

Qualitative assessment of counselling on infant and young child feeding provided by community health workers to caregivers at child welfare clinics in Ghana

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Abstract

Effective counselling of caregivers on feeding and young child feeding (IYCF) improves IYCF practices and reduces undernutrition. This study was conducted to assess the approaches used in IYCF counselling at outreach and facility-based child welfare clinics (CWCs), content of counselling delivered by community child growth promoters and community health nurses, and perceptions of mothers about the messages provided. Qualitative exploratory design comprising 12-months participant observation of CWC activities, structured observation of 60 counselling sessions using observational check-list and exit interviews with 20 mothers using open-ended questionnaire was conducted at four CWCs in the Greater-Accra region, Ghana. Findings were themed and coded inductively. Counselling provided by the growth promoters was individualized and tended to follow UNICEF recommended positive counselling skills whereas the nurses primarily provided didactic group counselling but none used educational materials or documented agreements reached. The community health workers counselled on breastfeeding but additionally, the growth promoters included complementary feeding whereas the nurses focused on immunizations. First time mothers and those below 30 years who participated in the outreach CWCs found the counselling most helpful. Mothers who claimed not to have received any IYCF counselling mostly attended the private facility-based CWC. Those who asserted that the counselling was non-beneficial cited reasons such as the messages being repetitive, nonspecific, and not solving their children's feeding difficulties while few mothers thought the counselling was unnecessary because their child's feeding and growth were apparently optimum. Counselling on IYCF should be tailored to the needs of caregiver-child pairs. Primiparous and young mothers should be targeted.

Key Words: Nutrition education; health education; community health nurses; community volunteers; behaviour change communication; growth promotion; mothers

Introduction

Behaviour change communication (BCC) is an integral component of all health promotion interventions and child growth promotion is no exception. It involves the strategic use of information, communication and education techniques to promote positive health outcomes. Key among these BCC strategies is health education. Health education basically is any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes (WHO, 2015). Health educational and promotional strategies have been recommended as an intervention for reducing child undernutrition, enhancing child survival and improving infant and young child feeding (IYCF) practices (Bhutta et al., 2008; Kushwaha et al., 2014; Pelto, Martin, Van

Liere, & Fabrizio, 2015). Pelto and co for instance have observed that BCC strategies aimed at promoting appropriate IYCF practices is usually embedded in broader public health and nutrition communication activities. These BCC strategies are delivered using existing interventions such as community groups, mothers' clubs, health centres and posts, home visits, schools and child welfare centres (Pelto et al., 2015).

As part of the global public health recommendation to protect, promote and support exclusive breastfeeding for six months, and to provide safe and appropriate complementary foods with continued breastfeeding for up to two years of age or beyond, the WHO in collaboration with UNICEF initiated the Global Strategy for IYCF in 2002. This strategy has been found to result in improved IYCF practices particularly breastfeeding with subsequent impact on

nutritional status, growth, health and survival of infants and young children (Bhutta et al., 2013; Dewey & Adu-Afarwuah, 2008). In developing countries where undernutrition is most prevalent and implementation of the WHO/UNICEF IYCF strategy is expected to be strengthened, community health workers including nurses, nutritionists, child growth promoters, peer supporters, educators and community members are trained and sensitized on positive IYCF counselling skills (WHO, 2006). In recent times also, most caregivers have recognized the need to receive IYCF counselling (Nguyen et al., 2015).

Findings from reviews have provided evidence on the impact of IYCF promotional strategies including counselling on caregivers feeding practices (Briscoe & Aboud, 2012; Dewey & Adu-Afarwuah, 2008; Renfrew, McCormick, Wade, Quinn, & Dowswell, 2012; Tylleskär et al., 2011). The Lancet Nutrition Interventions Review Group and the Maternal and Child Nutrition Study Group have provided evidence that counselling of caregivers on appropriate child feeding practices is an intervention that can improve children's nutrition and health status (Bhutta et al., 2008; Bhutta et al., 2013). According to Bhutta and colleagues, caregiver counselling has led to increased likelihood for exclusive breastfeeding in the neonatal period and additionally increased likelihoods for breastfeeding among infants age 1 to 12 months. Similarly, complementary feeding support and educational strategies have contributed to the reduction of stunting (Bhutta et al., 2013). In India for instance, peer counselling by mother support groups has led to significant improvement in early initiation of breastfeeding, exclusive breastfeeding for 6 months, timely initiation of complementary feeding and continued breastfeeding at one year (Kushwaha et al., 2014).

To ensure that IYCF counselling is holistic, effective and tailored to the needs of caregivers, other approaches to health education have been widely recommended and implemented as adjunct strategies to breastfeeding and complementary feeding promotion. Some of these interventions include home-based peer counselling (Haider, Ashworth, Kabir, & Huttly, 2000; Tylleskär et al., 2011), social franchising of IYCF counselling services especially within government primary healthcare facilities (Nguyen et al., 2014), use of counselling cards and other teaching and audiovisual aids (Katepa-Bwalya, Kankasa, Babaniyi, & Siziya, 2011), use of mass media programmes such as radio, television and newspapers (Naugle & Hornik, 2014) and strengthening implementation of the baby friendly hospital initiative (Coutinho, de Lira, de Carvalho Lima, & Ashworth, 2005). Inevitably, a combination of IYCF promotional systems and interventions that have documented guidelines and standards of care,

performance supportive supervision, training, monitoring and evaluation of IYCF interventions have the potential to strengthen systems that would lead to improved IYCF practices (Briscoe & Aboud, 2012; Sanghvi et al., 2013). In most developing countries, counselling on IYCF is conducted either at health facility-based or community-based child welfare clinics (CWCs). The counselling is usually delivered by community health workers including community volunteers. This counselling process could be individualized or done collectively for a group of caregivers. Studies have shown that irrespective of the approaches used in the counselling process, it yields some positive results (Bhutta et al., 2008; Hotz & Gibson, 2005; Roy et al., 2005). Nonetheless, combination of individual and group counselling seemed to have better impact on nutrition and health outcomes than individual or group counselling alone (Bhutta et al., 2013).

A number of service-provider factors have been identified to affect delivery and uptake of counselling messages. Knowledge of the counsellor on nutrition-related issues is a key factor (Faber, Schoeman, Smuts, Adams, & Ngomane, 2009; Mbuya, Menon, Habicht, Pelto, & Ruel, 2013; Mowe et al., 2008). Skillfulness to provide information on broader range of public health topics, counselor's ability to translate conceptual ideas into the local context and the interpersonal communication skills are also paramount. Furthermore, the overall counselling skills exhibited by the counsellor such as negotiating behaviour change with caregivers, encouraging them to identify solutions, obtaining commitment from the caregivers to try a recommendation and requesting them to repeat the advice received are positive determinants for the success of counselling (Nguyen et al., 2014). In addition, other factors such as availability of infrastructure and equipment, number of health workers assigned to provide the counselling service, availability and time commitments of providers, and accessibility and affordability of the services could affect the provision of counselling messages by community health workers and the uptake of same by caregivers (Laar, Marquis, Lartey, & Gray-Donald, 2015; Nguyen et al., 2014). On the other hand, intrinsic programme factors such as long duration of participation on the programme and access to health care services from multiple sources affect caregivers' uptake of counselling messages (Mbuya et al., 2013). However, attitudes and perceptions of caregivers on the usefulness of the messages communicated to them have not been extensively investigated.

In Ghana, caregiver counselling is expected to be an integral component of all child growth promotion programmes delivered at child welfare clinics (CWCs). Child growth monitoring and promotion has achieved

high coverage in Ghana. Unfortunately, inadequate health professionals coupled with inaccessibility and unavailability of the services are posing as major challenges (Ghana Health Service, 2014). As a result, the community-based growth promotion (CBGP) programme was adopted in 2005 to augment the traditional growth monitoring and promotion (GMP) programme. Differences between the two programmes have been elaborated elsewhere (Agbozo, Colecraft, & Ellahi, 2015). The aim of the CBGP programme is to increase attendance to CWCs, enhance the quality of IYCF counselling provided to caregivers and subsequently improve upon caregivers' IYCF practices, with the ultimate goal of improved child growth. In the CBGP programme, one of the primary responsibilities of the trained non-professional service providers called community child growth promoters (CCGP) is to provide individualized IYCF counselling to caregivers with children under 2 years (Ghana Health Service, 2010). On the other hand, in the GMP programme, counselling is the primary responsibility of community health nurses.

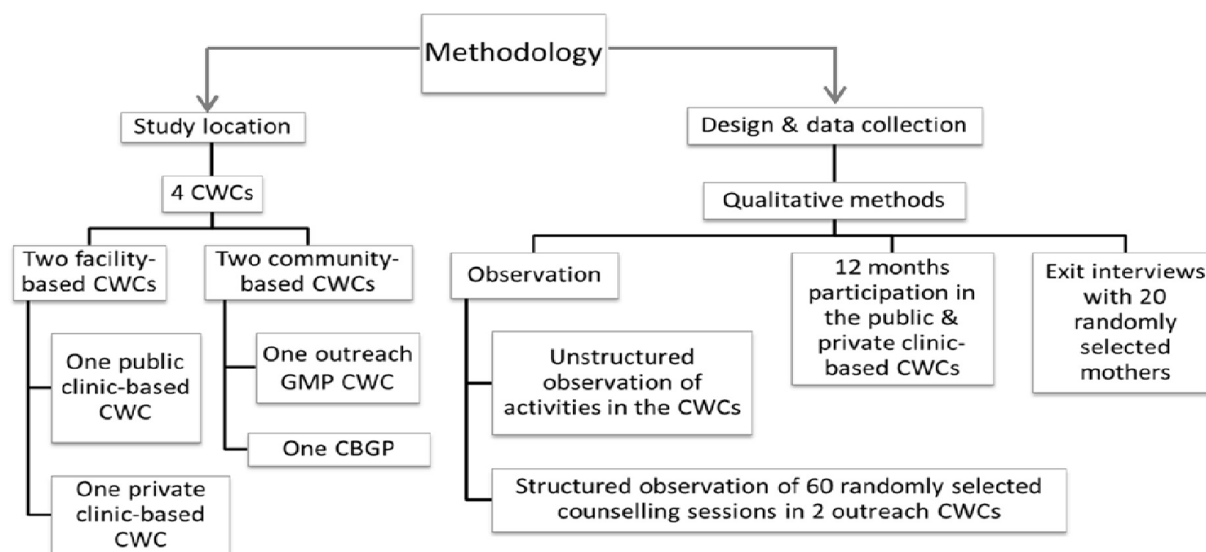
Per the CBGP programme objectives, counselling provided by the community volunteers is expected to be in accordance with the WHO/UNICEF counselling guidelines such that messages are tailored to the needs of caregiver-child pairs (WHO, 2006). Nonetheless, there is little documented evidence of the approaches used in caregiver counselling in CWCs in Ghana. Also, counselling practices in public and private

facility-based and community-based CWCs have not been assessed. Although in recent times, work have been done on provider and institutional factors that would affect IYCF counselling (Faber et al., 2009; Nguyen et al., 2014; Pelto et al., 2015), caregivers' attitudes and perceptions about the usefulness of messages provided by the growth promoters and nurses has not been fully explored. As a means of ensuring that caregivers are well informed and empowered to appropriately feed their infants and young children, it is necessary to routinely assess the format in which community health workers counsel caregivers, the content of messages given and the factors that may positively or negatively affect caregivers' satisfaction and acceptance of the messages rendered. Hence this study was conducted to examine the approaches used by community child growth promoters and community health nurses to counsel mothers who seek child welfare services in facility-based and community-based public and private child welfare clinics implementing the community-based growth promotion programme and the traditional growth monitoring and promotion programme in some rural and urban areas of Ghana. In addition, mothers perceptions on the counselling provided were assessed.

Material and methods

Summary of the study setting, design and data collection procedures is presented in Figure 1.

Figure 1 Summary of the study methodology



Study setting

The study was conducted at four public and private child welfare clinics (CWCs) located in two rural and two urban communities within the Greater-Accra region of Ghana. Three of the CWCs implemented the traditional growth monitoring and promotion (GMP) programme primarily managed by community health nurses (CHNs). Two of these were facility-based CWCs and were situated within a public and a private clinic whereas the third CWC was an outreach clinic. Meanwhile, the fourth study site implemented the community-based growth promotion (CBGP) programme which is a fundamental component of primary child health care delivery system found mostly in derived communities of Ghana. The CBGP programme was facilitated by volunteers called community child growth promoters (CCGPs) while CHNs played supervisory roles. The growth promoters provided essential services such as growth monitoring, caregiver counselling and home visiting.

Study design and data collection procedures

A qualitative study approach with exploratory design was used. Participant observation of activities performed at child welfare clinics (CWCs), structured observation of counselling sessions and exit interviews with caregivers were employed in the data collection process that lasted for one year. The investigator participated as a caregiver (participant observer) in the child growth promotion sessions, attended the monthly CWC sessions during the study period and made general observations of the manner of counselling and flow of activities at the four study locations. Field notes taken were recorded in a field diary. To assess the content of nutrition and health education delivered to caregivers by the community health nurses (CHNs) and the community child growth promoters (CCGPs), 60 one-on-one counselling sessions were covertly observed in two outreach CWCs. The systematic sampling method was used to select the counselling sessions to observe. Using a structured observational counselling check-list, 30 counselling observations were made in each of the two outreach CWCs that implemented the CBGP and the GMP programmes. The check-list was developed based on positive counselling skills recommended by UNICEF to be adopted by community workers for IYCF counselling (UNICEF, 2012). The number of counselling observations made during a particular CWC session depended on the average number of clients who attended the sessions per clinic day.

With the aid of an open ended questionnaire, exit interviews were conducted with 20 mothers who accessed the child welfare services and received counselling on infant feeding. Using the systematic

random sampling method, five mothers were selected from each of the four study sites. The aim of the exit interviews was to know their attitudes and perceptions about the counselling provided at the various CWCs and whether they found the massages beneficial to their needs. Only mothers who attended the CWC for at least three times and were the biological mothers of the accompanied child(ren) were eligible to participate in the exit interviews. All accounts were documented in a field diary. The data recorded included events observed, experienced and learned through interaction with the mothers, nurses and growth promoters.

Statistical analysis

Observations made at the CWCs were documented in a field diary. Author's notes from the participant observation and field work experiences were thematically coded. The data was synthesized and analyzed using qualitative content analysis. Findings were summarized as narrative accounts of observations at the child welfare clinics. Counselling observations were analyzed as string variables using Statistical Package for Social Sciences for Windows (version 20) to determine the number of times a particular counselling activity was performed. During the exit interviews, opinions expressed by the mothers were translated from the local dialect into English and recorded verbatim. From the content analysis, emerging concepts and experiences expressed as thematic codes were identified, appropriately sub-categorized and outstanding quotes extracted.

Ethics

The study was approved by the Institutional Review Board of the Noguchi Memorial Institute for Medical Research of the University of Ghana, Legon. The community health nurses and community child growth promoters were informed of the on-going study at their respective CWCs but were not told when and how the counselling observations were intended to be done. This way, the likelihood of awareness about the study influencing the community health workers' normal behaviours and routine practices were minimized. All study participants gave their consents prior to enrolment by signing informed consent forms. Also, permission was obtained from the mothers to quote them verbatim.

Results

Description of counselling sessions at the child welfare clinics

Who delivered the counselling?

Observations showed that two distinct behaviour change communication strategies were adopted at the CWCs visited. The method used depended largely on who was providing the counselling. In the growth monitoring and promotion (GMP) programme, community health nurses (CHNs) were responsible for educating caregivers on health and nutrition issues relevant to child feeding and growth. Whereas in the community-based growth promotion (CBGP) programme, this was the primary responsibility of community child growth promoters (CCGPs). But the CHNs also counselled the caregivers on issues outside the jurisdiction of the CCGPs. However, in the health facility-based CWCs, it was sometimes the responsibility of public health nurses (a higher grade of nurses) to counsel clients.

What was the scope of the counselling?

The topic for discussion was decided by the community health workers. It dealt on a wide range of issues pertinent to both child and maternal health. These included exclusive breastfeeding and continued breastfeeding up to two years; timely complementary feeding; importance of immunizations as well as the schedules. Others topics were related to clothing of newborns; vitamin A supplementation; appropriate complementary foods; prevention of malaria and diarrhoea diseases; first aid therapy for fever, diarrhoea and vomiting; importance of family planning; and hygiene practices especially when feeding infants and young children. Occasionally, topics such as interpretation of the growth curves and identification of developmental deficits in children were also discussed.

How was the counselling done and what messages were provided?

On a normal clinic day, the first activity performed at the CWCs visited was health education. This was delivered mainly by the CHNs using a group discussion approach. Specifically, the message was collectively shared with all the caregivers present at the CWC through a didactic one-way method of health education. In most cases, follow-up questions were asked by the nurses and the caregivers were allowed to share their thoughts. The group counselling usually lasted for about 30 minutes. After the children were weighed, and measurements documented in the child health record booklets, the community health workers had one-on-one sessions with the caregivers in

successive turns. During these one-on-one sessions, caregivers whose children were not growing according to the expected trajectory were often further advised. But the information given was usually generic and did not contain specific advice based on caregiver-child pairs' individualized needs. Also, all caregivers were informed of the next date of visit and this point was particularly emphasized to those whose children were due for immunization on the next monthly visit. Most outstandingly, caregivers whose infants were immunized were educated on how to minimize the side effects. Generally, the one-on-one counselling sessions with caregivers were brief and were usually incorporated with the other child welfare services particularly weighing and immunization such that, one could hardly tell if a formal counselling session was on going.

Similarly, in the CBGP programme, the nurses provided group counselling to caregivers. But the counselling skills exhibited by the growth promoters were quite unique. After all the necessary child health services were provided at the clinic, the growth promoters conducted individualized counselling with each caregiver. The counselling was mainly tailored towards assessing the infant and young child feeding (IYCF) practices of the caregivers in accordance with recommended IYCF practices. Once a while, advice was given based on the child's nutritional status, expected weight gain and feeding difficulties. It was compulsory for caregivers to attend counselling sessions provided by the growth promoters in the CBGP programme. When the caregiver declined to attend the counselling session, the child's health record booklet was withheld. The growth promoters had IYCF counselling cards but during observation of the counselling sessions, they were not visibly seen using the cards. None of the community health workers were observed to have documented the key messages shared with caregivers and the agreements reached. Overall, the counselling sessions took approximately ten minutes to complete.

Specific counselling messages provided to caregivers in the two child growth promotion programmes

In all, 60 one-on-one counselling sessions were observed during the study period. Thirty of the counselling sessions were delivered by the community health nurses (CHNs) who facilitated the growth monitoring and promotion (GMP) programme and another 30 by the community child growth promoters (CCGPs) who facilitated the community-based growth promotion (CBGP) programme. Generally, the counselling skills exhibited by the CCGPs tended to follow the positive counselling skills recommended by UNICEF (UNICEF, 2012) (See Table 1).

Table 1 Observation of counselling sessions and messages given to the caregivers by the community health workers in two outreach child welfare clinics

Steps	Positive counselling skills: Community child growth promoter or community health nurse:	Total observations made	
		CBGP (n=30)	GMP (n=30)
Step 1; Assess: ask, listen and observe	Greet/welcome caregiver in a friendly manner	14	8
	Inform caregiver of child's body weight	19	4
	Ask caregiver to interpret child's growth curves	7	0
	Assess child feeding practices and caregiver-child pair's condition	25	19
Step 2; Analyze: identify feeding difficulty & prioritize	Tell caregiver if the feeding practice is age-appropriate	14	3
	Praise caregiver if there are no apparent difficulties and provides information needed for the next stage of the child's development	17	4
Step 3; Act: discuss, suggest a small amount of relevant information, agree on doable action	Select small amount of information to share with caregiver	22	5
	Praise caregiver for what she is doing well	10	4
	Present options for addressing the feeding difficulty or health condition in terms of small time-bounded doable actions	16	4
	Share key IYCF information with the caregiver	11	7
	Use appropriate counselling cards/teaching aids	0	0
	Reach an agreement with caregiver on specific action to take	5	0
	Suggest where caregiver can find additional support	21	8
Nutrition-specific information given	Breastfeeding	23	25
	Timely complementary feeding	24	16
	Feeding frequencies	26	7
	Dietary diversification	21	2
	Vitamin A supplementation schedules	1	1
General health education	Importance of immunization and the schedules	7	21
	Management of minor ailments	0	9

CCGP, community child growth promoter; CHN, community health nurse; CBGP, Community-based growth promotion; GMP, growth monitoring and promotion; n, number of counselling sessions observed

From the counselling observations summarized in Table 1, it was realized that the CCGP often examined the caregiver-child pairs, identified feeding difficulties and discussed with the caregiver on a doable action plan. Unlike the CHNs, the CCGPs most often established rapport with the caregivers, actively participated and engaged caregivers in the counselling process. However, counselling cards which were supposed to be used as educational and promotional aids in the counselling process were not visibly used by either the CCGPs or CHNs. In 19 out of the 30 observations in the CBGP programme for instance, the CCGPs informed the caregivers of the children's body weight measurements and growth patterns and in few situations, asked the caregivers to interpret the plotted growth curves. In the GMP programme, it was only in four out of the 30 counselling sessions observed that caregivers were asked to interpret their children's growth charts. Also, in half of the observations, the CCGPs presented options for addressing feeding difficulties of

caregiver-child pairs but did not provide specific client-tailored messages in the suggestions offered.

Furthermore, it was noted that the messages communicated were typically generic and did not address the specific IYCF situations of the caregiver-child pair. For instance, "give more fruits and vegetables to your baby" was a statement that was often said. Moreover, in most of the observations, the counsellors failed to reach agreements with caregivers on the exact child feeding action to take. Overall, the child growth promoters counselled the caregivers on breastfeeding and timely complementary feeding most of the time whereas the community health nurses more often counselled caregivers on immunizations including the schedules, adverse effects and management of adverse effects. However, counselling on vitamin A supplementations was seldom done by both categories of service providers.

Opinions of mothers on the counselling received at the various child welfare clinics

Exit interviews were conducted with 20 randomly selected caregivers to assess their attitudes and perceptions on the IYCF counselling provided at their respective CWCs. Five mothers were selected from each of the four study locations. Although the opinions expressed by the caregivers regarding the IYCF counselling received were varied, four distinct themes emerged. Nine out of the 20 mothers were satisfied with the counselling, five claimed not to have received any counselling on child feeding, four did not find the

counselling useful while the remaining two mothers were not interested in receiving any IYCF counselling. Generally, most mothers who received child welfare services from the CBGP and GMP programmes which were implemented as outreach clinics said they found the counselling most useful. Mothers who claimed not to have received any IYCF counselling most often patronized the private clinic-based CWC whereas responses elicited from caregivers who used the public facility-based CWC were relatively varied (Table 2).

Table 2 Characteristics of mothers who participated in the exit interviews and their opinions about the IYCF counselling provided at child welfare clinics

No.	Mother's age (years)	No. of children	Child's age (months)	Specific type of child welfare clinic	Opinion on IYCF counselling received
1.	24	1	4	CBGP	Beneficial
2.	29	2	9	CBGP	Beneficial
3.	23	1	8	CBGP	Beneficial
4.	37	6	9	CBGP	Non-beneficial
5.	32	3	7	CBGP	Not interested
6.	27	1	13	Public clinic-based GMP	Beneficial
7.	24	1	11	Public clinic-based GMP	Beneficial
8.	26	3	18	Public clinic-based GMP	Not ever counselled
9.	28	4	9	Public clinic-based GMP	Not ever counselled
10.	24	2	14	Public clinic-based GMP	Non-beneficial
11.	33	3	10	Outreach GMP	Beneficial
12.	27	1	15	Outreach GMP	Beneficial
13.	22	1	12	Outreach GMP	Beneficial
14.	23	2	4	Outreach GMP	Not ever counselled
15.	31	4	9	Outreach GMP	Non-beneficial
16.	33	1	6	Private clinic-based GMP	Not ever counselled
17.	26	3	18	Private clinic-based GMP	Beneficial
18.	35	2	11	Private clinic-based GMP	Non-beneficial
19.	30	4	7	Private clinic-based GMP	Not ever counselled
20.	29	2	5	Private clinic-based GMP	Not interested

Note: IYCF, infant and young child feeding; CBGP, community-based growth promotion; GMP, growth monitoring and promotion

It was observed that primiparous mothers and those less than 30 years opined to having benefitted the most from the counselling. Below are translated verbatim excerpts emphasizing some reasons given by mothers who found the IYCF counselling to be beneficial to their children's growth.

- "The counselling has been informative to me as a young and new mother because despite what my mother taught me, education gotten from the clinic has helped me to care for my child. I have been educated on what to feed my

child with and how many times I should feed him".

- "Because this is my first child, I had little knowledge about my new role as a mother. The counselling has helped me to know what to cook for my baby and how to prepare it".
- "The health education has really been useful to me because I was taught about the need to practice exclusive breastfeeding during the first six months of my child's life and it has helped my baby not to get sick frequently".
- "Due to the counselling received, I am confident that I am doing something good for

my baby because I have been prepared for motherhood. The counselling gives a clear distinction between the false (misconceptions) things people already know and the right things they are supposed to know and do”.

On the contrary, five caregivers claimed they had not received any form of counselling particularly on complementary feeding at the CWCs. Table 2 shows that this assertion was made mainly by mothers who attended the private and public facility-based CWCs. Below are some extracts to affirm this assertion.

- *“Within these 6 months that I have been attending weighing, I have not met anyone giving any education on how to feed children during any of my visits”.*
- *“It is only when they (community health nurses) give the child injection (immunization) that they instruct you on what to do. As for education on child feeding, I haven’t heard anything beyond breastfeeding”.*

A 31 year old multiparous mother nursing a 9 month old infant claimed that the information received was not useful for her because the counselling did not contribute to solving her child’s feeding difficulty. Two others indicated that the messages given were monotonous and not detailed enough. Similarly, a 37 year old mother with six children believed she had accrued enough experience on child feeding through nurturing of her previous children and thus thought the counselling sessions were unnecessary. Here are some opinions expressed by the mothers who thought the counselling was non-beneficial.

- *“.....when applying the health education, it doesn’t work at all, especially the feeding aspects. I feed my baby like the nurses instruct. But still, my baby doesn’t like food and she is not growing well. All she (baby) enjoys is breastmilk, even at her age” (9 months).*
- *“Every time I go for counselling, all they (community health workers) say is, give your child more fruits and vegetables, and continue breastfeeding, nothing new”.*

Conversely, two mothers were not interested in receiving any counselling at the CWC either because they felt the child was apparently well nourished or the mother did not have time to wait for the counselling sessions. Here are some opinions expressed by the mothers to that regard.

- *“I think the counselling is not necessary for me because my baby is growing well and his weight is good”.*
- *“Honestly, I don’t wait for the counselling because I don’t have time. I just leave after the immunization because all the things the nurse will say, I already know”.*

Discussion

Findings from the study showed that the community child growth promoters (CCGPs) provided one-on-one counselling to caregivers who received child welfare services from the community-based growth promotion (CBGP) programme whereas the community health nurses (CHNs) counselled caregivers participating in the growth monitoring and promotion (GMP) programme using group-based one-way didactic health education approach. However, the nurses used other avenues at the child welfare clinic (CWC) during child weighing and immunizations to buttress salient health and nutrition messages where necessary.

Although group counselling has been found to be effective in promoting IYCF practices (Bhutta et al., 2008; Laar et al., 2015; Lartey, 2008), one-on-one approaches that is client-centered and culturally appropriate, conducted as part of home visits, make use of mother support groups, or community-recruited peer counsellors have proven to yield better IYCF outcomes (Guldan et al., 2000; Laar et al., 2015; Penny et al., 2005). A randomized study conducted in Ghana to evaluate the performance of nutrition educators revealed that 60% of counselling sessions conducted by the nurses were individualized (Laar et al., 2015). The authors reported that individualized counselling could not be provided to caregivers due to exhaustion of the nurses, inadequate time available for counselling due to late arrival of either the health workers or the caregivers to the growth monitoring sessions and caregivers’ time complaints.

In this study, the rationale for using a particular counselling method was not investigated. However, some few mothers thought the counselling sessions were a waste of time. Again, assessment of the counselling sessions from this study showed that unlike the community health nurses (CHNs), educational messages delivered by the community child growth promoters (CCGPs) were inclined to follow the UNICEF recommended positive counselling skills (UNICEF, 2012). This was probably because caregiver counselling was the primary responsibility of the CCGPs whereas the CHNs were saddled with more responsibilities. In over half of the observations, both the CCGPs and CHNs provided information on exclusive breastfeeding and timely complementary feeding but the former

provided extra information on meal frequencies and dietary diversification. Quite often, the CCGPs probed into the IYCF practices of the caregiver, shared IYCF information, and suggested where the caregivers could find additional support where necessary. Although the CHNs also assessed the condition of the caregiver-child pairs, they concentrated on providing information on immunization schedules. This finding is not surprising because the CCGPs have been specifically trained and assigned the primary responsibility of assessing the growth of children and providing IYCF counselling to mother/caregivers while the role of the nurses include specialized services such as giving immunizations. In Ghana, a key progress indicator for growth promotion is immunization coverage. Hence over the years, there has been considerable effort at promoting immunizations in Ghana most probably accounting for the focus on infant immunizations at the expense of growth monitoring.

There have been varied findings on the content of IYCF counselling delivered by community health workers in child growth interventions. Nguyen and co found that counsellors in programme-supported health facilities in Vietnam covered significantly broader range of breastfeeding topics (7 out of 11) than in the standard facilities where only three breastfeeding topics were discussed (Nguyen et al., 2014). Similarly, when the Ugandan community-based growth promotion was evaluated, the child growth promoters who provided counselling attained an average rating of 7.6 on a 13 performance rating scale (Muyeti-Stevens & Del Rosso, 2007). Contrarily, nutrition education provided by volunteers in the community nutrition programme in rural South Africa was below the recommended standards (Faber et al., 2009).

As observed from this study, the community health workers usually provided general guidance on child feeding and care rather than specific, tailored messages needed by each caregiver-child pairs, a typical example being "give your child more fruits and vegetables". Tailored messages on IYCF practices relevant to client's needs have the potential to improve child feeding practices, and subsequently child growth (Dewey & Adu-Afarwuah, 2008; Guldan et al., 2000; Lartey, 2008). Most educational interventions that use small number of specific key messages on relevant IYCF practices are more effective because it is more feasibly adopted by the target population (Dewey & Adu-Afarwuah, 2008). In this present study however, it was observed that the individual needs of the mother-infant pairs were not considered during the counselling process. Although 75% of the information given in the Ugandan programme was relevant to the age and health status of the children, 48% of these messages were found to be generic, providing general guidance on

feeding, rather than more specific, tailored guidance based on the peculiar circumstances of each participant (Muyeti-Stevens & Del Rosso, 2007). Further to this, the most common advice given to caregivers whose children were faltering in growth in the Integrated Attention to the Child programme in Honduras was to 'give more food to the child than usual' (Van Roekel et al., 2002). Because the IYCF messages were often non-specific as seen from this study, this probably accounted for the reason why some mothers did not find the need for counselling. Moreover, some mothers thought the messages given were not contributing to solving the feeding challenges of their children. This made them rate the counselling given as non-beneficial.

Although the growth promoters and nurses were expected to use educational materials such as counseling cards and child health records to facilitate the counseling process, none of the counsellors were seen using these aids even though they had access to them. Contrary to these findings, all community growth promoters in the Uganda community-based growth promotion were observed utilizing counselling cards to provide advice to caregivers on feeding, childcare and health (Muyeti-Stevens & Del Rosso, 2007). Perhaps, this is because the Ugandan programme was evaluated a year into its implementation where enthusiasm was probably still high accounting for the high usage of the educational materials. In Zambia, service providers in a counselling intervention group used visual aids in explaining IYCF messages during 79% of the counselling sessions, whereas in the control group, it was done in only 17% of the sessions (Katepa-Bwalya et al., 2011). Consequently, in the intervention group where IYCF counselling was conducted using counselling cards, quality of counselling was rated excellent by 70% of the mothers whereas in the non-intervention group where IYCF counselling was conducted without counselling cards, only 39% of the mothers rated the counselling as excellent.

The use of IYCF counselling cards during counselling can significantly improve the quality of the counselling sessions (Katepa-Bwalya et al., 2011). But because there is currently no standardized procedure or policy on how to conduct IYCF counselling in Ghana, diverse behaviour change communication approaches are been used by community health workers, some of which may have minimal effect on enhancing the IYCF practices of caregivers. Laar and co have recommended the use of educational tools to support and improve growth promotion in Ghana (Laar et al., 2015). Unfortunately, it was found in this study that the community volunteers had access to counselling tools yet failed to use them.

Strengths and limitations

This study was conducted in diverse health care settings and provides in-depth knowledge on IYCF counselling. Also, findings from the study can be triangulated because different methods of qualitative data collection were used. Even though the presence of an observer may have influenced the counselling sessions, this was minimized by covert observation. Besides, participation of the investigator as a caregiver minimized effect of the presence on habitual health worker behaviours. Nonetheless, subjectivity of the investigator cannot be completely ruled out. Several studies have evaluated effectiveness of child feeding counselling from health worker, client and health institution perspectives but to the best of the investigator's knowledge, this is one of the few studies in which perceptions of mothers about the messages received have been assessed.

However, it is important to note that studies in which IYCF counselling have been assessed have largely used quantitative methods of research as a means of evaluating impact of programmes and interventions. Hence comparing findings from this study with studies that have used different methodological designs may not provide a fair basis for comparison. Also, only a small number of caregivers were selected for the exit interviews. Despite these limitations, this study has provided useful insights about the content of counselling given to mothers/caregivers at CWCs, and how the end-users of the counselling perceive the usefulness of the messages given.

Implications of findings for counselling on infant and young child feeding

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Conflict of interest

The author declares that there is no conflict of interest regarding this study.

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Counselling on complementary feeding should be tailored to address the specific needs of caregiver-child pairs. Age-appropriate counselling that provides explicit information on what should be fed to the child, how it should be prepared, and how often the child should be fed should be the focus of complementary feeding messages.

Mothers who did not find the counselling to be useful cited reasons such as the information being repetitive, generic and not solving the child's feeding difficulties. Cognizance should be given to the backgrounds of caregiver-child pairs such as parity, age and child's feeding and growth, when providing IYCF information to enhance uptake and implementation. Likewise, it is recommended that prior to counselling sessions, community health workers assess the needs of caregiver-child pairs and offer specific suggestions. Perceptions of mothers on the IYCF messages given shows that a 'one size fit it all' approach to counselling would be non-beneficial and thus a waste of time to some caregivers and may not maximize the effectiveness of community health workers.

Community health workers need to be routinely trained on positive IYCF counselling skills and how to use the counselling aids as health promotional and educational tools. Finally, it is recommended that as counsellors, community health workers should take brief notes of issues discussed and agreements reached with caregivers in the child health record booklet. This would provide a reference point for the next counselling session, reduce repetition of messages, and provide a basis for assessing compliance with agreed action plans to ensure continuity of care.

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