Topic: **Household children feeding practices and its implications for health: A qualitative study in the Kumasi metropolis, Ghana.**

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Long Abstract

Introduction

Children under five years are prone to growth faltering, malnutrition, morbidity, and mortality. Studies conducted in some parts of Ghana and elsewhere have indicated that child growth and development hinge substantially on the feeding practices of their caregivers hence the need for caregivers to adopt appropriate child-feeding practices such as the World Health Organisation recommended Global Strategy for Infant and Young Child Feeding. Mothers are generally the primary child caregivers in most countries despite the considerable changes in gender roles. Globally, employment rates for women have increased while working mothers are expected to fulfil their domestic roles and still be able to excel in their careers. Consequently, a large number of young children grow up in the care of other relative or non-relative household members such as siblings, older children, aunts, and grandmothers. This study was conducted to explore children feeding practices of maternal and non-maternal household child caregivers in the Kumasi metropolis of Ghana.

Methods

Qualitative data was gathered through in-depth interviews (56 maternal and non-maternal caregivers), focus group discussions (3), key informant interviews (5), and non-participant observation. The maternal

caregivers were engaged in various economic activities such as banking, engineering, administration, or business management relative to the non-maternal caregivers who were generally full-time child carers (21%) or combined child caring with schooling (25%), home-based petty trading (38%) or apprenticeship. It is also significant to note that the caregivers were related to the mothers in various capacities but mainly as daughters (grandmothers of the children), relative or non-relative househelps.

Findings

Both maternal and non-maternal individual household carers interviewed generally mentioned seven hunger cues on which they regularly relied to ascertain that children were hungry. These were verbalisation, crying, mouthing, gesturing, finger-licking, facial expressions, and maternal intuition. It was also identified that, while most of the caregivers relied solely on one hunger cue (22 mothers and 25 non-maternal caregivers), there were few caregivers, irrespective of their academic backgrounds, who had been relying on two or, sometimes, three hunger cues. Among the 25 non-maternal caregivers who relied on one hunger cue, fifteen were househelps and almost all the grandmothers (10 out of 12 grandmothers). In three households, both caregivers mentioned the same hunger cues for the index children comprising picking a bowl, pointing to the kitchen, or neck stretching. While all the above-cited cues may be regarded as useful pointers to children's feelings of hunger sensation, reliance on the caregiver's institution, which was cited in four households, seems to be a weak pointer in the identification of a hungry child. The response of Eric's househelp and Alex's mother are illustrations of how this cue was being used: *"He doesn't say it. After observing how long he had played, I will be able to detect that he is hungry"* [Eric's househelp, 25 years old]. *I always see it myself. When I lift him, he becomes light-weight* [Alex's mother, 27 years old]. The dominant satiation cues cited by both household caregivers were verbalisation or gestures such as index children stopping to eat the food, taking interest in surrounding activities, and pushing food or breast nipple out of the mouth.

Responses from seventeen maternal and twelve non-maternal carers indicated that, in instances where their index children were not willing to eat the food served, they adopted four main practices to motivate the child to eat: taking the child to see a health professional, changing the food, encouraging the child to eat and forcing the food on the child. The decision to report the matter to a health worker, for instance, was made on the assumption that a child's refusal to eat food constitutes a sign of illness that will require medical attention. With specific reference to the practices of non-maternal carers, some househelps, compared to one grandmother forced the index children to eat. There were, however, no major differences in the practices of grandmothers and househelps in the other three practices. Furthermore, in four households, some differences were observed in the practices of the two carers. For instance, in two households, while the maternal caregivers indicated that they *"encourage the child to eat*", their corresponding househelps indicated that they *"force the index child to eat"* the food served.

The common feeding problems cited by the participants included dislike for food (food selectivity or pickiness), partial to total food refusal, and difficulty in breast milk sucking, swallowing, or chewing. Irrespective of the educational level and employment status of the caregivers, they could not, at least at the time of the data collection, roughly quantify the daily volume of water consumed by their children. If aligned with the recommended daily intake, some index children would be described as drinking water or being provided with water that is far less than their basic daily minimum required to ensure optimal growth.

Generally, both the maternal and non-maternal caregivers of non-exclusive breastfed index children indicated that they served the index children with enough fruits and vegetables to the extent that some caregivers described the index children as good *"competitors with adults."* There was no observed variation in the account of both carers regarding children's consumption of fruits and vegetables. The most commonly cited fruits served to the children, according to the carers, were banana, pawpaw, watermelon, apple, mango, and oranges as well as vegetables like carrots, tomatoes, and cabbage.

Feeding children with food prepared by food vendors seemed to be a challenge for a few maternal caregivers. The need for patronising these foods arose when the index children requested certain meals which were not readily available in the household. These caregivers, like Doris' 32-year-old mother, found this a challenge since those foods are usually not prepared under strict hygienic conditions but she had *"to go outside and buy the food for her though I do not like that practice."* Time constraint was also a challenge for some caregivers who had to juggle between childcare and other duties. This was particularly a challenge for maternal caregivers with children who eat slowly and combined eating with playing or taking an interest in other environmental activities.

Conclusion and recommendation

Mothers were more directly involved in their children's feeding decisions and made conscious efforts to ensure that food was available in the household. The dominant feeding style adopted by the carers was generally that of responsive feeding. Both caregivers reported serving index children with vegetables, fruits, and water although the water intake of some index children could be described as very low. It is recommended that public health education programmes in Ghana will emphasis responsive child feeding practices to promote quality child growth and development in the country.