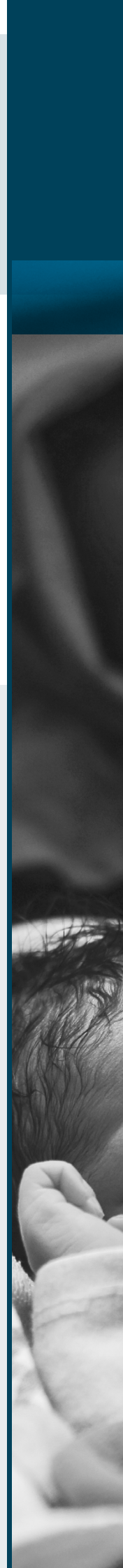
FIGURE 1. SUKKUR DISTRICT, SINDH PROVINCE, PAKISTAN



Site selection for the formative research included three *Talukas* of Sukkur District and within each Taluka, one Union Council (UC), which were purposively selected to represent the District's geographic and population/cultural diversity and maximize sample diversity (**Figure 1**). A variety of qualitative methods engaged multiple respondents to explore topics in detail and provided rich data to triangulate (**Table 3**). After the initial analysis of the formative research results, HHT tested the feasibility and acceptability of several proposed behaviours for IYC and pregnant women.

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	Caregivers of IYC
In-depth interviews with qualitative 24-hour dietary recall including topics of healthy pregnancy/IYC, dietary/feeding practices, influential household members and interactions with health workers	Pregnant women; Caregivers of IYC
In-depth interviews about service provision and counseling, and nutritional problems encountered	Health facility workers; Lady health workers
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 6-18 months; pregnant women





FINDINGS

Results from the formative research highlight important insights obtained on access and availability of local nutritious foods, nutrition for pregnant women and lactating mothers, 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 and access of nutritious foods

Results from market surveys revealed a selection of diverse nutritious foods available and considered “not costly”. Principal among affordable animal source foods (ASF) were eggs, which were also produced at home by some families. Other more costly options included chicken and fish, with chicken more available and usually cooked once weekly or once every two weeks by families. Milk offered another available “not costly” option. Affordable vitamin A rich vegetables and fruits included spinach, *saag* and mangos, but seasonality affected their availability and price. Oranges were affordable during high season. Lentils and carrots were widely available and affordable throughout the year. These foods provide the potential to diversify the diets of women and children. Biofortified foods were not yet found in the markets.

Poverty and nutrition perspectives

Across study sites, respondents mentioned poverty directly or indirectly as a pervasive barrier to improving the nutritional status of women and children. Poverty was linked to poor diet and lack of food diversity, insufficient food intake and inability to purchase and consume IFA. It also created perceptions that hindered the optimum use of available nutritious foods such as lentils—as they were perceived as being foods of the poor. For income, women worked long hours in the fields in addition to carrying out household duties. This limited time for meal preparation, rest during pregnancy, and breastfeeding. The perceptions of poverty stand as a challenge to change attitudes and behaviours for improved nutrition. Transforming poverty from a barrier to a target for improvement through an intervention strategy that addresses MIYCN appears critical.

Nutrition behaviours of pregnant women and lactating mothers

A healthy pregnancy was described by women to include physical signs as well as psychological aspects. Physical signs included “eyes without pallor”, “body not lean,” “glowing skin of the face,” and having the energy to carry out household chores without tiring or illness. Her demeanor would be “happy.” Similar descriptions occurred for a healthy lactating mother with the important additions of sufficient breastmilk and not experiencing dizziness. Diet was strongly linked to healthy pregnancy and lactation, including eating three meals daily, each of sufficient quantity. “Good food” and specifically meat, milk and fruits were all quoted as aspects of a healthy diet during this time. Strong food taboos were not mentioned. Taking IFA tablets, rest and regular antenatal care (ANC) visits were also deemed important.

While basic knowledge and positive attributes existed regarding nutritious foods to consume during pregnancy and lactation, actual practices stood in stark contrast. A monotonous diet of low quality and quantity defined their usual intake, with rice and wheat bread commonly eaten. Findings demonstrated that none of the respondents ate four or more times the previous day—instead most discussed a routine of eating two meals plus rusk and tea in the early morning. The main meal, often a potato curry served with rice, was prepared and eaten in the evening. No vitamin A rich foods or milk were consumed, but some mentioned drinking *lassi* (a drink made with a milk product base). A few consumed pulses two or three times in the past week. Encouragingly, ASF were consumed by most pregnant women the previous day, including eggs, chicken or beef. However, this was not true of lactating mothers and none of the pregnant or lactating women consumed ASF consistently during the previous week. Women did express an openness to eating more frequent meals and a more diverse diet, but poverty was mentioned as the barrier. The positive comments around ASF are reflected by this lactating mother:



Animal products are necessary. This is something that everyone knows. Even if we are illiterate, still we know that chicken and fish and egg and meat is needed for both pregnant and lactating women. We however are sick of eating potatoes. We wish we could eat fish in winters. Fish is hot food and gives energy to baby and mother.

lactating woman



Eating fruits such as mango and oranges depended on seasonality and expense. However, other vitamin A rich foods, such as carrots and papaya, were available but generally not consumed as they were considered outside the usual diet culturally. Lentils were common in these communities, yet few respondents had consumed them two to three times in the past week. One specific lentil was mentioned as beneficial for milk production (*masoor ki dal*). The awareness and generally positive responses about diverse foods provide real opportunities to improve diversity, frequency and overall maternal nutrition but must be defined as realistic doable behaviours in this context.

Consumption of Iron and Folic Acid supplements

Awareness of consuming IFA during pregnancy was high in the community. Benefits are known and include giving energy, making blood and inhibiting weakness. However, affordability stood as the main barrier to consuming IFA; free distribution through the health services was not mentioned. Yet, government protocols state that both antenatal clinics and lady health workers (LHW) provide IFA free of charge and thus the implementation of these protocols suggests a promising strategy to improve consumption.

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.²

Household trials for pregnant women

Based on initial findings from the formative research analysis, four recommended practices were identified to test in three HHT for pregnant women over the course of one week (see practices in **Table 4**). Each respondent was given several practices to try based on their current dietary pattern. Findings showed that all women recalled the recommended practices, most complied with the practice and all had the intention to continue the practice. **Table 4** shows the acceptability and feasibility of each practice tested. Families enjoyed eating egg with potato, and encouraged women to eat three meals per day. Leveraging family support to improve practices for pregnant women is critical and consistent with the role of their influence during pregnancy, specifically that of mothers-in-law and husbands. In addition, providing doable behaviours that are realistic to implement given the local context of poverty help women see that it is possible to improve their nutrition and health.

TABLE 5: FACILITATORS AND BARRIERS TO PRACTICES DURING HHT FOR PREGNANT AND LACTATING WOMEN

HOUSEHOLD TRIALS (HHT) FOR PREGNANT WOMEN		
PRACTICE	ACCEPTABILITY	FEASIBILITY
Mix egg and potato to eat three times a week	<ul style="list-style-type: none"> Highly acceptable “Tastes good”; “Gives energy, as good as chicken” Egg is a “hot” food but mixing with potato balances it Family members liked it 	<ul style="list-style-type: none"> Carried out 2-3 days in the week Affordable Easy to prepare
Eat snacks between 2 meals	<ul style="list-style-type: none"> Acceptable “Gives energy” Liked the idea of fruit as a snack 	<ul style="list-style-type: none"> Affordable to do 2-3 times a week
Eat 3 meals daily	<ul style="list-style-type: none"> Acceptable “Good feeling, lack of tiredness for the whole week” Family members encouraged practice 	<ul style="list-style-type: none"> Less affordable Difficult to cook lunch, but took leftovers from morning
Mix lentil and spinach to eat twice a week	<ul style="list-style-type: none"> Highly acceptable Tasty, increases consistency 	<ul style="list-style-type: none"> Affordable Easy to cook Spinach not easily available in summer

Nutrition for IYC

Caregivers aspired for male IYC to achieve educational success. This hope linked to overcoming poverty as well as bringing meaning to life. For female IYC, caregivers hoped for good fortune/luck in life generally and in married life specifically, as well as good health. Religious education was emphasized for female IYC. While these aspirations mirror the prevailing gendered roles found in these communities, they also reflect hope to escape the omnipresent state of poverty experienced.

Yet for others, a more pessimistic view of the future was conveyed. This underscores the need to identify doable nutrition practices, specific to this context, that are linked to overcoming poverty and achieving aspirations.

Growth

Across all sites and age groups, caregivers were cognizant of undernutrition and readily expressed physical signs of poor growth in their own children such as “physically weak according to his age,” “lean and weak” and “slow progress in height.” These signs were linked to insufficient food, poor eating, and lack of quality foods (e.g. fruit and meat). The underlying factors point back to poverty with a work burden that left insufficient time for child care. Yet, insufficient knowledge was also expressed and all mothers desired information to improve their child’s growth. LHWs similarly discussed children’s poor nutritional and health status, including anaemia and lack of “proper foods” as a cause. Although challenging, this context provides opportunities to build on the awareness of undernutrition, and the desire for improving IYC feeding and health.

Breastfeeding

Breastfeeding was a prevalent practice in these communities. However, exclusive breastfeeding (EBF) until six months remained challenged by pre-lacteal feedings of honey or ghutti and early introduction of complementary foods, commonly around four months.

Perceived insufficient milk supply was a common complaint leading to early introduction of other liquids and food. Long hours working in the fields and other demands on mothers' time also appeared influential in early introduction of other liquids and milk. Mothers reported receiving no counseling on breastfeeding during ANC visits nor during infrequent LHW home visits. The image and diet of a healthy breastfeeding mother described during interviews stood in stark contrast to mothers' current diet, workload and support received.

LHWs concurred with the current lack of breastfeeding advice during ANC visits. However, they discussed giving messages to pregnant women as part of their role, and included advice on not giving honey to newborns, EBF for six months and continued breastfeeding for two years, demonstrating knowledge of ideal breastfeeding practices. Building support for lactating women and breastfeeding practices is needed, but requires work through family, HFWs, LHWs and the community to address existing barriers.

The WHO recommends exclusive breastfeeding until 6 months at which point complementary (solid) foods are introduced, with continued breastfeeding up to 2 years of age or beyond.³



Complementary feeding

Children's diets lacked diversity with few children eating ASF and no children eating vitamin A rich foods. Staple foods such as potatoes or rice were common and thick consistency lentils were often added. Milk was given to some children. Continued breastfeeding was practiced by most but not all mothers interviewed. While caregivers associated positive attributes with ASF such as energy and growth, they were considered expensive and some (beef and mutton) were reserved for older children (12-18 months). Chicken and fish were considered acceptable ASF for younger children as were eggs, which were easily available. However, eggs and fish were considered hot foods, and thus were believed to be better to consume in the winter.

Caregivers linked milk with energy but lacked knowledge of what foods were rich in vitamin A. Some vitamin A rich foods were associated with negative attributes such as bloating occurring from carrots and diarrhoea from papaya. While poverty prevailed as the factor limiting adequate consumption of nutritious foods, LHWs felt a lack of knowledge about local foods was also at fault. Encouragingly, most caregivers



expressed openness to feed their children different foods if advised by a health worker. Caregivers wanted “knowledge and information” to improve feeding practices and desired support from LHWs. Meal practices and responsive feeding

Most mothers in the study worked in the fields from dawn to dusk, providing the main source of family income. Usually young children were left at home, with mothers sometimes returning at noon briefly to feed them. After returning home at the end of the day, mothers would cook the evening meal for the family, with children eating the same food. According to the dietary recall, only a few children ate an adequate quantity of food for their age. Most caregivers discontinued feeding once the child stopped eating. Encouragement to consume more was not mentioned.

WHO recommends practicing responsive feeding (feeding slowly and patiently, encouraging children eat but not forcing them, talking to the child and maintaining eye contact).³

Use of micronutrient powders

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

Household trials for IYC

Based on initial findings from the formative research analysis, four recommended practices were identified to test in three HHT for IYC over the course of one week (see **Table 5**). Each respondent was given several practices to try based on their current feeding patterns, which were assessed through dietary recall. Findings showed that all caregivers recalled the recommended practices, most complied with the practice and all had the intention to continue the practice. **Table 5** shows the acceptability and feasibility of the practices tested. The first three practices were easier to implement, with the child’s high acceptance; the fourth (encouraging the child to eat more during the meal) will likely take persistence and patience over a longer period of time. These findings are promising and provide insights on how to position and encourage these doable behaviours that are possible despite the existing poverty.

TABLE 5. HOUSEHOLD TRIALS FOR IYC: ACCEPTABILITY AND FEASIBILITY OF PRACTICES

HHT FOR IYC		
PRACTICE	ACCEPTABILITY	FEASIBILITY
Give egg to the child 3 times a week	<ul style="list-style-type: none"> • Child acceptability—very good • Egg mixed with potato neutralized the “hot” aspect of the egg, becoming a good food for the child • Child “did not feel hungry, asked to breastfeed less”; “good for child’s growth”; “tasty” and easy to eat 	<ul style="list-style-type: none"> • Carried out 2-3 days in the week • Easy to cook • Inexpensive • Eggs less available in one village
Feed 3 full meals to child	<ul style="list-style-type: none"> • Child acceptability—good • Child “becoming energetic, not asking for mother’s milk”; good for child’s growth 	<ul style="list-style-type: none"> • Carried out 4-7 days in the week • Feasible, although child not accustomed to eating at noon • Difficult to cook meal at noon but took food from the morning
Give leafy greens & thick consistency lentils twice a week	<ul style="list-style-type: none"> • Child acceptability—very good • Mixed spinach with lentils • “New, good recipe, all family members like it” 	<ul style="list-style-type: none"> • Carried out 2 days in the week • Easy to cook • Inexpensive • Adding spinach also thickens lentils
Encourage child to eat more (quantity); give meal before breastfeeding	<ul style="list-style-type: none"> • Child acceptability—gradual • “Child starts taking food, solids” 	<ul style="list-style-type: none"> • Carried out during the week • A little time consuming

Family and community role

Child care and feeding fell under the role of mothers. If guidance was needed on feeding, mothers asked either husbands or mothers-in-law, both trusted sources. Mothers varied in response to advice; some implemented it and others did not. Beyond advice, husbands and mothers-in-law provided little support in actual feeding or attending to the child’s other needs. This often extended to fathers’ lack of involvement in economic or social opportunities that could benefit the family. Respondents also discussed the lack of community involvement in IYC nutrition (**Table 6**). Interestingly, they did not mention seeking advice from health workers and some commented on the inability to consult LHWs due to lack of home visits.

In contrast, mothers-in-law were consistently mentioned as the dominant influence during pregnancy—either directly or through influencing her son—making decisions about medical appointments, where to deliver, and what to cook and eat in the household. Pregnant women described a need for family support during pregnancy, and especially for transportation to

ANC visits, provision of good food, and to lessen their work burden. Limited community support existed; the presence of a traditional birth attendant, either to visit during pregnancy or as influencing the advice of mothers-in-law was mentioned by some women (Table 6). Opportunities are needed to sensitize the community on MIYCN and involve families, specifically fathers and mothers-in-law, to support specific practices in the home.

TABLE 6. INFLUENCE IN DECISIONS ON CARE AND NUTRITION FOR PREGNANT WOMEN AND IYC

CURRENT LEVEL OF INFLUENCE ON NUTRITION AND CARE	
IYC	Pregnant Women
High/Some <ul style="list-style-type: none"> • Mothers of IYC (high) • Mothers-in-law (some) • Fathers (some) 	High/Some <ul style="list-style-type: none"> • Mothers-in-law (high) • Husbands (some)
Low <ul style="list-style-type: none"> • Neighbours/Community • Health workers 	Low <ul style="list-style-type: none"> • Traditional birth attendants • Neighbours/Community • Health workers

Use of health care services

Attending the health facility—basic health unit (BHU)—for well child visits was not practiced in these communities, although parents did seek out attention when their child was seriously ill. During these visits, HFWs did not take anthropometric measurements or give nutritional advice. Visits focused on writing prescriptions to treat illness, with little communication or interaction with caregivers who expressed considerable dissatisfaction with the visits. Consistent with this finding, HFWs were under the impression that BHUs did not carry the mandate of providing nutrition-related services.

In contrast, ANC visits were attended by most women during pregnancy and these visits were felt to represent an important component of care during this time period. One LHW stated that women attend ANC more often now than in the past and another discussed the presence of a female doctor as a prime influence to visit the BHU. However, women reported that weights and mid-upper arm circumference (MUAC) measurements were not taken nor any nutritional advice given. IFA was given in some cases, but with limited or no counseling. As one pregnant woman described:

In undernourished populations, WHO recommends nutrition education on increasing daily energy and protein intake for pregnant women to reduce the risk of low birth weight neonates.

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.⁴

“ I go to the BHU for ANC visits...I go every month for check up. This is useful. Yesterday ultrasound was done and nothing else. My weight was not measured, I was told nothing about my diet...staff does not tell much about the IFA tablets.

pregnant woman

Home visits from LHWs—a large network of trained healthcare workers across Pakistan and source of basic health education—were infrequent for IYC and only for polio vaccination. Recent changes within the BHU structure has resulted in weaker links between BHU staff and LHWs, as well as reduced supervision and capacity building among LHWs. Furthermore, the LHW curriculum lacked focus on maternal and IYC nutrition and job aids were non-existent. Women and caregivers repeatedly mentioned a strong desire for nutrition knowledge and emphasized the need for support from LHWs in this capacity.

These results speak to the need for clarity in service provision, capacity building in nutrition and communication, and stronger links between HFWs and LHWs. The results also highlight real opportunities for improved MIYCN—with women routinely attending ANC and interacting with HFWs, and for increasing the frequency and improving the nutrition content of home visits by LHWs during pregnancy, lactation and for IYC.

CONCLUSION AND KEY MESSAGES

Formative research and HHT led to a better understanding of the current MIYCN practices within the local context of Sukkur District, Sindh Province 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. Health workers require capacity building to take on a greater role in MIYCN counseling. Recommendations to improve MIYCN include the following priority behaviours/practices in addition to continually promoting EBF until six months of age:

PRIORITY BEHAVIOURS FOR PREGNANT AND LACTATING WOMEN

- Consume IFA daily during pregnancy and lactation
- Have at least 3 proper meals a day including a healthy breakfast, lunch and dinner
- Eat eggs at least twice in a week
- Eat thick consistency lentils at least 3 times per week

SECONDARY BEHAVIOURS FOR PREGNANT AND LACTATING WOMEN

- Eat chicken/fish at least once a week
- Eat mixed vegetables (potatoes, green peas and carrots) at least once a week
- Eat snacks between 3 meals; include at least:
 - One mango 3 times a week in summer
 - One orange 3 times a week in winter
 - One banana 3 times a week in all seasons

PRIORITY BEHAVIOURS FOR INFANTS AND YOUNG CHILDREN (6-23 MONTHS)

- Mix MNPs into your child's food and feed from 6 months: one sachet a day for two months followed by gap of four months; then again at 12 months—one sachet a day for two months followed by a 4 month gap; then again at 18 months—give one sachet a day for two months.
- Provide a full lunch-time meal for your child
- Give eggs to your child at least 3 times per week
- Give your child green leafy vegetables or mixed vegetables (potato, green peas, and carrots) daily from 6 months onward

SECONDARY BEHAVIOURS FOR INFANTS AND YOUNG CHILDREN (6-23 MONTHS)

- Feed your child healthy foods between main meals
- Give your child fish and chicken at least once a week
- Give your child thick consistency foods in the following quantities:
 - 7-8 months (1/2 cup/small bowl)
 - 9-10 months (3/4 cup/small bowl)
 - 11-12 months and above (1 cup/small bowl)

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

- Identify doable behaviours with clear motivations that work in the local context
- Identify key messages for behaviours to focus and unify the BCI strategy and improve coverage
- Address poverty through improved nutrition
- Target families to influence and support women and children
- Develop participatory and enjoyable activities for women and caregivers to learn priority practices
- Sensitize communities on the importance of MIYCN
- Build LHW capacity for MIYCN, strengthen visiting protocols and introduce field visits to reach groups of pregnant women and mothers where they work
- Recognize opportunities to strengthen MIYCN activities within health facilities, and build capacity

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