

UNIVERSITY OF CAPE COAST

CHILD CAREGIVING PRACTICES IN THE KUMASI METROPOLIS, GHANA

BY

SAMUEL ASIEDU OWUSU

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AUGUST 2017

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: .....

Date: 17-08-2017

Name: SAMUEL ASIEDU OWUSU


Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: .....

Date: 17/08/2017

Name: PROFESSOR ALBERT MACHISTEY ABANE

Co-Supervisor's Signature: For: .....

Date: 22/08/2017

Name: DR. DAVID TEYE DOKU

ABSTRACT

As work practices and living arrangements change rapidly in Ghana, mothers, who are considered as primary child caregivers, despite the considerable changes in gender roles, can be faced with making difficult decisions as they try to balance childcare with the demands of the workplace. Consequently, a large number of children grow up in the care of their mothers and other household non-maternal child caregivers. Despite these childcare arrangements, a comparative study of child caregiving practices of mothers and other household non-maternal caregivers and how their caregiving practices impact on children's health and survival outcomes have not been widely studied, hence the study to bridge this knowledge gap. The study focused on three main areas consisting of children's illnesses management, feeding practices and intra household decision-making on childcare. It employed a qualitative research method approach comprising in-depth interviews with mothers, household non-maternal child caregivers, key informants, non-participant observation and a small number of focus group discussions. Key findings from the study were that there were some push factors on mothers to engage household non-maternal caregivers as well as pull factors for people wanting to become household non-maternal caregivers. Also, some differences existed in the childcare practices of the two caregivers which have the potential to negatively influence child health outcomes. The study also found out that trust, communication and reciprocity between the caregivers were very influential in determining the quality of childcare provided by the caregivers. It is recommended that a guideline or policy should be promulgated in Ghana to regulate the engagement and practices of household non-maternal child caregivers in the country.

KEY WORDS

Child

Caregiving

Ghana

Health

Reciprocity

Trust

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DEDICATION

To the Hampshire-Wright family at Durham, United Kingdom

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
DPs	Development Partners
DOVSU	Domestic Violence and Victim Support Unit
GDP	Gross Domestic Product
GHS	Ghana Health Service
GNI	Gross National Income
GoG	Government of Ghana
GPHC	Ghana Population and Housing
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
IMCI	Integrated Management of Childhood Illness
IYCF	Infant and Young Child Feeding
JHS	Junior High School
JSS	Junior Secondary School
KATH	Komfo Anokye Teaching Hospital

LI	Legislative Instrument
MC	Maternal Caregiver
MDAs	Ministries Departments and Agencies
MDGs	Millennium Development Goals
MGCSP	Ministry of Gender, Children and Social Protection
MMDAs	Metropolitan Municipal and District Assemblies
MOWAC	Ministry of Women and Children’s Affairs
NFPP	National Family Planning Programme
NGOs	Non-Governmental Organisations
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NMCG	Non-Maternal Child Caregiver
NPC	National Population Council
PAHO	Pan American Health Organisation
GPHC	Ghana Population and Housing Census
PHC	Primary Health Care
SDGs	Sustainable Development Goals

SMI	Safe Motherhood Initiative
SSA	Sub-Saharan Africa
UCCIRB	University of Cape Coast Institutional Review Board
UK	United Kingdom
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION

A number of interventions such as the Primary Health Care (PHC) programme, Child Survival and Development Revolution and the Safe Motherhood Initiative (SMI) in the 1980s as well as the Integrated Management of Childhood Illness (IMCI) introduced in the 1990s have all been implemented at the local, national and international levels partly with the aim of improving the health status and survival of children.

Despite these interventions, comparative studies on household child caregivers caring practices and how these impact on the health of children have not been widely conducted in Ghana. This study was therefore conducted to assess maternal and household non-maternal child caregiving practices as a means of assisting in policy formulation and programming in Ghana to improve child health and survival outcomes. Drawing largely on the Bronfenbrenner human ecological model and the 3-delays model, this study presents findings on caregivers' child illness management and feeding practices as well as the significant role of trust, communication and reciprocity in childcare and how these shape child health and survival in an urban setting in Ghana.

This chapter presents issues on the background to the study, statement of the problem, aim and objectives of the study, research questions, rationale for the study and ends with an outline of the rest of the study.

Background to the study

Ghana was described by global financial and development institutions as posting impressive economic growth (Karuri-Sebina, Sall, Maharajh, & Segobye, 2012) and stepped into the path of unlocking her growth and development potential by becoming a lower middle-income country in 2011. According to the 2013 World Bank development indicators for Ghana, in 2012 Gross Domestic Product (GDP) of the country stood at \$40.71 billion and Gross National Income (GNI) per capita was pegged at \$1,550.00 (World Bank, 2013).

The 2015 Millennium Development Goals (MDGs) Report of the country which examined progress made since the implementation of the MDGs in 2000 indicated that “targets such as halving extreme poverty (MDG 1A), halving the proportion of people without access to safe drinking water (MDG 7B), universal primary education (MDG 2A) and gender parity in primary school (MDG 3) are attained” (United Nations Development Programme [UNDP], 2015, p. v). The report further indicated that “slow progress has been made towards the targets of achieving full and productive employment (MDG 1B), equal share of women in wage employment in non-agriculture sectors and women’s involvement in governance (MDG 3), reducing under-5 and child mortality (MDG 4) and reducing maternal mortality (MDG 5)” (UNDP, p. v).

In 2015, Ghana adopted the Sustainable Development Goals (SDGs) which has been described by the United Nations as “a comprehensive, far-reaching and people-centred set of universal and transformative goals and targets” (United Nations [UN], 2015, p. 3). Goal 3.2 seeks to “end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as

12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live birth” (UN, p. 16) by the end of the year 2030. This could be described as a renewed commitment in Ghana on measures aimed at improving the health of children. Besides, Ghana also adopted and implemented some international and national health interventions such as the IMCI which seeks to “offer simple and effective methods to prevent and manage the leading causes of serious illness and mortality in young children” (World Health Organisation [WHO], 2009, p. iii).

Despite these growth indicators and implementation of child-centred health interventions, Ghana still faces some developmental challenges. For example, there is a marked development disparity between the southern and northern divide of the country with most development indicators posting positive results in the south (Al-Hassan & Diao, 2007). Similarly, provision of social services such as electricity, potable water, health and education are below the standards expected of a lower middle-income country. Ghana also made slow progress towards the target of reducing under-5 mortality (MDG Goal 4 now SDG Goal 3.2) at the 2015 end date for the implementation of the MDGs (UNDP, 2015).

The 2010 Ghana Population and Housing (GPHC) census released by the Ghana Statistical Service (GSS) reported that 51% of Ghanaians live in urban areas with over 90% of these urban residents being economically active and employed largely in the informal economy (GSS, 2013). There has been a general global reduction rate of under-five mortality from 87 in 1990 to 51 deaths per 1,000 live births (WHO, 2013) partly due to some factors such as significant improvements in public health and increased access to formal education as well as sustained economic growth and investments in health systems

(Zhang et al., 2013). Nonetheless, urban under-five mortality rate in Ghana stood at 83 deaths per 1,000 live births at the end of 2010 (GSS). Some efforts, however, are already been made by the government and other stakeholders to improve the health status of Ghanaians in general and children in particular (Ministry of Health, 2007).

Despite the improvements, the vast majority of child deaths worldwide are generally attributable to preventable causes (WHO, 2013; Young & Jaspars, 2006). While these causes have been categorised as proximate including malnutrition, domestic accidents, infectious diseases such as diarrhoea, malaria and pneumonia (see for example Ashraf, Huque, Kenah, Agboatwalla, & Luby, 2013; Foote et al., 2013; Hazel, Requejo, David, & Bryce, 2013; Kahabuka, Kvaale, & Hinderaker, 2013; Kamal, 2013; Moyou-Somo et al., 2013; Rajatonirina et al., 2013; Whiteside et al., 2012), other researchers have argued that intermediate factors (e.g., household-level resource allocation, childcare practices, gendered social and cultural norms) and ultimate factors (structural and institutional) mediate aspects of child health which could impact negatively on infant and child mortality (Colvin et al., 2013; Hampshire, Panter-Brick, Kilpatrick, & Casiday, 2009; Millard, 1994; Young & Jaspars, 2006). It must also be noted that some of the causes of child morbidity and mortality are environmental rather than biological (Brann, 2010; Kandala, Emina, Nzita, & Cappuccio, 2009; Wellhoner et al., 2011; Wondafrash, Amsalu, & Woldie, 2012).

Child development does not take place in a vacuum. The various socialising agencies such as the family, the school, peer groups, the media and religion significantly impact on children's health and development (Bronfenbrenner, 2009; Dooris, 2006; Minniss, Wardrope, Johnston, & Kendall, 2013). For instance, these agencies play inter-

related roles in children upbringing because they act as the conduit through which children learn a number of life skills including food intake, personal hygiene and other health-related behaviours that eventually shape their future (Gittelsohn et al., 1998; Dev & McBride, 2013). In much the same way, the health status of children depends, to some extent, on the knowledge and practices of household child caregivers partly due to the notion that prevention and management of child illness and mortality usually begins in the home (Ministry of Health, 2007). It must be noted, however, that household responses to interventions are influenced by the economic, social, cultural, religious and political ecology of people (Hardee, Feranil, Boezwinkle, & Clark, 2004; Owusu, Blankson, & Abane, 2011).

Mothers or women are considered as primary child caregivers in most countries despite the considerable changes in gender roles (Hadley, Tessema, & Muluneh, 2012; Smith, 2004; Tolhurst, Amekudzi, Nyonator, Theobald, & Bartel, 2008; Vuckovic, 1999). Globally, employment rates for women have increased considerably and working mothers are expected to fulfil their domestic roles and still be productive in their careers. In recent years, the socio-economic, cultural and technological changes experienced globally have impacted on the lives of working women and their caregiving roles (Cassirer & Addati, 2007; Kalleberg & Marsden, 2013) which sometimes constrain their ability to provide quality care for their children (Marshall, Godfrey, & Renfrew, 2007).

In some households, working mothers or families juggle through their career and family duties by arranging for other relatives, non-relatives or institutions such as schools to share in the responsibility of caring for their younger children. Another alternative, as in the case of Malawi, is the practice of ensuring that males or husbands are actively

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involved in playing more and responsible roles in childcare (Kululanga, Sundby, Malata, & Chirwa, 2012).

In a study on partnership between parents and caregivers of young children in fulltime day-care at Trondheim city and nearby communities in Norway, Drugli and Undheim (2012) reported that one-third of the parents expressed lack of adequate knowledge about their children's day: although, Reedy and McGrath (2010) have found that, in general, parents would want to have a deep insight into what happened to their children in their absence. According to Drugli and Undheim, perhaps, parents who were satisfied with the institutional care were based on hope and belief than on information received from reports of the day-care staff. Arguably, delegating certain aspects of childcare to non-parental caregivers could be considered as a risk that parents take (Undheim & Drugli, 2012) and also a stressful moment for the children (Atwool, 2013; Drugli & Undheim; Gunnar, Kryzer, Van Ryzin, & Phillips, 2010) because the children would be expected to navigate complex sets of relationships with their parents and the other non-parental caregivers (Atwool).

The concept of childcare was explained by Engle, Bentley and Pelto (2000) as encompassing all the behaviours and practices of caregivers such as parents, teachers, relatives or non-relatives that provide food, healthcare, stimulation and emotional support necessary for children's healthy growth and development. For Hadley, Tessema and Muluneh (2012), childcare constitutes household or community provision of time, attention and support to meet the physical, mental and social needs of a growing child.

Two people who play cardinal roles in child growth and development are the persons who provide direct care and the one who takes key decisions about the care

process (Bezner Kerr, Dakishoni, Shumba, Msachi, & Chirwa, 2008). Generally, it is perceived that children rely on adult decisions for security and health-seeking (Atwool, 2013; Zimmerman, 2005). In some societies in Tanzania, Senegal, Zambia and Ghana, for example, women are able to decide on child health seeking options (Comoro, Nsimba, Warsame, & Tomson, 2003; Franckel & Lalou, 2009; Kaona & Tuba, 2005; Tolhurst et al., 2008) but some studies in Mali have indicated that the principal decision maker, in this instance, is the husband or father of the child because they have the financial resources to pay for the cost of child health treatment (Ellis, Doumbia, Traore, Dalglish, & Winch, 2013). They further indicated that mothers were expected to receive authorisation from their husbands or the most senior male member of the household, if the husband is absent, before they could seek treatment for a severely sick child. Bakshi et al (2013), on the other hand, reported that in the Kaliahun region of Sierra Leone, decision-making regarding seeking health treatment for sick children was arrived at by mothers in consultation with another female member of the household, and to a lesser extent, the child's father while in the Pujehun region in the same country, the process is collaborative in nature between the parents.

Apparently, other family members are involved in child care decision-making process for varied reasons. For instance, in the Volta Region of Ghana, the involvement of household elders such as mothers-in-law and male elders as well as community gatekeepers in deciding on healthcare for sick children is due to their perceived in-depth knowledge in illness diagnoses/interpretation, control of resources and respect for their ideas (Tolhurst et al, 2008).

Household decision making process obviously has differing outcomes on children health (Tolhurst et al., 2008). For example, the time lapse between illness perception and care seeking, choice of health facility or treatment options as well as the ultimate effect of the illness on the child's growth and development hinges on the household decision making process. As posited by Ellis and her colleagues, in rural Malian households, where fathers fail to honour their financial responsibilities, sick children "received treatment that was delayed and inadequate, ultimately resulting in more negative health outcomes" (Ellis et al., 2013, p. 751). A clear understanding of the complexity and nature of these inter-relationships and how the various household members decide individually or collectively to meet healthcare needs of children is fundamental in the quest to improve child health and reduce under-five child morbidity and mortality in Ghana.

Statement of the problem

Some studies conducted in both developed and developing countries have shown that childcare practices of household non-maternal child caregivers such as grandmothers and househelps impact variously on child health and survival (Bezner Kerr et al., 2008; Rosenthal, Crowley, & Curry, 2009). For instance, according to the 2008 Ghana Demographic and Health Survey, 33% of children who were being cared for by non-maternal household caregivers were more likely to be stunted (short for their age or failure to receive adequate nutrition over a long period) than children whose mothers were interviewed (28%) (Ghana Statistical Service, Ghana Health Service, & ICF Macro, 2009). Although the report did not provide exact reasons for this phenomenon, the 2014 survey reported that there is a steadily reduction of stunted children in Ghana from 35%

in 2003 to 19% in 2014 (Ghana Statistical Service, Ghana Health Service, & ICF International, 2015).

In countries such as the United States of America, United Kingdom or Australia, formal arrangements such as the engagement Nannies or Au pairs are used by some working mothers to meet their childcare needs. This arrangement may allow mothers get a one-on-one care for their children or appear as a flexible schedule of childcare that will free mothers to combine childcare with employment. On the contrary, in Ghana, at age four, children are eligible to start formal schooling in the form of state-run kindergarten (Ministry of Education, Youth and Sports, 2004), but childcare is also an issue during the long school holidays and before or after school especially in urban areas. Consequently, a large number of young children grow up in the care of other relative or non-relative household members such as siblings, househelps, foster children, aunts and grandmothers (GSS, 2013; Isiugo-Abanihe, 1985; Kuyini, Alhassan, Tollerud, Weld, & Haruna, 2009; Monasch & Boerma, 2004). Of the 4.4 persons average household size in Ghana reported by the 2010 Ghana Population and Housing Census, the proportion of non-relatives in households was estimated to be 10% while households with other extended family members accounted for 11% in urban areas (Ghana Statistical Service, 2013). Most often, these are unpaid relatives who may be brought in from other (sometimes distant) households to live with a family and take care of the young children while the parents are working.

The ensuing changes in responsibilities and practices of childcare may have serious implications for the health and wellbeing of children in low-income settings and children of urban middle class parents, yet remarkably, little research has so far focused

on this issue. For instance, Hampshire and her colleagues, in reviewing literature on risk, decision-making and child health among rural poor in Niger, noted that in some instances, maternal workloads tend to inhibit them from investing quality time to encourage a sick child to feed but rather such duties were delegated to young nursemaids, a situation which could have detrimental consequences on sick children (Hampshire, Casiday, Kilpatrick, & Panter-Brick, 2009). Similarly, Engle and Lhotská (1997) found that in Guatemala, when working mothers did not have a good alternate child caregiving system, their children were more malnourished than children of working women with good alternate caregiving systems.

Despite the large number of Ghanaian urban resident children who are being simultaneously cared for by their mothers and other non-maternal child caregivers at the household level, a comparative study of childcare practices of maternal and household non-maternal child caregivers and how their care practices impact on children health and survival outcomes in urban Ghana has not been widely conducted. There are therefore some questions that are worth answering through empirical research. For example, how do mothers and other household child caregivers practise children's illness management and feeding? What are the different child caregiver's knowledge in issues such as symptoms of children's illnesses, medicine regimen and children daily water intake? Are there significant differences between mothers and household non-maternal caregivers' knowledge and childcare practices? Are there differences in the knowledge and practices of child caregiving among relative and non-relative household non-maternal caregivers? How do household decision-making processes influence childcare practices and outcomes? How does the relationship between maternal and non-maternal child

caregivers affect child health and survival outcomes? The search for answers to these questions and the need to bridge this important knowledge gap in the study of risks to child health and survival in urban Ghana formed the basis of this study.

Aim and objectives of the study

The aim of this study was to investigate the child caregiving practices of maternal and household non-maternal caregivers of under five children in the Kumasi Metropolis of Ghana. Specifically, the study sought to:

1. describe the childcare practices of household child caregivers in the areas of children's illness management and feeding practices;
2. explore the differences in the child caregiving practices of mothers and other household non-maternal child caregivers;
3. assess child healthcare service and welfare providers' perceptions on maternal and household non-maternal childcare practices in the Kumasi Metropolis;
4. describe the role of trust and communication in facilitating maternal and household non-maternal child care arrangements; and
5. analyse the relevance of reciprocity as embedded in long-term relationships of care.

Significance of the study

This study on household childcare will contribute significantly to some important areas in health and social demography including the relationship between social networks, social capital and health, the social context of child morbidity and mortality as well as implementation of health policies and programmes in urban settlements in a lower middle-income country.

Ghana's drug and medicines policy (2nd edition) seeks to improve and sustain the health of Ghanaian residents through "rational use and access to safe, effective, good quality and affordable pharmaceutical products" (Ministry of Health, 2004, p. 3). Household child caregiver's knowledge and practices on medicines is essential in our understanding of medicinal use which would serve as a vital source of information for improving the quality of healthcare delivery to Ghanaian children. This study will contribute to the current empirical evidence on knowledge, attitudes and practices of household child caregivers on medicine use in Ghana.

A perusal of the Ghana under 5 Child Health Policy (2007-2015) provided an indication of improvements in the areas of ante and post-natal visits, nutrition, treatment of child illness and provision of quality facility healthcare. The strategy also identified the need to improve home practices such as care for new born, feeding practices, appropriate recognition and management of child illness as well as improved community awareness of the importance of using preventive strategies in the home and seeking care for sick children in a timely fashion (Ministry of Health, 2007). This study will undoubtedly assist the formulators and implementers of the strategy to identify areas

where they have to focus and some strategies they may have to adopt to succeed in implementing future child health strategies.

In developing countries where healthcare systems are largely supported by scarce government and donor funding and achievement of health targets such as SDG 3.2 (reduction in child mortality) is difficult, it is imperative to know what child caregivers do at home when children become sick and critically analyse the rationale behind their practices so as to plan adequately for scarce resources. Understanding family choices about treatment of childhood illness is therefore essential in providing information on household practices of caregivers which could also contribute to fashioning out programmes that would encourage early reporting of child illness to formal health care providers.

Obviously, child caregivers at the household level face some challenges in their line of duty of providing care to children. According to Glazer (1990), the home, in most societies, is usually the place where the highest level of care for sick people take place, yet the people who provide the care are generally the unskilled family members. This study would help to identify the challenges childcare providers face at the household level and offer recommendations on how addressing the challenges could be factored into national policies and programmes.

In developing countries such as Ghana, reports on children health provided by primary child caregivers to formal healthcare providers may not be accurate due to the influence of other powerful non-parental child caregivers (Bezner Kerr et al., 2008). For instance, in their study on breastfeeding, complementary feeding and the multifaceted role of grandmothers in Malawi conducted by Bezner Kerr and her associates, it was

observed that grandmothers played a powerful role in their grandchildren's lives including making feeding decisions which rendered the maternal caregivers powerless in their children feeding practices. This study will assist to evaluate the extent to which household child caregivers descriptions of caregiving represent their actual household practices (Hodges, Hughes, Hopkinson. & Fisher, 2008).

Finally, this study provides useful basis for other researchers to further conduct household-based studies that aim to unearth other factors that hinder children health and survival in Ghana which would culminate in devising comprehensive national response that could contribute substantially to achieving some national and international goals or targets on child health including the attainment of the recently launched SDGs.

Delimitations of the study

The study was delimited to three key childcare issues of illness management, feeding practices and decision making regarding childcare. These were considered as major key variables, despite the existence of other variables such as healthcare systems, in assessing children health and survival outcomes. Furthermore, basic needs of food and water could be risk factors for children morbidity and mortality in a developing country like Ghana. Caregivers understanding of illness management and feeding practices were considered as major factors accounting for children morbidity and mortality; hence, the limitation of this exploratory study to these two basic child health issues. Again, for a study on household child caregiving practices, identification of the key decision makers and how their decision could impact on child health were considered as very imperative in explaining issues that relate to household childcare and health.

Similarly, the study was confined to the Kumasi metropolitan area despite the existence of other metropolitan areas in Ghana. Kumasi metropolis was chosen because it is cosmopolitan, lies in the middle belt of Ghana and is inhabited by people with varied socio-economic background. It was also settled on to serve as basis for large scale study in the other urban areas of Ghana.

Limitations of the study

There are some limitations related to the research design adopted for this study of which the four major ones are presented below. The first limitation was the limited inclusion criteria of respondents. It was limited to only households with two child caregivers comprising the mother and another principal non-maternal household caregiver who cared for a child or children less than five years old. The caregivers were also expected to be available at the household and willing to be interviewed simultaneously on their childcare practices. Furthermore, there was to be, at least, one index child who had been reported sick by the mother within the one month preceding the study. These criteria did not lend to the inclusion of large sample households. The results presented in this study therefore are the accounts of a few child caregivers. This notwithstanding, the interviews were very in-depth and the respondents very cooperative which made it possible to gather comprehensive and insightful data for analysis.

Secondly, the study was delimited to only the Kumasi metropolis of Ghana. The issue under study is very general to children and their caregivers in Ghana and would have been appropriate to expand it to other urban areas in Ghana like Accra, Takoradi and Tamale. This would have provided additional insights into ecological differences in

the practices investigated as well as offer some additional perspectives into the phenomenon under study. However, the choice of Kumasi, which is very cosmopolitan and the second largest city in Ghana, also allowed for the meeting of respondents from the various ecological backgrounds in Ghana. Besides, this was an exploratory study which could be used as basis for the conduct of future large scale studies.

Thirdly, this study narrowed on children health issues to only illness management and feeding practices relative to the other child health variables. Even with these two, some variables such as children feeding styles and weight as well as fruit and vegetable consumption were not fully explored. Furthermore, the sampling strategy entailed selecting a sick index child per household, which made it impossible to compare the situations of other fostered and biological children as well as caregiving practices towards other under five children in the same household who might be unwell. On the other hand, the study has generated a wide range of variables on childcare practices and health which could be developed further by other researchers.

Lastly, the sensitive nature of some of the issues explored in this study might have also made some respondents uncomfortable to provide responses to some of the questions. Having a discussion about children morbidity and mortality seemed an unpleasant topic for some caregivers. Besides, some of non-maternal caregivers especially the young ones (relative and non-relative) did not provide enough data when asked about maltreatment or abuse meted out to them by their maternal counterparts except to say that all is well and relationships are very cordial. This yielded minimal responses on issues such as abuse and child labour.

Definition of terms

- **Communication** is the formal or informal means of sharing meaningful and timely information between two or more individuals or groups to reach a common understanding (Parham, Lewis, Fretwell, Irwin, & Schrimsher, 2015)
- **Househelps** consists of both relative and non-relative children and youth who are staying with mothers and actively assisting in household childcare.
- **Household** is a person or a group of persons, who live together in the same house or compound, share the same house-keeping arrangements and recognize one person as the head of household (GSS, 2013, p. 69).
- **Index child or children** is/are the randomly selected individual child or children under five years old in a household whose care practices formed the basis of household maternal and non-maternal interviews.
- **Medicine** is a substance or mixture of substances prepared, sold or represented for use in the diagnosis, treatment, mitigation or prevention of disease, disorder or abnormal physical state, or symptoms thereof, or restoring, correcting or modifying organic functions in man (Ministry of Health, 2004)
- **Middle class working mothers** were operationally defined in this study as constituting the group of mothers in the Kumasi Metropolis who had attained a higher academic degree (such as Bachelors or Postgraduate), or engaged in a professional career (such as Banking or Teaching) or private businesswomen who had disposable income, owned some assets like a car, house, a refrigerator, television and able to engage the services of household non-maternal caregivers.

- **Non-maternal caregiver** is the main substitute household caregiver who actively assists a mother to take care of a child in a household.
- **Non-relative maternal caregiver** consists of unrelated family members who are staying with mothers and actively assisting her in childcare at the household
- **Pull factors** are those that attracted people to become household non-maternal child caregivers.
- **Push factors** are the ones that necessitated maternal caregivers to engage household non-maternal caregivers.
- **Reciprocity** is doing unto others what others do unto you (Jung et al., 2014).
- **Relative non-maternal** caregiver consists of extended family members such as grandmothers, aunt or siblings who are staying with mothers and actively assisting her in childcare at the household.
- **Traditional medicine** is a sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as prevention, diagnosis, improvement or treatment of physical and mental illness (WHO, 2000, p. 1).
- **Trust** is a person's reliance on other's competence and willingness to look after, rather than harm, things one cares about which are entrusted to their care (Baier, 1986).

Organisation of the study

This thesis is divided into eight chapters. Following this introductory chapter is a chapter on review of related literature. The review centered on some policies and legislation on children's illnesses management, feeding practices, intra-household decision making processes regarding child health, trust, communication and reciprocity as well as some conceptual and theoretical frameworks.

Chapter three provides a description of the methods and procedures employed to gather and analyse primary data for the study. Chapter four provides information on results and discussions of data and this is presented in three sub-chapters. The first sub-chapter presents brief background characteristics of respondents and a detailed comparative analysis of child caregivers children's illnesses management practices. The second sub-chapter focuses on children feeding practices while the third sub-chapter presents analysis on trust, communication and reciprocity as well as a discussion of the findings of the study. The last chapter of this thesis summaries the study, provides key conclusions and recommendations for improving household childcare in Ghana as well as other emerging areas for further research.

CHAPTER TWO: LITERATURE REVIEW

Introduction

This study sought to investigate the child caregiving practices of maternal and household non-maternal caregivers of under five children in the Kumasi Metropolis of Ghana. Literature for this study was obtained from various sources such as published online journals, dedicated websites, books, newspaper reports and other unpublished studies such as thesis. The theme that guided the literature search was the problem statement, goal of the research and the research questions. The online journals were sourced from reputable databases such as Word of Science, Google Scholar and Google using keywords such as Ghana, children, illness, illness management, feeding styles, trust, communication, reciprocity and intra-household decision making. Once a good article or articles are identified in these databases, the other related published articles were perused for additional information. Similarly, other electronic databases hosted by Durham University and the University of Cape Coast (Sage, Jstor, Emerald and Hinari. for example) were also used to search for literature in some specific journals such as Social Science and Medicine.

Other dedicated websites such as www.ghanalegal.com, www.unicef.org and <http://www.who.int/en/> were used to source for literature on policies, programmes and legislations that specifically related to children and their welfare. In addition, websites of some Ghanaian public institutions such as the Ghana Statistical Service

(<http://www.statsghana.gov.gh/>), the Ministry of Finance (<http://www.mofep.gov.gh/>) and the Ministry of Health (<http://www.moh.gov.gh/>) as well as the Ministry of Gender, Children and Social Protection (<http://www.ghana.gov.gh/index.php>) were searched regularly for updated literature on childcare practices. Finally, some books in the subject area and related news items (both electronic such as Ghanaweb and hard like the Daily Graphic) were all consulted for current literature for this study.

Ghana is considered as one of the frontline countries that is promoting quality children growth and development. This is being done through its active involvement in the formulation, adoption and implementation of policies and programmes. It was the first country to ratify the United Nations Convention on the Rights of the Child (UNCRC) in 1989 which recognised the family as the natural environment for growth and well-being of children and recommended to state parties to ensure that children are brought up by their caregivers in the spirit of peace, dignity, tolerance, freedom, equality and solidarity (United Nations Children's Fund [UNICEF], 1989). This chapter reviews related literature on some Ghanaian policies, laws, programmes and interventions that seeks to promote child health and survival outcomes as well as decision-making process related to childcare.

Policies, laws and programmes on childcare in Ghana

Ghana adopted its first definitive population policy in 1969 entitled *Population Planning for National Progress and Prosperity* (National Population Council [NPC], 1994). The implementation of the policy led to the introduction of the Ghana National Family Planning Programme (NFPP) in 1970 which implemented a wide range of

population-related programmes and provided family planning services. Analysts have indicated that the policy failed to effect the needed changes in Ghana's population due to lack of political commitment, the notion that the policy was donor driven and an overemphasis on family planning at the expense of other population-related issues (Luke, 1998). In spite of the challenges, Luke observed that the implementation of the policy raised the awareness of Ghanaian urban residents on family planning issues.

A review of the 1969 policy which began in 1989 recommended a redefinition of the policy's objectives, implementation strategies, institutional framework and an incorporation of emerging population issues such as population and environment and Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) (Luke, 1998). Article 37(4) of Ghana's Fourth Republican Constitution under the directive principles of state policy also expressly enjoined the state to maintain a population policy consistent with the aspirations and development needs and objectives of Ghana (Government of Ghana, 1992; National Population Council, 1994). A revised Ghana Population Policy was adopted in 1994 in response to the shortcomings of the 1969 population policy, government's resolve to formulate a comprehensive, dynamic and explicit population policy in addition to meeting the requirements of the Constitution (Luke: NPC).

The revised policy was aimed at instituting measures that could facilitate the adoption of appropriate measures such as preventing premature illness, unsafe abortions and premature deaths that are all intended to promote maternal and child health. Similarly, the policy recognised the need for all stakeholders to implement programmes

that would ensure that parents properly provide, care and maintain their children (NPC, 1994).

The 1994 population policy outlined an elaborate implementation strategy that sought to integrate population issues into all aspects of national development planning and programmes. For example, the policy specifically advocated for health programmes that would reduce infant/child morbidity and mortality including expanding access to immunisation, oral rehydration therapy, birth spacing, breastfeeding, raising educational level of women and equitable distribution of health facilities (NPC, 1994). The policy also intended to fashion out appropriate programmes that would reduce the incidence and prevalence of children nutritional disorders and pay special attention to their nutritional needs. As a means of discouraging growth of families, the policy restricted paid maternity leave to applicants who have served for at least a year and to only three birth episodes during the entire working life of mothers.

The implementation of the policy in Ghana has led to some progress in improving the health conditions of children. However, a critical review of some current health indicators indicate that Ghana has achieved some of the targets that relate to child health and survival while others are yet to be realised. For instance, it was projected in 1994 that infant mortality rate could be reduced to 44 per 1,000 live births in 2005. The 2014 Ghana Demographic and Health Survey put this rate at 41 deaths per 1,000 live births (GSS et al., 2015, p. 99), however, it does not seem likely that the target of reducing infant mortality rate to 22 per 1,000 live births could be realised by the end of 2020.

According to the 1994 Ghana population policy, men were expected to earn some income to be able to take care of their children. The policy did not make provision for

paternity leave but restricted paid maternity leave to three months and child responsibility allowance to only three children. Article 18 of the UNCRC required States Parties to adopt appropriate measures that would ensure that children of working parents have the right to benefit from childcare services and facilities (UNICEF, 1989). With more women or mothers joining the labour force for varied reasons such as the need to supplement the family income or achievement of their career ambitions, working parents, are often constrained in their child caring duties due to the high demand on them to balance a career with childcare responsibilities. This has necessitated the phenomenon where mothers have to adopt several child caring approaches such as the engagement of household non-maternal child caregivers or enrolling babies and infants in day care centres (Bowlby, 2005).

In 2007, the Government of Ghana (GoG) launched an 8-year under five child health policy with the primary goal of promoting the survival, growth and development of Ghanaian children and a reduction of child mortality to 40/1000 live births by 2015 (Ministry of Health, 2007). Additionally, the policy was adopted with the intention of providing health caregivers a broad national framework for planning and implementing child health interventions which would provide treatments, technologies or key health behaviours that prevent or treat child illness and reduce deaths in children who are less than five years old as stipulated in MGD 4-now SDG 3.2 (Ministry of Health).

The policy defined an elaborate prevention and treatment strategies that would be implemented in all health facilities in Ghana as a means of achieving the policy goals. Some of the interventions included children's consumption of complementary foods that are of high quality, correct quantity and right frequency; management of malnutrition.

vaccination of children and promotion of healthy household as well as community practices. The policy also entreated child caregivers to know at least two signs for seeking immediate care for sick children and enjoined families to ensure that children sleep under insecticide treated nets, drink safe water and dispose household waste hygienically. As an evaluation tool, the policy called for periodic household surveys that would provide empirical evidence on the state of child health in Ghana and also aid in planning and assessment of interventions.

Progress has been made in Ghana through the implementation of these policies. For example, transmission of some diseases such as measles, poliomyelitis and diphtheria have been prevented. In the same vein, guinea worm infection has been halted while immunisation coverage has been expanded considerably. Certainly, the coming into operation of the NHIS, continued rehabilitation and expansion of health facilities across the country, training and re-training of health professionals are also some of the outcomes of implementing these policies. Also, some achievements have been made in the area of reducing the leading preventable causes of child morbidity and mortality in the country although malaria accounts for about 30% of under-five mortality while about 40% of childhood deaths are due to malnutrition in Ghana (Ghana Statistical Service et al., 2009).

In 2004, the Government of Ghana adopted two additional child-friendly policies geared towards providing the necessary framework and direction to all stakeholders that would promote the survival, growth and development of children and their caregivers (Ministry of Women and Children's Affairs [MOWCA], 2004). The objective of the national gender and children policy was to implement activities designed to promote children's development and protection (MOWCA, 2004). The early childhood care and

development policy, on the other hand, sought to provide the enabling environment that would assist children to develop their full cognitive, emotional, social and physical potential through the promotion of nutrition and household food security, provision of information and skills to parents and primary child caregivers as well as the enforcement of existing laws to reduce all forms of child abuse and socio-cultural practices which are detrimental to the well-being of children (MOWCA).

Prior to the adoption of the National Gender and Children as well as the Early Childhood Care and Development policies, Ghana had enacted a Children's Act (Act 560) in 1998 which was aimed at providing the legal framework that would enjoin courts, persons, institutions or other bodies to secure the best interest of children in all matters that relate to them (Government of Ghana, 1998). The Act brought together all laws relating to children into a single child-focused legislation in Ghana (Twum-Danso, 2011). The Act barred all persons from acts, omissions or commissions that would "deny a child the right to live with his parents and family and grow up in a caring and peaceful environment unless it is proved in court that living with his parents would lead to significant harm to the child or would not be in the best interest of the child" (Government of Ghana, p. 7).

The Act also required parents to protect their children from neglect, discrimination, violence, abuse, oppression, exposure to physical and moral hazards. In an event that parents would be temporarily absent from the household, the Act stipulated that they should make arrangements for the child or children to be cared for by a competent person and that a child under eighteen months of age shall only be cared for by a person of fifteen years and above except where the parents have surrendered their rights

and responsibilities in accordance with law. Similarly, the Act made it an offence for any person who would deprive a child access to education, immunisation, adequate diet, clothing, shelter, medical attention or any other thing required for quality growth and development. A parent or any other person who is legally liable to maintain a child or contribute towards the maintenance of the child is under a duty to supply the necessities of health, life, education and reasonable shelter for the child.

Although the enactment of Act 560 has provided a broad national legal framework for dealing with children issues such as adoption, prosecution of people who perpetuate violence against children and how social workers can handle parents who renege on their child caring responsibilities, it is worth noting that not all household child abuse cases are reported to law enforcement agencies. Again, there is widespread fostering in Ghana where children grow up in the care of people who are not necessarily their parents or members of their families. This study would attempt to assess how middle class urban resident child caregivers in Kumasi, Ghana, comply with some provisions of this Act which relate to household childcare and fostering and how the Act could be enforced to the betterment of children and their caregivers.

In July, 2015, as a means of strengthening Ghana's child protection system, the Ministry of Gender, Children and Social Protection adopted a new policy dubbed Child and Family Welfare Policy (Ministry of Gender, Children and Social Protection [MGCSP], 2015). Among other things, the policy is intended to address and prevent harm to children and recognise the integral position of the family in children upbringing. The policy thus aims at designing child and family welfare programmes and activities that will effectively protect children from all forms of violence, abuse, neglect and

exploitation as well as ensuring an effective coordination of the child and family welfare services at all levels (MGCSP).

The 1994 revised population policy of Ghana required the state to develop and implement a comprehensive food and nutrition policy that would meet the needs of the population (NPC, 1994). A National Nutrition Policy was adopted in 2013 by key government sectors to provide a standardised framework that will help them align their programmes and policies around specific nutrition objectives as well as the promotion of effective coordination and collaboration of all stakeholders (Government of Ghana, 2013). This policy acknowledged the slow progress being made in Ghana towards addressing poor child feeding practices, food insecurity and infections. The policy therefore aimed to “ensure optimal nutrition for all people living in Ghana, to promote child survival, and to enhance capacity for economic growth and development” (Government of Ghana, p. 2). As a specific intervention, the policy intends to increase coverage of high-impact nutrition-specific interventions that ensure optimal nutrition of Ghanaians throughout their lifecycle, with special reference to maternal health and child survival. The implementation of the policy is being done by the various related state institutions, civil society organizations, research institutions, academia and the private sector which is being coordinated by the National Development Planning Commission.

The country has also pursued a number of nutrition-related programmes that have tended to address issues on nutrition education, micro-nutrients intake, food hygiene, food storage, food preservation, salt iodisation, malnutrition in children, exclusive breastfeeding and supplementary feeding (Ghartey, 2010). The Ghana Breastfeeding Promotion Regulation 2000 (Legislative Instrument [LI] 1667) is also in place to prevent

aggressive marketing of breast milk substitutes and promote breastfeeding in Ghana (Alabi, Alabi, & Moses, 2007; Tampah-Naah & Kumi-Kyereme, 2013). In addition, article 107 of Ghana's Public Health Act (Act 851) prohibits any person to import, manufacture, package, label, advertise, store, deliver, distribute, trade, sell or export food for human or animal consumption that is not fortified (Government of Ghana, 2012).

Ghana is implementing a nutrition-specific programme by the Nutrition Department of the Ghana Health Service that are targeted at improving the nutritional status of children in the country. For instance, the Infant and Young Child Feeding (IYCF) programme seeks to improve knowledge and skills of service providers in nutrition behaviour and change communication on infant and young child nutrition feeding as well as to reduce chronic malnutrition in children under age two and acute malnutrition in children under age five. Similarly, the Micronutrient Deficiency Control Programme is intended to reduce underweight and wasting rates in children under age five in addition to urging households to consume adequate iodised salt. It anticipated that the coming into force of a substantive nutrition policy in Ghana will clearly set the parameters for assessing the country's nutritional goal, objectives, targets and implementation strategies.

The review of the above policies and programmes has provided an indication that Ghana has elaborate child-centred policies, laws and programmes that are geared towards providing a framework to safeguarding the survival, growth and development of children. The comprehensive nature of pursuing these policies and programmes gives the impression that children in Ghana ought to enjoy quality childcare and are largely insulated from some practices that would be inimical to their growth and development.

On the contrary, reports on some child-related issues such as abuse, labour, neglect, malnutrition, morbidity and mortality are replete in Ghana. Indeed, Ghana is regarded as one of the countries with the highest rates of violence against children in the world (GSS et al., 2009) and has been ranked seventh in violent discipline worldwide according to a study conducted by the UNICEF (Ghana News Agency, 2015).

Children's illnesses management

Child caregivers play pivotal roles in socialising children to become fully fledged members of society. They provide the basic affection and security needs of the child to create the needed conducive environment to support the child's growth and development. At the household level, and in most societies throughout the world, child caregivers comprise the parents (especially the mother), other members of the extended family or non-relatives who may be fostered children or hired child caregivers. At the community level, child caregivers include health workers, teachers or neighbours (WHO, 2012). It could therefore be inferred that the causes of child morbidity and mortality are partially attributable to the knowledge and care practices of the child caregivers. This may explain why most international, national and local interventions to combat child morbidity and mortality have focused on the activities of child caregivers at the household level. For instance, the Primary Health Care (PHC) concept, which was adopted in 1978, acknowledged household members as suitable agents in contributing to preventive health measures (UNICEF & WHO, 1978). In the same way, the Integrated Management of Childhood Illness (IMCI) programme, promulgated by the World Health Organisation and UNICEF in the 1990s to minimise the high rate of under-five mortality (Zhang et al.,

2013) and enhance the quality of care provided to children in health facilities. identified the family and improvement in home case management of childhood illnesses as pivotal in improving child health (Friend-du Preez, Cameron, & Griffiths, 2009; WHO, 2009).

Although the major causes of child morbidity and mortality are largely preventable and treatments available in most countries, pneumonia, diarrhoea and malaria continue to claim the lives of many children under age five in most developing countries (Kahabuka et al., 2013; WHO, 2013). Diarrhoea, for example, is transmitted through faecal-oral route occasioned by a range of human activities such as drinking contaminated water (Mattioli, Pickering, Gilsdorf, Davis, & Boehm, 2012) through contacts with contaminated containers, cups and hands at the point of fetching, transporting or storing (Mattioli et al.; McGarvey et al., 2008). Prevention of diarrhoea is occasioned by improvements in sanitation facilities and promotion of personal hygienic practices such as hand washing with soap (Mattioli et al.).

At El Alto in Bolivia, for instance, Claeson and Waldman (2000) indicated that more than half of child mortality in the area could be ascribed to inadequate knowledge or incorrect behaviour of child caregivers at the household or community levels. Similarly, a study conducted on care-seeking and quality of care for outpatient sick children at a rural settlement in China by Zhang observed that only a fourth of child caregivers who participated in the study had knowledge on at least two danger signs of children with fever, cough, or diarrhoea that would warrant seeking immediate health care in a village clinic or hospital (Zhang et al., 2013).

Household child caregivers in-depth knowledge and appropriate practices in issues such as child feeding, vaccines and compliance with medicine regimen contribute

immensely to successful management of child illness (Claeson & Waldman, 2000). Child caregivers, who are largely women, over the years and in most developing countries, perform various health-related activities for family members (Carpenter, 1980; Glazer, 1990). For example, nursing sick children at home or escorting them to health facilities are generally deemed as some of their primary functions. For middle class urban educated professional mothers, the discharge of these and other domestic-related functions could imply prolonged absence from work (Carpenter) which could also serve as a conduit for job insecurity. In most parts of the world, some of the mothers overcome these obstacles by engaging the services of other household child caregivers who are also generally females. These caregivers, in the discharge of their domestic duties, are also expected to perform some technical health functions such as monitoring children reactions to medication, feeding, treating wounds and deciding on options for seeking additional care for sick children (Carpenter).

The Patients Charter developed by the Ghana Health Service urged Ghanaian health workers to make full disclosure to patients on their health condition, management and the anticipated risks involved except in instances where the patient is unable to make a decision and the need for treatment is urgent. In response, the patients are also expected to provide full and accurate medical history for diagnosis, treatment and counselling as well as to comply with the prescribed treatment, reporting adverse effects and adhere to follow up requests (GHS, 2002). In a study among parents and guardians of children in Accra, Smith (2004) asserted that patient's poor knowledge of dose directions influenced their compliance with drug therapy. Health workers, most of the time, rely on the account of child caregivers to diagnose and treat sick children. Much therefore depends on the

caregivers to be abreast with the symptoms of the child illness, be able to accurately report these to healthcare providers to inform their diagnosis and treatment options. This will also enable the caregivers to implement the prescribed treatment when they return with the sick child to the household. With some children of middle class urban resident professionals being cared for by multiple caregivers at the household level, understanding the knowledge and practices of the various household caregivers and how these may affect child health outcomes has not been sufficiently reported in child health literature. In addition, there is empirical knowledge gap on how the caregivers complement or contradict each other when they report children's illnesses to healthcare providers. These literature gaps are among the issues that were explored in this study.

The knowledge and practices of household child caregivers are basic requisite for preventing child morbidity and mortality. Indeed, child caregivers ability to accurately recognise illness and seek appropriate treatment in time are critical elements for improving children growth and development (Ellis et al., 2013; United States Agency for International Development [USAID], 2011; WHO, 2009). In a study to assess caregiver recognition of childhood diarrhoea, care seeking behaviours and home treatment practices in a rural settlement of Burkina Faso, for example, Wilson et al (2012), reported that child caregivers who participated in their study were less likely to identify children who were suffering from diarrhoea. A key determinant to the success of the IMCI case management is prompt identification of danger symptoms at the household level and a timely decision by household child caregivers to seek healthcare for a sick child from trained health personnel. Delays in any of these could lead to preventable deaths (WHO, 2009). The health-care seeking behaviour of child caregivers which include their ability

to monitor children, understand and interpret sickness symptoms, take remedial action and respond to treatment (Mechanic, 1978) is essential in preventing child morbidity and mortality.

Most countries have an array of healthcare services that may comprise home treatment, faith healers, traditional healers, clinics and hospitals. However, the utilisation of any or a combination of these outlets depends on factors such as proximity to the facility, accessibility, religious beliefs, severity of illness, cost, social status and household income (see for example Forjuoh, Guyer, & Strobino, 1995; Nyamongo, 2002; Owusu & Amoako-Sakyi, 2011). A case in point is a study on household response to severe childhood febrile illness in Mali published by Ellis and colleagues in 2012. They observed that most childhood illnesses were home-managed for long periods of time with traditional or modern pharmaceuticals unless the caregivers observed severe signs such as excessive vomiting, extreme fever, persistent symptoms without improvement and convulsions before they decide to seek healthcare from health facilities (Ellis, Traore, Doumbia, Dalglish, & Winch, 2012).

In most developing countries, basic child lifesaving interventions are generally implemented at the household level by child caregivers and at the health facility level by first-line health care providers such as community health workers (Newbrander, Ickx, Werner, & Mujadidi, 2012; WHO, 2009) but in most instances, self-medication or home treatments are common procedures adopted by individuals and families to combat child illness. Self-medication is described by Anwar and associates as the selection and use of medicines by individuals to treat self-recognised illnesses or symptoms (Anwar, Green, & Norris, 2012). The reasons why people self-medicate are diverse including

convenience and availability of use, medicine shortages at health facilities, family influence, type of illness as well as caregiver age and level of education (Friend-du Preez, Cameron, & Griffiths, 2013; Vuckovic, 1999), high cost of clinical or hospital treatment, long waiting time at health facilities, shortage of health personnel at health facilities, health personnel knowledge perceived as not being up to the standard and people's self-confidence about knowledge of medicine (Anwar et al).

In a study on self-medication among working women in the southwest region of the United States, Vuckovic (1999) observed that the need for parents to work outside the home reduces the amount of time available to nurse sick children hence the mothers who participated in her study aggressively self-medicated their sick children. In Vietnam, for example, a study on drug use and health-seeking behaviour of childhood illness pointed to the fact that urban resident mothers self-medicated their children due to a suspicion of a recurring disease, time constraints, cost, perception of illness severity, imitation of a previous prescription and advice obtained from community members who have some demonstrated experience in medicine use (Hoa, Öhman, Lundborg, & Chuc, 2007).

Reliance on self-treatment as first choice option for treating sick children is generally associated with immediate and long term health problems for the child. In most developing countries, medicines that are usually self-medicated are procured from drug and pharmacy shops which are often manned by non-qualified lay persons who acquired their knowledge from experience gained when working in drug or pharmacy shops (Anwar et al., 2012). In addition, monitoring of patients or caregivers' compliance with the required dosage and timings of medicinal intake is difficult in instances when the medicines are self-administered in the household. Self-medication could also have

serious health risks for children especially if the caregiver has no or little knowledge in medicines. According to Hampshire and her collaborators, self-medication by older children, which is usually based on limited knowledge and funds, “can lead to misuse of pharmaceuticals which can be highly toxic if taken incorrectly (in excessive doses, too frequently or in combination with other drugs), while under-dosage can lead to pathogen resistance” (Hampshire, Porter, Owusu, Tanle, & Abane, 2011a, p. 703). Andersen, Holstein, and Hansen (2006) have asserted that wrong use of analgesics may lead to liver and kidney damage or gastrointestinal bleeding while in children, Zhang et al (2013) have reported that inappropriate use of medicines may be associated with harmful consequences.

As a result of the dire consequences that are associated with inappropriate use of medicines, most countries have adopted legislations that seek to regulate drug availability and administration to people in addition to emphasising that trained professionals like pharmacist are expected to advise people on management of common symptoms of illness through health education and promotion (Smith, 2004). In most developing countries such as Ghana, enforcement of such legislations is very weak thereby allowing most people, irrespective of age, to have easy access to over the counter medicines. This has also been compounded by the rapidly-changing therapeutic landscape in Ghana which is shaping people’s health-seeking practices. For example, the increased advertising of medicinal products in the Ghanaian mass media and sale of these products in drug stores, pharmacy shops or by traditional healers who are expanding their geographical reach, often without reference to medical indications (Hampshire & Owusu, 2013; Hampshire et al., 2011) may imply that child caregivers will have easy and cheap

access to a range of restricted drugs, without necessarily knowing how to use and administer them appropriately to children which would in effect jeopardise the health of the child.

Aside self-medication, sick children are taken by their caregivers to health facilities such as clinics, health centres and hospitals which may be publicly or privately owned. Public health facilities in most countries provide the biggest health-seeking outlet for most people but some studies have reported a number of reasons why people opt for private health services including better and more flexible access, shorter waiting times, greater confidentiality and sensitivity to user needs (Anwar et al., 2012). On the contrary, in Pakistan, for instance, Anwar and colleagues reported that absence of doctors and paramedic staff, shortage of medicines and general poor service quality were the main reasons that keep people away from using public health services while in Eastern and Western Cape of South Africa, patients doubted the efficacy of treatment they received from public hospitals due to perceived improper examination, poor quality of medicines and poor explanation of health problems by health professionals to patients (Friend-du Preez et al., 2013).

Apart from seeking health treatment from health facilities, other child caregivers prefer traditional medicine to treat child illnesses. Factors that influence caregivers to utilise the services of traditional healers may comprise their readily availability, low cost, constrained mobility to health facilities, inadequate formal health facilities, flexible payments mechanisms, traditional beliefs and use of herbal remedies as back up measure to complement health facility-based treatment. In Mali, for example, people engage the services of traditional healers due to the healer's sense of pity, fraternity and good

neighbourliness (Ellis et al., 2013). In Sierra Leone, Bakshi and colleagues (2013) reported that factors such as availability of herbs, flexible payment terms, herbalist responsiveness to patient's needs, shortage of allopathic medicines and perceived efficacy of traditional medicines account for people's reliance on traditional medicines.

In most urban areas where the various health seeking outlets are generally available to care seekers, patients who do not get the desired health seeking outcome from one outlet could easily switch to an alternative outlet. This phenomenon, which is termed as 'health switching' (Anwar et al., 2012; Nyamongo, 2002) normally moves from self-treatment to over the counter medicines and continues to private or government health care facilities but eventually reverts to the traditional sector if biomedical treatment is not successful or if their illness persists for longer durations. The extent to which child caregivers switch health seeking could have profound implications on the health conditions of the child. On one hand, if the current treatment option is not producing the required health outcome but the caregivers unduly take a long time to switch health care, it could exacerbate the child's health condition. On the other hand, if effective treatment is truncated because the child caregiver switched healthcare to an ineffective treatment option, this could also worsen the health condition of the child. Child caregivers' ability to switch healthcare in time to achieve optimum health care outcome for children is therefore essential for effective management of child illnesses.

The IMCI advocates that children who are diagnosed to be very ill by health providers are expected to be referred to a higher level health facility for treatment if the lower levels lack the capacity to treat the illness; however, some child caregivers refuse to comply with the referral. As in many other countries, caretakers in Ghana may be

faced with a number of barriers that prohibit them from complying with referral. Such barriers could be financial, geographic and cultural. Newbrander and associates (2012) indicate that in Sudan, child caregivers better compliance with referrals is due to their high levels of education and provision of medicines during the first visit while in Uganda, a low rate of compliance with referrals was attributed to access barriers, financial limitations and mobility-related constraints. Reporting on child caregivers' compliance with referral of sick children from five districts of Afghanistan, Newbrander and his collaborators found that caregivers' compliance with referrals depended on distance to the referred facility, transportation, lack of caregivers for other children in the household, influence of in-laws, costs and previous satisfaction with services received from the referred higher-level healthcare facility.

Caregivers who attend ante and post-natal clinics receive education on child caring practices from health professionals. The mass media has also been used by health personnel to provide public education (Wilson et al., 2012) in various appropriate household child caring issues. Without denying the fact that such education might have impacted positively on the knowledge and practices of child caregivers in Ghana. Owusu, Abane and Blankson (2011), in an exploratory study of mass media and sex education among informal economic sector workers in one district of Ghana, reported that most respondents failed to listen, watch or read health related programmes aired on radio, television or print media. Health education to child caregivers is essential in improving children health but the success of such education would depend largely on the caregiver's responsiveness to the education. An important issue that would need in-depth exploration

is how urban middle class household child caregivers receive information on child caring and the extent to which the information influences their child caring practices.

Children under five years are very active, mobile and very prone to household injuries. Injuries, intentional or unintentional, domestic or commercial, have also been cited as a major cause of childhood mortality, morbidity and disability (Agbenorku et al., 2010; Kamal, 2013; Whiteside et al., 2012). Children are particularly vulnerable to injuries due to their intense curiosity and inability to discern hazards. Reporting his findings on home injuries in a rural setting in Egypt, Kamal (2013) indicated that most home injuries involving children below five years were falls, burns and poisonings from unsafe environmental characteristics. In Bangladesh, burns and its consequences have been reported to account for a significant number of childhood illness and death (Mashrekly et al., 2010). In a study to assess incidence of road traffic injuries and crash characteristics in Dar es Salaam of Tanzania, Zimmerman and associates observed that almost all the children who were involved in road traffic injuries were pedestrians on highways or on small unpaved side streets (Zimmerman, Mzige, Kibatala, Museru, & Guerrero, 2012); a finding which is very similar to what Abane, in 2012, reported on Ghana (unpublished inaugural lecture).

In Ghana, the Ministry of Health has asserted that, based on existing data, childhood injuries do not contribute significantly to overall child mortality in the country despite the fact that data on injuries contribution to overall child morbidity is not readily available (Ministry of Health, 2007a). However, according to Whiteside and colleagues (2012) who conducted a study on non-fatal injuries among paediatric patients in an urban Ghanaian emergency department, injuries, especially falls, is the sixth leading cause of

death among children under-five years of age in the country. They also confirmed the paucity of empirical studies that focus on reporting how children sustain injuries and unreported non-fatal paediatric injuries in Ghana.

Injuries such as falls and burns have negative consequences on the victims' physique and psyche (Agbenorku et al., 2010). In addition, some family members would be significantly affected since they would be expected to provide appropriate care to the victim either at the health facility or at home. People who sustain severe burns are likely to die while physical recovery is characterised by pain and financial drain on those who survive the burns or their families (Agbenorku et al.). The problem is even compounded for victims who live in developing countries such as Ghana where burn centres are sometimes non-existent or situated in urban areas but stocked with a few health specialists and limited equipment. Considering the consequences that come with injuries to children, child caregivers would be expected to be diligent in their care duties in order to prevent children from injuries. They would be expected to prevent children from being injured or, in instances where injuries occur, they would be required to seek immediate and appropriate care from a qualified healthcare provider for the child.

Treatment options for childhood injuries, as it is generally reported for other child illnesses, take place in households, formal health delivery professionals or informal healers. For instance, reporting on health seeking behaviour of parents of burned children in Bangladesh, Mashreky and associates (2010) observed that almost two-thirds of the parents sought health care from unqualified service providers while the rest considered outlets such as drug stores, friends/relatives, homecare or traditional healers. They

explained the high incidence of preference for unqualified service providers as an influence of the health belief system of the mothers or the principal child care provider.

In some developed countries, care providers are required to complete a first aid course and become equipped in the use of some specific safety equipment to enable them contribute substantially to reducing household injuries (Rosenthal et al., 2009). In Ghana, such a requirement is either non-existent or not enforced. Owing to the dearth of empirical evidence on the broad nature of household injuries, dominant causes and how they influence child morbidity and mortality in Ghana, this study would contribute to current understanding of the depth of knowledge and skills possessed by Ghanaian middle class urban parents and other household childcare caregivers and how this could shape national response to reducing child morbidity and mortality to the barest minimum.

Management of children's illnesses and injuries is not an event but a continuous process that involve various stakeholders at the household and facility levels. Household caregivers' ability to recognise illness and prompt decision to seek appropriate health care as well as healthcare provider's response to the illness have been identified from the above reviews as constituting vital steps in safeguarding the health of children.

Children feeding behaviours and practices

Adequate nutrition is critical to the development of children especially during their first two years after birth but for many children in Ghana, this period is marked by growth faltering, micronutrient deficiencies and common food-borne diseases such as diarrhoea (GSS et al., 2009). This section of the chapter presents a review of literature on

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child caregivers feeding behaviours and practices. The review centres on issues such as exclusive breastfeeding, feeding styles and child feeding outcomes.

Infants are recommended to be exclusively breastfed during their first six months of life after which the breast milk is complemented with appropriate and adequate foods for up to two years of age or beyond (UNICEF & WHO, 1990). The numerous and compelling benefits derived from breastfeeding by infants, families and society including its provision of ideal nutrition for infants, reduction of incidence and severity of infectious diseases, reduction of mothers risk of breast and ovarian cancers, reduction in post-partum blood loss and fostering bonding between mother and child are well documented (GSS et al., 2009; Shroff et al., 2011; Sika-Bright, 2009; UNICEF & WHO, 1990; WHO & UNICEF., 2003).

Results from 2003, 2008 and 2014 GDHS indicated that almost 98% of all Ghanaian children born in the past five years preceding the surveys have been breastfed for some period of time however, the 2008 GDHS reported that the median duration of exclusive breastfeeding in Ghana was only 3 months (GSS et al., 2009). This proportion, according to the Ghana Statistical Service (2015a), had increased to about four months as reported in the 2014 GDHS. Tampah-Naah and Kumi-Kyereme (2013) conducted further analysis of the 2008 GDHS and have reported that mothers who reside in the Volta Region of Ghana are more likely to exclusively breastfeed their children compared to mothers in other parts of Ghana. The relatively low exclusive breastfeeding rate in Ghana has been largely attributed to mothers increased participation in the labour force and the setting of the duration of paid maternity leave to only twelve weeks (Alabi et al., 2007; GSS et al., 2009); incompatibility of certain types of work with infant care and feeding

(Sika-Bright, 2009); cultural beliefs and the influence of other household child caregivers (Tampah-Naah & Kumi-Kyereme, 2013).

In Niger, Hampshire and her colleagues (2009) in a study among subsistence farmers in a rural setting cited pressure on women to continue working as they become mothers as an influencing factor for early cessation of breastfeeding. The mass media advertising of food supplements in some countries despite international and national codes and legislation to promote exclusive breastfeeding (Alabi et al., 2007; Popkin, Bilsborrow, Akin, & Yamamoto, 1983; Tampah-Naah & Kumi-Kyereme, 2013) and bodily manifestations of breast-feeding that often require lactating mothers in some countries including China to renegotiate relations with husbands, coworkers and family (Gottschang, 2007) also account for mothers inability to exclusively breastfeed their infants.

According to the WHO and UNICEF's recommendation, children are to be introduced to complementary foods after six months of exclusive breastfeeding (WHO, 2003). The introduction of complementary foods before this time is discouraged for several reasons such as exposing infants to pathogens that would increase children risk of diarrhoeal infections, feeding children with nutritionally inferior foods (GSS et al., 2009) and children inability to digest other foods properly before 6 months. Nonetheless, most infants are fed with these foods before the expected duration (Wasser et al., 2013).

Poor breastfeeding practices, low nutrient density and poor quality of supplementary foods offered to children in their first two years after birth have been noted to account for stunting and underweight of millions of children worldwide (Engle et al., 2000). In the same vein, Hodges and colleagues (2008) have indicated that children

who are under or improperly fed are at great risk of being malnourished or overweight. These conditions are generally considered as very detrimental to the normal growth and development of children. For instance, malnutrition was described as a contributing factor for child deaths from diarrhoea, measles, acute respiratory infection, meningitis and malaria (Wondafrash et al., 2012). Ghana is not exempted from the problem of child malnutrition phenomenon (USAID, 2011) despite its middle income status and increasing urbanised middle class professional population. According to the 2014 GDHS (2015), 19% of children under age 5 at the time of the survey were stunted (short for their age), 5% were wasted (thin for their height), and 11% were underweight (thin for their age) while about 3% were overweight (heavy for their height). Similarly, the 2008 report cited children who were being cared for by non-maternal household caregivers (33%) as more likely to be stunted than children whose mothers were interviewed (28%) (GSS et al., 2009).

Water consumption by children is also an important component of their feeding behaviour. Water is a very important nutrient in the human body, therefore, any disturbance in its balance or lack of it, known as dehydration, is associated with adverse health consequences (Bellisle, Thornton, Hébel, Denizeau, & Tahiri, 2010; Kant & Graubard, 2010). Water is estimated to constitute about 60% of the human body weight on which every system or organ such as regulating body temperature, flushing out toxins and providing a moist environment for ear, nose and throat tissues generally depend to function. For children, Edmonds and associate reported in their study on the effects of drinking water on cognition in children that consuming water improved children's performance on tasks that require visual processing (Edmonds & Burford, 2009). Patel

and colleagues, on their part, reported in a study conducted among some fifty-eight school children in the United Kingdom, that drinking plain water, instead of sugar-sweetened beverages such as soda, may help prevent obesity and obesity related comorbidities (Patel, Shapiro, Wang, & Cabana, 2013). It must also be noted that unsafe/poor water quality, sanitation and hygiene have been identified as accounting for more than 3% deaths a year world-wide due to infectious diarrhoea (see, for example Ashbolt, 2004; McGarvey et al., 2008).

One or a combination of the three main feeding styles comprising authoritarian, authoritative and laissez-faire adopted by child caregivers have differing influence on the nutritional status of children which may impact on their health conditions (Birch & Fisher, 1995; Brann, 2010; Hughes, Power, Fisher, Mueller, & Nicklas, 2005; Patrick, Nicklas, Hughes, & Morales, 2005; Wondafrash et al., 2012). Patrick and colleagues (2005) have pointed out that authoritarian child feeding style largely restrict children to a type and quantity of food without recourse to the child's choices and preferences. They further indicated that the adoption of this style of feeding by the African-American and Hispanic child caregivers residing in Houston Metropolitan Area has led to instances where children have lower intake of fruits, juices and vegetables as well as fixation on eating the restricted foods; a phenomenon which may have unfavourable impact on child's health. On their part, Engle and associates (2000) observed that pressurising children to eat is commonly associated with high levels of food refusal in addition to caregivers' inability to monitor child food intake and childhood obesity.

The laissez-faire feeding style, referred to as a nutritional neglect style by Patrick et al (2005), on the other hand, allows children to eat at will without or with minimal

restrictions depending on the availability and access to foods. This style is normally associated with caregivers who make the least effort to feed children even if the later desires for food or is seen as malnourished (Patrick et al.). Child caregivers who often practice this feeding style make little effort to encourage eating or expect children to eat on their own irrespective of the child's age (Engle et al., 2000). In Mali, poor growth of children was linked to lack of parental supervision during meals, irregular meal times and laissez-faire attitude to child feeding (Dettwyler, 1986; Nti & Lartey, 2007). This style may be occasioned by households who live in risky environments and other wider macro-economic constraints which might be beyond their control as a result of poverty and other structural constraints on parental decisions (Hampshire et al., 2009).

Authoritative feeding, which is largely regarded as the most appropriate child feeding style, is connected to children consuming adequate healthy foods including fruits, vegetables and dairy which eventually impact positively on their health and wellbeing. Child caregivers who adopt this responsive feeding style are typically in close propinquity to the child during meal times, able to observe, interpret and respond to the child's hunger and satiation cues in a reasonable time (Birch & Fisher, 1995; Hodges et al., 2008; Patrick et al., 2005; Wondafrash et al., 2012). The child caregivers are able to adapt the feeding method to the child's psychomotor abilities, encourage children to eat, recognise children with poor appetite, affectionately relate to the child during feeding, create a satisfactory feeding environment for children by removal of eating distractions, develop a consistent feeding schedule and supervise children when they are eating (Engle et al., 2000). In Mali, Dettwyler (1986) observed that child caregivers who were more

responsive and fed children more frequently in a clean and safe environment had better nourished children.

Appropriate child caregiver feeding practices or behaviour may comprise encouraging children to eat, demonstrating to children appropriate eating skills, offering more food to children who need it, talking to children while they eat, supervising children when they are eating and monitoring the quantity of food eaten by the child (Nti & Larrey, 2007). Others include adoption of hygienic practices during feeding such as washing of their own and child's hands with soap and clean water during and after feeding, using clean feeding utensils, feeding children in a clean environment and drying hands and utensils with clean cloth/towel (Nti & Larrey, 2007). In their study on effect of caregiver feeding behaviours on child nutritional status in a rural settlement in Ghana, Nti and Larrey observed that a common feeding strategy adopted by child caregivers they studied was playing with children during meal times while forcing or ignoring a child who refused to eat was much more practiced by caregivers they described as negative deviants. The 2014 GDHS also reported that only 13 percent of children age 6-23 months met the minimum standards set by three core infant and young child feeding (IYCF) practices (GSS et al., 2015) while the 2008 report put the rate at 36% (GSS et al., 2009) which is an indication that a large number of Ghanaian children are not being fed appropriately by their caregivers.

Children's food preferences are determined by an interplay of genetic and environmental factors (Scaglioni, Arrizza, Vecchi, & Tedeschi, 2011). Scaglioni and her colleagues have indicated that a preference for sweet taste is universally present in neonates, along with an aversion to sour or bitter tastes. Furthermore, they were of the

view that high-fat and sweet foods are usually preferred by children of many countries, whereas vegetables are almost universally unwelcomed. This natural tendency for food preference also comes along with some health implications especially at the early stages of human development. Wasser and her colleagues (2013) have asserted that low intake of whole fruits and vegetables in addition to high intake of energy-dense foods such as sweets and sweetened beverages, are associated with obesity among older children and adults. In Ghana, the 2008 GDHS found that although 28% of children under five years were stunted, some 5% of children were overweight with a higher proportion of these children in the 9-11 month's age group, living in urban areas and of most educated wealthier mothers. The onus therefore lies with the child caregiver to ensure that children are provided with balanced meal that would promote quality growth.

Among the array of non-maternal child caregivers, grandmothers are often deemed to play particularly key roles in shaping the feeding environment (Bezner Kerr et al., 2008; Wasser et al., 2013). Wasser (2013) in their study on non-maternal child caregivers involvement in feeding among infants and toddlers of first-time African-American mothers, indicated that those children who were fed by their grandmothers tended to consume more juice than whole grain foods; a development which lend itself to some health-related problems such as under nutrition, diarrhoea and tooth decay. In a study on breastfeeding, complementary feeding and the multifaceted role of grandmothers at Malawi, Bezner Kerr and colleagues (2008) observed that grandmothers greatly influenced the frequency with which young children were fed. In Cape Coast, Ghana, Sika-Bright (2009) has indicated that grandmothers were widely cited by mothers as very influential in the initiation of children to early complementary feeding. In the

same vein. children who are cared for by teenagers or non-relative household members such as househelps have been identified in some societies as having poor nutritional status (Engle & Lhotská. 1997).

It might also be assumed that eating patterns of child caregivers determine children feeding behaviours or practices. In Ghana, the 2008 GDHS reported that nearly two-thirds of women and half of men drunk less than 6 glasses of water a day compared to a minimum of 8 glasses recommended by the Ghana Ministry of Health (GSS et al., 2009). The study also observed that only 3 percent of Ghanaian women and less than 1 percent of men reported having the recommended 5 or more servings of fruit a day while a substantial proportion of the population reported low consumption of vegetables during a typical week. Certainly these eating behaviours of Ghanaian adults might be expected to affect the eating behaviours of their children and perhaps hamper their proper growth and development.

Parents with higher socio-economic status are assumed to have access to more material, social and capital resources which could translate into them and their children having good health (Hadley et al., 2012). Maternal status which is generally measured by income in the hands of women has been observed to impact positively on the nutritional status of their children (Pfeiffer, Gloyd, & Li, 2001). In Mozambique, Pfeiffer and his associates observed that high income of fathers was associated with improved children dietary quality through greater consumption of meat, poultry and fish. Conversely, Hampshire et al (2009) reported that in Niger, some children from better-off households were found to be significantly malnourished. similar to children in poor-resource households. They further asserted that there was no guarantee that household food

security would mean adequate diets for all members. Parents with higher socio-economic status are sometimes constrained by time to provide their children with foods that would ensure quality growth. In their study on social learning, infant and young child feeding practices in Tanzania, Hadley, Patil and Gulas (2010) found that time constraints prevented mothers from feeding their children in ways that more closely matched global public health recommendations.

Children under age five are especially susceptible to growth faltering, malnutrition, morbidity and mortality (Nti & Lartey, 2007); therefore, it is expected that their caregivers should provide them with care environments that are of high quality (Rosenthal et al., 2009). Mothers are usually the focus of nutrition and health educational programmes with the assumption that the education they receive would translate to improved behaviour which would consequently lead to quality childcare, health and development (Bezner Kerr et al., 2008). However, in an era of Ghana's development: where some mothers are actively working full time, thereby necessitating the need for children to be cared for by other non-maternal household members, what has to be considered is to what extent the knowledge and practices of the other household caregivers conform to contemporary child feeding practices such as those recommended by the WHO in the IMCI and joint WHO and Pan American Health Organisation (PAHO). This is because their behaviour and practices determine children's taste preferences, eating habits, nutritional and weight status (Musher-Eizenman & Holub, 2007).

As has been discussed in this section, studies conducted in other settings have indicated that child growth and development hinge substantially on the feeding practices

of their caregivers. It is therefore imperative to assess the various child caregivers' knowledge of nutritional contents in foods and children's nutritional needs for proper growth and development. A thorough knowledge of the nutritional contents of foods, nutritional requirements of children and the various feeding styles adopted by child caregivers contribute significantly to averting malnutrition in children. Although some people may be able to provide very good meals to children without necessarily having good scientific nutritional knowledge, it is important to assess household child caregivers awareness of severe food-borne diseases such as typhoid, diarrhoea and cholera and the pathways of disease transmission such as flies, garbage, and faecal materials (Rheinländer et al., 2008).

A study to assess the knowledge and feeding practices of household child caregivers and the association between the behaviours and children dietary intake, eating behaviour, morbidity and mortality in Ghana would further our understanding of child health outcomes and guide our response to providing quality care for Ghanaian children. It will also enable stakeholders who are involved in ensuring proper growth and development of children to become aware of who participates in children feeding and how their feeding styles and practices affect the overall health and well-being of children and how these could be factored into policy formulation and implementation of intervention programmes. The next component of this chapter focuses on intra-household decision-making and children growth and development.

Intra-household decision making

Child-centred policies, laws and programmes as well as child caregivers' adoption of appropriate children's illnesses management and feeding practices may achieve ultimate results depending on the decision-making processes of the caregivers involved. Parents make individual or collective decisions on the choice of non-maternal child caregivers, child illness management options and feeding practices that may have profound impact on the survival, growth and development of children. This part of the chapter reviews some studies on intra-household decision-making processes on matters that affect children's illnesses management and feeding practices.

It is generally stated that children are best cared for by their mothers while their fathers play supportive roles through the provision of family income and other resources. However, the increasing number of mothers with young children who are also actively in the labour force is generally accompanied by a high proportion of children who experience non-parental care during infancy (Leach et al., 2006). According to Hynes and Habasevich-Brooks (2008), non-parental care is sometimes occasioned by the number of children in a household, proximity to other extended family members, availability of other child caregivers and increasing number of single mothers. In Turkey, for instance, grandmothers generally take care of their grandchildren due to the increasing number of mothers who are employed and the limited institutional day-care services available in the country (Kavas & Gündüz-Hoşgör, 2013).

In a study on childcare patterns of infants and toddlers in the United States of America, Ehrle, Adams and Tout (2001) reported that almost three-quarters of infants and toddlers of employed mothers were cared for by a non-maternal child caregivers with

slightly above a third of the children shuttling between two or more caregivers. They also observed that children of high-income working mothers tend to spend more time with non-maternal caregivers compared to their counterparts whose mothers are from low income families. In North London and Oxfordshire in the United Kingdom, Leach (2006) noted that mothers who had children less than six months old decided to engage the services of non-maternal child caregivers as a result of the expiration of their maternity leave, anxiety about job security, availability of non-maternal child caregivers, career progression, income and the desire for the baby to socialise with other people although most of the mothers expressed feelings of guilt about leaving their children in the care of non-maternal caregivers and anxiety about losing grips on their children's daily life and upbringing.

All household members could influence decisions in some proportion but the dominant influence of key household decision maker(s) have been found to have monumental impact on children growth and development. The extent of household members influence on decision making process largely depends on how empowered they are in the household. Alkire et al. (2013), described empowerment as the expansion of a person's capability to make strategic life choices especially in areas where they have been previously denied the ability to do so. For Wiig (2013), an empowered person has the capacity to make choices and transform them into desirable actions and outcomes. Balasubramanian (2013) on his part viewed female empowerment as manifesting in women's increased bargaining power over allocation of goods, services, work and leisure in the household.

The literature is replete with evidence to indicate that, in most cultures and households in developing countries such as Ghana, women or mothers tend to be less empowered to make independent household decisions on matters that relate to children health, although some studies have intimated that more empowered women are able to make significant contributions to overall development of the family, community and country (Alkire et al., 2013; Horrell & Oxley, 2013; Ngo & Wahhaj, 2012; Pfeiffer et al., 2001; Wiig, 2013). For instance, Horrell and Oxley (2013) observed that assets controlled by Asian and African women led to significant increase in their expenditure on childcare. They argued that intra-household decision-making processes where women are active participants is very vital and that the consequences of rendering women powerless could be very detrimental to the growth and development of children.

Women, and especially mothers, with relatively higher levels of formal education are generally empowered enough to make intelligent decisions or contribute actively to household decision making processes that would eventually lead to improved health outcomes of their children. In Vietnam, Nguyen and his colleagues (2013) asserted that Vietnamese mothers' ability to implement exclusive breastfeeding, utilise health services and use ante-natal care services depends on their educational levels and household resources. In Sri Lanka, despite high levels of malnutrition, child mortality rate is relatively low because mothers, irrespective of their socio-economic background, were found to be able to keep their children healthy by promptly responding to the onset of symptoms of illness and seeking medical care from qualified health service providers (de Silva, Wijekoon, Hornik, & Martines, 2001).

Apart from decisions on child illness management, household decision making on children food and feeding is an area that also has serious implications for child health. Decisions regarding the proportion of household income that should be spent on food, sources of food, who feeds children, quality and quantity of meals served children and meal times, are all made and implemented individually or collectively by parents and sometimes, non-parental caregivers. There are profound implications on children growth and development depending on how each of these decisions is made and implemented. For instance, if the principal household decision maker decides that a high proportion of the family budget should go into capital investments such as buildings and vehicles, the possibility that children in the household would be denied some food groups such as fruits and vegetables is not in doubt. Similarly, children health, growth and development would be seriously jeopardised if the household member who cooks and serves meals decides to serve children with less quantity of foods or feed children at long intervals.

The influence of the principal household member who decides on what children should be fed with and at what time is also another area where children's health can be in danger. For instance, despite mothers awareness of the enormous benefits of exclusive breastfeeding, Bezner Kerr and colleagues (2008) study on breastfeeding, complementary feeding and the multifaceted role of grandmothers at Malawi reported that grandmothers were key decision-makers on issues that centred on introduction of complementary foods and cessation of breastfeeding. They further indicated that the powerful influence of grandmothers made younger mothers feel helpless to follow feeding directives from health professionals (Bezner Kerr et al.).

Clearly there is one thing making decisions and another issue having the decisions enforced or implemented. The decision making process and implementation could even become complicated and elongated in instances where children are being cared for by multiple caregivers. For instance, a decision could be made by the parents to provide the needed foodstuffs but the decision of the caregiver who prepares the meals and feed the child, if different from the parents, matters a lot in promoting the health of the child. Obviously decisions on child feeding and the role of the various household decision makers cannot be addressed in isolation. There is, therefore, the need to assess intra-household decision making processes and how the processes shape childcare policies and programmes in Ghana.

Trust, Communication and Reciprocity

Trust is one of the key ingredients that define child caregiving arrangements. Various studies have been conducted on trust in disciplines such as psychology, sociology, law, politics, philosophy and business (Baier, 1986; Caliendo, Fossen, & Kritikos, 2012; Dohmen, Falk, Huffman, & Sunde, 2008; Driessen, Hund, Willems, Paar, & Holz, 2012; Ermisch & Gambetta, 2010; Faulkner, 2015; Gambetta & Hamill, 2005; Gilson, 2003; Molony, 2007; Overå, 2006; Ruppel & Harrington, 2000; Thomas, Zolin, & Hartman, 2009; Yamagishi & Misumi, 1994; Zeffane, Tipu, & Ryan, 2011); but not so much has been written on trust and childcare. Gilson, for instance, has underscored the fact that trust has contributed significantly to literature in the areas of economic development, governance, public sector and organisational management as well as social sector contracting.

Trust transcends one definition due to its wide usage in the various disciplines. In the area of business, for instance, some authors such as Jones and Yamagishi explained trust as the belief in a partner or someone's goodwill or the benevolence of human nature (Yamagishi & Misumi, 1994). They illustrated trust as an instance where the parties involved were assured that one will not cheat the other even if conditions may permit cheating or disappointment. Writing on trust versus mistrust from ethics point of view, Baier (1986) also defined trust as a person's reliance on other's competence and willingness to look after, rather than harm, things one cares about which are entrusted to their care. Trust, in other words, could be described as contingent in that most cooperative endeavours require the co-operators trust in one another to perform their expected bit (Baier). Two or more players are usually involved in matters that relate to trust, the truster and trustee, where the former trusts the latter to do something with the expectation that it will be done (Faulkner, 2015; Gambetta & Hamill, 2005).

Closely related to this study on childcare is the definition and elaboration on trust provided by Gilson (2003). In her article on trust and the development of healthcare as an institution, Gilson intimated that trust is a relational notion and "generally lies between people, people and organisations, people and events" (Gilson, p. 1454). Commenting further on the relevance of trust in our day-to-day activities, Gilson indicated that trust can be a "solution to the free-rider problem, can help people reconcile their own interest with those of others, provide friends or lovers a platform from which to negotiate their relations and, above all, keeping our mind open to all evidence, secures communication and dialogue" (Gilson, p. 1454).

Trust cannot be established at first encounter; usually, people look for signals that make others appear trustworthy. It is produced and communicated through signals; however, the challenge has always been the limited ability to decipher pretenders. Trust, according to Gilson (2003) can be voluntary, impersonal, interpersonal or ideological and may evolve through three levels comprising calculus-based, knowledge-based and identification-based.

Interpersonal trust could be explained as a person's belief that someone or something is reliable, good, honest or effective. It depicts someone's assured reliance on the character, strength, ability or truth of another person or something. Gilson (2003) described this type of trust as moralistic or altruistic which is based on the bounds of a relationship between two individuals known to each other. This trust expresses respect for others and catalyses cooperation with the anticipation that other person's future actions will be beneficial rather than detrimental to the other (Gilson, 2003). Finally, Gilson explained impersonal trust as encapsulating trust in strangers and social systems or institutions. On interpersonal trust, Ruppel and her associates (2000) have asserted that this trust evolves through frequency and duration of contact of two parties; a point which was also made by Johnson and colleague (1989) who opined that frequent, accurate and open communication would be required to build trust.

Communication could be defined as the formal or informal means of sharing meaningful and timely information between two or more individuals or groups to reach a common understanding (Parham et al., 2015) while trust could be explained as an expectancy held by an individual or group that the word, promise, verbal or written statement of another individual or group can be relied upon (Anderson, Narus, Anderson,

& Narus, 2016; Zeffane, Tipu, & Ryan, 2011). While some studies have focused on assessing the relationship between communication and trust (Ruppel & Harrington, 2000; Zeffane et al., 2011), others have also posited that trust precedes effective communication (Anderson et al.; Zeffane et al.).

In their study on the relationship between communication, ethical work climate and trust, Ruppel and associate (2000) found that trust is sustained by contact and regular dialogue between the parties involved while Thomas and colleagues have also reported that in business entities, for instance, quality information flow is positively correlated with trust for co-workers (Thomas, Zolin, & Hartman, 2009). This, according to Thomas et al. implied that if employees perceive they are being provided with timely, accurate and relevant information, they are more able to rely on their co-workers and superiors while the reverse makes them become more guarded and less trusting (Thomas et al.). In sum, trust and communication could be described as moving hand-in-hand or interactive where quality, frequent and cordial communication leads to the creation of trust and averts misperceptions which is usually at the centre of feelings of mistrust (Anderson et al., 2016; Zeffane et al., 2011).

In general, trust involves an element of risk which may emanate from one's uncertainty about the motives, intentions and future actions of the other person or party. In the case of childcare, trusting someone to take care of one's child is associated with some elements of risks such as leaving the child with the caregiver unsupervised which may result in some negative outcomes (Baier, 1986). It is not only adults who trust each other, children also depend on adult's trust or goodwill in matters such as nutrition,

shelter, clothing, health, education and love which are very pivotal to their survival (Baier, 1986).

The concept of reciprocity, as was the case of trust, has also been rarely used in studies on childcare, therefore not lending itself to a classical definition in relation to this study. However, it has been used to explain a number of issues in some disciplines of study including economics, sociology and psychology (Neo, Yu, Weber, & Gonzalez, 2013), ethnology and anthropology (Falk & Fischbacher, 2006) as well as in business (Jirjahn & Lange, 2015).

In Psychology, reciprocity is considered as a personality trait that influences behaviour (Caliendo et al., 2012; Falk & Fischbacher, 2006) (Caliendo, Fossen, & Kritikos, 2012; Falk & Fischbacher, 2006) or a person's intrinsic motivation to respond to the behaviour of a related person (Caliendo et al.). It could also be described as the act of responding to perceived kindness with kindness and perceived unkindness with retaliation (Dohmen, Falk, Huffman, & Sunde, 2008; Neo et al., 2013). In Business and relating reciprocity to exchange of gifts, Frémeaux and Michelson (2011) posited that persons that give much gifts to others try to get much from them while people who receive much from others are under corresponding pressure to give much back. In Sociology, Frémeaux and Michelson (2011) were of the view that the measured or interpreted responses evoked by reciprocity are the driving force which maintains or sustains human exchanges. They further pointed that, although the response(s) may not always be expected to be symmetrical, a relationship that is based on perpetual asymmetry response cannot be sustained; a view also shared by Wolff and Agree (2004). A major theme in the literature on reciprocity is a point asserted by Sakaiya and

colleagues indicated that human cooperation, which is ubiquitous, is sustained or maintained by reciprocity, especially in instances, where individuals encounter others repeatedly (Sakaiya et al., 2013).

Reciprocity could be categorised as either being positive or negative. Positive reciprocity occurs when an action that has a positive effect upon someone is reciprocated with an approximate equal positive effect action. It could also connote a party's willingness to reward those who have been kind. On the contrary, a negative reciprocity is described as a person's willingness to harm or punish another person who has been mean (Caliendo et al., 2012; Engelen, 2008; Jung et al., 2014). Revenge, according to Caliendo and colleagues, is the strongest form of negative reciprocity (Caliendo et al.). Dohmen et al have gone a step further to list some human actions that may depict a person's inclination to either reciprocate positively or negatively (Dohmen et al., 2008). According to them, actions such as return of favour, going out of way to help somebody who has previously been kind and readiness to undergo personal costs to help somebody who has previously helped usually elicit positive reciprocal responses. In reverse, revenge or insulting back are some actions that produce negative reciprocal responses. In business, Jirjahn and colleague (2015) have asserted that negative and positive reciprocity are usually considered to be important catalyst of sustaining cooperation when labour contracts are incomplete.

Theoretical and Conceptual frameworks

This study is anchored on some theoretical models and conceptual frameworks such as the 3-delays model by Thaddeus and Maine (1994), the human ecological model

developed by Bronfenbrenner and the conceptual framework of household decision making and pathways of care developed by Colvin and colleagues (2013). These frameworks were considered suitable for this study because they focussed principally on the three main thematic areas of the study comprising issues on children's illnesses management, feeding practices and intra-household decision-making processes.

In their study to assess causes of maternal mortality, Thaddeus and Maine identified three phases of delays that generally account for maternal mortality in most countries (Thaddeus & Maine, 1994). The phases of delay comprised delay in recognising illness and deciding to seek care, delay in reaching an appropriate source of care and delay in receiving adequate care (Figure 1).

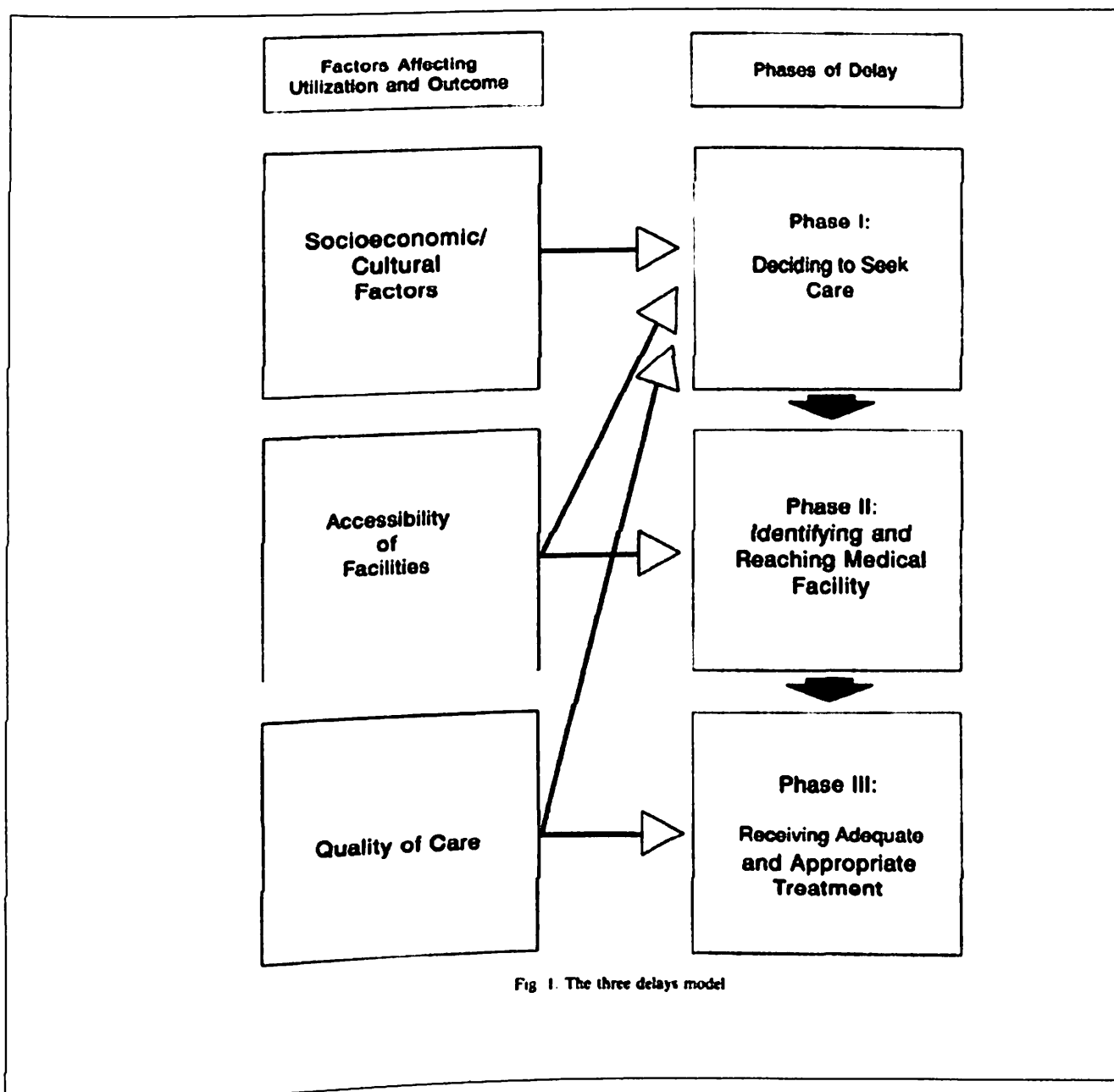


Fig 1. The three delays model

Figure 1: Three delays model

Source: Thaddeus & Maine, 1994

According to them, the first delay comes about on the part of the individual mother, the family or both in deciding to seek healthcare from an appropriate health service provider. This is due, in part, to some factors such as the stakeholders involved in the decision making process, the characteristics of the illness, distance from the health

facility, financial and other related costs as well as experience with the health system and perceived quality of care. For instance, Thaddeus and Maine (1994) asserted that distance has a two-fold influence on mothers or their families decision to seek healthcare. Travelling long distances to access health services as well as travelling on poor road networks or inefficient transportation system were good incentives to push mothers away from accessing health services. Buttressing this phenomenon with empirical evidence, Thaddeus and Maine, asserted that in the Oyo State of Nigeria, it was observed that people did not utilise health services “because the facility was too far” (Thaddeus & Maine, p. 1094). Similarly, they indicated that their findings based on records from some health facilities indicated that “the highest proportion of health users are located close to the facility-e.g. within a radius of five miles or kilometres-and that the proportion of users decline as the radius increases” (Thaddeus & Maine, p. 1094).

Still on the first delay and on the issue of maternal status (educational level, cultural, economic, legal and political position in a given society), as being a cause of maternal delay in seeking health care, Thaddeus and Maine (1994) indicated that in countries such as Nigeria, India and Korea, women have been found as not been in a position to independently make decisions to seek health care; a decision that has to be made in consultation with a spouse or other senior members of the family. In some cultural settings, women are restricted in their movements and could only do so with prior approval by spouse or other family members. They also asserted that “women’s status also interacts with the cost of treatment in the decision to seek care” (Thaddeus & Maine, p. 1098).

Explaining the causes of the second delay (delay in reaching a medical facility). Thaddeus and Maine (1994) intimated that factors such as location of health facilities, the travel distances that result from this distribution and the transportation means necessary to cover the distances constitute the actual obstacles that prevented women from reaching health facilities. They observed that most health facilities are concentrated in urban areas than in rural sites. This, in part, has also led to uneven distribution of general and specialised health service providers as well as resources for healthcare. The implication, according to them, is situations where pregnant women are unable to travel long distances to access healthcare; a problem that is also compounded by high transport costs and poor road networks, especially in the rural areas of most developing countries such as Ghana. These developments will certainly play critical roles that may lead to delayed decisions on health seeking for mothers in most households.

The third delay identified by Thaddeus and Maine (1994) was the delay in receiving adequate treatment after arriving at the hospital or health facility. The delay at the health facility were attributed to factors such as “shortages of staff, essential equipment, supplies, drugs and blood as well as inadequate management” (Thaddeus & Maine, p. 1102). Similarly, they attributed late or wrong diagnosis and incorrect action by health personnel as the other factors that contribute to delays in the timely provision of needed care.

This model has been adopted for a number of studies on child health. For instance, studies such as the ones conducted in Western Tanzania (Mbaruku, van Roosmalen, Kimondo, Bilango, & Bergström, 2009) and Eastern Uganda (Waiswa, Kallander, Peterson, Tomson, & Pariyo, 2010) have been carried out to find out why

newborn babies die. The study conducted by Waiswa and colleagues, for instance, ascertained that caregivers delay in care-seeking was a major factor that accounted for newborn mortality in Uganda (Waiswa et al., 2010).

The current study relied on some aspects raised in the first and second phases of delay identified by Thaddeus and Maine. For instance, based on the first delay in recognising illness and deciding to seek care, the maternal and household non-maternal child caregivers were asked some questions such as how long they waited before taken action on observed index child illnesses symptoms and the illness management actions that followed their observation. Similarly, some factors identified in the second delay phase such as caregiver's means of transportation to health facilities were also explored in this study.

According to Bronfenbrenner (2009), child growth and development takes place through a process of progressive complex interactions between the social, cultural, religious or political environment generally prevailing in the child's environment which is divided into four main layers. In Bronfenbrenner's human ecological model (Figure 2), a child is located in the innermost proximal microsystems layer which consists of the child's closest surroundings such as the home, school and peers who directly and actively shape the growth and development patterns of the child (Bronfenbrenner, 2009; Härkönen, 2001). The model also identifies three other nested structures which are somewhat removed from the child but have significant impact on their growth and development. The second layer, mesosystem, describes the influencing forces of the school, neighbourhood, religious settings and other household members on the child.

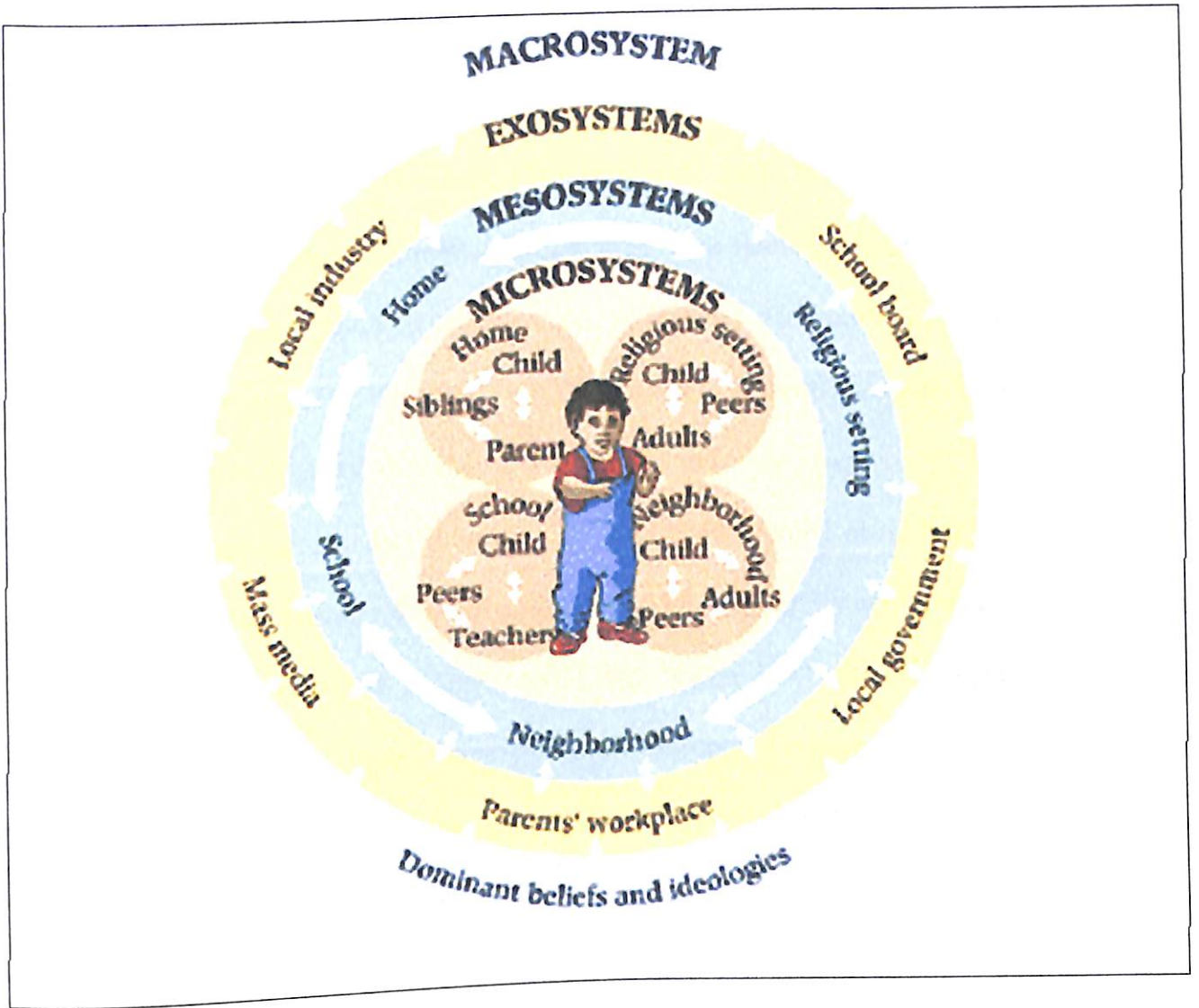


Figure 1: Human Ecological Model

Source: Bronfenbrenner, 2009

The child's exosystem layer highlights the environmental factors such as the mass media, government policies or programmes and caregivers' workplace environment or schedule and how these singularly or collectively shape the growth and development patterns of the child. Commenting on this layer, Härkönen (2001) asserted that in the case of children, the interface between the home and parent's work have some influence on the child's growth and development because the parents work schedule (working hours, nature of work and work environment), in no small measure, affect the developing child

in many ways including shuttling in-between caregivers. The macrosystem is the final layer of Bronfenbrenner's model. This layer describes the societal, cultural ideologies and laws that could affect child's growth and development. For Härkönen, the macrosystem encapsulates a societal blueprint for a particular culture, subculture or other broader social context such as people's life styles and life course options at the local, national or international levels which are often transferred from one generation to another through various institutions like the family, school and workplace.

A study conducted by Tudge, Mokrova, Hatfield and Karnik (2009) on uses and misuses of Bronfenbrenner's ecological theory of Human Development by analysing articles published in English between 2001 and March 2008 that were reported to have been based on Bronfenbrenner's theory located 25 published studies. Out of these studies, Tudge and collaborators indicated that some of them used the model to examine the differences in father involvement and quality of father-child interactions between biological father and stepfathers while another study used the model to assess biology-environment interactions through psychopathological contributions of biological and adoptive parents and their adopted adolescents' problem behaviour as a result of harsh discipline.

The type of care provided to children by the various child caregivers may be shaped by one or a combination of the four layers outlined by Bronfenbrenner. For instance, the knowledge of child caregivers on child caring could be shaped by the socialising influence of the family, peers, educational institutions, religious beliefs, caregiver's employment schedule and information received from the mass media. Similarly, the child caregiving practices adopted by caregivers in the areas of children's

illnesses management and feeding practices could be dictated by the information, experiences or training they have received from the mass media, friends, health delivery facilities, religious leaders or schools. The dynamic nature of these layers which are unique to each child's situation provide a useful basis for its adoption to guide this study in assessing how the spheres of influence of the various layers interact to define child caring among urban middle class professionals in Ghana and how intervention programmes could be focused on the dominant layer(s) to provide a conducive environment in Ghana that would support children optimum growth and development.

The conceptual framework on household decision making and pathways of care (Figure 3) developed by Colvin and colleagues in 2013 provides some of the broad patterns of household decision making and pathways to care seeking for sick children. The framework indicates that responses to child illness moves from inside the household to other caregivers over the course of the illness episode and operated in four different modes comprising direct caregiver recognition of illness and response, seeking advice and negotiating access in the family, making use of the middle layer of community-based treatment options and ending with accessing formal medical services at a clinic or hospital. The model points to the various individual and contextual factors that determine household illness treatment options and the level at which caregivers would seek outside treatment for a sick child. The decision to move from household treatment to external sources may be mediated by factors such as multiple treatments and interrupted treatments (Colvin et al., 2013).

Study area

The study was conducted in the Kumasi metropolis which is the administrative capital of the Ashanti region of Ghana and the country's second-biggest city. The metropolis also has the largest share of the Ashanti region's total population (43%). The Kumasi Metropolis is one of the 30 Metropolitan Municipal and District Assemblies (MMDAs) in the Ashanti Region of Ghana and has nine sub-metropolitan areas (Figure 4). It is inhabited by people from varied ethnic backgrounds but the Akan's dominate comprising about 75% of the region's population; the Akan's also constitute the largest sub-ethnic group in Ghana (Owusu & Agyei-Mensah, 2011). Owusu and Agyei-Mensah's study on ethnic residential segregation in Ghana also reported that migrant low-class neighbourhoods of Kumasi are concentrated by people of northern Ghana extraction relative to Akan domination in the middle and high-class neighbourhoods.

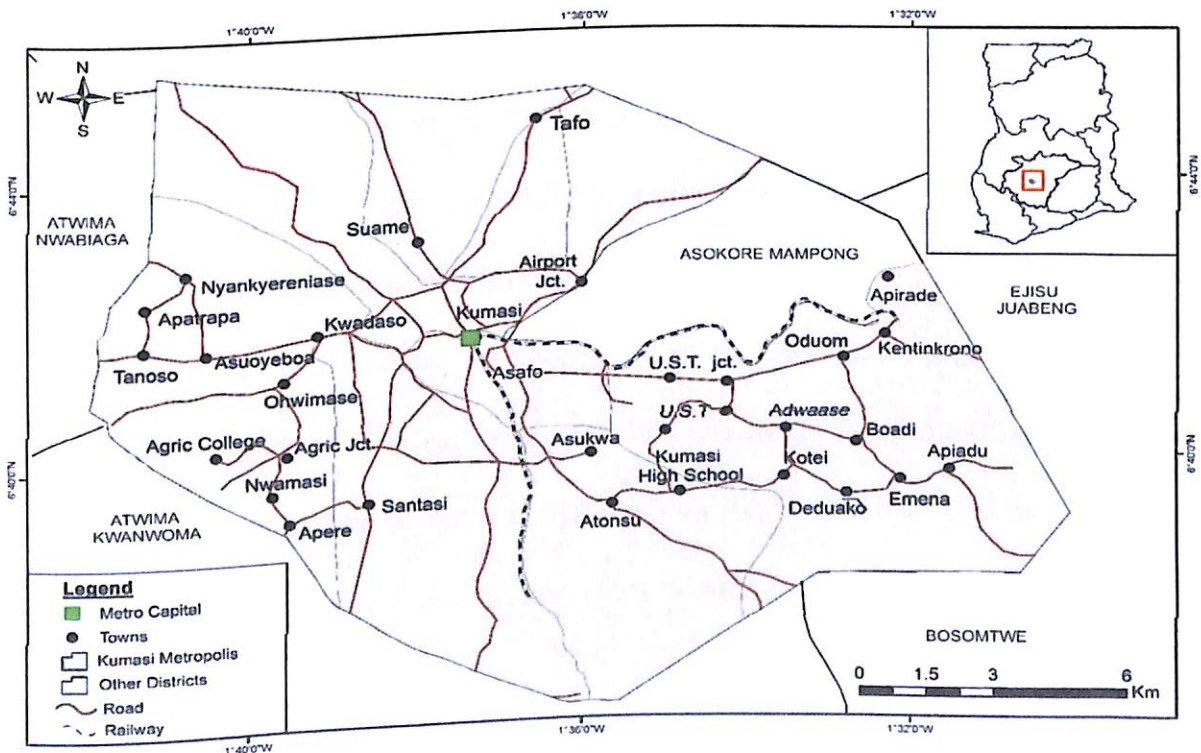


Figure 1: Map of Kumasi Metropolitan Area

Source: GIS and Cartography Unit of the University of Cape Coast

the part of households to see the course of the illness” as well as “rational and conscious decision to distinguish mild and self-limiting conditions from more dangerous ones” (Colvin et al., 2013, p. 74).

This framework was adopted to guide the study in the area of assessing household decision-making process on child health-seeking and how decisions on illness management move from the household to other healthcare providers, intervening factors and the length of time such decisions are concluded as well as the impact they have had on child health, growth and development in Ghana.

Conclusion

Provision of quality care for children has significant and consistent positive outcomes on their growth and survival. The review of related literature has brought to the fore the various international and national efforts that are being implemented to promote children growth and development in Ghana. It has also highlighted knowledge gaps that need to be filled in areas such as child caregivers’ compliance to medicine regimen as well as the role of trust and reciprocity in childcare. Assessing the knowledge and care practices of the various household caregivers in an urban setting in key childcare issues of illness management, feeding and intra-household decision-making processes would further our understanding of child health and survival outcomes and guide our response to providing quality care for current and future Ghanaian children.

CHAPTER THREE: METHODOLOGY

Introduction

This study assessed the childcare practices of mothers and household non-maternal child caregivers in an urban setting of Ghana. This chapter of the thesis describes the various approaches that were followed to gather primary data for the study and how the data was analysed. It covers the research design, a brief description of the study area, population, identification of eligible respondents, research instruments, data collection procedure, data analysis, ethical issues and ends with field challenges and how they were resolved.

Research design

O'Donoghue (2006) citing Connole et al (1993) has indicated that research methodologies can be grouped according to four main paradigms comprising positivism, interpretivism, critical and postmodernism. According to him, the conductors of research based on the positivism paradigm do so to satisfy the human cognitive interest of technical control which eventually leads to situations where humans want to know all the facts and figures associated with an area of interest with the answers being provided by empirical-analytic knowledge. He further explained that the basis of knowledge gained

through this research paradigm involves a careful and controlled observation, where the observer takes a dispassionate position independent of the object of observation.

Research studies based on the critical paradigm, according to O'Donoghue (2006), and based on an earlier study, places much emphasis on understanding the causes of powerlessness, recognising systematic oppressive forces and acting individually and collectively to change the conditions of life. According to O'Donoghue studies based on the fourth paradigm, postmodernism, represent an epistemological break from the other three paradigms and seek to challenge human understanding of knowledge being based on the truth.

The second research paradigm, the interpretivism, on which this study was based, draws its theoretical foundation from symbolic interactionism; methodology through the grounded theory, research methods generally based on semi-structured interviewing, participant and non-participant observation and document study (O'Donoghue, 2006). Interpretivism research hinges on the "four main theoretical perspectives of hermeneutics, ethnomethodology, phenomenology and symbolic interactionism" (O'Donoghue, p. 7).

This research paradigm indicates that human social interaction forms the basis for knowledge acquisition whereby the researcher uses his or her skills as a social being to understand how other individuals also comprehend their world. According to O'Donoghue (2006), interpretivism research satisfies the human interest in understanding the meaning behind something contrary to the positivist interest in prediction and control. To the interpretivist researcher, the individual and society are inseparable units and that

all human actions are meaningful, ought to be interpreted and understood. It also involves how people define events or reality and how they act in relation to their beliefs.

O'Donoghue (2006) has advanced four assumptions that underline effective conduct of research based on the interpretivism paradigm. The first assumption is that every day human activity forms the building block of society. Secondly, everyday activity is not totally imposed on an individual, but allowed some level of autonomy and freedom. The third assumption states that every day human activity nearly always involves a person interacting with other people rather than acting in isolation, which implies that individuals do not only give meaning to their own actions but that of others as well. The fourth assumption is that everyday activity involves a process of negotiation of meaning through which individuals modify their understanding and views.

For Travis (1999), studies conducted from the interpretivist perspective focuses on credibility rather than internal validity, dependability rather than reliability or transferability rather than generalisability or external validity. For Travis, the interpretivist researcher has multiple realities formed by people's social construction compared to the single reality stance of the positivist. Concluding, Travis indicated that interpretivist researchers acknowledge bias and subjectivity during the data collection process.

This study is situated in the interpretivist paradigm for varied reasons three of which are very pertinent. Firstly, and as noted by O'Donoghue (2006), there was the need to have an in-depth understanding of the social interactions between maternal and non-maternal caregivers as well as the children being simultaneously cared for by the two caregivers. Although some detailed studies such as demographic and health surveys as

well as population and housing censuses have been conducted in Ghana and elsewhere on maternal and child health, not much comparative qualitative studies have been undertaken (if any at all) in the country that had specifically assessed childcare practices of these two caregivers within the context of children's illnesses management, feeding practices and decision making processes underlying the care practices. What have been journalistically reported have been the occasional issues of non-maternal caregivers abusing or maltreating children. Conducting a qualitative study focusing on child health but with emphasis on household child caregivers' practices, seemed to be one of the vital means through which one could contribute empirically to the discourse on improving child health in Ghana.

Secondly, the decision to undertake this interpretivist or qualitative study was based primarily on the second and third assumptions underlying this research paradigm as highlighted by O'Donoghue (2006). The second assumption, as already indicated above, provides that everyday human activity is not totally imposed on an individual, but is allowed some level of autonomy and freedom. It was therefore assumed that mothers will have greater autonomy and responsibility than non-mothers during childcare. However, it was also noted that, at the household level, the non-mothers spent a considerable amount of time with children, usually alone especially in instances where the mothers have resumed full-time work outside the house. If these non-mothers had some freedom and leverage, then how were they practicing childcare in areas such as identification and treatment of children's illnesses, adherence to medicine regimen and children feeding? Were their practices in congruence with that of maternal caregivers and, if no, what were the potential health consequences of the divergence on the health, growth and

development of such children? Following on is the third assumption which states that every day human activity involves interactions with other people. This assumption also prompted the need to situate the study in the interpretivist paradigm as a means of delving deeper into the human interconnectedness relative to childcare and how caregivers were navigating childcare practices with other individuals whose actions could shape or have shaped the overall child caring process.

Finally, it was necessary to understand the social construction of household child caregivers, focussing on the decision-making processes that determined who becomes a household non-maternal caregiver and how their previous social construction maps onto their current environment as well as how the social construction of the maternal caregivers inter-relate with that of their non-maternal counterparts and how all these interwoven complex systems of social constructions mirror in on the health of Ghanaian children. For instance, the journalistic reports usually do not give detailed insight into the relationship and communication pathways between the two caregivers. They also do not provide empirical details on the remote factors that culminate in the abuse of children by their non-maternal caregivers. A study situated in the interpretivist context was therefore appropriate because using other designs could make it difficult to define and measure the phenomenon with standard instruments.

Similarly, the intention to conduct this study qualitatively was to understand the multiple realities of the caregivers and how they individually or collectively help to explain some of the factors that contribute to the unacceptable high urban infant and child morbidity and mortality in Ghana. The idea was not to generalise the caregiving practices of mothers and non-mothers but to contribute to the building of another theory that may

offer some explanations on child health challenges in Ghana and how the issue could be studied further using large scale inquiry.

Based on the above justification and the decision to situate this study in the interpretivist research paradigm, this exploratory qualitative study was conducted on childcare practices in the Kumasi Metropolis of Ghana. Exploratory research is about putting oneself deliberately at a place over a period of time for possible discovery of phenomenon (Stebbins, 2001). They may be conducted to provide baseline information that would help define exact research problems, offer insight into the various sources of data and suggest appropriate data collection methods for the conduct of future large scale studies. Singleton, Straits and Straits (1993) also opine that exploratory researches are generally conducted to discover new insights into a given situation or phenomenon although findings from such studies are generally difficult to generalise to the population due to their relatively small sample sizes and limited study areas.

This research was considered as an exploratory study because it was the first to be conducted among urban middle class cohort of Ghanaians in general and the Kumasi metropolis in particular. Besides, it focused on only three key childcare issues of illness management, feeding practices and intra-household decision making process. Moreover, it was limited to just children under age five in line with MDG4 (SDG 3.2) and other national policies and programmes specifically targeting children in this age bracket despite the United Nation's definition of children as people less than 18 years.

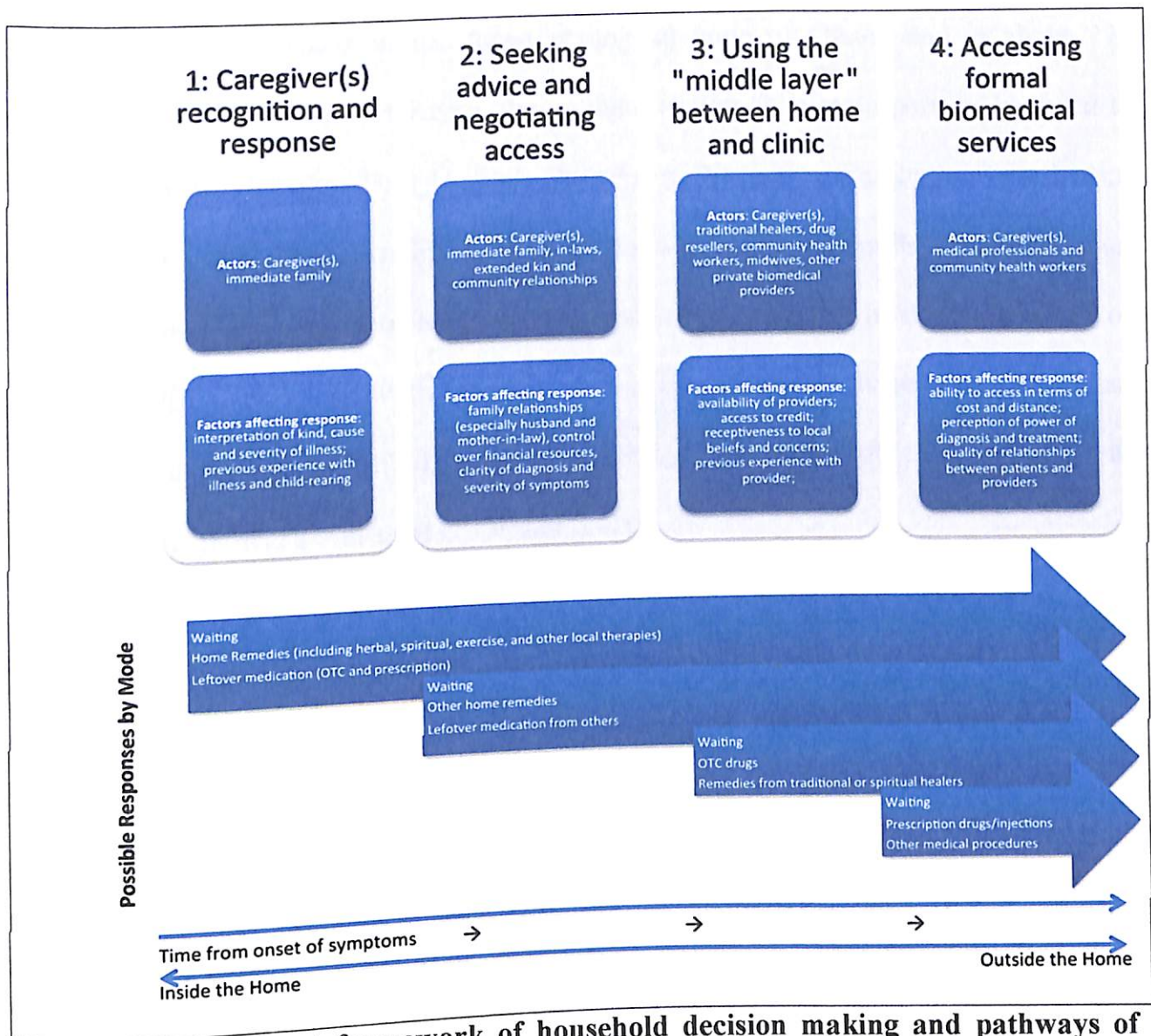


Figure 1: Conceptual framework of household decision making and pathways of care

Source: Colvin, et al, 2013

Colvin and associates in their framework observed that households generally tend to use the services of middle layer health care providers such as drug sellers, community health workers, herbalists and other traditional healers while a shift to biomedical intervention(s) is usually prompted by worsened conditions of the illness and uncertainty about the cause of the illness. The framework heightened the central role of waiting or time in household decision-making processes, describing it as a “conscious decision on

Kumasi is located in the forest ecological zone of Ghana and is about 270 kilometres (by road) north of Accra, the national capital. The metropolis is bounded to the north by the Kwabre East District, Bosomtwe District to the south, Ejisu-Juaben Municipal to the east and Atwima District to the west. The metropolis' unique location during the period of the trans-Saharan trade, its current location in the middle belt of Ghana and expansion of educational and the service sectors have shaped it to become an important commercial hub in Ghana (Owusu & Agyei-Mensah, 2011; Owusu-Ansah & Braimah, 2013; Owusu-Ansah & O'Connor, 2010).

Pipe-borne water coverage in the Kumasi metropolis is 83% but water supply is irregular in most of the peri-urban areas that have sprung up in the metropolis. As a coping strategy, some residents use water drawn from wells and boreholes for domestic use which are usually contaminated and do not meet acceptable health standards for human consumption (Boamah, Gbedema, Adu, & Ofori-Kwakye, 2010). Residents of Kumasi are also confronted with some environmental problems such as water pollution due to the discharge of human effluents into rivers, uncollected refuse piles and occasional flooding due to chocked gutters.

Some common children's illnesses in the metropolis are infectious, diarrhoeal, bacterial and parasitic diseases (Smith, 2004). Comparably, people who live in Kumasi have relatively easy access to formal health delivery outlets and personnel (Ghana Health Service, 2010). Some of the general and specialist health services provided to inhabitants in the metropolis include eye care, obstetrics, dental care, immunisation, reproductive and child health, disease control, nutrition and health information management. The Komfo Anokye Teaching Hospital (KATH), located in Kumasi, is the second-largest hospital in

Ghana and serve as the main referral hospital for mostly the regions to the north of Ghana (Agbenorku et al., 2010; Asundep et al., 2013; GSS, 2013). Kumasi metropolis also host the second largest public university in Ghana, the Kwame Nkrumah University of Science and Technology (KNUST) which trains students in various scientific disciplines such as medicine, law, pharmacy and engineering.

The Kumasi Metropolitan Area is completely urbanised and inhabited by people with varied socio-economic backgrounds. Its central location, existence of more social services, vibrant commercial activities and attractiveness to large middle class working professionals with disposable income and able to invest in childcare makes it an ideal site to conduct a study of this nature that sought to assess household childcare practices in an urban setting of Ghana.

Research participants

The participants in this study were obtained from households where biological mothers could be described as being a middle class working mother and had one principal household non-maternal child caregiver such as a househelp or a grandmother who were jointly taking care of children less than five years old in the household. Middle class working mothers were operationally defined in this study as constituting the group of mothers in the Kumasi Metropolis who either had attained a higher academic degree (such as Bachelor or Postgraduate) and engaged in a professional career (such as Banking or Teaching) or private businesswomen who could afford to stay or accommodate a non-maternal household child caregiver. The mothers were all resident in the Kumasi

metropolis of Ghana during the period of data collection and were present in the household at the time of the interview.

Some mothers were identified through asking community members for information on who they perceived fits into this description in the neighbourhood. Some were also identified through snowballing starting with an identified mother. The study participants were limited to this relative small group because the researcher was of the view that these mothers were more enlightened, had disposable income to provide quality healthcare and make adequate nutritional provision for their children as well as being more assertive in their children's growing environment and health needs.

The index child, the one on whom the caregivers' childcare practices were based, were reported to have been sick by the mother during the one month preceding the data collection. This was to ensure that issues on children's illnesses management practices adopted by the caregivers during the period served as the foundation for the interview. Besides, the one-month benchmark was set to minimise recall lapses on the part of the respondents. The final inclusion criterion was the willingness of both maternal and household non-maternal caregivers to participate in the study and to be interviewed simultaneously.

This meant that all mothers and household non-maternal child caregivers in the Kumasi metropolis who had children less than five years but have not been reported sick during the past one month, were staying with other household caregivers but not described as belonging to a middle class working mother were all excluded from the study.

In addition to the individual household maternal and non-maternal child caregivers, other key informant research participants were drawn from either the Ashanti Regional or Kumasi Metropolitan Directorates of the Ghana Health Service, Ghana Police Service, Ghana Education Service as well as Religious leaders (more details about the research respondents are provided in the next chapter).

Data collection instruments

Two separate in-depth interview guides were developed for individual household child caregivers and key informants respectively. Also, developed was a guide that sought to elicit primary data from focus group discussants as well as an observational checklist that was used to document some childcare practices at the household level. These instruments were developed based on the objectives of the study, the research questions and key knowledge gap issues identified during the literature review.

The in-depth interview guide had six sections which were preceded by an introduction which contained brief background to the study, reasons for the interviews and informed consent. The first section was a screener which was used to capture some data on the background characteristics of the respondents such as their age at last birthday, sex, ethnicity, household composition and ages of children in the household. The section also facilitated the process of identifying eligible households for the study as well as the procedure for seeking their consent to participate in the research. The last section of this instrument was also used to elicit additional demographic data about the respondents. Some of the issues captured in this section included the primary occupation of the respondent, highest academic qualification and, for the case of the non-maternal

caregivers, their relationship with the mother and the number of years they had served as non-maternal caregiver in the household.

The second section of the in-depth interview guide was used to generate detailed narratives of the respondent's account of the index child illnesses history during the past one month preceding the interview and how the illness was managed at the household. The third section focused on caregiver's feeding practices such as identification and interpretation of index children hunger and satiation cues, hygienic practices related to food preparation and feeding, water, fruit and vegetable intake as well as caregiver's challenges in child feeding. The fourth section focused on intra-household decision-making processes. Questions such as what informed maternal caregivers to engage the services of household non-maternal child caregivers, who take major household decisions on issues such as menu for children, treatment options for sick children, spending on sick children and feelings of mothers for sharing childcare duties with other household members were asked to elicit data on intra-household decision making regarding childcare. The fifth section ended the interviews with respondent's views on how the two caregivers could contribute to provide quality childcare.

The instruments for the focus group discussion followed the same structure of the in-depth interview guide except that some of the questions were modified and aimed at eliciting group responses and experiences. The key informant interview guide had four sections. The first gathered brief demographic data about the interviewees while the second delved into national policies that regulate childcare and the engagement of non-mothers as household child caregivers. This was followed by issues on children's illnesses management, children feeding practices, child neglect or abuse in the Kumasi

Metropolis and their recommendations for improving household child caring practices in the metropolis.

The observational checklist was designed to document some childcare practices, range of medicines in the household's first aid kits, feeding practices and, if permissible, caregivers' medicine administration to the index children and other non-childcare activities engaged in by non-maternal caregivers. Copies of all the research instruments and checklist are provided in Appendix 1.

Recruitment and training of field staff

Three female Research Assistants from the Faculty of Social Sciences of the University of Cape Coast were recruited and trained to assist in primary field data collection. This became necessary because of the simultaneous nature of the household interviews as well as the need to have a recorder during the focus group discussions. These Assistants were recruited based on their familiarity with qualitative research methodology, knowledge in child health, fluency in the dominant local languages in the study area as well as acquaintance with the study sites.

The contents of the training centred on reported children's illnesses in the study area and illness management practices, identification of hunger and satiation cues as well as feeding styles and hygienic practices involved in food preparation. Other issues treated during the training were research methodological issues such as identification of inclusion and exclusion criteria, interviewing techniques and data capture as well as data transcription, management and research ethics.

The training was implemented over a period of two days (refer to training timetable in appendix 2). The training was a mix of lecture, discussions and role plays which made it possible that at the end of the second day, they had acquired the requisite knowledge in the concept and theory of the research focus, peculiar skills needed in identifying the eligible respondents and data capturing techniques as well as the confidence to effectively carry out their respective roles and responsibilities.

Data collection procedure

Apart from personal identification of the field staff, an introductory letter was obtained from the Department of Population and Health, University of Cape Coast, to facilitate entry into the study sites (Appendix 3). Copies of the letter were sent in advance to some relevant metropolitan gatekeepers such as the Ghana Police Service, the Ghana Health Service and the Metropolitan Secretariat of the Department of Social Welfare. The rationale was to inform them of my presence in the metropolis; explain the objectives of the study and seek their permission, consent and support during the data collection period of the study.

The first phase of the primary data collection commenced on Friday, 5th June, 2015 through to Thursday, 9th July, 2015 excluding another month for transcription of the interviews. This comprised the individual household interviews of maternal and non-maternal caregivers. The main qualitative data collection methodologies used at this phase of the process was in-depth interviews and observation. In order to obtain responses from a cross-section of respondents in the entire metropolis, it was decided not to concentrate only on a few sub-metropolitan areas but endeavoured to have respondents from all the nine sub-metros that form the Kumasi metropolis. Identification of eligible

households therefore started from the sub-metro capitals. For instance, in the Asokwa sub-metro, identification of respondents started from the Asokwa Township similar to starting from Asafo Township in the Subin sub-metro area. The reason why the sub-metro capitals were used was that it was anticipated they were the likely dwelling places of most of the targeted respondents aside serving as a major point of reference for coverage in the metropolis.

Starting from the centre of the sub-metro, the purposive sampling procedure of qualitative research methodology was employed to identify eligible households and respondents. We were pulled to houses using the iterative (door to door) procedure, snowballing or based on a combination of some observable indicators such as drying of children washed clothing that suggested the presence of a child or children in the household. After identifying a house with children guessed to be within the benchmarked age range (under 5 years old), the research team established rapport with the maternal caregiver by explaining the purpose of our visit and the research project. This was followed by the completion of a screener which captured some background characteristics of the household and set out the inclusion and exclusion criteria of eligible households. Once it was established that the household meets the inclusion criteria, both caregivers were individually interviewed simultaneously by the research assistants. One index child was randomly selected for interviewing with the caregivers in households that had more than one eligible index child (i.e. if more than one child is below age five and have been reported sick in the month preceding the study).

The interview sessions were commenced by seeking the consent of the respondents to participate in the study. This happened after allowing the respondents to

choose a convenient place within the household where they felt comfortable for us to sit and that ensured their privacy. This was done by allowing those who could read the informed consent form to do so or was read to those who could not. They were subsequently allowed to ask questions about the consent or any related issues about the study before commencement of interviews.

The decision to simultaneously interview the two caregivers was premised on the assumption that interviewing them at different times may introduce some biases into their responses since the first respondent may confer with the latter on the contents of the interview which could re-shape their 'natural' responses. This implied that eligible households where both caregivers were not available to be interviewed simultaneously were omitted from the study. Interviewing the respondents individually also enabled them reflect on their childcare experiences and freely shared their practices with the research team.

There were a few instances, though, where the maternal caregivers agreed to be interviewed at their workplace while the non-mothers were interviewed at home. Moreover, in instances where one caregiver was busy at the time of our visit, the research team made appointment to visit the household at a later time but this yielded minimal results since the mothers especially were always busy with work outside home and other domestic engagements on their return to the house from work.

This process was repeated in all the sub-metros and after interviewing 56 individual respondents or 28 paired-caregivers, a thematic or theoretical saturation was reached. Rosenthal and her colleagues (2009) explained thematic or theoretical saturation as a recognised criterion for adequacy of sample size and the point in the interview

process where no new themes or concepts emerge from subsequent interviews. Bjerrum et al. (2012) explained it as when additional interviews no longer add any new insight to the collected data. Questions such as caregivers perceived causes of index child illness, treatment options utilised, household child illness management practices, awareness of child health educational programmes in the mass media, determination of hunger and satiation cues, feeding styles, awareness and practice of personal hygiene during food preparation as well reasons for engaging or becoming a household non-maternal caregiver were all not providing new perspectives after interviews in twenty-three (23) households.

Prior to the fieldwork, the anticipation was that a minimum of 40 in-depth interviews would be conducted before reaching saturation level. This number was based on previous studies of this nature. For instance, in a study on treatment actions and treatment failure of febrile illness in Mali, saturation was reached after interviews in twenty-five households (Ellis et al., 2012). Similarly, saturation was reached after interviewing 46 child caregivers in a study on understanding risk, decision-making and child health in a food crisis situation which was conducted by Hampshire and her associates (Hampshire et al., 2009) in two districts in Niger.

The breakdown of the respondents according to the sub-metros is provided in Table 1. Subin sub-metro recorded the least number of households due to its highly industrialised nature with a few residential facilities coupled with the closed inclusion and wide exclusion criteria.

Table 1-Paired-household respondents interviewed

Name of sub-metro	Paired-household respondents interviewed
Asokwa	3
Bantama	2
Kwadaso	2
Manhyia	5
Nhyiayeso	4
Oforikrom	5
Suame	3
Subin	1
Tafo	3
Total	28

Source: Field survey, Owusu (2015)

The interview sessions on child illness management practices were based on a detailed one-month retrospective narrative of the respondents' caregiving practices and life histories of the index child in the three thematic areas of the study. The individual respondents were asked to provide a detailed illness narrative describing their actions in response to an illness episode, respondent's concept of illness, causation, knowledge of symptoms, prevention, health seeking options, barriers to health seeking and linkages with health service providers. The session also focused on intra-household decision

making processes regarding child health-seeking options, roles and responsibilities of household members during the illness period and post treatment activities.

The segment on food and feeding included the respondent's 24-hour dietary recall of their activities involving identification and understanding of child hunger and satiation cues, food preparation and child feeding practices. The recall narrative was expanded to solicit data on respondent's dominant feeding styles, practices and adoption of hygienic practices during food preparation and feeding. Anwar and his colleagues (2012) have observed that using a short recall period produces better data because participants would be able to provide detailed and accurate report on the events under investigation.

The interview session on household decision-making focused on what informed the mothers to engage non-mothers and, in the case of the non-mothers, why they become non-maternal caregivers, communication between the caregivers and challenges associated with childcare. Other issues explored were whether the maternal caregivers gave detailed instructions to the non-mothers and how they verified that such instructions were followed. Some responses from previous interviews sometimes provided the opportunity to refine and re-direct some questions during subsequent interviews.

The other component of the household interviews involved a direct observation of some childcare practices implemented by the caregivers during the course of the interviewing. Observation of behaviour was reported by Gittelsohn and associates (1998) as sometimes being more accurate than recall in obtaining behavioural information. Some childcare practices such as hand washing with soap, feeding styles and caregiver behaviour during child feeding were observed. The observation was not intended for the respondents to change their behaviour but offered the research team some insights into

the similarities and differences in the caregiving approaches of the two caregivers. There were a few instances where other household members such as husbands and other siblings of the index children were present during the interviewing process. The husbands did not sit through the interviews but sometimes volunteered to comment on the responses of the maternal caregivers.

The second phase of the fieldwork involved the conduct of key informant interviews and focus group discussions. After initial contacts with seven policy making and implementing institutions in the metropolis, five of them agreed to be interviewed. They consisted of a Paediatrician with the Ghana Health Service, a Director of Education, a Reverend Minister, a Headmistress and a Police Officer who was attached to the Ashanti Regional Secretariat of the Domestic Violence and Victim Support Unit (DOVSU) of the Service. These institutions are usually manned by professionals who are deemed knowledgeable in childcare practices in the metropolis and were, therefore, in a good position to share their views on contemporary child caring practices in the metropolis. Their interviews centred mainly on common children's illnesses and feeding practices in the metropolis as well as the implementation of some national and regional child caring policies and their recommendations for improving household child caring practices in the metropolis and the country. All the key informant interviews were conducted in the offices of the respondents except the headmistress and the reverend minister who agreed to be interviewed in their respective homes.

There was also a focus group discussion involving maternal caregivers, female and male househelps. The discussants were recruited separately from the individual caregivers who were interviewed at the households. In all, eight mothers, nine females

and six male househelps participated in the discussions. The issues discussed did not differ much from what ensued during the individual interviews, however, the discussions offered group perspectives on the issues being investigated. This phase of the fieldwork was implemented between Friday, October 23rd, 2015 and 15th November, 2015.

All the interviews and focus group discussions were conducted in the Twi local language or English depending on the preferred language of a respondent. In addition, all the responses were digitally recorded and hand notes taken on some pertinent issues that emerged in the course of the data collection. The Research Assistants conducted the simultaneous household interviews while I joined them to conduct the key informant interviews and facilitated the focus group discussions.

All the responses were respected and not treated judgmentally. There were some respondents who provided detailed responses to some of the questions posed while a few others also had little to say about some issues that we were exploring. This made the duration for each interview session vary but on the average an interview lasted between 40 to 50 minutes.

Ethical issues

Studies of this nature involve a number of ethical issues that have to be managed carefully as a prerequisite for averting harm to research participants and the research community. Ethical clearance was obtained from the University of Cape Coast's Institutional Review Board (UCCIRB). The Board is an independent body constituted by the University to regulate research activities carried out by students and faculty by ensuring that their research work does not infringe on the rights of the research subjects.

Appendix 4 is the ethical approval letter obtained from the UCCIRB (Ethical Clearance – ID NO: UCCIRB/CHLS/2015/03).

The informed consent form clearly indicated the name and address of the researcher, aim of the study, anticipated duration of the interviews and respondent's ability to skip answering some questions or opting out of the entire study at any point. In addition, the document also contained sections that assured the confidentiality and anonymity of the research subjects as well as the contact details of the principal supervisor offered the respondents the opportunity to contact him for further clarification if need be. A copy of the informed consent form is attached to this research report as appendix 5.

The contents of the informed consent were read and explained thoroughly to respondents who opted for this and in a language that they understood. They were asked to sign or initial to the form or give verbal consent before proceeding to asking the specific questions that related to the study. Copies of the consent forms were also given to other respondents who wanted to peruse its contents by themselves and for keeps. This also helped in clearing doubts in the minds of the respondents and emboldened them to candidly share their child caregiving experiences with the research team.

Data capture using digital devices such as audio recorders and cameras sometimes pose ethical challenges especially when it comes to data storage or archiving coupled with the need to make the research data and findings public. To this end, all the respondents were notified in advance and their permission sought before such data capturing devices were used to record the interviews and discussions. Furthermore, the identity of all the respondents (names and location of households) have been anonymised

in this report using pseudonyms so that no personal identifiers are available to link respondents to the data collected (Bjerrum et al., 2012; Moyou-Somo et al., 2013). Moreover, after transcribing the recordings, the digital recordings have been completely deleted from the recorder and saved under a protective password. In addition, all paper transcripts have been burned. Finally, all the soft copies of the transcripts have been electronically saved for at least 5 years with a secured password which is known only to the researcher after which they would be completely deleted as well.

Before ending an interview session with each respondent, each research assistant read the contents of the data they had gathered to the respondent to ensure that the latter was fully aware of the data that they have provided and also gave the participants another opportunity to provide additional data that might have escaped their thought. This also ensured that the data captured was a true reflection of the issues that had been discussed between the interviewee and the interviewer. This, nonetheless, was done with extreme caution so that it did not give the respondents undue advantage to alter the data they had previously provided. The debate on ethical implications regarding offering financial rewards to research participants is inconclusive. No financial incentives were therefore offered to participants.

Data processing and analysis

All the digital recordings were first transcribed verbatim from the local language into English but leaving key or untranslatable terminologies in the original local language. All the digital recordings were played several times and cross-checked with each of the draft transcripts. In the process, some were edited to correct grammatical

errors, omissions, accuracy and consistency of translations. Similarly, all the hand-written notes were typed and added to the appropriate sections of the transcripts. Subsequently, all the transcripts were read and re-read to identify emerging themes.

Analysis of the data was based principally on the grounded theory, in which theoretical insight emerged from the data, rather than being pre-imposed (Strauss, 1987). Aside the two obvious thematic areas of illness management and feeding practices, the continuous reading of the transcripts generated other themes on trust, reciprocity and assertiveness. The transcripts were therefore manually coded according to these themes. Some salient quotes in the responses were noted and used to re-enforce the research findings. The data analysis was therefore thematic and inductive in nature.

The unit of analysis of the individual household data was the index children since the caregiving practices of the respondents related directly to these children. The analysis was also organised to highlight the similarities or differences in the childcare practices of maternal and non-maternal caregivers as well as the effect of modern technology such as mobile phones on childcare and health in the Kumasi Metropolis. All potential identifying details of the respondents have been altered or omitted to ensure the confidentiality and anonymity of the research participants.

Challenges from the field

One major challenge faced during the fieldwork was the lack of data on households in the Kumasi metropolis that met the inclusion criteria of this study. Perhaps, the paucity of research in this area accounted for the absence of such baseline data. The one-month child illness episode prior to field data collection as one of the inclusion

criteria as well as the simultaneous interviewing approach adopted for this study might have also contributed to the scarcity of eligible respondents. This challenge, which also makes the study a novelty, was, however, managed through the adoption of the iterative procedure in identifying respondents as well as the snowballing technique of qualitative sampling procedure.

Following on from the point above was the absence of other eligible respondents due to the cosmopolitan nature of the study site, busy schedule of the maternal caregivers due to their multiple tasks of childcare and work outside the home. Ideally, these middle class targeted respondents could have been available during the weekends but their social status also made them very well connected and mobile and therefore had to honour other social invitations such as weddings or funerals which made them equally unavailable during the weekends. This, notwithstanding, the few who participated in the study provided detailed and useful responses which have offered some broad perspectives on this childcare arrangement.

Lastly, the sensitive nature of issues explored in this study might have made some respondents uncomfortable to provide responses to some of the questions. Having a conversation about child illness seemed an unpleasant topic for a grandmother who remarked that the topic evokes bad memories. The interview session with her was therefore brought to an abrupt end almost at half way through the session. Besides, the non-maternal caregivers did not provide enough data when asked about maltreatment or abuse meted out to them by their maternal counterparts except to say that all is well and relationships are very cordial. This was countered by the open and detailed responses from majority of the respondents which were of sufficient quality and analysable.

CHAPTER FOUR: RESULTS AND DISCUSSION

Introduction

The aim of this study was to investigate the child caregiving practices of maternal and household non-maternal caregivers of under five children in the Kumasi Metropolis of Ghana. This fourth chapter of the thesis is presented in the next three chapters. This chapter four provides an insight into the demographic and socio-economic characteristics of the respondents, an analysis of the push factors that necessitate maternal caregivers' engagement of household non-maternal caregivers and the pull factors that attract people to become household non-maternal caregivers and ends with results on children' illness management practices.

Socio-demographic characteristics of individual household caregivers

Two categories of respondents are described here as constituting individual household child caregivers. The first category comprised biological mothers of the index children while the second group represents their respective non-maternal child caregivers. Nearly all the maternal caregivers and some 18 of non-maternal caregivers were in their reproductive ages (15-49 years old). Similarly, almost all the household caregivers were members of the Akan ethnic group in Ghana (Table 2).

Table 2- Background characteristics of individual household child caregivers

Background Characteristics	Maternal N (28)	Non-maternal N (28)
Age		
15-24 years	3	12
25-34 years	19	4
35-44 years	5	1
45-54 years	1	5
55-64 years	0	3
65-74 years	0	3
Non-response	4	4
Ethnic group		
Akan	23	22
Gonja	1	2
Non-response	4	4

Source: Field survey, Owusu (2015)

More than half of the mothers and over a third of the non-maternal caregivers had lived in Kumasi for more than twenty years (Table 3). Two-thirds of the maternal and a quarter of the non-maternal caregivers were married while the others had varied marital statuses such as divorced or never married.

Table 3- Other background characteristics of caregivers

Background Characteristics	Maternal N (28)	Non-maternal N (28)
Years of living in Kumasi		
0-10 years	3	9
11-20 years	5	4
21 years and above	16	11
Non-response	4	4
Marital status		
Never married	7	12
Married	17	7
Divorced	0	3
Widow	0	2
Non-response	4	4

Source: Field survey, Owusu (2015)

The maternal caregivers had attained various higher academic qualifications including Post Graduate to Higher National Diploma levels relative to the non-maternal caregiver's who either had attained or enrolled in Basic Education or had no formal education (Table 4).

Table 4-Highest academic level of respondents

Background Characteristics	Maternal N (28)	Non-maternal N (28)
Highest academic level		
None	0	7
JSS/JHS	12	19
SSSCE/WASSCE	6	0
Higher National Diploma	2	0
Bachelor	5	2
Post Graduate	3	0

Source: Field survey, Owusu (2015)

The maternal caregivers were engaged in various middle-class economic activities such as banking, engineering, administration or private businesses relative to the non-maternal caregiver's who were largely full-time child caregivers (21%) or combined child caring with schooling (25%), home-based petty trading (38%) or apprenticeship (Table 5).

Table 5-Primary occupation of individual household caregivers

Background characteristics	Maternal	Non-maternal
	N (28)	N (28)
Primary Occupation		
Banking	6	0
Private Business/Home-based petty	16	11
Student	2	6
Engineering	1	0
Insurance Brokerage	1	0
Administrative Secretary	2	0
Teaching	0	1
Apprentice	0	2
Full-time cares/Unemployed	0	6
Non-response	4	4

Source: Field survey. Owusu (2015)

Furthermore, the non-mothers had been working in this capacity for a period ranging from one to five years (17) with just a handful who had worked for less than a year. It is also significant to note that these caregivers were related to the mothers in

various capacities but mainly as daughters (grandmothers of the index children), relative or non-relative househelps (Table 6).

Table 6-Other background characteristics of the non-maternal caregivers

Background Characteristics	N (28)
Years as a non-maternal caregiver	
Less than one year	2
1-5 years	17
6 years and above	5
Non-response	4
Relationship to child's mother	
Elder sibling	1
Daughter (Grandmother)	12
Relative househelp/Maid servant	10
Non-relative househelp/Maid servant	5

Source: Field survey, Owusu (2015)

Background characteristic of Focus Group Discussants

In addition to the individual mothers who were contacted and interviewed in their houses, another set of eight mothers were organised for a focus group discussion to elicit

data on group perspectives and experiences in living with non-maternal child caregivers. All the discussants were professionals with not less than five years working experience. They were between 25 and 59 years old and had been staying with their biological children and househelps for at least five years (Table 7).

Table 7- Background characteristics of maternal Focus Group Discussants

	N (8)
Age	
25-34 years	1
35-44 years	2
45-54 years	3
55-64 years	2
Years of work experience	
Less than 10 years	2
11-20 years	4
21-30 years	2
Academic qualifications	
Bachelor	5
Post Graduate	3

Source: Field survey. Owusu (2015)

Similarly, all of the discussants were married and have been living in Kumasi since birth. All the discussants also had higher academic qualifications with the least being a Bachelor's degree.

Another category of focus group discussants in this study were female and male househelps in the Kumasi Metropolis. As noted by some researchers including Goberman-Hill and Ebrahim (2006) as well as Hadley and associates (2010), women are largely associated with the responsibility of taking care of children in most societies, however, this traditional notion is gradually changing due to considerable changes in gender roles in most parts of the world. In the Kumasi Metropolis, it was not only women and girls but boys were sometimes engaged as househelps or houseboys (Table 8).

Table 8-Background characteristics of househelp Focus Group Discussants

	Female househelps	Male househelps
Background Characteristics	N (9)	N (6)
Age		
10-14 years	2	5
15-19 years	7	1
Relationship to maternal caregiver		
Relative househelp	8	5
Non-relative Househelp	1	1

Source: Field survey, Owusu (2015)

Overall, nine females and six male househelps were respectively recruited as focus group discussants for this study. All of them were teenagers staying with relative (9) or non-relative maternal caregivers.

Background characteristic of Key informants

The key informants comprised three females and two males (Table 9) who had attained tertiary academic qualifications and had, at some points in their life, stayed with househelps, received briefings or mediated on issues that centred on maternal caregivers and their househelps. They had also acquired various experiences in policy and practice on matters that relate to children's health, education, welfare and abuse.

In sum, the participants for this study were generally Akan's resident in the Kumasi Metropolis at the time of the study and lived in households with children less than five years of age. They were composed principally of either parents who needed other household caregivers to assist in childcare or househelps who had accepted to assist in household childcare. Additionally, most of the maternal caregivers were married and largely engaged in middle-class economic activities such as teaching, banking or private business while the non-maternal caregivers were relative/non-relative househelps (children or late adolescents) and grandmothers who were full-time caregivers or combined childcare with other activities such as schooling or petty trading.

Table 9- Brief Background characteristics of key informants

Background Characteristics	N (5)
Sex	
Males	2
Female	3
Professional Background	
Ghana Education Service	2
Ghana Police Service	1
Minister of religion	1
Paediatrician	1
Highest academic qualification	
Bachelor	3
Post Graduate	2
Years of professional experience	
Less than 10 years	2
More than 10 years	3
Age	
35-44 years	1
45-54 years	1
55-64 years	3

Source: Field survey. Owusu (2015)

The push factors that necessitated maternal caregivers to engage househelps and the pull factors that attracted househelps form the second part of this chapter.

Push and pull factors

Childcare is one of the major prime responsibilities of parents therefore, as Undheim and Drugli (2012) have already indicated, delegating this responsibility or certain aspects of it is a risk that some parents take. In Ghana, as well as in other countries, households do not necessarily compose of the nuclear family but a host of other extended family members and sometimes non-related members. It was therefore necessary to, first of all, find out from the maternal caregivers what influenced their decision to engage a household non-maternal caregiver to assist in caring for the index children.

The mothers cited a number of factors termed or referred to in this write up as “push factors” to explain their engagement of non-maternal caregivers. Some of the factors included household security concerns, a helper to assist in childcare and house chores, companionship, assisting less endowed family members to take care of their children or as a goodwill gesture to other extended family members who, otherwise, might struggle in taken care of their children. For instance, according to a 40-year old maternal discussant, her house is *located at a place that is remote and becomes very quiet in most parts of the day* so she decided to engage a househelp who would keep her company, *care for the children when I am away from the house and somebody who could play with the children when they are bored.* Similarly, the accounts of these three

maternal caregivers are very illustrative of the other push factors explained by the other maternal caregivers.

The nature of my profession is very demanding which makes it difficult for me alone to combine it with childcare. I needed somebody to help me in my day-to-day activities as a mother and as a professional. For instance, I have to come to work very early in the morning and return home late in the evening for most times of the week. But because I also have children in the house, it was necessary for me to engage a househelp who would assist me in childcare [Maternal Caregiver, 42 years old].

My househelp is an orphan. Her parents died through a car accident but while the father was on admission at the hospital, I visited him and he asked me to take care of his children in case he does not survive. [...] I had to fulfil my part of the promise when he died. I have my own biological children that I am also staying with so the househelp has been assisting me in caring for my children as well [Maternal discussant, 49 years old].

I once stayed with a relative househelp whose parents were in dire need of assistance to take care of their children. They liked the way I trained my children and the househelps so up till now it has become a routine for me to take care of other relative househelps when the need arises [Maternal discussant, 56 years old].

There were also rare instances where one of the key informants indicated that some mothers or households engage househelps as a public show of prestige or worth. According to the Education Director, there are some mothers in the Kumasi Metropolis who perceive staying with househelps as *an evidence of belonging to a middle or high social status* since it is perceived that it is only the privileged or rich households that can afford househelps.

On the other hand, when enquired from some of the househelps why they decided to leave their parents and become a househelp in Kumasi, it was deduced from their responses that several “factors pulled” them to become househelps. Principally, their desire to live and school in a city as well as economic hardships being encountered by their parents informed their decisions to relocate to Kumasi and become househelps. On arrival in the households, their receiving or fostered parents were expected to feed, shelter, cloth and/or enrol the househelp in school or apprenticeship in return for their childcare and other domestic services. The two examples presented here are typical of the pull factors:

My father told me that life in the village will not allow me to have quality education and better career opportunities so he wants me to come and stay in the city with my grandmother so that I can further my education. I obliged and, to my surprise, realised that she was also taking care of her grandchildren and will require my involvement in the childcare [15-year old female househelp discussant].

My madam needed a househelp to assist her in childcare so she discussed it with a family member. Around that same period, my father died [...] so

that relative informed my mother to allow me to come and stay with my cousin in Kumasi and help her in childcare while she also enrolls me in school [16-year-old Househelp).

There are no specific policies or legislation in Ghana that regulate the engagement of househelps, although Ghana has adopted various national and international policies that seek to protect children from abuse, exploitation or neglect. Corroborating the above, the Education Director observed that the arrangements are generally domestic in nature between the sending and receiving parents or households. The Police Officer drew attention to the existence of the Ghana Children's Act (ACT 560) which was assented to on 30th December, 1998. The Act, according to him, seeks to partly protect these children but bemoaned the general lack of enforcement of the provisions of the act which makes it appear that these practices are not regulated.

Both maternal and non-maternal caregivers could be described as coming from backgrounds that are dictated by pull and push factors respectively. The former was in relatively higher economic status category with stable employment and income, limited time to effectively combine full time employment with childcare and therefore were pushed to engage househelps. On the other hand, these househelps were pulled into childcare principally due to their parent's economic challenges that inhibit their desire for their children to live and attend school in cities as well as inability to fully meet the needs of their children. The engagement of househelps through the system of fostering, the practice whereby a child or children live with an adult caregiver who is neither their biological parent is widespread in sub-Saharan Africa. This system either comes with benefits or exploitation (Hampshire et al., 2015). Similarly, househelps combination of

childcare, schooling/apprenticeship and performance of other household chores may not be compatible with the provision of quality childcare. There are also other issues of positive and negative reciprocity as well as trust embedded in this system of care. The next chapter presents the findings on household caregiver's management of index children's illnesses.

Child Illnesses Management Practices

This section provides an analysis of household child illness management practices by both maternal and non-maternal caregivers (househelps or grandmothers). It discusses the management practices in the context of common child's illnesses reported by the caregivers, illness symptoms identification, caregivers perceived cause(s) of illness, treatment options utilised, household treatment practices and challenges encountered in the illness management processes. The analysis is structured to compare the practices of the various caregivers with the aim of distilling similarities or differences in the various practices. The analysis was also done with reference to the theoretical models and conceptual framework discussed in chapter four.

Common illnesses reported by caregivers

Child caregiver's ability to manage children's illnesses will depend on their ability to recognise illness symptoms. Undeniably, it will take the caregivers deeper and accurate understanding of the illness affecting the child to inform their subsequent decisions and actions at health seeking. For instance, it will take the caregivers proper

interpretation of the illness symptoms to decide on the seriousness of the illness, avoid delays in seeking treatment. choose treatment options and comply with post-treatment directives such as referrals, regimen and reviews. To this end, all the household maternal and non-maternal individual respondents and focus group discussants were asked to recall the most recent illnesses of the index children during the past one month prior to the interview. On the part of the key informants, they were asked to indicate their perceived common children's illnesses reported in the Kumasi Metropolis.

In general, the caregivers reported that they perceived the index children had been affected by various illnesses such as diarrhoea, fever, malaria and flu/cold (Table 10).

Table 10-Caregivers' perceived index children's illnesses

Perceived index child illness	Maternal (N=28)	Non-maternal (N=28)
Diarrhoea	4	4
Fever	6	6
Boil/Rashes	4	3
Malaria	7	4
Flu	2	5
Growth Impairment	1	1
Headache	1	0
Measles	1	1
*Other	2	1
None	0	3

Source: Field survey, Owusu (2015)

***other**-Blood in child's genitalia, inability to take breast milk and chicken pox

All the twenty-eight maternal caregivers reported that their index children had been sick during the month preceding the interviews. On the contrary, twenty-five househelps/grandmothers shared a similar opinion. This therefore suggested that three non-maternal caregivers (a grandmother and two househelps) did not accept the fact that their index children were sick contrary to the assertion made by their maternal counterparts.

Another discrepancy which was identified from their responses was the respective caregiver's interpretation of illness symptoms. For instance, while some mothers reported that they thought the index children were ill from malaria or flu, not all their corresponding househelps/grandmothers shared that view but interpreted their observed symptoms differently from that of the mothers. It is, however, important to point out that, in some households, both caregivers were equally able to indicate that the index children were sick from the same illness.

The accounts of both caregivers of three index children – Emelia, Doris and Seth – are illustrative of some of the issues discussed above. One and half year-old Emelia's mother (27 years old) indicated that she observed some blood stains around Emelia's genitals and was thinking it might be due to a fall or an injury. On the contrary, Emelia's 57-year-old grandmother was of the opinion that the girl was sick with malaria. Similarly, when Doris (3 years old) househelp (14 years old) was asked to mention Doris' illness, she indicated that Doris was ill with chicken pox (which is largely visible and easily verifiable), the maternal caregiver (32 years old), on the other hand, narrated that Doris was sick from malaria because she had high temperature, was vomiting at some point and became dull. Lastly, according to 8 months old Seth's mother (25 years old), Seth fell

from the bed in one of his sleeps so she suspects her son would be sick with severe headache; Seth's 39-year-old grandmother, however, was of the view that her grandson only *had high temperature during the past month*.

All the key informants also cited illnesses such as malaria, diarrhoea, fever and malnutrition as some of the main illnesses reported in the Kumasi metropolis. The response of the paediatrician is typical of the responses of the other key informants:

The illnesses that child caregivers in the metropolis report for treatment are mainly diarrhoea, bacterial infections, sickle cell, severe or acute malnutrition and almighty malaria [Paediatrician, 42 years old].

Children under five years of age in most parts of sub-Saharan Africa suffer from a range of illnesses through bacterial and parasitic infections. For instance, pneumonia, diarrhoea and malaria have been identified by the World Health Organisation and other international health institutions as a major cause of morbidity and mortality in under-five children who generally reside in sub-Saharan Africa and other developing countries. Similar studies conducted by other health researchers as well as reports from the Ghana Health Service affirmed the fact that Ghanaian children below 5 years are generally vulnerable to malaria infection (Edmonds & Burford, 2009; Ghana Health Service, 2014; Orish et al., 2015; Smith, 2004; Yansaneh et al., 2014). It is, however, important to note that in 2014, the malaria case fatality rate in under-five children reduced from 0.6% in 2013 to 0.51% in Ghana (Ghana Health Service) partly due to interventions such as increased efforts at integrated vector control through continuous distribution of bed-nets and improvements in health facility malaria management practices. The narratives by the

caregivers is, somewhat, a confirmation of the existing evidence of the common childhood illnesses recorded generally in Ghana and the Kumasi Metropolis in particular.

A common understanding of illness symptoms and diagnosis by both household caregivers could facilitate decision-making processes such as treatment options and allocation of resources to maximise childcare. Similarly, a variation in their perception of symptoms, as described above might, to some extent, influence how the illness is reported to health practitioners for diagnoses and treatment.

Caregivers perceived causes of children's illnesses

The initial decisions, response and actions of child caregivers towards children's illnesses are very crucial in ensuring that the child receives prompt and adequate treatment. Expedited decision-making processes regarding the caregivers understanding of the illness symptoms, the possible cause(s) of the illness and the choice of a health-seeking facility or personnel, in part, contribute positively to the healing process. For instance, in situations where a grandmother wields so much decision-making powers as opposed to the maternal caregiver, but the two interpret the symptoms differently, there is the likelihood that the decision-making process will be prolonged or delayed due to the exchange of divergent information and sharing of experiences by which the sick child will be the eventual loser or sufferer. Similarly, the weight or seriousness that caregivers attach to the child's illness may also determine how quickly or otherwise they respond to the illness as well as the amount of time and resources they will be willing to commit into the management process. These are the possible factors that could lead to the first delay

in recognising illness and deciding to seek care as observed by Thaddeus and Maine in their 3-delay model (Thaddeus & Maine, 1994)

In health care facilities such as clinics or hospitals, it is trained health personnel who are the first responder to an ailing child. Their assessment of the illness symptoms and condition of the child enables them to either offer treatment or prepare the patient for a thorough examination by a paediatrician or physician. At the household level, however, first responders to child illness are the principal caregivers (maternal or non-maternal caregivers in the case of this study). Indeed, it is imperative that they take quick decisions and actions towards illness treatment with an effective medicine or therapy. Based on these, it became necessary to assess the caregivers understanding of their perceived causes and symptoms of the index children's illnesses.

Eight mothers and ten non-maternal caregivers (5 househelps and 5 grandmothers) indicated that they did not know what caused the index child to fall sick but the remaining twenty mothers and eighteen non-maternal caregivers cited different causes of the illnesses. It was deduced from their responses that they attributed the index children's illnesses to four main causes comprising the effect of the weather, sweets intake, mosquito bites and teeth eruption (Table 11). A further perusal of Table 11 gives areas of similarities and points of divergence in the responses of the two household caregivers.

Table 11-Caregivers' perceived causes of index children's illnesses

Illness/Cause	Perceived causes												Total	
	Mosquito bite		Weather conditions		Teeth eruption		Sweets		Injury/Falls		Don't know			
	MC	NMCG	MC	NMCG	MC	NMCG	MC	NMCG	MC	NMCG	MC	NMCG		
Malaria	5	2	1										2	
Diarrhoea					1	1	2	1			1		2	
Fever	3	2		2	4	1					1		1	
Growth impairment											1		1	
Cold and cough			2	3							1			
Boil/ Rashes			1	1							2		2	
Headache									1					
Measles											1		1	
Other illness											2		1	
No illness (NMCGs)													10	4
Total	8	4	4	6	5	2	2	1	1	1	8		4	

Although some of the caregivers perceived cause(s) of a child's illness may not be entirely accurate, there were some caregivers who were correctly able to attribute some illnesses such as malaria and diarrhoea to their respective major causes of mosquito bites and viral infection respectively. A case in point was 4-year old Ruth whose mother (42 years old) narrated that she suspected her daughter to be ill from malaria *because she had recently been bitten by mosquitoes.*

Comparably, maternal caregivers were abler to make correct attribution of illnesses to the perceived cause(s) than househelps/grandmothers. For instance, while five mothers were able to link mosquito bites to malaria, only two non-maternal caregivers were able to do so. For example, three years old Robert's grandmother (52 years old) viewed her grandson's malaria as not caused by mosquito bites but described it as *children's troublesome illness*; a view expressed by other non-maternal caregivers such as 2-year old Kate's grandmother (49 years) and 7 months old Eugene's househelp (26 years).

Five mothers and two non-maternal caregivers attributed index children teething to fever and diarrhoea. Index children such as nine months old Joyce, for example, was reported sick from fever and her mother (31 years) perceived that the fever was due to her daughter's teeth eruption. Similarly, 2-year old Mercy's mother (31 years) was of the view that her daughter's current fever and diarrhoea were caused by teeth eruption and further asserted that *children in those stages of physical development usually show such symptoms.*

Natural consequences of milestone such as teething, crawling and walking have been linked to childhood illness such as diarrhoea (File & McLaws, 2015), this

notwithstanding, teething has been reported as not a known cause of diarrhoea or fever (Kakatkar et al., 2012) as reported by the maternal caregivers. Although Memarpour and colleagues (2015) explained that the process may cause problems for children including physical disturbances like pain, disturbed sleep and loss of appetite, they were of the view that the association between teething and illness symptoms such as fever, diarrhoea, rashes or infections remains inconclusive since some studies have found associations while others failed to find any causal relationship.

During the female househelps focus group discussion, for instance, four of the househelps attributed diarrhoea to poor personal and environmental hygiene while malaria was cited to be caused by mosquito bites. The narration below from a 15-year old female househelp who stays with her Auntie and takes care of her 5-year-old child is illustrative of the responses by the other discussants:

I think children fall sick largely because of the attitude of some of the parents [...] exposure to mosquito bites can cause malaria [Female househelp FG discussant, 15 years old].

The key informants, on their part, also shared common views on the perceived causes of children's illnesses in the Kumasi metropolis. They attributed illnesses to proximate factors such as malnutrition, domestic accidents/injuries, mosquito bites or poor personal hygiene as well as intermediate factors including childcare practices especially the practices of househelps. For instance, the education director indicated that poor personal hygiene was a risk factor that exposes children to illnesses such as diarrhoea and malaria. Similarly, the paediatrician indicated that acute malnutrition was a major cause of most childhood illness reported at her hospital. The headmistress

attributed household injuries to caregivers' neglect while the Police officer blamed the *ignorance and some childcare practices of caregivers especially househelps* as predisposing children in the metropolis to illnesses. This response by the Education Director is a typical example of the views expressed by the other key informants:

I consider poor personal hygiene as one of the most risk factors that exposes children to diarrhoea. [...] I will cite househelps as the worst culprits but I will not entirely blame them because [...] their madams should have taught them exactly the right child caregiving practices to adopt. There are, however, some instances where the househelps will simply refuse to oblige or practise what they have been taught or instructed to do [District Education Director].

This section has highlighted some of the caregivers perceived common index children's illnesses and their corresponding causes. Illnesses such as diarrhoea, malaria and fever were generally cited by the respondents and attributed their causes to proximate and intermediate factors such as infections and mosquito bites as well as the practices of some child caregivers. It must, however, be noted that mere identification of illnesses and attribution of possible causes are not enough in securing the health and well-being of children. The next issue presented in this chapter is household child caregiver's practices in the context of children's illnesses diagnosis.

Caregivers' identification of index children's illnesses

Following on from caregivers' identification of the possible cause(s) of index children's illnesses is their ability to link the observed symptoms or signs with a particular illness. Even among trained health professionals, diagnosis of illnesses sometimes becomes a challenge since some symptoms or observed signs are not illness specific or may overlap with other illnesses. For example, it has been reported that malaria in children is generally difficult to diagnose because the initial presenting features are usually subtler than adults and do not display the classical presenting features (Dyer, Waterfield, & Eisenhut, 2016). Furthermore, the illness diagnosis becomes a challenge since some children are generally active and playful even in times of sickness; a phenomenon that has the potential to elude caregivers in identifying illness symptoms.

Child caregiver's ability to relate perceived illness symptoms to an illness was considered as one of the key issues for this study for two principal reasons. Firstly, it is generally these observed symptoms or signs that would influence their decision on children treatment options. Their ability to accurately understand the severity of the observed symptoms would certainly feed into their decision to self-medicate the child at home; resort to faith healer or traditional medicine; consult a pharmacist/druggist or seek clinical/hospital treatment. Secondly, it is the caregiver's observed symptoms that constitute illness history that health professionals rely on to make diagnosis and prescribe treatment options. This is so because the index children may not be able to properly articulate their symptoms to the health professionals to aid in diagnosis due to their young age. Thus, if caregivers are unable to accurately understand the child's illness symptoms, there is a likely potential to delay the treatment process. Again, disagreements in the

understanding of illness symptoms by the two caregivers may compromise quality illness treatment processes. The two caregivers were therefore asked to outline their observed symptoms that help them to deduce that the index children were ill (Table 12).

All the maternal caregivers were able to attribute symptoms to a perceived illness while only twelve non-maternal caregivers (4 grandmothers and 8 househelps) were able to make such attributions without asking permission from the interviewers to consult the maternal caregivers. Indeed, among the remaining twelve non-maternal caregivers (excluding the four who have already indicated that they did not think the index children were sick in the first place), two grandmothers and two househelps did not cite any symptom while four relied on the account of their corresponding maternal caregivers.

In the case of diarrhoea, for instance, the common caregivers perceived symptoms exhibited by the index children were high temperature, passing of frequent watery stools, stomach ache, crying and vomiting. In much the same way, caregivers narrated symptoms such as headache, persistent high temperature, evidence of mosquito bite, lethargy and child shivering as constituting symptoms of malaria. The two excerpts below from 3-year old Doris' mother and 1 year four months old Jona's househelp are typical illustrations of the caregivers who were able to attribute symptoms to illness:

It was malaria [...]. She had high temperature, was vomiting and became dull [Doris' mother, 32 years old].

He has cold, running nose, could not breathe and eat well. [...] he makes you the one taking care of him scared and restless [Jona's househelp, 19 years].

Table 12- Caregivers' perceived symptoms of index children's illnesses

Illnesses/Symptoms	Perceived symptoms	
	Maternal caregivers	NMCGs
Diarrhoea	High temperature, frequent watery stools, stomach ache, headache, child gesturing-e.g., holding of stomach, child crying	Vomiting, gesturing, appearing of new teeth. maternal account
Cold	High temperature, running nose, coughing, difficulty in breathing.	Running nose, lost appetite, high temperature. coughing, difficulty in breathing
Fever	High temperature, body weakness, lethargy	High temperature, maternal account
Malaria	Headache, persistent high temperature, evidence of mosquito bite on child, lethargy, vomiting, child shivering	High temperature, vomiting, evidence of mosquito bite, maternal account
Boils/Rashes	Physical observation	Physical observation

Source: Field survey, Owusu (2015)

Although some of the perceived symptoms may not be accurate, the importance of child caregiver's timely perception and response to child illness symptoms cannot be underestimated. To prevent childhood illnesses such as diarrhoea, early diagnosis and treatment is considered very critical in the process (File & McLaws, 2015) and for malaria, late diagnosis is more likely to deteriorate rapidly and develop into severe malaria (Dyer, Waterfield, & Eisenhut, 2016).

Based on the first phase of delay in recognising illness and deciding to seek care, as identified by Thaddeus and Maine (1994), the caregivers were further asked how they reacted to the observed symptoms and what health-seeking actions followed their reactions. In general, all the maternal and non-maternal caregivers, except in three households, reported viewing the symptoms as serious developments that merited their *prompt or immediate* actions. In two households, the mothers described the symptoms as serious while the corresponding non-mothers (one househelp and a grandmother) described the symptoms as not that serious. It was only in one household where both caregivers perceived the illness symptoms as a *normal* growth and development issue. The narratives from Robert and Emelia are typical examples of what transpired in the first two households.

Robert is a 3-year old boy who was being cared for by her 28-year-old mother and 52-year-old grandmother. The two caregivers felt his temperature was high and suspected that he might be ill with malaria. When asked what seriousness they attached to their observed symptoms they respectively responded as follows:

Eii. as for me when my child is at this age and cannot really express how he feels and he becomes ill. I also become frightened and more so when I

do not have enough knowledge on child illness, diagnosis and treatment, so I sent him to a hospital for treatment [Robert's mother, 28 years old].

Robert always become very pale, timid and dull so I become very uncomfortable about the situation so I always ask his parents to take him to the hospital and as you know children are very complex and if something is wrong with them, you can hardly tell. It is only the doctor who can do so [...] [Robert's Grandmother, 52 years old].

Emelia was one year and 5 months old when her caregivers were interviewed. Her 27-year-old mother, a Banker by profession, indicated that she saw blood around her daughter's genitalia. When asked how she perceived the symptom she replied as follows:

In fact, it was very frustrating and terrifying especially when you do not know what is actually wrong with the child so the best option is for you to always take the child to the hospital. I was very frightened so I took her to the hospital for the doctor to examine her [Emelia's mother, 27 years old].

On her part, Emelia's 57-year old grandmother indicated that Emelia is not someone who usually falls sick so Emelia suffers from malaria that affects children. Besides not perceiving the symptoms as seriously as the mother was thinking, the grandmother's perception that Emelia was ill with malaria was also a sharp contrast with that of mother.

It is very instructive to note that generally all the caregivers treated their perceived symptoms with some seriousness and decided to take some actions that led to seeking healthcare for the sick index children. Some of the factors that contributed to this,

according to the responses of some maternal caregivers, included interventions such as increased and sustained health promotion programmes in Ghana through the mass media, caregiver's assertiveness in taking greater responsibility for child's health and implementation of some social intervention programmes such as the National Health Insurance Scheme (NHIS). These views were also expressed by the Paediatrician.

The maternal caregivers exhibited some level of assertiveness in their ability to identify or guess, at an early stage, that their children were exhibiting some symptoms that suggested that they were unwell. It also came to the fore that some maternal caregivers were able to correctly attribute illnesses to their corresponding causes than the non-maternal caregivers. Similarly, maternal caregivers appeared to attach some seriousness to issues regarding their children's health by considering unusual developments as illnesses while some househelps and grandmothers viewed such developments as not constituting illnesses. The various children's illnesses treatment options and the decision-making processes that informed the choices of the various options are next presented.

Index child illness treatment options

A critical component of health seeking process is the choice of treatment option(s) utilised by the child caregivers. In the Kumasi Metropolis, child caregivers have access to a wide range of health facilities such as government and private hospitals, clinics, pharmacies, drug stores and faith healers. Indeed, the Komfo Anokye Teaching Hospital, which is the biggest referral hospital in the middle and northern belts of Ghana, as well as the Ashanti Regional Hospital and a host of Government and Private Hospitals and

Clinics, all located in the Kumasi metropolis. Child caregivers therefore have options in terms of health facilities to choose from depending on factors such as distance, economic constraints, cultural beliefs and the severity of the illness. It was therefore relevant to ask the caregivers which health facility they often accessed when the index children were perceived to be ill and the underlying reasons for utilising each facility.

Biomedical care emerged as the most preferred option by a large proportion of the caregivers. Besides, there were accounts of caregivers who resorted to pharmacy/drugstore, herbal medicines or home treatments (Table 13). This comprised taking the sick child to a hospital/clinic, reporting the illness to a Pharmacist for medication or using surplus biomedical medicines at home which are kept in household as 'first aid.' None of the caregivers mentioned using herbal medicine or consulting a faith-healer for any of the reported illnesses during the one-month recall period benchmarked for this study.

Table 13- Choice of caregivers' treatment options

Health Facility	Maternal	Non-maternal
Hospital/Clinic	18	15
Pharmacy	2	5
Home treatment/First Aid	4	3
Missing Data	4	5
Total	28	28

Source: Field survey. Owusu (2015)

Further analysis of their responses was indicative that the decision on which health facility to contact first was largely the prerogative of maternal caregivers. None of the househelps was involved and only three out of the 12 grandmothers reported taking the index children to a health facility at some point in time (to be discussed later in this section). At this stage of the illness management process, the maternal caregivers were generally assertive and exerted a lot of agency in the decision on the choice of treatment options.

Three main factors influenced maternal caregiver's decision to seek biomedical care for the index children's illnesses (Table 14). Fourteen mothers cited the expertise of health professionals and resources at hospital/clinics as their prime reason. Furthermore, household's proximity to the health facilities facilitated by good road networks in the metropolis and availability of transport, either private or public as well as the perceived severity or previous index children bad illness experiences were the other factors.

Table 14-Reasons for using biomedical healthcare

Reasons	Number of maternal caregivers
Proximity to health facility	6
Expertise and health resources	14
Severity of illness/Bad experience	3
Non-response	5
Total	28

Source: Field survey. Owusu (2015)

The accounts of eight months old Rebecca's mother and her non-maternal caregiver are examples of the caregivers who opted for biomedical care due to perceived severity of the index child's illness and previous bad experience with illness. The 37-year old mother observed that her daughter's temperature was very high coupled with running nose. Again, Rebecca was severely coughing and had cold that made her weak and timid. When the mother was asked about her subsequent actions, she responded as follows:

Rebecca is a girl who normally falls ill and anytime she is ill I become scared so when I observed that she was not feeling well, I did not waste time at all but sent her immediately to the hospital because she nearly died the last time she had malaria and I relaxed so now I do not want to take such risks again [Rebecca's mother, 37 years old].

I have been told that she nearly died for a delayed treatment so if I am alone with her and her temperature goes up, I will first of all sponge her with cold water [...]. I would call her mother to come and take her to the hospital but if she had still not arrived, then I will proceed to the pharmacy shop to buy medicines for her [Rebecca's Non-maternal, 45 years old].

Similarly, the response from Juliet's mother is an illustration of maternal caregivers who preferred biomedical treatment based on health provider's expertise and availability of health facilities. Juliet was five months old at the time of the study. According to the mother, she saw some reddish swellings on her daughter's forehead and around her breast. On seeing the swelling, this is what the 23-year-old mother narrated:

I sent her to the hospital when I first saw the boil on her forehead. I was initially scared since she kept crying and I did not know exactly what was wrong with her. Moreover, she is my first child [...] I was really disturbed. [...] I took her to that particular hospital because [...] their services are good [...]. Besides, it is relatively close to my house which takes me about 15 minutes to drive there if there is no traffic. I think it is a public a hospital since they do not charge as high as that of the private hospitals [Juliet's mother, 23 years].

Besides, there were a few instances where the maternal caregivers were switching between biomedical health facilities such as pharmacy shops to hospitals or in-between hospitals. Such mothers mentioned considerations such as long queues at facilities, proximity to health facilities, severity of index child illness and time lapse in seeing a physician as key factors that influenced their choices of health facilities. Doris and Kate's mothers are classical examples of such mothers. Doris was a 3-year old girl who was being cared for by her 32-year old mother and 14 years old househelp. The mother suspected that Doris was sick from malaria and when asked her about her primary choice of health treatment option, she mentioned a couple of facilities that she patronises based on the exigencies of the time. According to the 32-year old Businesswoman:

I sometimes go to the pharmacy shop to buy medicines for Doris. [...] I sometimes take her to Komfo Anokye Teaching Hospital or the Manhyia hospital. As for the latter, it's just here so I can even use less than 15 minutes to get there but for Komfo Anokye, it takes me about 30 minutes or more [...]. My choice depends on the condition of Doris and the time I will

take to get a Physician to attend to her. If the illness becomes severe in the evening I can easily go to Manhyia Hospital in the morning so that I wouldn't have to join a long queue. If the illness is very serious, I will take her to Komfo Anokye Teaching Hospital because it is already the biggest hospital in the Ashanti region [Doris' mother, 32 years old].

Kate's mother's choices, on the other hand, represented the mothers who based their choice of healthcare facility decisions on perceived quality of care. Such mothers were of the opinion that private health facilities offer quality care with relative turn-around time but expensive while the opposite is what pertains at public health facilities. According to the 26-year-old mother:

I either take her to a public or a private hospital depending on the illness condition at the time. I access healthcare from the public hospital when her illness does not seem severe and serious while I take her to the private health facility when the illness is severe and I need her to be attended to urgently although it is expensive [...] I go there when there is that urgent need because there are always long queues at the government hospitals which usually delay the turn-around time for seeking medical care for your child [Kate's Mother, 26 years old].

As already observed by File and McLaws (2015), some caregivers sometimes resort to herbal or traditional treatment methods when they observe that biomedicine is not delivering the expected therapeutic results. In this study, three maternal caregivers indicated that they had previously resorted to herbal medicines for treatment of some

illnesses of the index children because they observed that biomedicine was ineffective in curing the illness. The account of Kate and David's mother's highlights maternal caregiver's decision to use traditional medicine for the index children:

*Yes! she had measles, we took her to the hospital several times and they were not able to detect what was wrong with her so my mother told me to give her **Akpeteshie** so that if the disease is hidden in her body it could come out. We did that and [...] after four days everything vanished [Kate's mother, 26 years old].*

He could go to toilet for about 30 times in a day [...] which was not normal [...]. I tried both private and government hospitals but to no avail. Even a doctor told me that he has given all the necessary medicines he knew could cure him yet [...]. So it was a friend's mother who directed me to a herbalist in one of the nearby villages. I followed up and after giving David the herbs everything went away [David's mother, 40 years old].

The decision to use biomedical health facilities as the preferred choice for child illness treatment options, although very laudable, does not necessarily rule out the issue of caregivers' delay in seeking care. The caregivers (twenty maternal and three grandmothers) who were directly involved in the decision on choice of health facility for the index children provided data on what they did during the period between the onsets of the perceived illness symptoms and reporting to healthcare providers (Table 15). It could be inferred from Table 15 that most mothers reported the illness to healthcare providers the same day.

The assertive nature of the mother's decisions could be derived from some of their expressions such as taking the index child to the health facility *immediately* or *the same day*.

Table 15-Time lapse in reporting child's illness to healthcare providers

Time lapse	Number of caregivers
Same day	14
Next day	6
3-7 days	2
After one week	1
Total	23

Source: Field survey, Owusu (2015)

For instance, the accounts of Emelia (1.5 years old) and Jona (1 year, 4 months old) maternal caregivers as well as that of Deborah (4 months old) non-maternal caregiver are just a few examples that illustrate the mother's swiftness in decisions regarding seeking health care for the index children:

For me when I see anything about my child that I am not familiar with, I inform my husband and straight, we take the child to the hospital. The hospital is just here. So we take her there immediately [Emelia's mother, 27 years old].

We didn't self-medicate but took him to the hospital the very first day I realised that he was not fine. [Jona's Mother, 47 years old].

Her mother immediately took her to the hospital when she observed the illness symptoms because she did not want to wait for too long for the rashes to become worse. [Debora's Non-maternal, 30 years old].

For two of the maternal caregivers, their relationship with health professionals influenced their decision to seek early care at a health facility for the index child. According to Simon's 28-year-old mother, her Mother-in-law is a midwife and will always want Simon to be taken to the hospital immediately for treatment; a view which was also shared by Prince's househelp. The 16-year old househelp was not aware of the health facility utilised by her madam for Prince's recent illness from diarrhoea but she inferred that:

I believe my madam took him to that hospital to be seen by that doctor because since I came here, he has been our doctor so I think it is because the doctor is my father's friend that is why we go there [Prince Househelp, 16 years old].

Medicines are essential elements in alleviating suffering of the sick (Ette, 2004). Medicines play a central role in the provision of health services but at the same time, they could become very powerful or dangerous if not properly administered or consumed. Access to medicines by the general population have been a subject of some research (see for example Hampshire et al., 2011). Even though only 4 maternal caregivers admitted directly applying first aid as a treatment option for the index children, further scrutiny of

the responses of 13 out of the 18 caregivers who went to the hospital/Clinic (12 mothers and one grandmother) indicated that they self-medicated (without prior advice from health practitioners) the index children before going to the hospital.

Indeed, except only in two households where the caregivers said they do not keep medicines in the house, all the other households have some medicines in their houses they referred to as first aid. The key reasons, according to the caregivers, for keeping the first aid were their intuition *to do something* immediately to mitigate the severity/the pain associated with the illness or the notion that they are already familiar with the treatment option(s) due to previous experiences with *similar illnesses*. The two mothers who did not keep medicines at home mentioned either *always taking the child to the hospital for new medicines* or because of their close proximity to a pharmacy shop where access to medicines any time of the day will not be a problem.

The contents of the medicines in the first aid boxes included ante malarial, bacterial and viral infection medicines, plasters, gentian violet and pain relievers. The main sources of the medicines in the first aid boxes, according to the caregivers, were generally from *surplus prescribed medicines* from index children previous illnesses. Such medicines were re-administered at home to the index children if previously observed illness symptoms resurface. Such caregivers indicated following the previous regimen prescribed by health professionals.

What is not certain from the caregivers' account above on medicines in the household is the extent to which the caregivers may misapply or abuse the administration of the medicines based on the fact that some illness symptoms or observed signs are not generally illness specific and may overlap with other illnesses (see Cohen & Scheeringa.

2009). Furthermore, how the unused or expired medicines are disposed of at the household level is something that was not explored in this study, but has become an issue of major studies in countries such as the United Kingdom, USA and New Zealand (Bound, Kitsou, & Voulvoulis, 2006; Bound & Voulvoulis, 2005; Seehusen & Edwards, 2006; Tong, Peake, & Braund, 2011). The explanation from Prince's mother is a characteristic example of the mothers who kept medicines at home:

I gave Prince Espanol and metrolex F. I did that based on my little knowledge in childcare and [...] my doctor prescribed that same drugs for me for his treatment and I also decided to keep the surplus since the expiration date of the medicines was not due [Prince Mother, 36 years old].

As already indicated in this chapter, there were rare instances where the maternal caregivers had ceded the child's illness management practices to their mothers (grandmothers). Two out of the three grandmothers were active agents in the choice of health treatment options because the maternal caregivers had given them some authority on decisions that border on the childcare either due to time constraints (combining childcare with further studies), inexperience or trust in their judgment (the issue of trust will be discussed further in chapter 8).

All the other non-maternal caregivers interviewed indicated that they were either informed of the decision by the mother or became aware of the choice of health facility after the mother had returned home with the child. It must, however, be noted that the duration of active participation by non-maternal caregivers in seeking healthcare for the sick index children was not always permanent. Some of them assumed temporal

responsibilities due to the absence of the mother from the house as reported by two female househelps during the focus group discussion:

I went to the pharmacy shop to buy medicines for the child when we were alone and she became sick. The mother was not in the house so I had to take the initiative to save the life of the child [Female househelp discussant, 15 years old].

I was alone with the child in the house and she was attacked by convulsion again. I became very frightened but quickly remembered that the mother used garlic so I also did the same and the child was back to life. I consequently called the mother on her cell phone to come home and take care of the child [Female househelp discussant, 13 years old].

Healthcare professional's ability to diagnose and treat children's illnesses depends on the history or background information given by the caregivers to the health personnel. In most cases, the diagnoses become problematic for health personnel if the caregiver does not have full grasps of the observed symptoms. In situations where the symptoms were first observed by househelps, they had to communicate their observed symptoms to the mother who will eventually narrate same to the health personnel. This instance comes with the possibility of distortion in the illness history due to information decay, wrong interpretation of observed symptoms, or when a caregiver is concealing the true cause of the illness to the other caregiver or to the health personnel. When the Paediatrician was asked about the accurateness of the illness history provided by child caregivers to aid in decisions on diagnosis and treatment, she responded as follows:

Ideally, it is very easy to diagnose child illness, however, it becomes difficult if the person who sends the child to the health facility is not the actual caregiver because the information they will provide sometimes make tracing the illness history difficult due to unreliable nature of the information [Paediatrician].

Child caregivers may decide, based on several reasons including cost, severity of illness and previous experience with illness, to report the illness to a health professional at a clinic or hospital. Subsequently, the child may be treated and discharged as an out-patient, admitted and treated as an in-patient or referred to another facility for further advanced diagnosis and treatment. Irrespective of the choice of healthcare facility chosen by the caregivers, the majority of post-treatment illness management practices take place at the household level. The interview sessions also focused on caregiver's household illness management practices which is presented in the next section of this chapter.

Child caregiver's household illness management practices

This section presents analysis of some household illness management practices adopted by both the maternal and non-maternal child caregivers who participated in this study.

One of the illness management practices that would be expected from child caregivers is the administration of prescribed medicines to sick children according to the recommended regimen. Caregiver's ability to systematically follow the laid down plan in relation to medication, therapy or diet is very critical in improving and maintaining the

health of the patient. The household respondents were asked a series of questions related to adherence to regimen, checking for medicine expiry dates and ability to recognise the side effects of administered medicines on the index children. This was meant to ascertain their adherence or otherwise to the recommended regimen and the reasons behind their actions.

In seventeen households where caregivers provided responses on medicine regimen, side effects and expiry dates, it became evident that both caregivers were actively involved in the medicine administration process compared to the decision-making stage on choice of treatment options where the maternal caregivers were the only active agents (Table 16). This was not different from what pertained in the remaining eleven households where only one caregiver provided responses. For purposes of comparability, this section was based on the data from the seventeen households where both caregivers provided information.

Table 16-Caregivers' household child illness management practices

	Maternal caregivers	NMCGs
Medicine related issues		
Compliance with recommended regimen	17	17
Checking for medicine side effects	17	2
Checking for other medicine caution details	12	5
Checking for medicine expiry dates	9	8

Source: Field survey, Owusu (2015)

It was only in two households where the househelps indicated that they were not allowed to administer medicines to the index children. The other non-maternal caregivers had the permission or instructions from their maternal caregivers to administer medicines to the index children. For instance, according to Joyce's househelp, as typical of most of the non-maternal caregiver's responses:

My mother gives me strict instructions on how to administer the medicines to Joyce. She tells me about the dosage, time and all the other information I will need [Joyce's Househelp, 18 years old].

With regards to following the recommended regimen, both caregivers in the seventeen households indicated their strict compliance. The remaining maternal caregivers indicated discontinuing the regimen on seeing that the index child was *healed, has become very active and goes about playful activities.*

In relation to knowing or understanding the side effects of medicines on the index child, seventeen maternal caregivers and only two non-maternal caregivers (one househelp and a grandmother) indicated consistently understanding this before the medicines were administered to the index children. Reasons cited by the non-maternal caregivers included health doctors, pharmacist or maternal caregivers' refusal to educate them on the importance of knowing medicine's side effects, illiteracy or the notion that the maternal caregivers were already aware of the side effects. The account of Eric and Doris' househelps are a few examples of their responses:

They don't tell us the side effects. They only tell us the time to give him the drug, either morning or evening, before or after eating [Eric's Househelp, 25 years old].

No I do not read the instructions on the medicines because I didn't go to the hospital with my madam when Doris was sick [Doris Househelp, 14 years old].

With regards to caregivers understanding and knowledge of basic medicinal precautions or instructions such as storage or allergies, more mothers, once again, than non-mothers (twelve and five respectively), indicated being consciously aware of these before administering the medicines to the index children. For the maternal caregivers, the common precautionary measures they were familiar with, at the time of the interview, were keeping medicines away from children or storing them in a cool dry place.

The caregivers were also asked if they regularly check expiry dates of medicines they have administered to the index children. It was only in eight households where both caregivers indicated that they always checked the expiry dates of the medicines administered to the index children. Indeed, it was only two households (mothers and househelps) where both caregivers of an index child indicated consistently making this checks on medicines. The other households consisted of where either the maternal or the non-maternal caregiver indicated verifying the expiration dates of the medicines.

The issue of child caregiver's household illness management practices were also further explored during the focus group discussions and key informant interviews. The experiences shared by all the discussants were largely not different from what have already been described by the individual caregivers. For instance, according to this 16-year-old female househelp discussant:

If you are given the medicine at a pharmacy shop or at the hospital, they give you clear instructions on how to administer them to the child and so that is what I

follow. I have only read the information and instructions once but my Auntie normally reads them. I don't check the expiry date on the drugs but even the sight of the medicine can inform me that the medicine is expired or not [16 years old, female househelp].

Some of the maternal discussants were doubtful that their househelps followed the recommended regimen when they were left alone with the children. There were also rare instances where some maternal discussants indicated that they had not familiarised themselves adequately with medicines prescribed for the index children. The responses of these two maternal discussants illustrate the two instances described above:

Hmm, I read the instructions before I give out medicines to my children. I also try to give out this same information to my househelp but as to whether she practices them when she is left alone with the child is still a mystery that I always leave into the hands of the Almighty God [Maternal discussant, 42 years old].

I have seen the information on the leaflets but I do not always read them. I just follow what the medical practitioners have told me. Hmmm I have not even taken time to ask myself if the medicine has expired. I have not even checked whether the way I administer the medicine is the right way to give out medicines to the child [Maternal discussant, 32 years old].

The maternal discussion and key informant interviews also unearthed some negative health consequences that children have suffered as a result of the illness management practices of some househelps. The consequences ranged from physical

injuries to critical health conditions eventually to death. A female maternal discussant narrated an incident that once happened to her child. She narrated that she returned to the house that fateful day to observe that her househelp had “*severely*” hurt her daughter by intentionally pushing her to the floor. Another 57-year-old maternal discussant shared her unpleasant experience of her househelp who administered an overdose medicine to her child:

There was a day my househelp was supposed to give medicine to my child while I was away. She was supposed to give it to her in the afternoon and the evening but she forgot the afternoon dose [...] She gave out a double dose in the evening thinking that it will cater for the afternoon one she missed. My child nearly died [Maternal discussant, 57 years old].

The Minister also recalled a report he recently received from one of his congregants: *About four months ago a mother came to complain to me that her househelp has given her child an overdose medicine [...] The health condition of the child became so critical to the extent that the child was admitted at the hospital for some days.*

It could be observed from the narrations above that various child illness management practices take place at the household level. These include households where both caregivers complied with medicine regimen and adherence to other information that relate to administering medicines to the index children. The combined effects of these caregiving practices have led to instances where some children recover fully from their illness or suffer prolonged illness or death. Despite the active engagement of both caregivers in managing index child illnesses at the household level, non-maternal

caregivers, compared to maternal caregivers, appeared to lack the requisite capacity to effectively discharge this caregiving function. What accounts for caregiver's challenges in managing index children's illnesses at the household constitute the next section of this chapter.

Caregivers challenges in children health management

Child caregivers may encounter certain challenges in their management of child illnesses such as inadequate knowledge of the illness, cure and prevention as well as social or economic challenges such as unavailability of treatment options, cost of treatment, distance to health facilities and, in the case of multiple caregivers, issues of divergent opinions or approaches to child illness management. For instance, in a study on home care of children with diarrhoea in Bangui, Central African Republic, Giles-Vernic and her colleagues (2015) identified that, although child caregivers received good care at paediatric hospital, they found the costs of transport, consultation and treatment very high. They further asserted that the caregivers managed their incomplete knowledge of diarrhoea's causes and evolution by delaying and observing, consulting with kin and neighbours as well as experimenting heavily with street vendor-purchased antibiotics and herbal infusions (Giles-Vernick et al.).

Both the maternal and non-maternal child caregivers who participated in this study were asked to indicate the main challenges they encounter in managing the index child illnesses at home. To some extent, a large number of the respondents indicated that they did not encounter any challenge, however; there were some challenges that were cited by a few of the caregivers. These challenges included limited knowledge in

children's illnesses management, high cost of accessing formal health services and multiple directives on treatment options from other household members. The maternal caregivers especially, also proffered some strategies that they had adopted to scale over the challenges.

Felix, Robert and Eric were among the index children whose mothers were facing the challenge of multiple directives from their non-maternal caregivers to adopt different treatment options. According to Felix's 31-year-old mother, she encountered some instances where she received multiple directives from her non-maternal caregiver (mother) to opt for herbal medicines but declined the suggestion. Others such as Eric's mother also encountered a similar challenge but overruled it based on her academic background (tertiary) and knowledge in the effectiveness of biomedicines.

'New mothers' and non-maternal caregivers, especially the househelps, also cited their limited knowledge in children's illnesses management related issues. This scenario was more akin to new mothers whose index children were their first or the young househelps who had limited experience in childcare.

The third challenge elucidated by the caregivers was the high cost involved in health-seeking for child such as cost of providing the children with balanced meals and payment of hospital bills. This challenge was more evident with caregivers who were taking care of children with chronic illness such as Alex's 27-year-old maternal caregiver who quipped that:

As for the cost of healthcare, I do not want to talk about it. I always need to have money on me to take him to the hospital... Rebecca's mother resorted that I will say that it is quite expensive footing these health bills

even in this metropolis where the National Health Insurance Scheme (NHIS) is no longer effective. [Rebecca's mother, 37 years old].

Summary

The common perceived illnesses that attacked the index children, as reported by their caregivers, included malaria and diarrhoea which have also been identified by health officials as constituting common illnesses in the Kumasi metropolis. Both maternal and non-maternal caregivers were utilising various health seeking options especially biomedical care for the treatment of index child illnesses. The maternal caregivers, especially, were more assertive in this decision making process, however, both caregivers were active agents in post health facility treatment practices particularly in the area of medicine administration.

The non-maternal caregivers relied more on the account of maternal caregivers on matters that related to child health. Although this seems laudable, it may also provide an avenue for illness complications such as the accounts of administering overdose medicines or skipping medications as noted from the accounts of some mothers and key informants. Challenges such as limited knowledge in childcare, financial constraints and multiple directives from other household members were cited by some caregivers as inhibiting their effort at effectively managing index child's illnesses. Children feeding practices is another caregiving activity that directly impact on child health and well-being. The next chapter presents result of caregiver's household children feeding practices.

CHAPTER FIVE: CHILD CAREGIVERS FEEDING PRACTICES

Introduction

Children under five years of age are prone to growth faltering, malnutrition, morbidity and mortality. Studies conducted in some parts of Ghana and other countries have indicated that child growth and development hinge substantially on the feeding practices of their caregivers, therefore, it is imperative for their caregivers to adopt appropriate feeding practices such as the ones recommended in the Global Strategy for Infant and Young Child Feeding developed by the World Health Organisation (WHO, 2003). Among other provisions, the strategy recommends that infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. Furthermore, it calls for the introduction of nutritionally adequate and safe complementary foods while breastfeeding for up to two years of age or beyond. Finally, to ensure that children receive the required nutritional needs from complementary foods, the strategy requires that feeding children with such foods should be timely, adequate, safe, properly fed and suitable for the child's age. This chapter presents findings on caregivers feeding practices and covers index children hunger and satiation cues, caregivers feeding practices, fruit and vegetable consumption, water intake as well as food-related hygienic practices.

Caregiver's identification of hunger and satiation cues

Child caregivers who practice responsive feeding are the ones who are able to correctly perceive, interpret and respond to children hunger and satiation cues within a reasonable time period (see for example, Wondafrash, Amsalu, & Woldie, 2012). Perception, for example, involves the caregiver's awareness of the child's hunger and satiation cues while interpretation refers to their ability to correctly assign meanings to an observed cue. Responding, on the other hand, connotes providing the child with adequate and balanced meal as a follow up to the observed hunger cue(s) and cessation of feeding in response to fullness or satiation cues (Hodges et al., 2008).

Some cues such as mouthing or crying are usually associated with children's hunger while slowing of eating pace, refusing additional food or taking interest in the environment while eating represents some signs of satiation cues (Hodges et al., 2008) and, in the case of older children, verbalisation can constitute both hunger and satiation cues. Caregiver's ability to, first of all, identify children's hunger cues is therefore very important since it serves as the basis of all the subsequent child feeding decisions and practices. Besides, their ability to identify satiation cues serves as an important parameter in identifying instances of over or under feeding which may have negative consequences on the child's growth and development.

Both maternal and non-maternal individual household caregivers interviewed generally mentioned seven hunger cues on which they regularly relied on to conclude that the index children were hungry. These cues were verbalisation, crying, mouthing, gesturing, finger licking, facial expressions and maternal intuition (full details of respondents observed hunger cues are attached as appendix 6). 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 some caregivers, irrespective of academic backgrounds, who had been relying on two or, sometimes, three hunger cues for the index children. 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 addition, among the older index children (2-5 years), verbalisation or their ability to talk was the main hunger cue relied on by their caregivers while crying was often used for the infant index children. In three households, both caregivers mentioned the same hunger cues for the index children comprising picking a bowl, pointing to kitchen or neck stretching.

While all the above cited cues may be regarded as useful pointers to children feeling of hunger sensation, reliance on caregiver's intuition seems to be a weak pointer in the identification of a child who is hungry. Of the four households, the caregivers consisted of one grandmother with no formal education and three househelps with Basic level education background. 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 has 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-weighted [Alex's mother, 27 years old].

Not many differences were identified between the maternal and non-maternal caregivers in relation to commonly used index children hunger cues; however, it was observed that in a few households, the maternal and non-maternal caregivers were using different hunger cues for the same index child (Table 17).

Table 17- Discrepancies in caregivers' observed hunger cues

Index Children	Maternal hunger cues	Non-maternal hunger cues
Jona (1 yr 4 mts)	Verbalise and gesturing-picks a bowl or a cup point to food	Perception- lift him you will realize that he has become light weight.
Dorothy (2 yrs)	Verbalise	She becomes quiet but she will not tell me when she is hungry.
Eric (5 yrs)	Verbalise	He doesn't say it. After observing how long he had played, I will be able to detect that he is hungry.

Source: Field survey, Owusu (2015)

For instance, while Eric's mother (27 years old) relied more on her son (5 years old) telling her that he is hungry, her corresponding househelp (25 years old) used her intuition to determine that Eric was hungry; similar to what happened in Dorothy's household. This discrepancy may affect the feeding pattern of such index children in some ways. It may suggest that the househelps were misinterpreting the index children hunger sensations.

A major responsibility of child cares is their ability to respond appropriately and promptly to observed hunger cues by feeding children with adequate balanced meal. Correct identification and interpretation of hunger cues without following it up with food could lead to adverse nutritional consequences such as starvation, malnutrition, child illness or death. The World Health Organisation and the United Nations Children Fund have recommended that child caregivers should embark on early initiation of

breastfeeding within one hour of birth and continue with exclusive breastfeeding for the first six months of the child's life after which nutritionally-adequate and safe complementary foods could be introduced at six months together with continued breastfeeding up to two years of age or beyond (Rollins et al., 2016; UNICEF & World Health Organisation, 1990; World Health Organisation & UNICEF., 2003).

Caregivers who feed children with complementary foods are expected to practice responsive feeding such as feeding the children directly, encouraging them to eat without coercion and practicing good hygiene (Engle et al., 2000). They are also expected to gradually increase the child's food as they get older as well as the number of times of feeding the children. Infants within 6-8 months are expected to be fed three meals daily while those between 9-23 months of age are to be fed 3-4 meals per day with two additional snacks (UNICEF, 2005). It must be noted that optimal complementary feeding depends not only on what is fed to the child, but also comprises how, when, where and who feeds the child (Dewey, 2001). Both household caregivers were asked to indicate their follow up practices after satisfying themselves that the index child was hungry.

According to both caregivers, they routinely responded to observed children hunger cues by feeding the index children with various meals depending on the time of the day. Generally, both the maternal and non-maternal caregivers did not express divergent views on the foods they fed the index children in the household. It is instructive to note that, of the three index children who were less than six months old, only one was being exclusively breastfed by the mother. The other two children (4 and 5 months olds respectively) had already been introduced to porridge by their mothers. While the sole mother's compliance with exclusive breastfeeding may not be entirely linked to her

tertiary educational level status due to the age of the index child (one month old); it is however, significant to point out that one of the non-compliant mothers had secondary education background. Data on how the caregivers managed the breastfeeding, especially in instances where the mothers were away from the house, were not sufficiently explored in this study but the account of a grandmother (57 years old) indicated that in such circumstances, the maternal caregivers may squeeze some breast milk into a feeding bottle, store it in a food warmer which would be subsequently used to feed the index children when they are hungry.

The dominant complementary foods fed the index children included fortified foods (Cerelac); foods made from cereal grains (porridge, rice, banku); roots and tubers (yams, potatoes); meat, fish, poultry and eggs as well as fruits and vegetables. It is also informative to note that in two: Ruth and Rebecca's households, the maternal caregivers, both with basic educational level qualification and businesswomen, indicated that they consciously vary the index children's meals by following a menu so that they can always give the children a variety and balanced meals. Although this was not clearly evident in the responses of the other caregivers, the large variety of meals reportedly being fed to the index children seemed to suggest that the index children were being fed with varied meals comparable to what pertained in the two households described above.

Decision-making regarding feeding and who feeds children is an area where child caregivers are expected to be assertive. Foods chosen for infants or children are very vital because infancy may be a valuable time for establishing healthy eating habits towards subsequent prevention of chronic disease, overweight, obesity, dental decay and maintaining health over the life-course (Boak et al., 2016). As has already been indicated

elsewhere in this study, grandmothers especially wield significant amount of power in some societies when it comes to children feeding. However, twenty-four of the maternal caregivers interviewed (Table 18), irrespective of their educational levels, indicated that they make direct decisions on matters that related to what food should be prepared and served the index children; an assertion which was confirmed by their non-maternal caregivers through expressions such as *the mother decides on that and I leave what the child eats for the mother to decide*.

Table 18-Decision-making on index children feeding

Main decision-maker of index children feeding	Number
Mothers	24
Non-maternal caregivers (Grandmothers)	2
Non-maternal caregivers (Househelps)	2
Total	28

Source: Field survey. Owusu (2015)

Even the only two grandmothers who were involved in this decision making process were allowed to make partial decisions such as when the maternal caregiver travelled or was away from the house for a long period while the other grandmother was consigned to decisions on complementary foods but not breastfeeding such as Pricilla's grandmother who indicated that she makes some decisions on feeding *except for breastfeeding that her mother does* [Pricilla's grandmother, 53 years old]. The other two were elder siblings of the maternal caregivers. Maternal caregiver's assertiveness in this decision-making process was also observed in a study on complementary feeding practices in Kumasi conducted in 2003 by Davis and colleagues (2003).

Both caregivers also appeared to have adopted some cues that prompted them on index children's satiation and no longer want to eat again. The dominant cues cited by both household caregivers were verbalisation or gestures such as index children stopping to eat the food, taking interest in surrounding activities or pushing food or breast nipple out of mouth. There were also other instances where the caregivers indicated that their index children start wasting the rest of the food which gives them the indication that the children were satisfied. There was also a rare instance of a maternal caregiver with tertiary educational level qualification, using observation (how big the child's stomach has become) to ascertain the satiation status of her daughter. It must be noted that, unlike hunger cues where some caregivers reported divergent cues for the same index child, the maternal and non-maternal caregivers had common satiation cues for the index children.

The individual maternal and non-maternal accounts above on hunger and satiation cues in addition to the foods fed the index children were not entirely different from what transpired during the focus group discussions aside a few negative incidents that came up during the discussions. For instance, a 14-year-old male househelp indicated that the child he takes care of *has never said he was satisfied no matter the quantity of food served so he does not serve him food again after serving a ladle of rice and stew*. Another incident also revolved around a 14-year-old male househelp who reported feeding the index child (3 years old) with *only gari and sugar* (only carbohydrates nutrient foods) *anytime he uses lunch money to buy sweets*. Some of these incidences were not reported during the female househelps focus group discussions but according to the boys, it happened when they were alone with the index children.

It is very important to note that the caregivers who participated in this study generally appeared to understand children hunger and satiation cues and, in a way, responded appropriately by feeding the index children. However, there are other requirements to responsive feeding such as adapting the feeding method to the child's psychomotor abilities, encouraging a child to eat, using an affectionate or warm style of relating to the child during feeding, supervising and protecting children during eating (Engle et al., 2000). The next sub-chapter presents caregivers' responses when other responsive feeding styles they practise in the household were probed further.

Child Caregivers feeding practices

Practising responsive child feeding requires that the caregiver is able to encourage but not coerce the child to eat healthy foods and also give some choices about eating options (Patrick et al., 2005) even in instances where the child is not willing to eat (Engle et al., 2000) through offering encouragements in the form of praise or talking to the child while eating. Responses from seventeen maternal and twelve non-maternal caregivers 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 child to see a health professional, changing the food, encouraging the child to eat and forcing the food on the child (Table 19). The decision to report the matter to a health worker was made on the assumption that a child's refusal to eat food constitutes a sign of illness which will require medical attention.

Table 19-Caregivers' practices when index child refuses to eat

Practices	Maternal Caregiver (N)	Non-maternal caregiver (N)	
		Househelps	Grandmothers
Taken to health personnel	4	1	0
Changed the food	5	2	2
Encouraged to eat	4	2	1
Forced to eat	4	3	1
Total	17	8	4

Source: Field survey, Owusu (2015)

With specific reference to the practices of non-maternal caregivers (table not shown), for instance, 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 caregivers. 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.

Index children such as Doris (3 years old) and Eric (5 years old) were among the category where their maternal caregivers encouraged them to eat while their househelps forced the food on them. Alex, for example, also belonged to the category whose caregivers considered their refusal to eat as a development that would require medical

attention. Alex's mother (27 years old), for instance, said that she *takes it that something is wrong with him so I will go to the pharmacy shop to buy medicines that could boost his appetite.*

Obviously, caregivers will have to provide children with sufficient quantities of food at every meal time to enhance the growth and development of the index child; however, some children have feeding challenges which usually inhibit their eating abilities thereby having some significant negative nutritional, developmental and psychological sequel. The common feeding problems manifested by children include multiple food dislikes including food selectivity or pickiness, partial to total food refusal, difficulty in breast milk sucking, swallowing or chewing (Arts-Rodas & Benoit, 1998). It is therefore imperative for child caregivers to identify these problems early and devise measures that will enable their children to overcome the challenges. It was found worthwhile to ask the respondents if they had observed feeding problems exhibited by the index children and, if yes, what measures they have put in place to ameliorate the problem(s).

Caregivers with index children who were on exclusive breastfeeding did not report any observed sucking problems. In the same vein, none of the index children were reported to be having swallowing or chewing problems. The feeding problems that were, however, commonly reported by both cares were index children who partially refused foods and had to be placated, forced to eat or food varied. The index children who were picking or choosy with foods sometimes had their caregivers resorting to food vendors when the requested meal(s) were readily not available in the household. In an earlier study conducted in the Kumasi metropolis on children feeding, Davis and associates

concluded that the lack of infant's interest in food led to harsh measures such as force-feeding or coaxing children by their cares to eat (Davis et al., 2003). As already pointed out, the index children were being fed with various meals prepared from fortified, cereal grains, roots and tubers, meat, fish, poultry and eggs as well as fruits and vegetables. Water, vegetable and fruit consumption also play special roles in the growth and development of children. The next section of the chapter, therefore, presents what was gleaned from respondents on water, vegetable and fruit consumption by the index children.

Water intake, vegetables and fruits consumption

When the caregivers were asked to indicate the main source (s) of drinking water for the index children, sachet water-300 to 500 ml sealed plastic sleeves of purified drinking water, followed by bottled mineral and pipe-borne water were the three main sources mentioned by the caregivers. The 2010 Ghana Population and Housing Census also identified pipe-borne and sachet water as the main sources of drinking water in urban localities in Ghana (GSS, 2013). Indeed, according to the 2014 Ghana Demographic and Health Survey report, the most common source of drinking water in urban areas was sachet water (43%) followed by public tap or standpipe (23%) (GSS et al, 2015).

The quantity of water needed in a day by every individual depends on varied factors such as the state of health and climatic conditions of the settlement. However, it has been suggested that people should drink a minimum of eight glasses or an approximate of 1.9 litres of water a day although there are no scientific evidence that supports this claim (Valtin, 2002). For children, it is suggested that those weighing 6

kilograms require a minimum of 600mls of water daily while those weighing 10kgs, 12kgs or 25kgs need a daily minimum water intake of 1 litre, 1.1 litres or 1.6 litres respectively (Behrman, Kliegman, & Jenson, 2004). The physiologic need for water is primarily met through the intake of plain water and from the moisture content of foods and beverages consumed (Kant & Graubard, 2010b). Both the maternal and non-maternal caregivers were therefore asked to estimate the daily minimum water intake of their index children. Analysis of their responses indicated that a greater proportion of both caregivers, irrespective of their educational level and employment status, could not, at least, roughly quantify the daily volume of water consumed by the index children (Table 20). Although the data collected did not include the weight of the index children, if measured according to the recommended daily intake, there were some index children who would be described as consuming water far less than the basic daily minimum required to ensure optimal growth.

A further scrutiny of the responses from eleven mothers and their corresponding non-maternal caregivers also revealed four contrasting scenarios: where both caregivers were oblivious of the minimum water intake of the child, where only one caregiver was aware of the quantity, where both caregivers were aware of the quantity and where both caregivers were aware but with varying estimates. Among the non-maternal caregivers also, the househelps appeared to be more conscious of the index children's minimum water intake compared to the grandmothers. In general, both caregivers were of the view that their observed *high frequency* or *the frequent number of times* with which the index children drunk water in the course of the day was their key indicator for concluding that

the index child has had *adequate* water needed for the day, hence, their reluctance to consciously monitor the *quantity* of daily water consumed by the index children.

Table 20- Reported index children daily minimum water intake

Index children water intake	Maternal caregivers	Non-maternal caregivers		
		Househelps	Grandmothers	
0.2 litres		0	1	0
0.3 litres		1	0	0
0.5 litres		3	1	1
0.6 litres		0	1	0
0.7 litres		0	0	1
1 litre		4	3	0
1.5 litres		3	1	2
Don't Know		17	9	8
Total		28	16	12

Source: Field survey, Owusu (2015)

The story of Maxwell is very typical of what happened in some households. Maxwell was four years old at the time of data collection in his household. His 38-year old mother had a tertiary education qualification and was working as a Secretary while

his 67-year old grandmother did not have any formal education. According to the grandmother, they *buy sachet water for drinking*. When asked to estimate the quantity of water Maxwell drinks in a day, she responded that *unfortunately, I cannot measure since he fetches it and drinks himself so I cannot tell*. His grandmother, however, was able to indicate that Maxwell drinks *about three sachets of water a day* and finally the mother quipped: *Maxwell drinks water a lot; sometimes I even complain*.

There were rare instances (four households), where both caregivers were insistent that they endeavoured to monitor the water consumed by the index children as well as ensuring that the water is safe. According to Rebecca's Auntie (45 years), the index child has her own *water bottle so we can know how much water she has drunk in the day* and also because we want to *prevent her from becoming ill by drinking contaminated water from other cups in the household*. This was also evident in the responses of four mothers but not with such strong emphasis by the other corresponding non-maternal caregivers, although, the responses from the househelps compared to the grandmothers', indicated that, more househelps than grandmothers were very careful about the quality of water served the index children. There was also a maternal caregiver (42 years old) who indicated that the index child's (1 year four months old) water intake is based primarily on the *prevailing weather conditions of the day* and based her explanation on the assumption that cool weather requires a minimal intake of water and vice versa.

According to the 2003 Pan American Health Organisation (PAHO) and the World Health Organisation (WHO) Guiding Principles for Complementary Feeding of the Breastfed Child, breastfed children aged 6-23 months should receive vitamin A-rich fruits and vegetables daily (GSS et al., 2015; WHO, 2003). Fruits and vegetables perform

vital functions in the human body. They provide the needed vitamins and minerals that perform various functions such as regulation of blood pressure, effective blood circulation, building of strong bones and boosting of the immune system.

Despite the clear evidence that a high intake of fruits and vegetables reduce the risk of contracting different chronic diseases and cancer (Foterek, Hilbig, & Alexy, 2015), intake of fruits and vegetables is estimated to be below the recommended quantities for both children and adults in most developed and developing countries (de Wild, de Graaf, Boshuizen, & Jager, 2015; Foterek et al., 2015; Holley, Haycraft, & Farrow, 2015; Zellner & Cobuzzi, 2016). Some reasons that have been adduced for some children's dislike for fruits and vegetables include bitter and sour taste of fruits and vegetables (Foterek et al.; Zellner & Cobuzzi) or presenting vegetables alongside better-liked foods (de Wild et al.).

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* when it comes to consumption of fruit and vegetables. There was no observed systematic variation in the account of the mothers from that of the non-mothers regarding index children fruit and vegetable intake.

The most commonly cited fruits liked by the index children, according to the caregivers, were banana, pawpaw, water melon, apple, mango and oranges as well as vegetables like carrots, tomatoes and cabbage. The reported high intake of fruits and vegetables by the index children, according to the caregivers is due, in part, to fruit and vegetable availability in the households, caregivers' 'appealing packaging' and

presentation to the index children as well as the caregiver's manifest interest in the consumption of fruits and vegetables. For instance, in three households – Emelia, Mercy and Prince –, the maternal cares asserted that they usually *blend* the fruits to make it appealing to the children. The response of Prince's (3 years) mother is very illustrative:

He eats every fruit [...] banana, pawpaw, water melon, apple and even mangoes. Sometimes we blend and put it in the fridge for him. He also likes all the green leafy vegetables, cabbage and green pepper. As for carrot and cucumber, he can eat them raw. [Prince's Mother, 36 years old].

The above high reported index children intake of fruits and vegetables, notwithstanding, there were a few households (two) where the caregivers reported low intake. In the case of Emmanuel (8 months old), for example, his 26-year-old mother indicated that Emmanuel is not keen on fruits despite her repeated attempts to motivate him either by varying or making the serving attractive. In the case of Rebecca's (also 8 months old), her Auntie (45 years old) was hesitant to feed her with fruits because she *feels Rebecca is very young and might suffer from stomach upset* but the mother contrasted this response by indicating that *Rebecca normally quarrels with us over pineapple, oranges and banana but she does not like vegetables*. Similarly, in Seth's (8 months old) household, his 25 years old mother reported that *Seth eats blended fruit juice which may have banana and apple* but his 39-year-old grandmother indicated that *even if you give him fruits, he will not eat*.

During the focus group discussion with male househelps, it was observed from their responses that they were not so particularly interested in ensuring that their index children eat fruits except one discussant who even conditioned that *we also serve him*

fruits if they are available. The responses of the other male discussants were succinctly narrated by this 13-year old househelp: *The mother cooks only on Sunday evenings because she works almost throughout the week so the child eats fruits only twice in a week [...].* The non-serving of fruits by non-maternal caregivers did not necessarily depend on the type of the caregiver. There were some instances where female and male househelps as well as a grandmother were not assertive in this endeavour.

One of the major issues that have ramifications on children's health is the wholesomeness of the food served by their caregivers. Observance of hygienic practices is one of the means through which food could be prepared and served to derive maximum benefit. The next section therefore sheds light on some of the food hygienic practices implemented by the child caregivers.

Child Caregivers household hygienic practices

Both the maternal and non-maternal caregivers were asked a series of questions to elicit data on their hygienic practices particularly those related to food preparation and index child's feeding.

The common practices cited by both maternal and non-maternal child caregivers centred on keeping separate bowls and cutlery for the index children, keeping bowls and cutlery clean, hand washing with soap, preparing and serving index child's food in a clean environment and personal hygiene. Clearly, eating from dirty bowls and cutlery will contaminate the food and cause cross-contamination which eventually will lead to ill health. In ten households, for instance, the respondents cited their conscious practice of having *separate eating bowls and cutlery* for the index children and always making sure

that they are thoroughly washed or cleaned as one of their food-related hygienic practices. This consciousness was more evident in the responses of househelps than grandmothers. Indeed, five househelps cited this in their responses while none of the grandmothers indicated this in their responses. The narrative from Ruth's 42-year-old mother is very illustrative of this practice in the ten households:

Ruth has her own eating bowl so I always make sure that it is well cleaned with soap and kept in a very hygienic place. I also take the same care of her cups and cutlery.

The caregivers had various motivations for providing their children with separate eating bowls and cutlery such as making sure the index children did not eat from contaminated bowls, avoiding instances where sharing bowls with adults may adversely interfere with their children's eating times and maintaining high hygienic standards. According to Doris's 14-year-old househelp, for instance, it is imperative for the household to provide Doris with separate eating bowls and cutlery so that she could monitor the soap that is used to wash the bowl because *some of the soaps have large quantities of soda so if I should use it to wash her bowl, as some members of the larger household do, she might fall sick.*

Another major hygienic practice which was generally cited by both maternal and non-maternal caregivers and also observed being practised during the household interviews was hand washing with soap at some point in the food handling process. This practice was done at several stages in the index children food preparation, feeding and after feeding stages. Hand washing with soap was variously mentioned by almost all the respondents. This was practised by the caregivers and the index children as well. Even

index children who were being fed by the caregivers had their hands washed with soap before and after meals to prevent them from eating dirt as was pointed out by Rebecca's Auntie (45 years old) *Although Rebecca does not eat with her hands, I wash them with soap before and after feeding her.*

Scott and her colleagues reported that in 2002, prior to the launch of the National Truly Clean Hands Campaign in Ghana which actively exposed the citizens to the health benefits of hand washing with soap, health issues were not found to be strong motivators for mother's hygienic behaviour (Scott, Schmidt, Aunger, Garbrah-Aidoo, & Animashaun, 2008). However, after more than a decade of public education on the importance of hand washing with soap, awareness of this practice has increased. Indeed, in almost all the households, hand washing with soap was being enforced by the maternal caregivers. A case in point is what was happening in Evelyn's household. According to the 26-year-old househelp they have to wash their hands with soap *before we do any other thing* anytime they return from school similar to Eunice's mother who also kept hand sanitizer with her so that *anywhere I am, I make sure my hands are cleaned before I feed her.*

Child caregivers sporadically come across instances where, in the middle of food preparation, they were required to attend to the index child who has defecated or soiled him/herself. The interface of food handling and child cleaning provides a major route where faecal contents could easily be transmitted into the food being prepared if proper hygienic practices are not observed. The caregivers were therefore asked to explain how they juxtapose cooking with cleaning soiled children.

The practices, as narrated by both the maternal and non-maternal caregivers were generally not different from each other; however, the mothers were more assertive in their responses on this since they mostly prepared the children's meals. The commonly mentioned process involved covering the food being prepared, hand washing with soap to clean food particles such as pepper, removing the soiled diaper/dress on the child, disposing the soiled diaper in designated refuse bins, cleaning the child with soap, another round of hand washing and that of the child with soap and finally reverting to the continuation of the food preparation process. The response of Fred's mother is very demonstrative of what has just been narrated above:

I stop preparing the food, wash my hands with soap and water to clean any pepper on my hands before I clean him up. I will then change the diapers, properly dispose it off come and wash my hands again with soap before I continue with the food preparation [Fred's mother, 27 years].

Comparatively, and where the two caregivers were available in the household during the food preparation period, four maternal cares were very categorical in their responses that cleaning of the soiled index child was performed by their househelps while the maternal caregivers continued with the food preparation. For instance, Joyce's 31-year-old mother said that *I stop the cooking, clean her up, [...] but if my helper is also not busy then I make her do that work and I take care of the food preparation.* In the same vein, Prince's mother (36 years old) indicated that she stops the food preparation and clean him up but *when my househelp is not busy, she takes care of all that and I will concentrate on my cooking.*

Preparation and serving children meals in congenial environment was also a paramount practice for both caregivers. Food is usually prepared in a kitchen but, in a study conducted in some households in the United Kingdom, Wills et al (2015) reported that kitchens were not solely reserved for food work but used as a space in which various activities like laundry, childcare and office work take place. This implied that the environment where food is prepared may also serve as a major source of cross-contamination. Conscious of this fact, perhaps, some caregivers in this study were so particular about the environment where meals were prepared and served to the index children.

Aside observing kitchens in some households (at least from the spot where interviewing was taking place), the caregivers were asked some questions that related to issues on food hygiene. For instance, they were probed for their knowledge in some practices such as own and index children's hand washing with soap during and after feeding, using clean feeding utensils, feeding in a clean area and hand drying using clean napkins or towel. Both maternal and non-maternal caregivers of Robert as well as the maternal caregivers of Emmanuel and James were among these households that placed premium on preparing and serving meals in a clean environment. While Robert's 28-year-old mother intimated that she always makes sure that she *cooks in a hygienic and clean place* his 52-year-old grandmother responded that her kitchen *is one of the neatest and cleanest places in the house* due to her belief that preparing and serving children with good meals *is one thing you can do as a caregiver to stay away from going to the hospital.*

Aside ensuring that meals were prepared in a clean environment, there were other maternal caregivers such as Emmanuel's mother who used clean environment as a yardstick when buying food from vendors; however, it must be noted that several studies conducted in Ghana and elsewhere have raised issues of deficiencies in the quality of foods prepared and sold by vendors (see, for example, Assob et al., 2012; Rheinländer et al., 2008). The concept of clean environment was also a yardstick for other caregivers when choosing eating places for their children as was indicated by Juliet's 23-year-old maternal caregiver that feeds her daughter *in this room (place of interview) to avoid flies from contaminating Juliet's food.*

Regular and thorough cleaning of cooking utensils and napkins also featured prominently as one of the caregiver's household hygienic practices as alluded to by caregivers of some index children including Emelia, Mercy, Rebecca, Joyce and Eugene. For instance, Eugene's 30-year-old mother was of the considered opinion that doing so would prevent flies from contaminating foods and thereby preventing children from falling sick. She asserted, *I first of all wash all the items-the stick for stirring, the saucepan and the strainer for sieving the flour, the bottles and flasks for storing the porridge [...]. I also boil all the items because flies may settle on them while the utensils might have attracted some dirt on the surface before using them to prepare meals for Eugene.*

Preservation of cooked meals or food leftovers, if not done properly, also provides an avenue for the growth of harmful bacteria. The process of packaging these foods for storage was also an issue that came up strongly in the interviews with grandmothers like those for Emelia, Kate and Maxwell. They indicated that they either store left over foods

in a refrigerator, re-heat, keep it in a food flask or give the food to other children. The underlying push factors for these storage practices, according to the grandmothers, were largely based on their effort not to feed the index children with contaminated foods. Emelia's 57-year grandmother's narrative is very typical of this practice: *If she could not eat everything, I store the left over in the refrigerator. I do not leave it anyhow [...]*.

As already indicated in this chapter, index children are being fed with various meals. What was not explored in-depth in this study, except in two instances where a maternal group discussant and a key informant shared unpleasant experiences about their househelps, was an in-depth assessment of the appropriateness of the various storage practices and the health effects of children consuming left-over foods. A 32-year-old maternal discussant recounted her experience as follows:

There was a day I left food in the fridge but due to the frequent power crises the food went bad but my househelp was not able to detect that [...]. She eventually fed my daughter with the poisonous food which nearly killed her.

The Director of Education also narrated incidences where her househelp earlier made her aware that she did not like tin milk but any time she left milk in her fridge, she came to see that *the milk in the can has been diluted with water* which seemed to suggest to her that sometimes her househelp fed her children with diluted milk.

The last hygienic practice gleaned from the responses of two mothers and a househelp (18 years old, secondary education) was the observance of personal hygiene as a sequel to preparing and serving children with hygienic foods. These personal hygiene practices included keeping finger nails at lower levels and covering hair while preparing food as well as keeping breast nipples very clean. These practices, according to the

caregivers, were being observed in order not to provide safe haven for dirt which could eventually be introduced into the food during the preparation and feeding processes.

Aside maternal caregivers' assertiveness in decision-making related to child feeding is their ability to observe basic hygienic practices when preparing children's meals. These mothers and indeed their non-maternal caregivers demonstrated in clear terms how they appreciated the health benefits of hand washing with soap and were practicing same during food preparation as well as before and after feeding children. In the middle of food preparation, the caregivers indicated or demonstrated some of their hygienic practices such as covering food, removing soiled diaper and replacing it with new one and washing hands with soap before going back to continue with the food preparation. These acts may go a long way to minimise incidence of children suffering from diarrhoea and other food related challenges which have been identified as major causes of children morbidity and mortality.

Caregivers challenges in children feeding

In the households studied, maternal caregivers assumed greater autonomy in deciding on what food to feed their children, who feeds the child and how the child should be fed. Almost all the mothers indicated that they had no challenge in making adequate food available in the household to feed the index children and other household members; a function they usually discharged with their husbands. The above notwithstanding, the feeding practices of some househelps were described as below expectation. For instance, according to the Director of Education who also had some experiences while living with househelps, monitoring the feeding and hygienic practices

of some househelps is difficult since the mothers will *usually not be in the house when the househelps are feeding children*. Moreover, she asked: *what happens to the child, for instance, if the child's food is also the favourite food of the househelp?*

Feeding children with food prepared by food vendors seemed to be a challenge for a few maternal caregivers. The need for patronising these foods arises when the index children requested for certain meals which were not readily available in the household and the caregivers were compelled to buy from food vendors. These caregivers like Doris' 32-year-old mother found it 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*.

Inducing children with sweets to persuade them to eat 'proper foods' in situations where one caregiver may refuse but the other may yield was also mentioned by some caregivers as a challenge in their feeding practices. Jona's 47-year-old mother summarised this 'frustration' when she retorted that *my son prefers biscuits and fizzy drinks to proper food so if I allow my househelp to always feed him, the possibility that he will bully his way through for these biscuits and drinks is very high*. Such mothers, being mindful of the health consequences of excessive sweet intake, have attempted to withdraw them but the incessant crying of the children has also introduced another challenge that they are grappling with.

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 interest in other environmental activities.

Summary

Mothers were found to be more directly involved in their children's feeding decisions and made conscious efforts to ensure that food was available for household consumption. There were not much observed differences in maternal and non-maternal caregivers account of children satiation cues; however, divergent cues were observed for hunger. The dominant feeding style adopted by the caregivers was generally that of responsive feeding such as encouraging children to eat and varying foods fed to children. Both caregivers reported serving their children with vegetables, fruits and water; however, the adequacy of these against international standards were not explored in-depth in this study although the water intake of some index children could be described as very low.

Both maternal and non-maternal caregivers reported undertaking basic hygienic practices when preparing foods and feeding children, nonetheless, in some households, househelps appeared to be assigned greater responsibility of cleaning soiled children in the course of food preparation while maternal caregivers concentrated on food preparation. The practice of feeding children with both home-made and street vending foods as well as laxity on the part of some househelps regarding children feeding posed some challenges for maternal caregivers.

CHAPTER SIX: TRUST, COMMUNICATION AND RECIPROCITY

Introduction

This chapter therefore presents analysis of data that relates to maternal caregivers trust in their non-maternal counterparts and vice versa, communication among the caregivers and end with reciprocity embedded in this relationship.

Maternal caregivers trust in non-maternal caregivers

Maternal caregivers involved in this study had mainly engaged their mothers (12), other family members (11) or non-relatives (5) as their non-maternal caregivers. When the maternal caregivers were asked why they specifically opted for their current non-maternal caregivers, trust emerged as a dominant influencer in the decision-making process. The trust stemmed from their kin relations or, on the part of those with non-family caregivers, trust in the person who recommended the caregiver. Another area where trust emerged as a key theme was the maternal caregivers trust in their non-maternal counterparts to act in good faith and in the best interest of the index child.

The data being presented and analysed here was gleaned from nineteen maternal, ten non-maternal caregivers, focus group discussants and key informants who repeatedly emphasised the issue of trust in their childcare practices. A large number of the maternal caregivers indicated that they chose their own mothers as caregivers while a few of them

opted for a non-relative or a relative househelps. According to the mothers, these three categories of non-maternal caregivers were the people they trusted to seek the welfare of the index children. The trust, according to the maternal caregivers, emanated from their blood relations/connectedness or the trust they already had in the person who recommended the non-relative househelp. These three responses presented here are typical representations of the reasons cited by the maternal caregivers who opted to engage their own mothers:

As for my mother, she is a like a part of me that I trust so much than any other person around me. I trust in her genuine heart not to harm the child as well as in her ability to seek the welfare of my child. I think she sees my child as her own and the caring manner she brought us up when we were children is the same way she is caring for Mercy [Mercy's mother, 31 years old].

There is so much wickedness in this world so it is very risky to allow an outsider to take care of your child for you. You cannot even trust your close friend these days but for my mother, at least, I can trust her with my son [Fred's Mother, 27 years old].

A mother is a mother, she knows better than I do on issues related to child bearing and caring so my husband was even the one who suggested that I should make her come and stay with us to support me take care of the child [Robert's mother, 28 years old].

As already indicated about the choice of mothers as caregivers, the option for relative househelps was also based on maternal caregiver's trust in other extended family members such as younger cousins to take care of the index children as their own child. For instance, Simon's mother used the word 'gyè di' to describe her househelp as, "mè gye nò di", to wit *I trust she can take care of Simon when I am away* while Jona's mother used the expression *I trust in the word of my sister* to take good care of Jona even in her absence. Juliet's mother trust in the trustworthiness of her relative househelp stemmed from a long relationship between them when they were growing up. When asked why she decided to settle on her younger sister as a househelp, the 23-year-old mother had this to say:

My sister is the closet person who can take care of my daughter because of the way we grew up together.

Maternal caregiver's trust in their househelps largely depended on trusted persons comprising mothers, sister-in-laws, friends and other relatives who introduced or recommended the latter. This trust was subsequently reinforced by the trustworthy behaviour demonstrated by the househelps after staying together with the maternal caregivers. The two narratives presented here illustrate the typical accounts of the mothers who trusted in others to accept their househelp:

My househelp [...] was named after my mother so she wanted to bring her from the village to the city [...] when I became pregnant she discussed with me and brought her to stay with me [...]. My husband and I were also comfortable since she was family member [...] I believe in her as a good person [...]. She is very ok for me [Prince's Mother, 36 years old].

I have a girl who helps me. She's my friend's younger sister and since she came to stay with me, she has been very good, humble and supportive [...]
I am a busy woman so when I alerted my friend that I needed a good person to stay with and help me she recommended her sister and because she is from that friend of mine and the good things she said about her, I trusted it and she has proved to me that she is a trustworthy person [Doris' Mother, 32 years old].

Unlike the maternal caregivers who emphasised trust as a key prerequisite for their choice of non-maternal caregiver, the latter, which comprised largely relative househelps and four grandmothers emphasised their desire or being in a position to *help* the maternal caregivers cope with their busy schedule of employment and childcare, and in the case of the grandmothers, teach their *inexperienced young mothers child care*, as their motivation to become non-maternal caregivers. The account of Emelia and Felix grandmothers typifies the mothers who came to *help* and *teach* while the narration by Evelyn's Auntie exemplifies the ones who only came to help.

Oh, you see my daughter is here alone with her husband, and it is painful to give birth with no one available to help you out [...] so why should I allow her to suffer alone? [...] I have come to help her in some of these little things and also teach her a few things she does not know about child care [Emelia's Grandmother, 57 years old].

She is my daughter and since this is her first child I have to teach her how to hold new born babies. Such inexperienced mothers do not know how to

do this properly so it is my duty as her mother to teach her how to handle him after this one she can properly handle the next child [Felix's Grandmother, 50 years old].

I came to take care of Evelyn. The mother is my sister and she is very busy with work so she and the husband requested that I should come and help them [Evelyn's Househelp, 26 years old].

It has already been reported in chapter six that maternal caregivers were the ones who generally took the sick index children to health facilities for treatment. It therefore implied that they were the ones who directly received instructions or education on appropriate post-illness treatment practices from the health professionals. When the Paediatrician was therefore asked whether health practitioners often meet both caregivers and instruct them in the medicine regimen, post-treatment activities in the household process or check with mothers who come for follow up whether they accurately instructed their non-maternal caregivers the treatment process, she responded in the negative and in a lower tone by saying that *seriously I have never thought about this.* However, during the interview with the Education Director, she indicated that *there is a disconnect when it comes to utilising the knowledge acquired because the househelps or the non-maternal caregivers do not usually attend these clinics yet they are the ones who take care of the children in the house.*

The Education Director, although did not cite any evidence or personal experience to buttress her point on this, was of the view that non-maternal child caregivers, especially househelps, cannot be trusted to follow medicine regimen. She expressed

difficulty in how mothers could verify that they have complied with the regimen. She was also apprehensive that some househelps may not even tell the truth when they forget to administer the medicines as directed thereby worsening the condition of the sick child. She ended on the note that *we leave our children in their care by hope and trust*. Similarly, during the focus group discussion with mothers, there were some discussants who appeared physically helpless so depended on *God* than the trustworthiness of their househelps in complying with medicine regimen. The two quotes captured here exemplify the dilemma of such mothers:

Hehehe, she is just like a robot. She needs to be reminded or prompted on almost everything she does. Even the little ones I ask her to do [Quiet for some time]. I leave God to judge that. I think our kids are kicking just by the grace of God [53 years old maternal discussant, old].

I try to give this information out to my househelp but as to whether she practise them when they are left alone with the child is still a mystery that I always leave into the hands of the Almighty God [42 years old maternal discussant].

The issue of maternal caregivers' trusts in their non-maternal counterparts to follow medicine regimen for convalescent children was a predominant theme that was explored during the interview sessions with the individual mothers at the household level except in two households where this was inadvertently not explored. They were first asked if they provided clear instructions on medicine regimen to their non-maternal caregivers just as was given to them by health professionals. Some mothers indicated that they do

not delegate such responsibilities to their househelps or the grandmothers; however, most of them asserted issuing out such instructions. The paucity in this response is how likely is it that mothers would admit not issuing out such instructions to their non-maternal counterparts.

A follow up question to the mothers who responded as giving out the instructions was how they were able to determine that their non-maternal caregivers duly complied with their instructions. Analysis of their responses indicates that the mothers largely depended on the trustworthiness of their non-maternal caregivers to follow the medicine regimen. Besides, they had developed some verifiable indicators to 'authenticate' the trust aside the verbal assurances from their non-maternal counterparts. A greater part of the mothers with older index children who could talk depended on *confirmation from the index children*, while others *made the non-maternal caregivers to demonstrate how they went about the process or checking the reduced contents of the medicines*. It was identified from the maternal responses that this verification exercise was conducted mainly by maternal caregivers who were staying with relative househelps or grandmothers. These three maternal accounts illustrate these different kinds of verification of trust:

When I return home, I first ask my mother if she did as I said and I will ask her to demonstrate to me how she measured the medicine. I also look at the reduced contents of the medicine to see it for myself [James' mother, 31 years old].

Don't worry yourself, even Doris will tell me whether she was given the medicine or not because apart from asking my househelp, I also ask Doris

and also check the bottles to see so that is not a problem and she always adhere to whatever I ask of her [Doris (3 years) mother, 32 years old].

Well she is my mother and I trust leaving my child in her care no matter what. All I need to do is to tell her what to do and even sometimes she knows better than me [Robert's mother, 28 years old].

Narratives from the ten non-maternal caregivers and two female househelp focus group discussants supported the assertion that the mothers indeed followed up on how they administered the medicines or complied with the recommended regimen. For instance, the two narratives from Joyce's 18-year-old househelp and a 15 year old discussant are typical of the account of the other non-maternal caregivers:

Yes, she does that. My auntie tells me everything and sometimes demonstrates to me before she leaves and I do exactly as she has instructed me. I am human and if the children are not feeling well I feel worried and it even give me extra work since Joyce will cry and cry for me to even get frustrated [...] so I give her the medicines the way I have been instructed [...]. When my auntie comes home too she asks me how I did it and I demonstrate to her [Joyce's househelp, 18 years old].

I inform the mother on her return what I have done to the child and she appreciates my efforts. Maybe she has the confidence in me to take proper care of the child [15 years old female househelp discussant].

For the index children who had been enrolled in pre-school crèches or nursery, teachers became another trusted non-maternal caregivers with regards to following

medicine regimen. This hint was given during the interview session with 42-year old Ruth's mother who indicated that she puts the medicine in Ruth's school bag and instructs the teacher on the afternoon regimen. She was, however, unable to tell formally whether indeed the teacher complied. A response from a single respondent is obviously not enough to advance this phenomenon. A further study on this will be very helpful in filling this gap.

What can still not be ascertained is whether verbal assurances, practical demonstrations, reduced contents of medicines as well as verbal assurances from the index children actually translates into performance of an activity. Some loose ends still exist such as if reduced contents of medicines could not be attributable to spillage rather than child intake or whether practical demonstration could not be due to mastery of the skill than actual administration of the medicine. The same may also apply to feedback from children's confirmation which may probably be due to the children's aversion for medicines except to say that the reported open communication between the two caregivers crystallises the trust in their relationship.

Communication, mobile phones and trust among caregivers

Based on the above background, the responses from nineteen and twelve maternal and non-maternal caregivers respectively gave some insight into the level of communication that exists amongst the two household child caregivers. The assessment of communication was therefore extended to include the use of mobile phones and its related applications in the caregiving process.

Assessment of responses from the respondents suggested that exchange of information between the two household caregivers was very regular and cordial with some of the maternal caregivers describing it as *very fantastic, close, good or cordial* while some of the non-maternal caregivers used attributes such as *very strong, easy, good or talks about everything*. None of the responses indicated instances of poor communication between the two household caregivers. Prince's mother, 36 years old, for example, responded that *it has been fantastic* when she started talking about communication between her and the househelp. She further indicated that *it has been more than good since I am always updated on all the things that go on in my home even in my absence*. Confirming the response of her 'madam', the 16 years old househelp indicated that *communication between me and Mummy has been very well [...]. She treats me like her own child, I also feel free to talk to her about everything whether right or wrong, sad or jovial about Prince*. Similarly, 5 years old Eric's mother described the communication with her relative househelp as *very good* while Eric's 25 years old auntie also indicated that *it's been very cordial. We talk a lot*.

The perceived cordiality and openness with which the caregivers communicated among them also extended to other household caregivers such as the fathers of the index children. Responses from eleven maternal caregivers indicated that the cordiality and open exchange of information on the index children has, in a way, empowered their non-maternal caregivers to directly report issues on the index children to their husbands or the fathers of the children. The two quotes presented here are a few of such examples:

She first calls me or sometimes calls Seth's father, especially if it involves money so that we see what we can do about it [...] [Seth's mother, 25 years old].

*It has been more than good since I can always call my **mother** or **father** if there is something about Prince that needs to be attended to [Prince's househelp, 16 years old].*

Further scrutiny of the caregiver's responses revealed that the dominant themes in their communication are issues that revolved around index children's eating behaviours, illness management, knowledge sharing on childcare, money for index children upkeep, reporting on unusual symptoms exhibited by index children, emergencies and other day-to-day decisions that have to be made towards the upkeep of the index children.

Communication could be written like emails or letters, non-verbal such as facial expressions, gestures or in the form of verbal expression which could take the form of face-to-face or telephone/mobile phone. Caregivers could adopt any or combination of the above forms of communication to share information about the index children, however, the recent expansion and adoption of mobile phone use in most parts of the world, especially in sub-Saharan Africa has been very remarkable which could be described as having revolutionised the world's communication system. Mobile phones have facilitated the process for people to easily keep in touch with other family members, business and access, store and share information. The introduction of cell phones has, however, been viewed by some people as undermining trust in others or systems (Driessen, Hund, Willems, Paar, & Holz, 2012; Molony, 2007). The household caregivers

were entreated to explain how cell phones have affected their child caring practices and enhanced their trust for each other.

All the maternal and non-maternal caregivers, with the exception of two non-maternal caregivers, indicated that they own and use cell phones with some maternal caregivers describing the phone as a *messenger* or a *cost saver*. The respondents indicated various means through which they use cell phones in matters that related to the index children's care practices. Almost all the maternal caregivers indicated that when they were away and leave the index children in the care of the non-maternal counterparts, it was the cell phone that *connects* the two thereby allowing the former to *monitor or make surveillance* on the latter's childcare practices while also offering the non-mothers the opportunity to *update* the mothers on the index children as typically illustrated by 3-year-old Simon's mother:

Through the cell phone I am always updated with whatever that goes on in the house and about Simon when I am not around. I am also able to call and find out what is going on with Simon and his elder siblings [...]. It makes me be at peace and do whatever I am doing very well without any stress. Now phone does everything [Simon's Mother, 28 years old].

Furthermore, for some maternal caregivers, the mobile phone enabled them to *coordinate* other stakeholders such as husbands/fathers, health personnel or other relatives to attend to *emergency* issues that affected the index children. Three examples of such scenarios based on the account of 8 months old Rebecca, 5 years old Eric and 4 years old Ruth maternal caregivers are presented below to illustrate this point:

If anything happens to my daughter and I am away, my househelp calls me on phone [...] and I will also call the father. There was a time Rebecca was sick [...] so my sister called me to find out what needed to be done so I instructed her to take Rebecca to the hospital [...]. I then called the father to go to the hospital and be with them [...] he went there [...] paid the hospital bills and went home with them [Rebecca's mother, 37 years old].

It has been very helpful since my househelp is able to communicate emergency situations to me while I am away so that the necessary action could be taken. I remember [...] I was at work and she called to inform me that Eric is ill [...]. I was very busy so I asked her to take him to the hospital and then called my husband to take care of the situation and I was relieved [Eric's mother, 27 years old].

It has been very helpful to me. [...] I called my househelp to meet me at the hospital with Ruth [...] called my husband to ask for money or received directions from him on where to find money to pay for the hospital bills [Ruth's Mother, 42 years old].

On the part of the twenty-two non-maternal caregivers who were using cell phones, almost all of them, aside giving feedback to their maternal caregivers, indicated that they relied on cell phones to report *unexpected challenges* such as incessant crying to their maternal caregivers or asking maternal caregivers for medicine regimen when they forget or are unsure of the recommended regimen. Nine months old

Joyce's househelp, for example, responded that it is the cell phone that she usually used to update the mother when she is asked to take Joyce to post-natal clinic. On the part of Juliet's househelp *sometimes when Juliet is crying non-stop, I called her mother [...]*. Evelyn's househelp was a tertiary student and, according to her, it is the cell phone that enabled her to coordinate her childcare schedules and lectures while 4 years old Frank 58 years old Grandmother indicated that *if I forget about his dosage, I just call the mother to remind me all over again and she does that.*

Some maternal caregivers also pointed out that they have the cell phone numbers of health professionals that they sometimes call to discuss illness management of their children. One month old Felix's 31-year-old mother asserted that:

We have the doctor's number so we call him if there is a problem and he can either come over to take care of the child or we take him to the hospital [...].

The increased availability of internet-enabled (3G) cell phones in Ghana offer users the possibility of communicating through online messaging and networking applications. These phones permit users to be connected to the wider world through the various social media applications such as Facebook, Whatsapp or Twitter; however, none of the caregivers, except one maternal caregiver, reported ever using any of the mobile phone's social media applications to source information on childcare. Some reasons cited for this failure, especially by the non-maternal caregivers, included their inability to read properly or operate a smartphone. The only mother who asserted browsing for information from the internet on her cell phone was five months old Juliet's 23 years old mother who used to look for information on pregnancy when she was pregnant but currently "do it no more" explaining further that she has not encountered any serious

information challenge on childcare that will force me to check from the internet.

Certainly, this is another phenomenon that needs further investigation.

Some responses provided by participants in this study pointed to the concept of reciprocity in the entire caregiving process where caregivers would either respond positively or negatively to each other's actions which eventually will have some bearings on the growth, development or survival of the index children. The section is structured along two main thematic areas comprising daughters or maternal caregiver's reciprocal actions towards their mothers (grandmothers of index children) and mother-relative/non-relative reciprocity.

Daughter-mother reciprocity

Twelve out of the twenty-eight index children had their grandmothers as non-maternal caregivers. In relation to reciprocity, the maternal caregivers were asked to indicate the benefits they have derived from engaging their mothers and, in reverse, what compensation or responsibility they also owe to them for the specific childcare services they are rendering. Almost all the twelve maternal caregivers reported positive reciprocal relationship between them and their mothers. Analysis of their responses indicated that one of the key benefits to maternal caregivers was knowledge acquisition on child caring practices through constant interactions with their mothers in the same household. Some of the maternal caregivers described their mothers as *advisers, confidants* or *teachers*. The close proximity with which the caregivers stay together offered them the regular opportunity to share ideas on how best to take care of the index child or other children in the household. The blend of contemporary with indigenous knowledge and experiences

from their mothers, according to the maternal caregivers, which in this study rarely conflicted as already reported in the chapter on illness management, have increased their knowledge and built their capacity in childcare. These two accounts are illustrative:

I had some basic knowledge in childcare but that was not enough so I am still learning from my mother. Felix is my first child and although I have been reading in books for knowledge and all that but even bathing and handling him sometimes becomes difficult and a bit challenging [...]. She is my mother and has the experience so I felt she was the best person close enough to help me on this so I tap her knowledge and it has been incredibly great. She has been very helpful but does not impose her knowledge and experience on me. We all share ideas and come to a conclusion on what to do that would be best for the child and his health [Felix's Mother, 31 years old].

She has been the closest person in times of support to me in everything and she gives me advice that has helped me so much in taking care of my children so I prefer her to any other person and she also knows better than I do in terms of childcare. [...]. Traditionally, when you give birth and your mother is alive [...] she teaches you some of the things that you have to do with child bearing and caring so that we can pass it on from generation to generation. She has been very supportive and helpful, that I must say. She has really been great [Emelia's Mother, 27 years old].

Another area, aside knowledge acquisition, was providing *helping hand in other household chores* which eventually eases the working mothers to return to work or attend to other activities. The account of the mothers of Mercy and Robert are very characteristic of what the other mothers said:

When I am busy with Mercy, my mother takes care of the house chore and when I am also busy with house work, she takes care of Mercy so I feel relieved and I am able to do all that I have to do [Mercy's mother, 32 years old].

I leave my child and go to work, come in the evening, and sometimes even travel and my mother takes care of the child [...]. In fact, she has been very helpful since I become a little eased up [Robert's mother, 28 years old].

In return, the maternal caregivers reported that the arrangements are *reciprocal* in nature or like a *win-win* situation since they also have the responsibility to take care of the needs of their aged mothers which may include provision of shelter, meals, clothing and, sometimes, other personal effects. As indicated by one month old Felix's 31-year old maternal caregiver, engaging her mother is also offering her *the opportunity to take care of my aged mother as well*; a sentiment which was also echoed by the other maternal caregivers.

The grandmothers did not mention specific direct physical or material benefits they are deriving from their childcare roles except to say offering a *helping hand* to their daughters or seeing it as a *moral responsibility* for mothers to assist their daughters in

childcare. The two quotes provided below are indicative of the views expressed by some grandmothers:

I always tell my daughter that though it was not time for her to have given birth but it has happened so we should do our possible best to take care of the child so that she can also be happy [Pricilla's Grandmother, 53 years old].

She is my daughter and since this is her first child I also had to teach her how to hold new born babies. Such new mothers don't know how to handle babies so it is my duty as her mother to teach her how to handle him after this one she can properly take care of the next child [Felix's Grandmother, 50 years old].

The above findings are consistent with the assertion by Apt who has posited that some elderly Ghanaians have reported, among other things, that living with their children and other family members are strong predictors of life satisfaction (Osei, 2000). In relation to reciprocity, the engagement of elderly people to share experiences with young parents is an avenue that would enable the latter to become productive even in their old age. This could also provide opportunity for other family members to care for their aged mothers or provide them with other caregiving support services. Similarly, elderly women or grandmothers in some countries such as Poland, Turkey, Ghana and Malawi play critical roles in the upbringing of their grandchildren (Kavas & Gündüz-Hoşgör, 2013; Osei; Wasser et al., 2013). Grandmothers in Turkey, for example, take care of their grandchildren due to the increasing number of mothers who are employed in the labour market and the limited institutional day care services available in the country while in

Malawi and Ghana, they have been found to play a central role in breastfeeding and introduction of complementary feeding to their grandchildren (Bezner Kerr et al., 2008).

Mothers-househelps reciprocity

The remaining sixteen maternal caregivers also provided some responses that depicted reciprocal relationships with their househelps. The responses from the mothers did not give any indication of differences in the reciprocal relationship between relative and non-relative househelps. Similar to the benefits derived from mothers, the househelps also assisted the maternal caregiver's in house chores and childcare which freed the working mothers to return to work or attend to other activities. The responses from Juliet and Joyce's mothers, both staying with relative teenage househelps, illustrate the point above:

To be frank, my househelp has been of great assistance to me since she eases my work on childcare in the sense that, when I am busy, she takes care of Juliet and make me feel like childcare is not a one person's affair
[Juliet's Mother, 23 years old].

When the driver brings them from school, my househelp takes care of them till I return from work [...]. If you want more information about the children she is the best person to consult [...] She also takes care of the house chore [...] so I feel relieved and I am able to do all that I have to do
[Joyce's Mother, 31 years old].

In return, some of the maternal caregivers, apart from providing shelter, food and clothing to their househelps, have enrolled them in school or apprenticeship. The account of Prince, David and Maxwell are some examples:

My househelp has been enrolled in a school and attends the same school with Prince [Mother, 36 years old].

After staying with my househelp for a year, she was just staying at home [...] so I enrolled her to learn dressmaking and in no time she will be her own boss and can leave and establish her own business, if she wants to [3 years old David's mother, 40 years old].

I used to stay with my step-daughter when I first married and people thought she was my biological child [...]. She is now at a College of Education [...] and she is so proud of me [Maxwell's Mother, 38 years].

It is significant to note that while the account of the individual maternal caregivers were, to a greater extent, positively reciprocal, a maternal caregiver focus group discussant pointed an element of negative reciprocity about her experience with her househelp. The 32 year old mother who once stayed with a non-relative househelp shared her experience during the maternal focus group discussion:

I am very disappointed and I still feel like I just wasted my resources on this girl. When she came, she was in Class 4. I took care of her through to Senior High School. But after completion [...] she just decided to go back to the parents and up till now I don't know her whereabouts. Huh, when I sit and recollect the potentials in her... I weep.

Nine individual househelps comprising five relatives and four non-relatives also provided some responses that elucidated positive reciprocity. By assisting their maternal caregivers with child caring, these househelps indicated that they were *gaining practical hands-on experience in childcare*. Furthermore, there were some who enumerated some benefits ranging from acquisition of personal effects, to learning a trade or having the rare opportunity to school in the city. The experiences of three househelps are illustrative of the benefits they have acquired:

Oh, as for advantages, a whole lot. If she buys something and it is nice, she buys some for me. I take care of a child and I also do street hawking as well. [...]. I sell sachet water [Doris' househelp, 14 years old].

I needed somewhere to learn dressmaking so I observed that this madam also had a baby so I discussed with her, became her apprentice and, as a return of gesture, decided to assist her take care of the son [Emmanuel's househelp, 23 years old].

The mother is my sister and [...] very busy with work so she and the husband requested that I should come and help them in taking care of Evelyn while I also further my education [Evelyn's househelp, 26 years old].

Although both individual maternal and non-maternal caregivers did not report of any incidence of negative reciprocity such as physical abuse during the interview sessions despite the probing during the interview sessions, aside the maternal discussant whose experience have already been indicated, the advice from five male househelps during the

focus group discussion seemed to suggest some form of abuse or negative reciprocity from their maternal caregivers. For example, a 14-year old discussant entreated his maternal caregiver (uncle's wife) to stop *maltreating* him since it *affects* his studies while another 13-year old discussant also narrated that:

The mothers turn us away when we ask for some basic needs. They tend to give their children all the goodies but neglect us. I can transfer my frustration onto the child so the mothers should treat us equally.

Similarly, two other male discussants also had this to say:

My auntie should extend the same love that she shows to her children to me. She sometimes gives me small quantities of food. Her children do not help in house chores yet she serves them big portions of meals. I sometimes go to bed hungry [16 years old male househelp].

Last week, the child went to fight with another child and I scolded the child but the mother became very angry and slapped me [...]. I will eventually transfer my anger on the child when we are alone [14 years old male househelp].

Both positive and negative reciprocal accounts were also reported during the girls' focus group discussion. For example, on the positive front, a 15-year-old discussant expressed her joy in the *increase* in her social status compared to her colleagues still living in her village concluding that *I now travel to my hometown or another place during the vacation and they say that I am also now a city girl*. In contrast, another 15-

year-old househelp who stays with her Auntie expressed her disappointment in becoming a non-maternal caregiver. Her response went as follows:

Initially I was very excited about the whole idea but now I am not happy at all. My madam is not appreciative of all my efforts. She will go and complain to others that I am a lazy girl and does not do my house chores well despite all the good things I have been doing for her.

It is informative to note that both positive and negative reciprocity are linear directional with the positive being meted out by maternal caregivers to relative househelps and vice versa. The accounts presented indicated that this is irrespective of the relationship between the two caregivers. For instance, David and Emmanuel househelps are non-relatives yet their maternal caregivers have enrolled them in apprenticeship contrasted with the account of some discussants whose contributions were reportedly not being appreciated by their relative maternal caregivers including aunties.

The accounts of both positive and negative reciprocity provided above tie in with similar findings reported on child fostering in sub-Saharan Africa. Inferring from two separate studies conducted by Hampshire and Isuigo-Abanihe, at the positive reciprocal level, for example, fostering facilitates children's socialisation, training or continuation of further education (Hampshire et al, 2015; Isuigo-Abanihe, 1985) while, at the downside, some fostered children have reported detrimental consequences to their education due to high workloads (Hampshire et al, 2015).

It was not only individual caregivers and group discussants who narrated issues on positive and negative reciprocity. The key informants also shared some of their experiences and encounters with mothers and their househelps and how reciprocity has

enhanced or endangered the lives of the parties or other family members including children. The 59-year old Headmistress narrated a personal experience where her househelp *started misbehaving* and even packed her belongings and left the house *without notice after establishing her to become a dressmaker*. Similarly, the Police Officer also reported of abusive cases that are sometimes reported to his outfit. He cited an instance where the hand of a househelp was severely burnt by her maternal caregiver to the extent that the hand had to be amputated. He also cited a case of a mother who stabbed her house boy with a broken bottle in 2013 as well as instances of sexual abuses or harassment by husbands or the fathers of the index children. In addition, he also indicated some instances where caregivers had framed false criminal charges against their househelps.

It was worth prodding to know how many househelps reported such cases to his outfit during the one-month period earmarked for the study. The Security Officer, responded that such cases usually came to their attention through neighbours or other relatives but rarely were they reported by the victims themselves. Explaining why the victims were unable to do so, the concept of reciprocity was very illuminated in his response:

Most of the victims depend on these people for survival. They feed them, cloth them, shelter them and even support their education. The other thing is that most of them are afraid [...] to tell anyone about it. But generally, it is fear of losing all these support that leads to these victims shutting up

[Security Officer].

The Minister also narrated an incidence of negative reciprocity where a househelp was maltreated and she, in turn, *punished* the household with an unwholesome meal. According to the 61-year old Minister, *I heard of a story which concerned a househelp who used urine to cook food for the household because the mother was not treating her well.*

Apart from the positive and negative reciprocal issues discussed above, nearly all the respondents strongly emphasised the important role of *immaterial* or *psychological* positive reciprocity in the provision of quality childcare. The general phrase in the responses of the research participants was *do unto others what you want them to do for you*. Psychological reciprocity was explained as maternal caregivers' show of love, appreciation, dignity, respect and upholding of the fundamental human rights of househelps while the maternal caregivers also entreated their househelps to provide quality care to the index children as they (children) will also grow to reciprocate their gesture. Similarly, respondents shared the view that if maternal caregivers intimidate, maltreat or disrespect their househelps, quality childcare may also be compromised. The four illustrations, one each from maternal, non-maternal, discussants and key informants are typical:

Some househelps, even after cooking have to hang around till everyone finishes eating before they can get something to eat. Some wash husband's clothes and lay beds. If the maid lays a bed, can't she also lie on it? If you live peacefully with her, she will also take very good care of your child, if not she will not even feed your child [...]. She soils the babies clothes with food and leave some around the lips [...]. She might even eat your child's

food and will not sacrifice anything for the child. If you treat her well, she will treat your child as her own [Emelia's grandmother, 57 years].

The mothers should also appreciate our efforts [...] by treating us equally as their own children so that househelps can give up their best in caring for the children [Eugene's househelp, 25 years old].

We need to be patient with the children so that posterity will judge us upright. If we inflict any damage on them now through our beatings, we will be guilty and ashamed in the future when we meet them [13 year old Male househelp discussant].

I want to tell the parents that they should treat their househelps with love [...] Househelps should also try to love the children they take care of and this will be reciprocated in future [Education Director].

The foregoing account on reciprocity has some direct bearings on the growth and development of children. The child becomes the direct recipient of caregiver's responses to reciprocity. In households where maternal caregivers positively reciprocate the care of their househelps, the child is more likely to receive quality care where the child is made to feel comfortable, relaxed, happy, properly supervised, fed with good nutrition, plays in a clean environment with appropriate play materials and where the caregiver does not demean or maltreat the child. On the contrary, negative reciprocity, according to the observations above, tends to lend itself to child maltreatment, abuse, neglect, morbidity and mortality. Perhaps the sporadic media reportage of some non-maternal caregivers in

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Ghana and elsewhere maltreating children in their care could be a result of negative reciprocity.

Interpersonal trust between child caregivers is very essential in providing an enabling environment that facilitates quality growth and development of children. Maternal caregivers trust in the abilities of their househelps and this trust, facilitated by regular communication and information sharing, is a significant contribution in providing such enabling environments. It must, however, be noted that verifying trust by verbal assurance or practical demonstrations may not be enough for maternal caregivers to assure themselves that children receive quality care from non-maternal caregivers.

Reciprocity as used in other disciplines has been found to play a major role in childcare. It enables maternal caregivers, especially new mothers, to tap into the knowledge and experiences of their mothers in child caring while offering another opportunity for the growing aged population in Ghana to be cared for in an urban setting. Similarly, the engagement of other relative and non-relative members to support childcare at the household level is freeing working mothers to return to work and access to helping hands in childcare even in households where children have started schooling.

Ensuring the provision of quality childcare for children also, to a large extent, depends on the relationship between the caregivers. Reduction or removal of maternal caregiver's negative reciprocal actions against househelps with a corresponding return of positive responses could go a long way to facilitate the nation's quest to providing enabling environment that supports children's optimum growth and development.

Discussion

This section discusses reflections on the entire empirical analysis presented in this thesis on issues related to caregiver illness management, feeding practices, trust and reciprocity as well as how the findings relate to the theoretical and conceptual frameworks adopted for this study. The discussion is situated in the context of assertive and non-assertive child caregivers.

Warland and colleagues posit that an assertive behaviour is seen when an individual gives expression to their rights, thoughts and feelings in a way that does not degrade but recognises and respects the rights, thoughts and feelings of others (Warland, McKellar, & Diaz, 2014). On the contrary, non-assertive behaviour, as defined by Parham and colleagues, is the denial of one's own personal rights by placing the opinions, feelings, and needs of others before their own (Parham et al., 2015). Begley and Glacken (2004) argued that a person's ability to be assertive is multi-factorial and factors such as lack of knowledge, opinions about what others may think and lack of confidence in decisions contribute to a person becoming unassertive. A person's ability to be assertive or unassertive is also directly linked to some factors such as a person's work, gender and status (Parham et al., 2015; Twenge, 2001).

The two categories of individual child caregivers interviewed in this study have some characteristics that could be described as being assertive or unassertive. For instance, the maternal caregivers were all occupying higher statuses in the households than the non-maternal caregivers. The maternal caregivers were relatively highly educated than the non-maternal caregivers, were employed and came from nuclear family backgrounds that could be described as middle class in the metropolis. In contrast,

judging from benchmarks or indicators that make a person assertive, the non-maternal caregivers may be classified as unassertive on matters that related to household decision making. In much the same way, their current basic education level and poor economic status give them minimal opportunities to be assertive. It will therefore imply that, in comparing the childcare practices of these two caregivers, the maternal caregivers will be more assertive and exert more control in the caring process, however, and as has been pointed out in this thesis, there were some instances where both caregivers were either assertive or unassertive in their childcare practices.

In relation to decisions on index children's illnesses treatment options, a greater number of the maternal caregivers interviewed demonstrated some high level of assertiveness by deciding to be in full charge of this decision. They were directly and actively at the forefront in deciding on which health facility to utilise even in the face of some mothers encountering multiple directives from other household members. Drawing on some assertive tools such as *education* and *economic status*, most of the mothers did not *appreciate* herbal or faith healing treatment options and urged their non-maternal caregivers to abide by their decisions. Clearly, some of these mothers could be described as being assertive for standing up without undue pressure to express their thoughts and feelings (Begley & Glacken, 2004; Parham et al., 2015) contrary to some of their colleagues in Malawi and other rural parts of Ghana who succumbed to grandmothers on decisions regarding child care (Bezner Kerr et al., 2008; Tolhurst, et al., 2008).

In describing the assertive nature of some maternal caregivers, Thaddeus and Maine (1994b) three delays model could be used as an illustration. In their landmark study exploring the causes of maternal deaths, Thaddeus and Maine identified three main

areas of delay that contributed greatly to maternal mortality. The first delay happened at the household level where due to some social, economic and other factors, the decision to seek health care for pregnant women were delayed. Once the decision was made, a second level of delay in reaching the hospital or health facility may also become an impediment for pregnant women to reach health facilities on time. At the facility level, a third delay may also arise before the pregnant woman receives treatment. Although assessment of the third delay was not explored in detail in this study, the responses from a large proportion of the maternal caregivers suggested that they did not delay deciding to seek health care nor transportation to health facilities being a problem for them. They either sent the ailing index children to a health facility the same or next day. This notwithstanding, those who delayed to the next day and beyond reported giving the sick children 'first aid' based on previous regimen from health personnel. The wide variety and easy access to the various health facilities in the Metropolis were being actively utilised by these mothers. Access seemed not to be a problem due to the good road networks and availability of private and public means of transport to these facilities. There were some mothers who even had clear guidelines on how to navigate through the health facilities to avoid or minimise the second and third delays by identifying which health facilities offer quick-turn around time.

Another area where the maternal caregivers asserted more authority and control was in the area of following medication regimen for sick index children, checking for danger/warning signs or side effects in addition to expiry dates of medicines. Their consideration of these issues as very critical mark them as caregivers who are conscious and deeply concerned about the well-being of their children. Furthermore, mothers who

could not be available at home throughout the index child's illness episodes, exerted more agency by instructing their non-maternal caregivers in these issues. Some maternal caregiver's insistence on their non-maternal caregivers to demonstrate how medicines were administered or through other verifiable means without necessarily overly relying on the trustworthiness of non-mothers further strengthen their assertive resolve in ensuring that the index children received appropriate illness management. This supervisory role re-enforces Smart and Cottrell assertion that mothers perceive children's illnesses management as an important parenting responsibility for which others would hold them accountable (Smart & Cottrell, 2005).

It was not only in illness management that the mothers were assertive. This was also evident in some of their feeding practices as well. Although they collaborated principally with their husbands, they ensured that food was always available in the household to feed the index children and other household members. The mothers were also equally active in ensuring that food is prepared and served under relative good hygienic conditions. Their regular practice of hand washing with soap is also a practice that could be described as appropriate in helping minimise child's mortality from food related morbidities.

Comparatively, the maternal caregivers were more assertive than their non-maternal caregivers in most of the issues that have been discussed above which may result from the unbalanced power relations embedded in this caregiving arrangements. The maternal caregivers appeared to be the principal decision-makers and the non-mothers as decision implementers. Nonetheless, there were some non-mother caregivers who were assertive in collaborating with their maternal caregivers in childcare. Some

grandmothers were very active in decisions on healthcare options while some househelps were very assertive in adhering to recommended regimen as well as observance of medicine warning signs, side effects and expiry dates before administering to index children. The grandmothers, especially, in assisting their 'inexperienced' daughters in childcare, were also conscious of the need to use biomedical care as a first option for treatment. This practice therefore provides a relationship whereby the participation of the young househelps in childcare is serving as a conduit through which they could be oriented, albeit informally, to become assertive mothers in future.

Furthermore, the non-maternal caregivers reported undertaken basic hygienic practices during food-handling, an important assertive care practice that could greatly contribute to reducing child morbidity and mortality. In a caregiving arrangement where the actions and inactions of both caregivers have direct effect on the index children, it would be worthwhile that both caregivers operate at some equal levels that will inure to the benefit of the child. The index children whose both caregivers understood their hunger cues, responded appropriately by preparing and serving them food under good hygienic conditions, were encouraged to eat or had their meals varied when they refused to eat. could certainly be considered as receiving quality care from their caregivers.

The assertive nature of most of the mothers and some househelps and grandmothers, notwithstanding, there were some findings from this study that could also mark some of them as unassertive child's caregivers. These could be gleaned from practices such as inability to identify basic illness symptoms, not being particular with medicines side effects and instructions, the practice of using intuition to determine hunger and satiation cues, force feeding as well as children's low water intake.

Perception or diagnosis of illness is a delicate matter that ideally should be done by professionals. Even among professionals, sometimes, this becomes a difficult task as a result of symptoms overlaps (Cohen & Scheeringa, 2009) and, in the case of children, this becomes a major challenge for non-professionals such as the caregivers analysed in this study. As has been reported earlier in this thesis, all the maternal caregivers were able to attribute some symptoms to a perceived illness, while among the non-maternal child caregivers, only twelve (4 grandmothers and 8 househelps) were able to make such attributions without recourse to information provided by their maternal caregivers. There were even some non-maternal caregivers who held the view that symptoms identified by mothers did not constitute illness despite their fore knowledge in the inclusion criteria of the study. Such non-maternal caregivers could be described as unassertive. Their inability to immediately 'guess' index child's illness could result in the first delay espoused by Thaddeus and Maine which could also affect respective mothers to take action. This has the potential to delay decisions to seek care; the first delay as posited by Thaddeus and Maine (1994), refusal to report child's illness to maternal caregivers, misreporting of observed symptoms to mothers or health professionals.

Some of the grandmothers and househelps interviewed at the household appeared to be meticulous when it came to following medicine regimen or checking for some health and safety information on the medicines before administering to the index children. In general, it was evident from their responses that non-maternal caregivers were very active agents in household post-illness treatment management practices. The negative consequences of administering overdose or expired medicines and skipping regimen were cited by maternal caregivers against househelps. Perhaps, their low

educational level, improper briefing from maternal caregivers, combining childcare with other household chores and negative reciprocity might explain these negative practices. While the effects of these negative practices may be very consequential for the parents- emotionally or financially, the effect on the innocent child or children may be far reaching. This may include severe pain, prolonged illness, deformity or death.

The importance of formal higher education cannot be understated and for women, formal education provides a lot of returns to them as individuals and to the larger society in general. This is worthwhile since they may bring knowledge acquired from higher education to bear on childcare, but this may also affect childcare negatively due to competing demands on their time for studies and childcare. Almost all the grandmothers interviewed have no formal education. Similarly, most of the househelps had only basic education. It was, however, noteworthy to note that some mothers were making conscious efforts to actively engage their non-maternal counterparts through the use of mobile phones.

There is no single proven means of identifying children's hunger and satiation cues. Nonetheless, some cues such as crying, mouthing, verbalisation and gesturing could be described as 'good enough' compared to caregivers who relied on personal intuition or perception such as bigness or smallness of child's stomach or how long the child has played. Certainly, this cannot be a good indicator since human intuitions vary all the time. Besides, it was identified that, in some households, different hunger and satiation cues were being employed by the two caregivers for the same index child. While this may not come with adverse consequences on the nutritional needs of such children, there is also the possibility of this becoming the case. It has the potential of leading to over or

under-feeding the index child. The application of intuition to determine a child's hunger and satiation as well as variations in caregiver's hunger and satiation cues may be considered as unassertive practices that have to be re-considered and streamlined.

Forced feeding is a characteristic of authoritarian or controlling feeding style (Engle et al., 2000; Wondafrash et al., 2012) which is generally not encouraged due to its negative effect on children nutrients intake (Nti & Lartey, 2007) or difficulty in monitoring child's food intake which may eventually lead to child obesity (Engle). Similarly, authoritarian feeding has been linked to children's lower intake of fruit, juices, and vegetables (Patrick et al., 2005); a development that could have negative effects on children's food preferences and self-regulation of energy intake as well as dietary intake and disruption in children's short-term behavioural control of food intake (Savage, Fisher, & Birch, 2007).

Forced feeding was reported as one of the feeding practices adopted by both maternal and non-maternal caregivers. In the case of the non-maternal caregivers, this may be due, in part, to the fact that the decision on what food to feed the child largely depended on the mothers and thus may see themselves as policy implementers who were expected to adopt all measures to get the index children eat the food served, however detrimental it may be to the child. However, it is imperative for both household caregivers to realise that this practice is not helpful to children's growth and development and must align more to practising responsive feeding practices.

Access to safe drinking water remains a problem in many developing countries including Ghana (GSS et al., 2015). Intake of contaminated water is associated with severe diseases (Ashbolt, 2004; World Health Organisation, 2002) including diarrhoea,

typhoid fever, cholera and dysentery which are all known major causes of children's morbidity and mortality. Sachet water, popularly called pure water in Ghana, generally consists of 300-500 milligrams sealed plastic bags of purified drinking water. As reported by most caregivers in this study, sachet water has become a very common source of drinking water in most Ghanaian households due to its low price, convenience, and perception that it is of higher quality than tap water (McGarvey et al., 2008; Stoler, 2012; Stoler, Tutu, Ahmed, Frimpong, & Bello, 2014).

Findings from the 2014 GDHS indicated that the most (43%) common source of drinking water in Ghanaian urban areas was the sachet water (GSS et al., 2015). The report further indicated that "the most notable change in access to drinking water sources between 2008 and 2014 is the increase in the proportion of households using sachet water from 8 percent to 29 percent in the past six years" (2015, p. 12). Although the potential health effects of plastic packaging of water remains unknown (Stoler, 2012), an assessment of 60 samples of sachet water in the Accra Metropolis by Stoler and colleagues found no faecal contamination in any sample (Stoler et al., 2014). However, a study conducted by McGarvey and colleagues on community and household determinants of water quality in coastal Ghana found that almost three quarters of households had water with > 2 E. coli /100 ml H₂O except that household water from the tap had lower E. coli/100 ml H₂O compared with all sources except bottled and sachet water (McGarvey et al., 2008).

Despite household caregivers being assertive in providing quality water to the index children, the adequacy of the daily minimum water needed by the index children to enable them optimally function was found to be very low. There was a large number of

the index children who would be described as drinking water quantities far less than expected. Even though, feeling of thirst is a human sensation that has to be identified and expressed by an individual, it is also important for caregivers to note that children may not be able to express this sensation accurately and timely. It therefore reverts to the caregivers to assist children in this process. The practice where the caregivers were relying on the *countless* number of times they observed the index children ingesting water cannot serve as a good pointer to *adequate* water consumption. Despite the fact that none of the respondents reported of any child dying from thirst, it might be worthwhile that child caregivers are very assertive in knowing the right quantity of water needed by children at every stage of their growth and consciously monitor the water intake of children so that the children will have the needed quantities that will support optimum growth and development.

Although dietary recommendations vary, most countries are using the World Health Organization's recommendation to consume a daily minimum of 400g of fruit and vegetables, or the equivalent of five portions of fruit and vegetables per day (Nguyen et al., 2016; Oyeboode, Gordon-Dseagu, Walker, & Mindell, 2014; WHO, 2003). While this prescription may not be entirely applicable to children, it is relevant that children receive a good proportion of fruits and vegetables to enhance their growth and development process. What was not clearly evident from the responses of both caregivers was the regularity and quantity of fruits and vegetables consumed by the index children comparable to other studies on adults in Ghana which have indicated that consumption of fruits and vegetables are very low relative to other countries (Amo-Adjei & Kumi-Kyereme, 2015). This may imply that children are also not getting enough quantities of

fruits and vegetables since the adults, on whom they rely for their nutritional needs, are lacking in this aspect as well.

Although none of the individual respondents reported of physical abuse meted to or received by non-maternal caregivers involved in this study, there were reported incidences of abuse of househelps by maternal caregivers or foster parents. Despite this practice amounting to a clear violation of the victim's fundamental human rights, it also puts the infants or children being cared for by these househelps at risk through the practice of negative reciprocity. Ghana has assented to various international and national legislations that seek to promote human rights, eliminate domestic abuse, protect the weak and vulnerable as well as provide the enabling environment that will ensure that individuals are able to grow and develop to their full potential in a free society as enshrined in the country's Children Act (Act 560). It is worrying that some househelps have become victims of abuse by maternal caregivers but are unable to report due to fear of losing their livelihood. The eventual net consequence might be a negative reciprocal treatment on the index child under their care who would be improperly cared for by the affected househelps. This may serve as an entry point through which efforts aimed at promoting child' health could be reversed.

Traditionally, family members have been responsible for providing care to their elderly relatives (Osei, 2000). In the study area, as in other parts of Ghana, family ties are still strong and the family still remains a source of support for elderly parents who also reciprocate by assisting in some activities of the household such as childcare. Similarly, fostering has offered some of the househelps interviewed the opportunity to school or learn a vocation aside the basic human needs of accommodation, clothing and food. On

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the reverse, this practice has also served as a conduit through which some househelps have experienced detrimental outcomes such as feeling of overburdened with domestic work as reported by a female househelp who became "surprised" on realising that she was in Kumasi to school and perform childcare duties. Although the individual househelps interviewed at the household reported of cordial relationship with their foster maternal caregivers, the accounts by some discussants and key informants suggested that some househelps are at a disadvantage. This may not auger well for the index children involved since they may be, innocently though, made to bear the brunt when left alone with the ill-treated househelps. Furthermore, the combination of petty trading, street hawking and apprenticeship with childcare may also lead to divided attention which may negatively affect the health and well-being of the index children involved.

The human ecological model developed by Bronfenbrenner in 1979 placed the child in the innermost proximal microsystems layer which consisted of the child's closest surroundings such as the home while the second layer, mesosystem, described the influencing forces of the school, neighbourhood, religious settings and other household members. The third layer, exosystem, according to Bronfenbrenner, highlights other environmental factors and how they collectively shape the growth and development patterns of children. The final layer, macrosystem, encapsulates a societal blueprint for a particular culture, subculture or other broader social context. The care provided to children by the various household caregivers is being shaped by one or a combination of the four layers outlined above by Bronfenbrenner. The various socialising influences of the caregiver's family, peers, educational level, employment schedule and the mass

media have all been found to shape the caregiving practices of the mothers and non-maternal child caregivers who participated in this study.

The grounded theory data analysis process which provides avenue for the emergence of new themes and subsequent explorations re-enforces the circular nature of research. This exploratory study has generated useful insights into childcare practices and offers a significant research and policy gaps that need to be addressed. The issues of trust and reciprocity embedded in childcare are a few examples.

Summary

This study has highlighted some maternal and non-maternal household child caregivers' practices in two important areas that directly have either positive or negative consequences on child health. There are a number of child caregivers located in the various layers in the Bronfenbrenner human ecological model who are acting individually or collectively to influence children growth and development. The accounts presented in this thesis came principally from two caregivers located in the first layer of the model. The practices of the other caregivers in the same layer such as other biological children and fathers as well as the other outer layers should further the discussion with the aim of unravelling all the factors accounting for the relatively high infant and child mortality rates in Ghana and how they could be reduced to the barest minimum.

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CHAPTER SEVEN: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter deals with the summary of study, the conclusions drawn from the findings and recommendations.

Summary

The various socio-economic and technological changes currently being experienced have had some significant impact on the traditional child caregiving roles of mothers especially those who are resident in urban areas with middle-class status lifestyles including working outside the home to earn an income. Such working mothers therefore navigate through a complex system of arrangements in seeking childcare for their children during pre-school and after school. In Ghana, the option widely used by working mothers is the engagement of other household non-maternal child caregivers who may be a grandmother, a relative or a non-relative househelp. In the case of househelps, the arrangement is usually informal or in a form of fostering. This study was therefore conducted in the Kumasi metropolis of Ghana to explore the knowledge and childcare practices of mothers and household non-maternal child caregivers with the aim of identifying areas of similarities and discordance in their caregiving practices in two areas of children's illnesses management and feeding practices as well as the underlying decision-making processes embedded in the arrangements and caring activities.

This study was exploratory and qualitative in design. The respondents were 56 individual maternal and non-maternal child caregivers, eight maternal focus group discussants, 15 non-maternal focus group discussants and five key informant interviews. The individual maternal and non-maternal caregivers were interviewed simultaneously in their households. All the interviews were digitally recorded and transcribed and analysed deductively using the grounded theory approach. Ethical clearance was obtained from the University of Cape Coast Institutional Review Board. Confidentiality of the respondents was ensured at all times and names used in this thesis are all pseudo which makes it difficult to identify or guess the respondents.

The household individual maternal respondents were largely engaged in middle class economic activities such as teaching, banking or private businesses while the non-maternal caregivers comprised children (less than 18 years old), youth and grandmothers who were either full-time child caregivers or combined childcare with other activities such as schooling, petty trading or apprenticeship. Both the maternal and non-maternal caregivers came from backgrounds that were defined by pull and push factors respectively. The former was in relatively higher economic status category with stable employment and income, limited time to effectively combine work away from home and childcare while the househelps were pulled into childcare principally due to their parent's economic challenges that constrained their desire to live, school or learn trade in a city.

The common reported illnesses that attacked the index children were malaria, diarrhoea and upper respiratory infections. Both maternal and non-maternal caregivers were utilising various health seeking options especially biomedical care for the treatment of index children's illnesses. The maternal caregivers, especially, were more assertive in

this decision making process; however, both caregivers were active agents in household illness management practices particularly in the area of medicine administration. The maternal caregivers were more assertive in the observance of some children's illnesses management practices such as adherence to regimen and medicines side effects on children. There were some accounts of househelps who either give overdose medicines to children or skipped some of the regimen.

Mothers were found to be more directly involved in their children's feeding decisions and made conscious efforts to ensure that food was available for household consumption. There were not much observed differences in caregivers account of children satiation cues; however, divergent cues were observed for hunger. The dominant feeding style adopted by the caregivers 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.

Trust was identified as one of the key virtues that bonded the two caregivers together. The maternal caregivers trusted in the trustworthiness of their non-maternal counterparts to take good care of the index children. The trust was enhanced by regular cordial face-to-face and mobile phone communication between the two caregivers. Reciprocity was also found to be a major catalyst in the childcare arrangements investigated in this study. Positive reciprocity enabled the maternal caregivers to tap into the knowledge and expertise of their mothers in child caring while offering an opportunity to the maternal caregivers to take care for their aged mothers. The househelps were also freeing the working mothers from some activities in childcare while at the same time, empowering the non-maternal caregivers with knowledge and practical experiences

in childcare. The consequences of negative reciprocity on househelps such as abuse and infringement on some of their fundamental human rights are sometimes transferred to children that may compromise their health and well-being.

Conclusions

Women's participation in labour force has increased in some developing countries including Ghana which has invariably affected traditional expectation of their lead role in childcare. There is therefore a growing need for childcare which is being met through various means including engagement of household non-maternal child caregivers. The household non-maternal caregivers, compared to maternal caregivers who participated in this study, were lax in some household childcare practices such as illness management and feeding. There might not be any immediate overt consequences of this laxity on the health of children; however, it tends to reason that both caregivers will operate from similar knowledge backgrounds that would ensure uniformity of thought and practice.

The current modern forces of change such as urbanisation, rural-urban migration and trends of having more women educated, becoming professionals and empowered, however, offer some glimpse of hope that future mothers and grandmothers will be well knowledgeable and experienced in contemporary childcare practices that will guarantee improved well-being of Ghanaian children as it pertains in other developed countries. However, this is also coming along with the situation where children are not receiving maximum attention from their household caregivers due to competing demands on caregivers which may have both physical and psychological consequences on their young growing children.

The relationship between maternal and non-maternal caregivers studied in this research was based on trust and moral obligations which may not be binding enough to get the full participation of non-maternal caregivers as it is the case in some advanced countries where Nannies or Au pairs have 'contractual' obligations to take maximum care of index children in their care. Similarly, trustworthiness can be pretended, faked or betrayed by both parties which may lead to negative reciprocity and its attendant negative consequences on child's health and survival outcomes in Ghana.

Ghana has adopted various policies and programmes that seek to provide the enabling environment to support quality growth and development of children in the country. It must be noted that the achievement of these policies and programme goals such as the SDG 3.2 may depend on the caregiving practices of their household caregivers. The child caregiving practices highlighted in this study should engage all stakeholders to provide the needed interventions so that we can have a Ghana where prospective mothers can be optimistic that their children will live past age five and children having the assurance that they will survive to adulthood.

Recommendations

The following recommendations are made based on the findings of the study:

1. It is recommended that mothers should make extra effort at childcare without too much reliance on the trustworthiness of non-maternal caregivers.
2. The government should consider the introduction of some innovative measures like flexible working schedule for mothers with children less than

five years or the granting of paternity leave to enable fathers take active part in childcare.

3. It is also recommended that guidelines could be developed to regulate the engagement and activities of household non-maternal caregivers. Among the issues that the guidelines could address should include basic qualification of househelps, responsibilities towards childcare and compensation. The au pair guidelines could serve as an example.
4. Future studies will be required to explore the caregiving practices discussed in this study with a larger sample and in wider geographic scope.
5. There are other caregivers such as teachers whose trustworthiness in administering medicines to sick pupils was not explored in this study which will be worth doing in the future.
6. A longitudinal study of househelps and children raised by househelps may also be conducted by other researchers to determine the health impact of growing up under the care of two caregivers.

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Appendix 1: Research Instruments

1A: In-depth interview guide for household respondents UNIVERSITY OF CAPE COAST

DEPARTMENT OF POPULATION AND HEALTH CHILD CARE PRACTICES IN THE KUMASI METROPLIS, GHANA IN-DEPTH INTERVIEW GUIDE FOR HOUSEHOLD RESPONDENTS

Introduction

My name is _____ I am from the Department of Population and Health of the University of Cape Coast. We are conducting a research on child caring practices of mothers and non-maternal household child caregivers in the Kumasi Metropolis of Ghana. To make sure we are getting a cross-section of respondents who have different knowledge and experiences with child care for this study, I will like to ask you some questions to see if you can participate in the study. Your name will not be used in our report nor will it be linked to the data that you will provide. Even if you qualify to be a respondent for the study, you will not be forced to participate in the study. May I proceed with asking you a few questions about yourself?

SECTION A: SCREENING FORM

- 1) Household Identification Number:
 - 2) Date:
 - 3) Name of screener:
 - 4) Name of Sub-metropolis:
 - 5) Time of start:
 - 6) Age at last birthday: _____
 - 7) Sex (*interviewer circle one*): (1) Male (2) Female
 - 8) Ethnic group:
 - 9) Religion:
 - 10) Years of living in Kumasi:
 - 11) Household composition/members of household:
 - 12) Do you have any children in this household? (1) Yes, # _____ (2) No
- # of girls + ages: _____

of boys + ages: _____

13) Is/Are the child/children in this household who are being cared for by the mother and another household caregiver?

Yes [] No []

14) Respondent being recruited for which category:

Mother []

Other household child caregivers (father, aunt, grandmother, sibling, non-relative)

[]

INTERVIEWER'S CHECK

1. This individual was selected for the study: Yes [] No []

(a) If yes, would individual like to participate in study?

(i) Yes []

(ii) No []

(b) If yes, how was the consent form presented to the respondent?

Read to the respondent []

Respondent Read it []

Method for obtaining Consent:

Signed []

Initialed []

Thumb Printed []

(c) If no, why s/he was not selected:

(i) Did not meet selection criteria

(ii) Had required number for that category

(iii) Did not want to participate

(iiii) Other (please specify): _____

SECTION B: CHILD ILLNESS MANAGEMENT

15) Has (NAME OF CHILD) been ill or experienced any household accident(s) within the past one month? If yes, probe for details such as:

a. Duration of illness (dates of onset and end of illness)

b. Type of illness (e.g., malaria, diarrhoea or accidents).

c. Severity of illness (identification and understanding of illness symptoms).

- d. Cause(s) of illness or accidents
- e. Treatment options utilised and reasons for each option (e.g., household, traditional, drug/pharmacy shops, faith healers, public or private clinics/hospitals? **Probe for incidence and rationale for health switching.**
- f. Any delay in seeking outside care (difference between the first day of recognising the illness/injury and the date of the first contact with outside healthcare provider) and reasons (such as cost, distance, religion).
- g. Distance between household to nearest health facility

16) How was the illness/accident(s) managed in the household? **Probe for:**

- a. household illness management practices such as administration of medicines, dosage, adherence to medicine regimen).
- b. caregivers' recognition and understanding of medicines side effects.
- c. warnings, expiration of medicines.
- d. compliance with referrals
- e. treatment of injuries including administration of first aid treatment and ownership of first aid kit in household, etc). **Observe where First Aid kit is placed and check contents**

17) Are you aware of any child health educational programmes in the mass media? If yes.

probe for

- a. Main sources of education/information
- b. application of knowledge acquired to manage child illness/accident(s) (e.g., symptoms of illness, medicines, healthcare providers or impact of advertisements on child care, etc.)

18) What was the outcome of the child illness/accident(s)? **Probe for (cured, undergoing treatment, etc)**

19) What are the main challenges you encounter in taking care of (NAME OF CHILD) especially in this Kumasi Metropolis? **Probe for challenges such as respondents limited knowledge in child care, high cost of accessing health services, multiple directives from family and friends, undue influence from other household members, etc)**

(Summarise the Section and continue with Section C)

SECTION C: CHILD FEEDING ISSUES

- 20) How do you determine that a child is hungry/satisfied? **Probe for child hunger cues (crying, fussing, infant oral behaviours, schedule and time demand, licking lips, child asking for food or reaching for food, etc) and satiation cues (child turning away from food, caregiver estimation of right quantity, behaviour when child refuses to eat etc)**
- 21) How often do you feed [NAME OF CHILD] and what do you do if [NAME OF CHILD] refuses to eat? **Probe for respondent's dominant feeding styles (authoritarian, authoritative and laissez-faire) along the lines of child having to request for more food, refusing child food, encouraging child to eat, providing low quality foods or contaminated water to children, replacing food, playing with the child while eating, forcing child to eat or ignoring the child, etc).**
- 22) Are you aware of any hygienic practices expected from you during food preparation for children? **Probe for respondent's knowledge in practices and how respondent puts them into practice. Probe for practices such as soap washing of both own hands and that of the child during and after feeding, using clean feeding utensils, feeding in a clean area, drying hands using clean cloth/towel, etc).**
- 23) What food does [NAME OF CHILD] usually eat and why? **Probe for child regular intake of fruits, vegetables and water per day and who determines what a child eats).**
- 24) What challenges do you face in providing food to feed [NAME OF CHILD]? **Probe for challenges such as food shortage in household, no money to buy more food, reducing food quantity, child skipping food, encouraging child to eat healthy foods,**
- (Summarise the Section and continue with Section D)

SECTION D: INTRA-HOUSEHOLD DECISION-MAKING

- 25) Let mothers explain what informed the household decision to engage the services of non-parental household child caregiver? **Probe for cost, cultural/social, previous experience) and the processes involved in identifying and selecting non-parental**

child care givers including their sources of information (leaflets from or print media, friends, mother, etc).

- 26) Who is the principal household decision maker in this household on issues such as menu for children, seeking health care for sick child, how much to be spent on child health care, immunisation of children).
 - 27) Let mothers explain their feelings and thoughts about engaging other household child care givers and their perception of the quality of care they provide to child.
 - 28) Ask mothers whether they give detailed instructions to the other household care givers on child illness management and feeding practices and whether such instructions are followed or not and how they are able to determine this.
 - 29) For non-maternal household child care givers, ask if they receive detailed instructions from parents on child illness management and feeding practices and whether such instructions are easy to follow or not?.
 - 30) For non-maternal household child care givers, ask about their previous experience in childcare Probe for when, where and similarities/differences in the care giving practices.
 - 31) For all respondents, ask about communication channels in the household especially on matters that relate to child illness management, feeding and decision-making.
 - 32) How has modern technology affected child caring in the Kumasi Metropolis? **Probe for influence of mobile phones, internet, social media, media, etc on child care practices.**
 - 33) What challenges do you face taking care of [NAME OF CHILD]? For non-maternal caregivers, probe for instances with which they have been made to do chores too difficult or dangerous for their age and health, go without basic needs like regular meals, clothing, shelter, school, and medical treatment when sick or hurt or experienced any form of domestic violence)
- (Summarise the Section and continue from Section E)**

SECTION E: THE WAY FORWARD

- 34) Ask respondents to suggest ways by which both mothers and household non-maternal child caregivers could collaborate to improve child health and survival in Ghana.

35) Ask the interviewees whether there is anything else they want to tell you about parental and non-parental child care in Ghana that has not been covered so far.
(Summarize section and conclude the interview)

SECTION F: OTHER BACKGROUND DATA OF RESPONDENT

36) Primary occupation (part-time, full-time, student, etc) : _____

37) Highest Educational level: _____

38) Marital status of respondent: _____

39) Main source of household drinking water: _____

40) For non-maternal caregivers, years of working as non-maternal child caregiver and reasons:

41) For non-parental caregivers, relationship with child parent(s):

42) Number and ages of children being cared for by non-parental caregiver:

END OF THE INTERVIEW

These are all the questions that I have for you. Thank you very much for your cooperation. Do you mind if my supervisor returns to make sure I did my work correctly?

Yes []

No []

Record time interview ended.....

INTERVIEWER'S FINAL NOTES (e.g. Presence of others and how it might impact on the interview?)

.....
.....
.....

1B: Focus group discussion guide for household respondents
UNIVERSITY OF CAPE COAST

DEPARTMENT OF POPULATION AND HEALTH

CHILD CARE PRACTICES IN THE KUMASI METROPLIS, GHANA

FOCUS GROUP DISCUSSION GUIDE FOR HOUSEHOLD RESPONDENTS

Introduction

Thank you for agreeing to be part of this discussion. My name is _____ I am from the Department of Population and Health of the University of Cape Coast. I am here with..... from the same Department. We are conducting a research on child caring practices of mothers and non-maternal household child caregivers in the Kumasi Metropolis of Ghana. The purpose of this discussion is to find out more about your opinions, knowledge and understanding of child caring practices in the Kumasi Metropolis and how they affect child health. The discussion will solicit data on some background data about you; child care practices in the metropolis with specific reference to child illness management, feeding and household decision-making regarding child care. Every discussant is encouraged to express his or her opinion during the discussion. Everything you say during the discussion will be treated as confidential.

Before we begin, we would like to get some brief background data of all discussants.

SECTION A: Section A: Demographic and background data of Discussants

Date of Discussion:.....

Time discussion commenced:.....

Name of Moderator:.....

Name of recorder:

Before we begin, we would like to get some brief background data of all discussants.

1) Age of discussant: _____

2) Sex of discussant: Male (2) Female

3) Religion of discussant:

4) Years of living in Kumasi:

5) Is/Are the child/children in this household who are being cared for by the mother and another household caregiver?

- 6) Primary occupation (part-time, full-time, student, etc) : _____
- 7) Highest Educational level: _____
- 8) Marital status of respondent: _____
- (Check data for accuracy and continue to section B)

SECTION B: CHILD ILLNESS MANAGEMENT

- 9) What are the common childhood illnesses in the Kumasi Metropolis and what are the various treatment options usually used by parents? **Probe for type of illness (e.g., malaria, diarrhoea or accidents), severity of illness (identification and understanding of illness symptoms), cause(s) of illness or accidents and treatment options utilised and reasons for each option (e.g., household, traditional, drug/pharmacy shops, faith healers, public or private clinics/hospitals)**
- 10) How are children's illnesses/accident(s) managed in the household? **Probe for management practices such as administration of medicines, dosage, caregivers adherence to medicine regimen, caregivers' recognition and understanding of medicines side effects, warnings, expiration of medicines, caregivers compliance with referrals and treatment of injuries including administration of first aid treatment and ownership of first aid kit in household, etc).**
- 11) Are you awareness of any child health educational programmes in the mass media? If yes, probe for
- Main sources of education/information
 - application of knowledge acquired to manage child illness/accident(s) (e.g., symptoms of illness, medicines, healthcare providers or impact of advertisements on child care, etc.)
- 12) What was the outcome of the child illness/accident(s)? **Probe for (cured, undergoing treatment, etc)**
- 13) What are the main challenges you encounter in taking care of (NAME OF CHILD) especially in this Kumasi Metropolis? **Probe for challenges such as respondents limited knowledge in child care, high cost of accessing health services, multiple**

directives from family and friends, undue influence from other household members, etc)

(Summarise the Section and continue with Section C)

SECTION C: CHILD FEEDING ISSUES

- 14) How do you determine that a child is hungry/satisfied? Probe for child hunger cues (crying, fussing, infant oral behaviours, schedule and time demand, licking lips, child asking for food or reaching for food, etc) and satiation cues (child turning away from food, caregiver estimation of right quantity, behaviour when child refuses to eat etc)
- 15) How often do you feed [NAME OF CHILD] and what do you do if [NAME OF CHILD] refuses to eat? Probe for respondent's dominant feeding styles (authoritarian, authoritative and laissez-faire) along the lines of child having to request for more food, refusing child food, encouraging child to eat, providing low quality foods or contaminated water to children, replacing food, playing with the child while eating, forcing child to eat or ignoring the child, etc).
- 16) Are you aware of any hygienic practices expected from you during food preparation for children? Probe for respondent's knowledge in practices and how respondent puts them into practice. Probe for practices such as soap washing of both own hands and that of the child during and after feeding, using clean feeding utensils, feeding in a clean area, drying hands using clean cloth/towel, etc).
- 17) What food does [NAME OF CHILD] usually eat and why? Probe for child regular intake of fruits, vegetables and water per day and who determines what a child eats).
- 18) What challenges do you face in providing food to feed [NAME OF CHILD]? Probe for challenges such as food shortage in household, no money to buy more food, reducing food quantity, child skipping food, encouraging child to eat healthy foods,
- (Summarise the Section and continue with Section D)

SECTION D: INTRA-HOUSEHOLD DECISION-MAKING

19) What inform household decision to engage the services of non-parental household child caregiver? **Probe for cost, cultural/social, previous experience) and the processes involved in identifying and selecting non- parental child care givers including their sources of information (leaflets from or print media, friends, mother, etc).**

20) Ask discussants about communication channels in the household especially on matters that relate to child illness management, feeding and decision-making.

21) How has modern technology affected child caring in the Kumasi Metropolis? **Probe for influence of mobile phones, internet, social media, media, etc on child care practices.**

22) What challenges do modern mother face taking care of their children? **Probe for instances with which they have been made to do chores too difficult or dangerous for their age and health, go without basic needs like regular meals, clothing, shelter, school, and medical treatment when sick or hurt or experienced any form of domestic violence)**

(Summarise the Section and continue from Section E)

SECTION E: THE WAY FORWARD

23) Ask respondents to suggest ways by which both mothers and household non-maternal child caregivers could collaborate to improve child health and survival in Ghana.

24) Ask the interviewees whether there is anything else they want to tell you about parental and non-parental child care in Ghana that has not been covered so far.

(Summarize section and conclude the interview)

END OF THE INTERVIEW

These are all the questions that I have for you. Thank you very much for your cooperation. Do you mind if my supervisor returns to make sure I did my work correctly?

Yes []

No []

Record time interview ended.....

INTERVIEWER'S FINAL NOTES (e.g. Presence of others and how it might impact on the interview?)

.....

.....

**1C: In-depth interview guide for key informants
UNIVERSITY OF CAPE COAST**

DEPARTMENT OF POPULATION AND HEALTH

CHILDCARE PRACTICES IN KUMASI METROPOLIS, GHANA

IN-DEPTH INTERVIEW GUIDE FOR KEY INFORMANTS

Introduction

This study is intended to elicit data on the knowledge and child caring practices of parents and non-parental household child caregivers in the Kumasi Metropolis of Ghana. The in-depth interview sessions are intended to allow key child care policy makers and implementers to provide detailed narratives on child caring in the Kumasi Metropolis of Ghana with specific reference to issues in children's illness management, feeding and decision-making.

SECTION A: BACKGROUND DATA

- 1) Date of interview:
- 2) Name of interviewer:
- 3) Time of start of interview:
- 4) First name of interviewee:
- 5) Status of interviewee:
- 6) Highest Educational level of interviewee:
- 7) Years of working in current position:
- 8) Place of work of interviewee:

SECTION B: POLICIES AND DECISION-MAKING

- 9) What informs parents or mothers to engage non-maternal child care givers at the household level?
- 10) Are you aware of any national policy that regulates the engagement of non-maternal child care givers? **Probe: If yes, what is the rationale, implementation strategy(ies) and challenges with implementation. If no, why?**

- 11) Have you personally or do you know somebody who has engaged non-maternal child caregiver(s)? **Probe: If yes, when, where, why and outcomes. If No, why? Probe: If yes, what are/were your impressions with his/her care giving practices?**
- 12) What cases of child health and survival issues have come to your attention as a result of the activities of maternal and non-maternal child caregivers at the household level? **Probe for specific cases such as child neglect, abuse, etc**

SECTION C: ISSUES ON CHILD ILLNESS MANAGEMENT

- 13) In your view, what are the common childhood illnesses in the Kumasi metropolis? **Probe for type of illness (e.g., malaria, diarrhoea or accidents), severity of illness (identification and understanding of illness symptoms), cause(s) of illness or accidents and treatment options utilised and reasons for each option (e.g., household, traditional, drug/pharmacy shops, faith healers, public or private clinics/hospitals).**
- 14) What are some of the risk factors that children are exposed to in the house that may negatively affect their health? **Probe for factors such as exposure to electrical shocks, food poisoning, sharp objects, drugs. Who is most likely to expose children to these risk factors?**
- 15) What are your views on differences or similarities regarding maternal and non-maternal household child caregivers knowledge and practices on children's illness management in the metropolis? **Probe for similarities and or differences in adherence to medicine regimen, caregivers' recognition and understanding of medicines side effects, warnings, expiration of medicines, caregivers compliance with referrals and treatment of injuries including administration of first aid treatment and ownership of first aid kit in household, etc).**
- 16) What are the current child health educational programmes in mass media in the metropolis and what informed the choices of those programmes? **If yes, probe for**
 a. **Main sources of education/information**

- b. **application of knowledge acquired to manage child illness/accident(s)**
(e.g., symptoms of illness, medicines, healthcare providers or impact of advertisements on child care, etc.)

SECTION D: CHILDREN FEEDING PRACTICES

- 17) What are the standard recommended child feeding practices? **Probe for type of food, right proportions, food preparation handling, timing of feeding, hygienic practices, etc.**
- 18) What are your views on child caregivers' knowledge and practices on children feeding in the metropolis? **Probe for foods fed to children (with emphasis on fruits and vegetables), children nutritional status, state of nutrition education in the metropolis.**
- 19) What would you suggest should be done to improve household child caring feeding practices in the metropolis in particular and Ghana in general?
(Summarize section and conclude the interview)

END OF THE INTERVIEW

Record time interview ended.....

INTERVIEWER'S FINAL NOTES (e.g. Presence of others and how it might impact on the interview?)

.....

.....

.....

1D: Observation checklist

UNIVERSITY OF CAPE COAST DEPARTMENT OF POPULATION AND HEALTH CHILD CARE PRACTICES IN THE KUMASI METROPOLIS OF GHANA OBSERVATION CHECKLIST

Introduction

This checklist is to be used to document some practices of parents and non-parental household child caregivers in the Kumasi Metropolis of Ghana and how the practices impact on child health and survival in Ghana. The following scenarios would be observed.

- 1) Household Identification Number: _____
- 2) Date of observation:
- 3) Name of observer:
- 4) Person observed (Parent/Non-parent):
- 5) Observe and record where the following household assets are placed in the household (for example on the floor, near power source, easily accessible by children, etc):
 - a. radio
 - b. pressing iron,
 - c. standing fan
 - d. television
 - e. refrigerator
 - f. sharp objects (e.g., blades, knives, etc)
- 6) Main source of household drinking water and how water is drawn for children to drink.
- 7) Place of household refuse disposal bins and toilets and observe how child (ren) uses them.
- 8) In households where there are sick children receiving treatment observe how the caregiver:
 - a. administer medicines to the child according to recommended dosage
 - b. administer medicines according to recommend time

- 9) In households where there is an injured child who is receiving treatment observe:
- how the caregiver adheres to hygienic injury treatment requirements such as application of antibiotics, etc
 - outcomes of household unintentional injuries (deformed, scares, etc)

10) In households with First Aid kits, observe its contents to verify if they are not expired.

11) Observe at least the preparation and serving of one main meal and record the following:

a. caregiver responsiveness during feeding:

- encourages the child to eat []
- demonstrates to child how to eat []
- offers more food to the child []
- talks to child whilst eating []
- supervises the child feeding []
- monitors how much the child eats []
- does not threaten the child to eat []

b. caregiver hygienic practices related to feeding:

- washing own hands during food preparation and eating []
- washing of child's hands during feeding []
- using clean feeding utensils []
- feeding in a clean area []
- use of clean water and soap to wash hands []
- drying hands using clean cloth/towel []

c. feeding atmosphere: cordial [] confrontational []

d. Child's interest in food during feeding: highly interested [] disinterested [] refused to eat []

e. Caregiver behaviour when child refused to eat:

- replacing food []
- verbally encouraged the child to eat []
- played with the child []

4. forced or ignored the child []

f. Feeding style(s) adopted by caregiver (emphasis on parents and non-parents)

g. Number of child intake of fruits, vegetables and water during observation period

12) Observe other tasks undertaken by household non-parental child caregivers.

13) Conduct a transient walk in the community and observe availability and accessibility of health care services, sources of water and sanitation.

14) Any other additional observation.

Appendix 2: Research Assistants Training Time table
UNIVERSITY OF CAPE COAST
DEPARTMENT OF POPULATION AND HEALTH
CHILD CARE PRACTICES IN THE KUMASI METROPOLIS OF GHANA
RESEARCH ASSISTANTS TRAINING TIME TABLE

Tuesday, 2nd June, 2016

Session 1: Theory and Methods

9.00 – 9.30	Welcome and introduction – research problem, aims and objectives
9.30 – 10.30	Children’s illness management practices
10.30 – 11.00	----- Break -----
11.00 – 12.00	Children feeding practices
12.30 – 13.30	----- Lunch -----
13.30 – 15.00	Methodology: Eligibility criteria, interviewing techniques and recording
15.00 – 15.30	-----Wrap up and closure-----

Wednesday, 3rd June, 2016

Session 2: Methods and Ethics

9.00 – 10.00	Methodology: transcription
10.00 – 12.00	Role plays and discussion
12.00 – 12.30	----- Lunch -----
12.30 – 13.30	Research ethics
13:30-14:00	Discussion and Logistics
14:10	Closure

Appendix 3: Introductory Letters

UNIVERSITY OF CAPE COAST
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF POPULATION AND HEALTH

Telephone 03321-32440/4 & 32480/3 Direct 03321-30416
03321-30680
0289538948
Fax 233-34072, UCC, GH.
Telex 2552, UCC, GH.
Telegrams & Cables: University, Cape Coast.



UNIVERSITY POST OFFICE
CAPE COAST, GHANA

8th October 2015

Our Ref: DPH/I.8/V.1/2
Your Ref:

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION

This is to confirm that Mr. Samuel Asiedu Owusu is a PhD student of the Department of Population and Health, Faculty of Social Sciences, University of Cape Coast.

His research topic is "*child Care Practices in the Kumasi Metropolis, Ghana.*" Kindly provide him with the relevant information for his PhD thesis.

We would be very grateful if you could give him your maximum co-operation and do not hesitate to contact me if need be.

Thank you.

Yours faithfully,

Prof. Augustine Tanle
HEAD

UNIVERSITY OF CAPE COAST
COLLEGE OF HUMANITIES AND LEGAL STUDIES
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF POPULATION AND HEALTH

Telephone: 03321-32440/4 & 32480/3 Direct: 03321-30416
03321-30680
0289538048
Fax 233-34072, UCC, GH.
Telex 2552, UCC, GH.
Telegram & Cables University, Cape Coast



UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref:

8th October, 2015

Your Ref: DPH/L.8/V.1/2

The Ashanti Regional Commander
Ghana Police Service
Kumasi - Ash

Dear Sir/Madam,

LETTER OF INTRODUCTION

This is to confirm that Mr. Samuel Asiedu Owusu is a PhD student of the Department of Population and Health, Faculty of Social Sciences, University of Cape Coast.

His research topic is "*child Care Practices in the Kumasi Metropolis, Ghana.*" Kindly provide him with the relevant information for his PhD thesis.

We would be grateful if you could give him your maximum co-operation and do not hesitate to contact me if need be.

Thank you.

Yours faithfully,

A handwritten signature in black ink, appearing to read 'A. Tanle'.

Prof. Augustine Tanle
HEAD

Appendix 4: Ethical clearance letter from the UCCIRB

UNIVERSITY OF CAPE COAST
INSTITUTIONAL REVIEW BOARD SECRETARIAT
C/O Directorate of Research, Innovation and Consultancy

TEL: 03321-33172/3 / 0207355653/ 0244207814

E-MAIL: irb@ucc.edu.gh
OUR REF: UCC/IRB/3/15
YOUR REF:



28TH MAY, 2015

Mr. Samuel Asiedu Owusu
Department of Population and Health
University of Cape Coast

Dear Mr. Owusu,

ETHICAL CLEARANCE –ID NO: (UCCIRB/CHLS/2015/03)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for implementation of your research protocol titled **“Child care practices in the Kumasi Metropolis, Ghana.”**

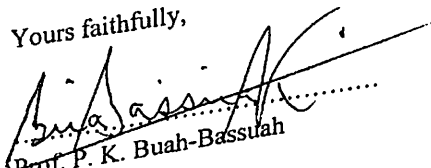
This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol

Yours faithfully,


Prof. P. K. Buah-Bassuah
Chairman

cc: Administrator

Appendix 5: Informed consent form
UNIVERSITY OF CAPE COAST
INSTITUTIONAL REVIEW BOARD

INFORMED CONSENT FORM FOR HOUSEHOLD CAREGIVERS

Title: Child care giving practices in the Kumasi metropolis, Ghana

Principal Investigator: Samuel Asiedu Owusu

Address: Department of Population and Health

University of Cape Coast

Cape Coast

Email: sowusu@ucc.edu.gh

Cell: 0244207814

General Information about Research

In Ghana, as in many other lower-middle-income countries, formal childcare arrangements for children below 5 years are either non-existent or unaffordable for those not in well-paid formal-sector employment. Consequently, a large number of young children grow up in the care of other relative or non-relative household members such as siblings, foster children, aunts and grandmothers. Despite the large number of Ghanaian urban resident children who are being simultaneously cared for by their mothers and other non-maternal household child caregivers, a comparative study of child care giving practices of mothers and non-maternal household child caregivers and how they impact on children health and survival outcomes in urban Ghana has not been widely conducted. This Ph.D research is intended to investigate the child care giving practices and health of under five children in the Kumasi Metropolis of Ghana.

Procedures

You have been asked to participate in this study to provide responses to the questions that I will ask you on issues that border on children who are sick and how they receive treatment, how food is prepared and fed to children as well as how parents take decisions on engaging non-maternal child caregivers. If you accept, you will be required to participate in an interview with [Samuel Asiedu Owusu] who is the principal investigator

for this study. You are being invited to take part in the interview because we feel that your experience in child caring can contribute much to achieving the aim of this study.

The interview will take place in this house or any location of your choice near the house and no one else but the interviewer will be present. The information recorded is considered confidential, and no one else except me, the interviewer and my principal supervisor (Prof. A. M. Abane) will have access to the information documented during your interview.

Duration of interview

The interview will usually take between 45-60 minutes to complete depending on my ability to ask the questions as clearly as possible and your approach to answering the questions

Possible Risks and Discomforts

There are no anticipated physical, social, economic or psychological risks or discomforts to you by participating in this study except in instances where a question or some questions may cause you to recall an unfortunate incident during the interview sessions, however; I would be most grateful if you kindly agree to answer the questions as frankly as possible since the study is in the interest of everybody in Ghana in general and children in particular.

Confidentiality

Please be assured that all pieces of information you provide will be strictly treated as private and confidential and will be used only for purposes of this study. Your identity will be made anonymous in the report through the use of pseudonyms or assigning of codes to the interviews so that no personal identifiers would be available to link you to the data you have provided. Moreover, after transcribing, the digital recordings would be immediately destroyed. All paper transcripts would be burned as well while the soft copies would be electronically saved for 5 years with a secured password which would be known only by the principal researcher after which they would be completely deleted.

Compensation

You will not be rewarded financially for taking part in the study since this is a purely academic work which is intended to make recommendations that would lead to the betterment of society. No financial incentives would be offered to participants but in instances where it becomes glaring that an index child is seriously at risk of needing financial assistance, I would liaise with the appropriate service provider(s) to discuss the modalities of meeting the peculiar need of the child.

Voluntary Participation and Right to Leave the Research

If we should come to any question you do not want to answer, just let me know and I will go on to the next question. You can also withdraw from the study at any time without having to give reasons.

Contacts for additional Information

If you wish to raise any questions or seek further clarification on this study, you may contact my Principal Supervisor, Prof. Albert Abane on 0244280629, abanealbert@gmail.com or the Head of Population and Health Department, Prof. Augustine Tanle on 0243604141, augtanle@yahoo.com

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of University of Cape Coast (UCCIRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8:00 a.m. and 4:30 p.m. through the cell phone 0244207814 or email address: irb@ucc.edu.gh.

If you have any question regarding this study, you may ask me (**pause for questions**). Please, do I now have your permission/consent to ask the questions?

Yes [] No []

I understand the nature of the research and my participation

Yes [] No []

I understand that I may withdraw at any time, without having to give a reason

Yes [] No []

I agree to participate in the study

Yes [] No []

I agree to be digitally recorded during the interview

Yes [] No []

(Respondent's Initials).....

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title **(Child care giving practices in the Kumasi metropolis, Ghana)** has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_____ Name and signature or mark of

Date

volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____ Name and signature of witness

Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_____ Name Signature of Person Who Obtained Consent

Date

Appendix 6: Index children hunger cues

Maternal caregiver	Index Children	Non-maternal caregiver
Gesturing –picking bowl	Emelia (1 yr 5 mts)	Verbalise-mama
Finger licking	Doris (3 years)	Verbalise
Verbalise	Maxwell (4 years)	Verbalise
Gesturing-pointing to kitchen	Eunice (1 yr 5mts)	Gesturing
Crying	Fred (11 mts)	Crying
Crying	Simon (years)	No response
Body language-very quiet	Emmanuel (8 mts)	Body language-very quiet.
Maternal perception	James (3 years)	No response
Crying	Mercy (2 yrs)	Crying.
Crying and gesturing	Rebecca (8 mts)	Mouthing
Verbalise and gesturing-point to food	Jona (1 yr 4 mts)	Cry and maternal perception
Verbalise	Dorothy (2 years)	Gesturing-becomes quiet
Crying, gesturing and perception	Joyce (9 mts)	Crying and gesturing
Verbalise	Eric (5 years)	Perception
Crying	Eugene (7 mts)	He frowns the face
Crying and gesturing	Seth (8 mts)	Crying and finger licking
Crying and mouthing	Juliet (5 mts)	Crying
Verbalise	Ruth (4 yrs)	Verbalise
Perception	Alex (1 yr 8 mts)	Perception
Verbalise	Evelyn (2 yrs)	Verbalise
Verbalise	Frank (4 yrs)	Verbalise
Crying	Deborah (4 mts)	Crying and gesturing
Crying	Kate (2 yrs)	Crying and finger licking
Verbalise	Robert (3 yrs)	Verbalise
Crying and mouthing	Felix (1 mt)	Crying
Crying	Pricilla (1 yr 5 mts)	Crying
Verbalise	Prince (3 years)	Verbalise
Verbalise	David (3 yrs)	Verbalise