An Examination of the Social and Cultural Factors Surrounding Complementary Feeding Practices among Young African American Mothers with Infants 6 to 24 months Old

Research Thesis

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by

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Abstract

African American infants tend to have poorer diet quality compared to other demographic groups in the United States. The goals of the study were to examine the complementary feeding practices of young, low-income African American mothers with infants between the ages of 6 to 24 months and examine cultural and social factors influencing complementary feeding practices of these mothers towards their infants. Low-income, African American mothers, between the ages of 18 and 30, living in Franklin County, Ohio were recruited through Facebook, daycare centers, and other organizations working with low-income populations. For this mixed-methods study, quantitative data were collected on the participants’ demographics and qualitative data were collected on the participants’ complementary feeding practices through virtual interviews. The data from the participants were analyzed using descriptive statistics and classical content analysis to determine the trends among the participants. The mean age of the participants was 28.29, most had some college experience or a college degree (87.5%), and 62.5% were not married. Qualitatively, four trends were discovered: pediatricians and other health professionals played a prominent role in early feeding decisions; cultures emerged in interesting ways; responsive feeding cues were used to determine hunger and fullness in their children; media did not influence early feeding decisions. Among the participants in the study, it was learned that direct influences (health professionals) were more influential than indirect (media) ones, participants followed recommended complementary feeding patterns, and media was not a strong influence on food choices. These findings imply that healthcare professionals should continue to be utilized in future research, WIC and other organizations have a positive impact on women’s complementary feeding practices, and policies should be developed to educate pregnant women on complementary feeding.
Chapter One: Introduction

Childhood nutrition is important to later health because diets early in life can shape food habits into adulthood (Bryant, 2020). Research suggests that children who are properly fed during their early childhood years are much more likely to have optimal long-term health and decreased disease risk (Au et al., 2018). It is essential that interventions to improve health take place early in child’s life to develop healthier eating habits (Knol et al., 2005; CDC, 2021). The period 6 to 24 months, especially beginning at 6 months, is an important time for such interventions as children are just beginning to be introduced to solid foods and are developing food preferences based on what their parents feed them. The World Health Organization (WHO) defines complementary feeding as “a process starting when breast milk alone is no longer sufficient to meet the nutritional requirements of infants, and therefore other foods and liquids are needed, along with breast milk” (Abeshu et al., 2016). The World Health Organization also recommends complementary feeding to begin around the age of six months, because this is when an infant needs more energy and nutrients than what they get from breast milk (Abeshu et al., 2016). It is important to understand complementary feeding and the feeding practices in the first two years of life. Through gaining an understanding of feeding practices early in life, future research will be able to be conducted on interventions to improve the diet quality of young children to reduce the likelihood of them facing negative health outcomes as they get older.

Examining what low-income mothers and caregivers feed their 6-to-24-month children is essential for several reasons. Some research studies that African American households may feed their children semi-solid foods as early as one to two weeks old (Bentley et al., 1999). Furthermore, the emphasis on improving the diets of African Americans is essential, especially for African American children because some research shows obesity and overweight to be
present in African American children, specifically those who are low-income, as early as the first year of life. One study specifically determined that 10.4% of African American infants aged 0 to 11 months and 15.8% of African American infants aged 12 to 23 months have a weight for length that is above the 95th percentile for their age group (Thompson & Bentley, 2012). The association between complementary feeding practices such as the timely introduction of solid foods, feeding frequency, and the diversity of foods introduced, and early obesity have been suggested in the literature (Yeshaneh et al., 2021).

Although several studies have examined complementary feeding in children, few have examined complementary feeding among infants in low-income African American households. Additionally, to the best of my knowledge, no study has examined the social and cultural factors associated with complementary feeding in low-income African American households. The present study will fill the gap in this area.

There is a plethora of research on the diets of African American women, but for young African American mothers (between the ages of 18 and 30) and their infants, there is a gap in information on complementary feeding in this age group. It is essential for this gap to be filled because obesity and poor feeding decisions is a growing problem in younger age groups and especially among young African American women (Lipsky et al., 2017). This ethnic and age group is often considered a difficult to reach group as young African American mothers generally have responsibilities as caregivers while they are still navigating the challenges of early adulthood. For these reasons as well, infants of young African American mothers may be more likely to have low quality diets that can predispose them to obesity, making it important to examine complementary feeding practices among this age group (Thompson & Bentley, 2012). Because African American women are an underserved and understudied population, it is
important to understand how they feed their children to develop interventions that will improve their diets in the future.

**Purpose**

The goal of the study is to learn about the complementary feeding practices of infants (6 to 24 months) in households with young African American mothers and to understand the factors impacting what the mother decides to feed her children. By doing this, culturally appropriate interventions can be implemented to improve diet quality of African American infants. Additionally, the study aims to inform public policy decisions and prevent future morbidity and mortality among African American households.

**Objectives**

The objectives of this study are to:

1. Examine the complementary feeding practices of young, low-income African American mothers with infants ages 6 to 24 months
2. Examine the social and cultural factors influencing complementary feeding practices of young African American mothers between the ages of 18 to 30 years old
Chapter Two: Literature Review

Throughout the years, progress has been made towards studying the diet quality of African American women, however, several gaps exist, especially in understanding the diet quality of young African American women who are mothers of 6 to 24 months old infants. The goal of the study is to learn about the diet quality of infants (6 to 24 months) in households with young African American mothers and to understand the factors impacting what the mother decides to feed her children. By doing this, culturally appropriate interventions can be implemented to improve diet quality of African American infants. Additionally, the study aims to inform public policy decisions and prevent future morbidity and mortality among African American households. The objectives of this study are to: (1) Examine the complementary feeding practices of young, low-income African American mothers with infants ages 6 to 24 months; (2) Examine cultural and social factors influencing complementary feeding practices of these mothers towards their infants.

This literature review is divided into two main sections. Section one examines obesity and the diet quality of children (6 to 24 months) of young African American mothers, it will then review complementary feeding practices. Section two focuses on African American women, especially young African American women and factors impacting their diet quality, with the goal of understanding the complementary feeding decisions they make for their young infant.

Obesity Among Children under 2 years of Age in Low-Income Households

Children in low-income households have higher incidence of obesity; some research shows that children in low-income households may gain weight faster as they age, indicating the need to intervene at an early age (Jo, 2014). In a study, it was determined that 11.0% of low-income children ages 0 to 23 months were obese, unlike other research, however, low-income
African American infants had the lowest rates of obesity while Hispanic and Native American infants had the highest rates (Pan et al., 2013). This may be due to a lack of proper nutrition and/or a lower probability of meeting/exceeding their calorie goals because of less food availability among the African American children in this study. Research by Jo (2014) also indicated that racial minority children have a higher incidence of obesity compared to their White counterparts. It is important to understand the obesity rates in young children and work to alleviate the issue early because childhood obesity rates can inform adult obesity occurrence and those who are obese as children are more likely to make less income as adults (Jo, 2014). Factors that can correlate to a higher incidence of obesity as children are related to how parents perceive the foods that they feed their children. For example, parents can perceive their child being larger as being healthier rather than as being overweight and parents may use food to calm their children and/or show them that they love them, leading to higher childhood food consumption rates (Pan et al., 2013). The environment around where the family lives is an important indicator of childhood obesity and food consumption as well because families who live in places where long travel is required to buy healthy foods and only have fast-food places nearby are more likely to eat unhealthy foods that contribute to higher obesity rates (Pan et al., 2013). Further research on obesity in children under the age of two years old is sparse, so future research needs to be developed on this age group. Additionally, it is important to understand what is currently known about infant obesity rates to understand the diet quality of infants, how parents feed their infants, and the diets of individuals once they are older.

**Diet Quality of Children (6 to 24 months) of Young African American Mothers**

From the literature, the diet quality of African American infants 6 to 24 months old tends to be lower than the diet quality of infants in other ethnic groups. For example, an important
aspect of diet quality for all infants is related to whether they are breastfed in the first year of their life and for how long they are breastfed for. It is recommended to exclusively breastfeed for the first six months of life because it promotes optimal growth, lowers co-morbid conditions, influences cognitive development, and prevents chronic diseases (Romero-Velarde et al., 2017). However, among African American mothers, rates of breastfeeding are much lower compared to other ethnic groups. This trend can be attributed to African American mothers having less abilities to take maternity leave, lack of access to pumps, pressure from others to formula feed, the belief that breastfeeding makes an infant too dependent on their mother, and lack of a normalization of breastfeeding amongst people the mothers are close to (Deubel et al., 2019). This not only adversely impacts the child, but it can also impact the mother because breastfeeding lowers the rates of breast and ovarian cancer, type 2 diabetes, and high blood pressure (Deubel et al., 2019). Understanding breastfeeding trends in infants is important to further gaining knowledge on the way diet quality is developed over the course of one’s lifetime.

The diet quality of children is also related to how much they eat and how often they can do so. Some research showed that African American mothers are more likely to pressure their children to eat larger amounts of food compared to women of other ethnic groups (Sacco et al., 2007). Wen et al. (2014) found that 6-month-old infants of mothers with low education or who were African American consumed higher amounts of dairy and regular cereal. Additionally, 12-month infants in these households consumed higher intakes of sugar, fat, protein, dairy, and cereal. African American infants having a low diet quality is no fault of their own, or even of their mothers in some cases, so it is imperative to not blame mothers for the foods that they find most accessible for their children and instead work towards understanding these eating habits and making healthier foods more accessible for these young children.
A study of infants ages 6-24 months in which 63% of the infants were African American revealed interesting information about the eating habits and dietary intake of children at this age. Among 7- to 12-month-old infants their total calorie intake was about 988 calories, which consisted of 10% protein, 34% fat, and 56% carbs. For children 13 to 24 months old, their total calorie intake was about 1,123 calories, which consisted of 13% protein, 31% fat, and 56% carbs. Ninety percent of children ages 7 to 12 months in this study were formula fed more than four times a day. Information on formula feeding was not collected for children ages 13 to 24 months; however, data on dairy product consumption was studied in this age group. Because children 13 to 24 months old were no longer drinking formula, 90% of them consumed dairy 2.4 times a day (Sharma et al., 2013). A further trend was established considering the amount of high fat and high sugar foods consumed as a child got older, their parents became more likely to feed them these snacks and desserts. For example, snack intake was 80% in children ages 7-12 months, however, once children were 13 to 24 months old, 100% of them had consumed about 2 snacks a day compared to 1.3 snacks when they were 7-12 months old. Fruit consumption decreased as children aged as well. At 7- to 12-months-old, 90% of infants ate fruit daily compared to 43.8% of children ages 13 to 24 months old. In total, the study concluded the most popular foods among children ages 0 to 24 months old were formula, cow’s milk, apple juice, chicken, and rice cereal (Sharma et al., 2013). As the study showed, trends in the diet quality of children change as they age, making it important to understand how diet quality may vary in children and how it implicates the foods that these infants will eat once they become older children who can make their own food choices.

Complementary Feeding Among Young African American Mothers
Complementary feeding is the process of formula / breastfeeding an infant while also introducing solid foods to them—it begins when breastfeeding is no longer sufficient for the infant’s nutrient requirements (Romero-Velarde, 2017). Understanding complementary feeding practices among young African American mothers is important because complementary feeding patterns have a strong implication for the foods that the child will eat once they are older as the complementary feeding phase gets their taste buds used to some foods over others. While the World Health Organization recommends exclusive breastfeeding for six months and then continuation of breastfeeding for the first year of life, there is less information on when solid foods should start to be introduced (Wen et al., 2014). However, the World Health Organization recommends that at six months old infants can eat puréed foods, at eight months old they can eat finger foods, then, at a year old, they can eat the same types of foods as their family members (Romero-Velarde et al., 2017). The recommendations of complementary feeding are important to understand as they inform the way mothers decide to feed their children.

Despite the recommendations, previous studies show that African American women and low-income mothers are more likely to start complementary feeding practices early compared to other ethnic groups (“Timing of Introduction…”, 2020). Specifically, in a study of 23,927 children from 1 to 5 years old found that 40.5% of African American children were introduced to complementary foods early, meaning before four months of age (“Timing of Introduction…”, 2020). This is not ideal because complementary feeding before four months of age seems to be associated with increased risk for being overweight and obesity, along with other issues such as malnutrition, iron deficiency and anemia (Romero-Velarde et al., 2017). To understand previously researched complementary feeding patterns of African American mothers towards their young infants, other studies were examined to gain more knowledge on the relationship.
In one study, 32% of African American parents had introduced solid foods to their children when they were only 7 to 10 days old, then, by 8 weeks old, 77% of parents had introduced solid foods to their children (Bronner et al., 1999). The mothers who did not start complementary feeding practices early were more likely to be married and breastfeeding while the mothers who did start complementary feeding earlier were more likely to be younger (under 19 years old) and planning to return to work or school soon (Bronner et al., 1999). The factors associated with early complementary feeding are essential to develop an understanding on why the practice occurs.

Additionally, Bentley et al. (1999) described complementary feeding practices among adolescent African American mothers and described how grandmothers endorsed the idea of feeding the infant foods such as baby cereal, mashed potatoes, and applesauce within a month of the child’s life to keep them full longer. Grandmothers were shown to be a strong influence on whether a mother would follow the recommendations on what foods their child should eat, when these foods should be eaten, and if complementary feeding practices start earlier than usual. This was because mothers traditionally were financially and emotionally dependent on their mothers in the study and would follow what they considered to be the best practice. The presence of early complementary feeding tended to be most impacted by the child’s size, appetite, frequency of crying, and sleeping patterns in that smaller children with bigger appetites who cried often and slept less were most likely to be introduced to complementary feeding early in the study. This was predominantly associated with the belief that the grandmothers had that, despite the recommendations of when complementary feeding should start and the type of foods that should be fed, they had the most knowledge due to their own experiences in raising children and that drinking only milk went straight through the child, so they needed actual food to not be hungry.
Other important factors that led to early complementary feeding are ethnotheories about infant feeding (an example of this occurred when grandmothers did not consider baby cereal to be a type of food), the child’s characteristics (especially if the child seemed to be very ‘greedy’), and a caretaker not taking notice of the differences between the nutritional needs of an infant versus an adult (meaning the caretaker believed that the infant could eat the same foods they did). A main theme in this study is that the households who introduced complementary feeding earlier were prone to considering their children to be greedy, however, this was viewed in a positive light by the family which, likely, played into the reasoning behind these families giving the young infant more food. Furthermore, grandmothers being directly involved in the mother’s and infant’s lives made it more likely that they would be the one making the decisions on the foods the child ate, rather than the mother (Bentley et al., 1999). The study developed a picture of the factors behind early complementary feeding to understand the reasoning behind why mothers chose to feed their children early.

In another study, focus groups were conducted with African American women and many of them believed that solid foods and cereal should be introduced earlier than six months- some mothers gave their children solids such as oatmeal or rice in a bottle when they were two weeks old (Underwood et al., 1997). The goal of this study by Underwood et al. (1997) was to gain an understanding of the feeding practices of low-income African American women and the beliefs, values, and healthcare practices associated with them, along with understanding more about how poverty impacted the women and their families. The study was specifically targeted to research African American women in low-income communities by conducting four total focus groups on 35 low-income African American women who were either mothers or were involved in providing childcare to young infants. These women tended to rely on physical and behavioral
cues from the infants to determine when and how much to feed them— for example, mothers believed that their baby’s abdomen should be tight enough to keep them content. Mothers were additionally prone to preparing formula to make it the consistency of milk, as they believed this would keep their child full for a longer time, based on the infant’s growth, nutritional needs, and the mother’s perception on how formula should be similar to milk. The study found that culture, beliefs, and values predominantly impacted the decisions the women made regarding feeding their infants, and that the African American women were not aware of the recommended standards of feeding, as they had not discussed these with their care providers (Underwood et al., 1997). The 6- to 24-month-old age group is important to focus on in the study of complementary feeding because, through this analysis, it becomes clearer on how children are being socialized around food and how this impacts their future eating habits.

**Review on African American Women**

This proposal examines the diet quality of infants ages 6 to 24 months in households with African American mothers. To understand the dietary choices the young African American mothers make for their infants, it is important to also understand the statistics regarding obesity and chronic disease among young African American women and the food decisions they make for themselves, as these will give background to the reasoning behind mothers choosing to feed their children as they do.

**Disparity in Obesity and Chronic Disease Among African American Women**

African Americans experience the highest rates of obesity among all ethnic groups. Approximately, four out of five African American women are either overweight or obese (National Center of Health Care Statistics, 2019). Compared to all other ethnic groups, African Americans have the highest age-adjusted prevalence of obesity at 49.6%, Hispanic adults have a
rate of 44.8%, White adults have a rate of 42.2%, and Asian adults have a rate of 17.4% (Hales et al., 2020). Furthermore, African American women were 1.5 times more likely to be obese than non-Hispanic white women and were 1.2 times more likely to be overweight (National Center of Health Care Statistics, 2019). Supporting the urgency to understand obesity in African American women, statistics have shown that for African American females over 20 years old, 66% of them are overweight or obese (Sutherland, 2013). There is minimal research on African American women and their obesity consequences in correlation to the prevalence of the problem, so it is imperative to develop more information and research on African American women’s obesity rates.

The consumption of poor-quality diets is a leading cause of obesity, chronic disease, morbidity, and mortality among African American women (Webb et al., 2014). Diet quality is a dietary pattern or indicator of variety consumption of different food groups in relation to recommended dietary guidelines - a higher diet quality is related to lower risk of noncommunicable diseases (Dalwood et al., 2020). Diet quality is related to the amount of nutritious and healthy foods an individual eats, and so a high diet quality is associated with a healthier diet that consists of fruits, vegetables, whole grains, fat-free or low-fat milk, and lean protein (CDC, 2021). Additionally, a healthy diet stays in an individual’s calorie limits while being low in added sugars, sodium, saturated fats, trans fats. In Southern states especially, African Americans tend to consume diets with a high amount of fried and salty foods along with sugar beverages, and red and processed meats, the meats having a high implication in obesity risk (Sterling et al., 2019). Obesity is closely related to having an unhealthy diet and is a prevalent health issue among African American women compared to other ethnic groups because African Americans, especially young ones, tend to consume poorer quality diets compared to
other ethnic groups. For example, in a study comparing the diet quality of African Americans and white individuals, the researchers found that African Americans consumed more polyunsaturated fats and cholesterol and less carbohydrates and fibers compared to white individuals while having similar calorie consumption rates in both groups (Raffensperger et al., 2010). Raffensperger et al. also found the difference between diet quality in the two ethnic groups was strongly attributed to the consumption of soul foods (pork, pork fat, chicken, organ meats, corn, sweet potatoes, and greens) in African American culture and lower food availability in African Americans.

Consumption of unhealthy diets is not only related to obesity, but it is also associated with increased risk for other chronic diseases, such as type 2 diabetes, coronary heart disease, hypertension, and certain types of cancers (Hartman et al., 2015). Stroke and heart disease are especially prevalent in African American women as stroke is the third leading cause of death and African American women have a 54% higher death by stroke rate compared to white women (Williams, 2009). Meanwhile, 45% of African American women are impacted by heart disease compared to only 32% of white women (Williams, 2009). Type 2 diabetes is also especially prevalent in African American women in that one in four African American women older than 55 has type two diabetes, emphasizing the importance of performing diet interventions when African American women are younger (McNabb & Tobian, 1997). The disparities between young African Americans and white individuals for chronic disease are prevalent as well in that high blood pressure impacts 12% of African Americans, ages 18 to 34, compared to 10% of white Americans (CDC, 2017). Diabetes impacts 1.5% of African Americans compared to 1.4% of white Americans and stroke impacts 0.7% of African Americans compared to 0.4% of white Americans in the age group 18 to 34 (CDC, 2017). It is important to note that the disparity in
these diseases only increases as these individuals get older. For example, in the age group 50 to 64, 61% of African American adults have high blood pressure compared to 41% of white adults (CDC, 2017). The disparities in chronic disease outcomes are mostly fueled by the difference in diets across African Americans and other ethnic groups, providing a foundation for the importance of developing an understanding of the motivation behind the diet quality of African Americans and the reasons behind their food choices.

**Dietary Intake and Diet Quality of African American Women**

Because the negative impacts of a poor diet quality typically do not show themselves until later in life, it is important to understand the diets of young African Americans, especially women. An aspect of this is understanding whether they simply have a poorer diet quality or if they make poorer food choices than other ethnic groups. Prior research has indicated that African Americans eat less dietary fiber, vegetables, whole grains, and dairy while consuming more fat, sodium, and sugar beverages compared to other ethnic groups (Adams et al., 2019). However, having a diet of high quality typically consists of eating a lot of vegetables, fruits, whole grains, proteins, low-fat dairy, and healthy oils, and less saturated fats, trans fats, added sugars, and sodium (Adams et al., 2019). From this, we can see that African Americans have a poorer food diet quality that results from making poor food choices compared to the foods that are recommended to eat. A distinction between the types of foods African Americans typically eat and the foods that are traditionally recommended is important to determine because this further explains the reasons behind African Americans having a lower diet quality and more negative health outcomes related to diet than other ethnic groups.

As previously reflected on, African American dietary intake tends to be described as consisting of high fat foods, high daily caloric intake, and low consumption of fiber and grains
(James, 2004). Furthermore, another study on the diet quality of African American women provided support to the matter that African Americans are less likely to consume the recommended daily quantity of fruits and vegetables (Webb et al., 2014). The same study determined that African American women are much more likely to eat processed foods that are high in sodium and proceed to add more salt to their foods, which contributes to the high rate of hypertension amongst African American women (Webb et al., 2014). Even with this increased understanding, however, there is still the potential of under-estimates in the amounts of foods consumed because African American women may underreport the foods they consume (Thomson et al. 2018). Information on the diets of young African American women remains scarce although several researchers have examined the types of foods that African American women eat that lead to increased morbidity. Because there is a need to increase the information on the diets of African American women in the literature, it is important to understand more about how and why these food choices are made to further gain knowledge on the complex nature of one’s eating habits.

An area of research where there is more information on the dietary choices of African American women is when they are pregnant. This is an important group to reflect on for the project because, although this is not the same as studying the diets of postpartum women and how their children are impacted by these diets, it is still an important topic to consider when thinking about the dietary choices of parents, especially those who are African American. On average, 52% of women gain weight beyond what is recommended for women to gain while pregnant and African American women can be greatly impacted by this statistic, therefore, they become more likely to become obese after pregnancy (Groth et al., 2016). Additionally, 33% of African American women are obese prior to pregnancy because of their dietary choices, which
are primarily driven by food cravings, taste, and appetite (Groth et al., 2016). It is also important to consider that these women are not eating as many healthy foods as they should because there is a lack of knowledge given to them about healthy foods by those they are close to, grocery stores, and public health spaces. Furthermore, cravings, time, and lack of money also played a role in women not having enough healthy foods in their diets—out of the three, cravings seemed to have played the biggest role as supported in other studies while time was another large contributing factor due to the perception that healthy foods take longer to cook (Groth et al., 2016). One of the most important strides towards healthy foods that could be made is to make healthy foods seem more appealing to eat by African American women through gearing them with ways to cook healthy meals (Groth et al., 2016). Through developing an understanding of the diets of African American mothers while pregnant, more of an understanding can be developed towards how these diets impact women post-pregnancy, along with their children.

Furthermore, the diets of African American women postpartum have been focused on as well in terms of their dietary intake. When it comes to meeting the dietary guidelines of food intake, African American and other ethnic groups of women postpartum, all of whom were low-income, reported that they did not follow the dietary guidelines of eating the proper amounts of grains, vegetables, dairy, or fat during and/or after pregnancy (George et al., 2005). However, fruits were consumed at the recommended servings amount although 45% of the fruits consumed consisted of apple juice or orange juice (George et al., 2005). In terms of meats, women postpartum ate hamburgers and other types of ground beef the most, then boiled, roasted, or stewed poultry and beef were commonly consumed next (George et al., 2005). Overall, fish consumption was low although it is recommended that women eat about 8 ounces of fish a week in the U.S. dietary guidelines (USDA, 2020). Total daily calories among postpartum women
mostly came from foods that were high in calories and fat, such as french fries, whole milk, biscuits, cheese, and fried foods (George et al., 2005). These findings further support that woman will eat the foods that are most easily accessible to them, which are likely less healthy and cheaper compared to the alternative options, emphasizing the importance of understanding why women see these unhealthier foods as more palatable compared to more healthier options and what can be done to make healthier foods seem more obtainable to women to better impact their health in the long-term.

**Factors Associated with Diet Quality of Young African American Women**

There are factors to consider when examining the association between African American women and the poor food choices that they make to reflect on the reasoning behind poor food choices are more prevalent in African American women than other ethnic groups. Socioeconomic status, social support to eat healthy from friends and family members, knowledge and access to healthy foods are three of the biggest components to consider when thinking about the factors that are associated with the foods that women decide to consume (Richards-Adams et al., 2019). Furthermore, stress is associated with poor food choices because, when one is stressed, they tend to eat foods that are faster to prepare and less nutritious (Pickett & McCoy, 2018). Because African American women are more likely to be faced with socioeconomic stress and stress in relation to their jobs, family, and friends, it becomes more likely they would make poorer food choices to cope with these stressors in their lives. Additionally, African American neighborhoods tend to have higher prevalence of corner stores and fast-food places, both of which are known to carry a lot of unhealthy foods (Antin & Hunt, 2012). So, due to less healthy food accessibility, African American women, who do most of the food shopping in their households, are more likely to go to these less nutritious places to save on time, transportation
efforts, and cash. Other factors associated with poor food choices, as to be described later in the literature review, are familiarity of the food, convenience, nutritional quality, enjoyableness, cost, and hunger (Antin & Hunt, 2012). The complexity behind these food choices is important to facilitating a conversation on what factors impact the foods that African American women decide to eat and learning more about how these factors impact their lives. Demographic, environmental, social, and cultural factors are all associated with the diet quality of young African American women, as the research shows.

Several factors are associated with the increased prevalence of unhealthy diets or poor diet quality in African American communities. Some of these factors include low socioeconomic status because it is cheaper for individuals to buy processed foods instead of healthier ones, and education because people who have less education are less likely to know how to adopt healthier eating habits. Additionally, healthy foods are seen as more expensive with some African American women stating that they would be more likely to eat healthy foods if they cost as much as the regular versions of the foods (Thompson et al., 2021). African American culture is another reason why diet quality in African Americans tends to be lower as foods prepared by seasoning with animal fat, frying, or adding refined sugar tend to be consumed often (Webb et al., 2014). Culture is also essential to understanding why African American women feed their children some foods over others in that most of the foods offered to children are passed down through generations and learned from family members and other significant people within the community (Underwood et al., 1997). Furthermore, there is also the issue that taste and cost are highly associated with the foods African Americans in low-income communities decide to eat, which manifests in these populations eating cheaper foods that taste better than other foods (Fulp, 2009). In low-income families, due to a lack of supermarkets and grocery stores that sell proper
fruits and vegetables, it tends to be difficult for these families to buy these nutritious foods and store them properly, especially in the face of inadequate refrigeration (Lee et al., 2002). Within the social realm, time was also an important factor to whether young African American women were able to eat healthy (Thompson, 2021). For example, women with busier schedules report having less time to prepare meals that are healthy, so eating on the go or eating meals that are fast and easy to make was more common among these women compared to taking the time to prepare healthy meals. For women who have families, they report their family having strong influence on the foods they decide to eat, so if a woman was a part of a family that was more willing to eat healthier foods, then she would be more likely to do so compared to a woman who is in a family where her children and/or other people who live in the household do not prefer to eat healthy foods (Thompson, 2021). Research on the topic of factors impacting food intake of African American women is scarce, so the current study’s goal is to learn about the reasoning behind the diet quality African American women have and the food choices these women make to see how this impacts not only themselves, but their family members as well.

Summary

Throughout the years, progress in research has been made towards studying the diet quality of African American women and their children, however, much more work needs to be completed because of the prevalent gap in the knowledge towards the diets of infants to African American mothers. Because African Americans are known to have some of the poorest diet qualities of any demographic group in the United States, it is imperative to study their eating habits and come up with interventions while they are young and more likely to follow implemented changes. If the families follow the interventions, then they will stand to benefit
from these changes through later adulthood. In this way, the young women and their children will be more likely to live the rest of their lives with positive and healthy eating habits.

Previous studies have examined African American children’s diets and the negative outcomes that can result from their diets, however, there is a lack of research focused specifically on infants to young African American mothers and their diets. Young African American mothers are an important demographic to reach out to and understand the eating habits of their children because then proper interventions can be put into place to help their children and other family members eat healthier foods that will improve the quality of their lives. By conducting research on the relationship between the diets of African American infants, this gap in the literature will be filled, which will allow for more culturally sensitive interventions to be developed and will foster a healthier society for future generations to grow and prosper in.

Through conducting a review of the literature, the information researched by others on the diets of African American children and women and the outcomes of them were reviewed in this text to further elaborate on where the gaps are in the literature and how performing qualitative interviews on young African American mothers about their children’s diets could close this gap.
Chapter Three: Methods

Research Design

The objectives of this study are to examine the complementary feeding practices of young, low-income African American mothers with infants ages 6 to 24 months and examine cultural and social factors influencing complementary feeding practices of these mothers towards their infants. This is a cross-sectional study that used a mixed-method approach, where both quantitative and qualitative data were used to understand the research question. The mixed methods approach was beneficial because it gave a better understanding of the problem through avoiding over-reliance on one research technique (Jogulu & Pansiri, 2011).

Participants and Recruitment

The sample consisted of eight African American mothers between the ages of 18 and 30 who had a child between the ages of 6 and 24 months and whose income fell at or below 185% of the Federal Poverty Income Guidelines. Participants were recruited through Research Match and Facebook advertising via the Clinical Center for Translational Research (CCTS) at The Ohio State University. In addition, participants were recruited through flyers placed at different daycare centers, food pantries, and health fairs, and other events around Columbus that focused on low-income populations. Additionally, snowballing techniques were also used. In these instances, recruited participants informed potentially eligible individuals about the study may have occurred. Recruitment took place from January to April of 2022. The study was approved by The Ohio State University Institutional Review Board.

Procedures

This study is part of a parent study examining the diet quality of infants 6 to 24 months in low-income households in Franklin County, Ohio. Participants interested in participating in the
study scanned a QR code on the flier or clicked a link on the Facebook ad and were redirected to the screener for the study to assess their eligibility to participate. After filling out the screener, if the participant was deemed eligible for the study, they were then prompted to fill out a form with their contact information to indicate they are interested in participating in the study. Once the participants filled out their contact information they were contacted by text or phone call to coordinate a time for the interview. The timing of the interviews was based on the participant’s availability. The interviews took approximately one hour to complete and were conducted privately via Zoom.

**Quantitative Interview**

During the quantitative portion of the study, demographic information on the parent or caregiver and child was collected as well as information on, social and mental wellbeing, food security, and the child’s feeding patterns.

**Qualitative Interviews**

For the qualitative portion of the research, single interviews were conducted to learn more about why the parent or caregiver chose to feed their children certain foods and to further understand the social and cultural factors underlying parent or caregiver’s decisions. The interviews took place on Zoom. At this first interview, participants were informed of the goals of the study.

The interview was audio recorded to allow for accurate analysis. Each of the participants were informed that the interviews would be recorded, and consent was obtained verbally before starting the recording. Participants received a $20 Amazon gift card for each of the interviews they completed.

**Inclusion Criteria**
Inclusion criteria for the study included being between the ages of 18-30 years old, living in Franklin County, Ohio, having a child between the ages of 6-24 months old, being African American, and identifying as low-income. Being low income is defined as meeting income guidelines at 185 percent of the Federal Poverty Income Guidelines. Exclusion criteria included having a child with a special diet that required accommodations.

**Measures / Materials**

**Quantitative Questionnaire**

The quantitative questionnaire consisted of six sections: a participant demographics section, a section on the participant’s social and mental wellbeing, a child demographics section, a section on the USDA six-item food security survey, a section on the National Health and Nutrition Examination Survey (NHANES) child feeding pattern survey, and a final section consisting of questions specific to the project.

Related to demographics, participants were asked six questions about their gender, age, race, marital status, education level, and occupation. The questions were all derived from the demographic section of the NHANES (National Health and Nutrition Examination Survey) data set. Next, participants were asked nine questions related to their social and mental wellbeing. Three of these questions were related to social support, two were related to stress, three were related to mental health, and one was related to the participant’s self-rated diet quality. For example, one question related to social support stated, “How much interest and concern do people show in what you do?” Responses to the question included “none”, “little”, “uncertain”, “some”, or “a lot”. For the question related to self-rated diet quality, participants were asked “In general, how healthy is your overall diet?” The responses were then analyzed on a 5-point Likert scale, ranging from poor to excellent. These questions were used to develop more context behind
the life of the participant and how their social support and well-being impact the food choices they make for their child. Additionally, ten questions were asked about the child’s demographics. Questions included the child’s relationship to the parent or caregiver, how old the biological mother was when the child was born, the child’s gender, date of birth, weight and length at birth, the participant’s self-rated diet quality and weight of the child, whether a doctor has told the parent that the child was overweight, and how many children between the ages of zero and five live in the household. These questions were derived from the demographics section of the NHANES data set and were chosen to learn more about the child. Furthermore, participants were asked questions based on the six-item USDA Food Security Questionnaire (National Center for Health Statistics, 2012) to determine the level of food security. An example of a question asked in the survey was “The food that (I or someone in my household) bought just didn’t last and we didn’t have enough money to get more. Was that often, sometimes, or never true for you and your child in the last 12 months?” The answers the participants could have given to the question were ‘never true’, ‘sometimes true’, ‘often true’, and ‘do not know’. Also, the survey consisted of additional yes or no questions to capture food security.

The next section of the quantitative questionnaire consisted of the four question NHANES Child Feeding Pattern Survey (Centers of Disease Control and Prevention, 2011). The survey asked parents or caregivers if the child was breastfed or given formula when they were first born, how old the child was when they were first fed anything besides breastmilk or formula, how old the child was when they were first fed dairy milk or milk alternatives, and about the types of milk the child has drank. An example of a question on the survey is “what was the child fed when he/she was first born?” The options given to this question are “breastmilk”, “formula”, or “other”- for the “other” option, the parent or caregiver had described the item that
the child was given. As the survey has been used by governmental agencies and other researchers (Davis et al, 2018) to measure the intended constructs, it can be considered a strong measure to use to evaluate child feeding patterns because it uses a stratified design to provide cross-sectional health data, despite the lack of mention about validity and reliability scores in other research.

**Qualitative Interview:** An interview guidebook was developed with a list of questions that provided answers on the reasons for the feeding decisions parents or caregivers made for their 6-to 24-month-old infant, as well as the social and cultural factors impacting these food choices. (See Interview Guidebook). The interview questions were validated by a group of experts in child feeding practices.

**Interview Guidebook**

1. Explain when was the first time you introduced solid foods to your child?
   a. What factors guided your decisions to introduce solid food at that time?

2. Are there individuals who influence the way you feed your baby? If so, who are these individuals and what advice have you received from these individuals?

3. Where do you get information on how to feed your baby or infant?

4. Culture is defined as the set of beliefs and practices that a common group of people follow. Talk to me about how your culture influences the foods you feed your child?

5. What signs, if any, do you use to determine or to know that your child is hungry?
   a. What signs do you use to tell you that your child is full?
   b. How often do you use these signs to know that your child is hungry or full?

6. Do you think the media influences your feeding practices or how you feed your baby?

**Data Analysis**
Data from single interviews were recorded and transcribed verbatim. With the transcripts from the interview, the data coded and collected into a table to identify the project trends by two researchers. The coding had high inter-rater reliability amongst the two researchers. The data were then analyzed through content analysis. As explained by Onwuegbuzie et al. (2009), content analysis involves creating smaller sets of data and placing a code within each data set, then the codes will be placed into similar groups to determine their frequency. Through this classical content analysis, the data collected from each of the interviews were used to identify which themes that emerge during the study. These themes were used to understand the interpretations and meanings behind the food and health opinions the participants in the study have towards their children. As recommended by Onwuegbuzie et al. (2009), the information regarding the frequency of each theme were mentioned and used to understand the cultural and social factors influencing complementary feeding practices of young African American women. The trends were further supported with a description to facilitate a mixed methods content analysis, using the descriptive statistics.

To analyze the quantitative data, descriptive statistics were used to characterize the sample. Descriptive statistics provide summaries about the samples and measurements, forming the basis of the quantitative analysis of data, because they allow for the quantitative information to be condensed and compared across the participants in the study (Trochim). The data from the demographic surveys were analyzed based on their frequency of occurrence per question among the participants and were noted in a table displaying the statistics.
Chapter Four: Results

Demographics

Eight (n=8) African American mothers took part in individual interviews to determine the social and cultural factors influencing their complementary feeding decisions for their 6- to 24-month-old infant. Most participants were unmarried (62.5%), with some college experience or a college degree (87.5%) and were employed 62.5% of the time. The mean age of participants was 28.29 with the ages ranging from 23 to 30. Based on the demographic survey given, the data obtained from the eight participants were analyzed (See Table 1).

<table>
<thead>
<tr>
<th>Table 1. Participant Demographics (N = 8)</th>
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<tbody>
<tr>
<td>Age</td>
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<tr>
<td>Marital Status</td>
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<td><strong>Food Security (Based on USDA Survey)</strong></td>
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</tr>
<tr>
<td>High (No or Never True on all questions besides one)</td>
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<tr>
<td><strong>What was child fed when they were first born?</strong></td>
</tr>
<tr>
<td>Breastmilk</td>
</tr>
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</table>
Qualitative Interviews

Participants responded to six questions during their individual interviews. In the first question, participants were asked when they introduced solid foods to their child and the factors that guided their decisions. The next two questions asked about individuals who influence how they feed their children, what advice they get from these individuals, and where they find information on feeding their children. In the fourth question, a definition of culture was given, and participants were asked to share how culture may impact the foods they feed their children. The fifth question was used to gain information on how participants know whether their child is hungry or full (feeding cues). Lastly, the final question was about whether the participants believed the media influenced their feeding practices.

Four trends were discovered from asking these questions: (1) pediatricians and other health professionals were impactful in determining what children ate; (2) culture emerged in interesting ways among the participants; (3) participants followed responsive feeding practices and were attentive to their child’s hunger cues; (4) media did not influence the participant’s feeding decisions.

Question 1: Explain when was the first time you introduced solid foods to your child? What factors guided your decisions to introduce solid food at that time?

Most participants (n=6) introduced solid foods at six (n=3) or seven (n=3) months. A few participants (n=2) introduced foods a bit earlier at the five-month mark.

When participants were asked, “Why did you choose to introduce solid foods at this time?” Most participants (n=6) mentioned their decision was based on their pediatrician’s advice. Some participants (n=3) also mentioned they knew it was the right time to introduce solid foods
because of developmental cues that were being shown by the baby. For example, reaching for the plate, being hungry more often, sitting upright, and losing the tongue reflex were mentioned. A couple of participants (n=2) stated they received information on the timing for the introduction of solid foods from WIC. Only one participant mentioned she had received information from her child’s daycare center.

- *I think because her pediatrician said by that time she should be eating solid foods. Not really, only it was just the right age.*

- *And then he was also showing signs of being ready to eat solids. Reaching for regular food, being hungry more often... Yeah.*

When asked about the foods that were offered first and why these foods were chosen, most participants (n=6) stated that puréed or foods with a soft consistency were offered first. Although participants mentioned offering a range of food items as first-foods to their children, the reason given for the type of the food that was offered first was mainly because of the texture of the food (puréed fruits, vegetables, and baby cereals). Two participants (n=2) offered both puréed foods and table foods. Only one participant (n=1) offered only table food as the baby’s first introduction to solid food. Apart from the texture and going directly to table foods, two participants stated that they offered a variety of foods when introducing the child to solid foods to prevent the child from being or becoming a picky eater.

- *Just because she was more interested in it [table foods]. She was my baby that I nursed the longest. So, I think she was more like, "You're not eating baby food. So why should I?"*

- *I don't want a picky eater. All of my older kids, they'll eat anything that I put in front of them. Any fruit, any vegetable, any meat, they'll eat anything, and I feel like it all started*
when they were babies and I offered them everything from the beginning, not keeping anything out.

Participants were also asked, “Are there foods you avoid feeding your child?” Half (n=4) of the participants specifically mentioned that they avoided honey because of information they received from the pediatrician or from their involvement in programs such as WIC (Women, Infants, and Children) and Moms2B. Some (n=3) participants reported that they avoided offering their child foods with processed or artificial sugar mainly because they did not want the child to develop a liking for sweets or sweet foods. Two participants highlighted safety concerns as a reason for avoiding certain foods. For example, they did not introduce foods that they felt would lead to choking, such as foods that required a lot of chewing.

- I knew it wasn't going to be healthy for him and I had access to healthy foods through like WIC program and SNAP. With those types of resources, what would be the reason to give him things that I knew was less than nutritious.

- ...Because of the choking hazard ... I just knew he couldn't chew it, so he wouldn't be able to swallow it.

Question Two: Are there individuals who provide advice on how to feed your baby?

Many participants (n=5) initially answered the question by stating that there was no one who provided advice on the way they fed their child. Participants felt that they were in control of what their family ate mainly or because they made decisions based on the experiences they had with their other children. Two participants mentioned that they received advice from others, but they did not always follow the advice, preferring to use their own personal experiences over what
others told them. Two other participants mentioned their husbands provided advice on feeding their children.

- **Because I feel like if there were, the things that I usually see on social media are typically people who don’t give their kids jar food. They make their own. They make their own baby food and all that. So, if I was influenced by anything, it would be that. So, the reason why I say no is because I know that, typically, it's starting to be and some of the mom communities are starting to be frowned upon to give your kid jar food, but for me, I don’t have an issue with it, so I just give them whatever I can.**

- **He grew up in a foreign country. So, I do like to incorporate his upbringing into the way that we raise our kids. So yeah, if he suggests something, I’m definitely thinking about it and trying to incorporate it into their diet.**

Using a probing question, participants were asked if there were potential organizations or other individuals who could have had an impact on what they fed their child. Most participants (n=6) mentioned the Pediatrician providing advice on what they fed their child. Two participants mentioned organizations for mothers, such as Moms2Be, then three participants mentioned family members providing advice. Only one participant remained adamant that no one had provided advice to her on how she fed her child.

- [About Moms2Be] **I just feel like they're very knowledgeable. A lot of the stuff that they say are within current guidelines. They keep up with current guidelines and everything. Things that they're following, I'm almost certain that it is backed by research and it's not just something that they just pulled off the internet and just found. I trust their teachings.**
● The pediatrician provides factual information, even though each child is different. But I feel like they know what they're talking about, obviously because they're a pediatrician. But I don’t know, they had her best interests.

When participants were asked, “What advice have you received from these individuals?” Most of the participants (n = 6) mentioned that they had received advice on the types of food to offer their children. For example, these participants mainly discussed how the Pediatrician told them when to introduce solid foods, to feed their child soft foods when first introducing foods, to introduce allergens early, and to ensure the child was eating a balanced diet. One participant remarked she had received similar information from the mom support groups she attended. Two participants mentioned their family members gave her negative advice towards breastfeeding and encouraged her to start solid foods earlier, however, they did not follow this advice. The two participants who stated their husbands provided advice specifically said the husbands would influence what kind of foods were eaten and when the foods were eaten. However, these participants also mentioned that they follow their own beliefs on what their children should eat before looking towards their husband for additional advice.

● They [the Pediatrician] always give these little sheets, for whatever the checkup is they'll give sheets that just corresponds with particular milestone it is, and it'll show like servings, how many servings, how much servings, recommended serving for each food group, stuff like that.

● They'll [Moms2B] have sessions on feeding baby, what things to feed. Actually, I've received a lot of advice from them, things such as when you're introducing solids, introduce one, maybe one flavor, one item, one fruit, one food item for a couple of days, just to make sure there isn't an allergic reaction. Then if there is, at least you know where
you can tie it back to. Then things like that, I received that kind of advice from them. I might have gotten that from my pediatrician, too. I'm not sure.

**Question Three: Where do you get information on how to feed your baby or infant?**

For the third question, participants were asked about where they received information on how to feed their infant. As a response to this question, many participants mentioned their pediatrician (n=5) as a source of where they got information on how to feed their children. Five mothers also mentioned online resources, such as social media (n=4) and/or health websites (n=3), as places where they found information on how to feed their infant. All the participants who mentioned social media also mentioned that they did their own additional research based on what they had heard from social media sites, then used that information to inform their feeding decisions. Two participants mentioned the mom support groups they were a part of as essential sources for information. Common knowledge and life experiences was cited as a source by two participants as well, and, by this, the participants meant their experiences with previous children and experiences they had growing up with younger individuals around them. WIC was a source for three of the participants and, lastly, family and friends were mentioned by three participants as well.

- [About WIC] Let's say, first of all, usually at six months, they'll give you they'll start giving you the solids, like the fruits, the vegetables and the cereals. Which I know they give these foods based off of, I guess, whatever, like based off of guidelines.
- [About social media usage] Yeah. So, I'm on a mommy page, a Muslim mommy page that we share a bunch of information and that was something that someone had mentioned.
So, I did some research, went to Google, found a couple of things, and wasn’t very happy with the ingredient list. So said, "I'll keep my child from eating this."

**Question Four: Talk to me about how culture influences the foods you feed your child**

When asked, “Can you talk to me about how your culture influences the foods you feed your child?”, some participants (n=5) indicated that their culture did not directly influence the foods that they fed their child because they did not feel they had a strong identification with their culture and, generally, just ate whatever they felt like. One participant mentioned her husband’s culture having an impact on the foods she fed her children because her husband came from a culture where pork products were not consumed, but she did not have any impacts directly from her own culture. Another participant stated not eating pork products as well but considered it more of a religious aspect to her life than a cultural aspect. Furthermore, two participants used American culture to explain the foods they fed their child, specifically one of the participants said the foods she cooked had a strong Southern influence. On the other hand, the other participant stated traditional holidays and American meal structures influenced the foods she fed her child. One participant, who has a cultural background in Nigeria, mentioned the emphasis on meats, vegetables, and spices in her culture impacted the foods that she fed her son as well.

- *The only cultural thing that I have is we don’t eat pork. That's more of a religious/culture thing. We don’t eat pork. So that's something that so, obviously, I don't feed my child pork, but as far as that goes, I don't think it really has much of an influence on what I feed my kid.*

- *The eggs, sausage, maybe a waffle or pancake, or piece of toast. I guess that is American. And then lunch, it's light too. But then dinner, it could be like when I was eating meat. It*
could be burger and fries homemade, or it can be meatloaf, mashed potatoes and vegetables. It could be fried fish, since I've been eating a lot of fish. I do fry it, because it do taste better. I guess just like an American diet, I guess. Oh, and then also of course holidays, like Easter, Thanksgiving, definitely Thanksgiving, and Christmas.

As a probe, participants were asked in more detail if they had any cultural beliefs or practices that would influence the foods they fed their children or the manner in which they fed their children. Five participants mentioned that they believed in feeding their children when they were hungry and did not endorse the idea of forcing their child to eat when they were not hungry. Reasons for this included not wanting the child to develop negative associations with eating and believing that the child could properly self-regulate their own hunger and that they would eat whenever they were hungry. One participant, although she did not follow this, stated that her family believed in adding rice to baby’s bottle and feeding a child right before bedtime to make them sleep longer. Three participants stated that they believed in having their families always eat together during mealtimes. Then, as another common trend, three participants also mentioned that the way they grew up and older family members who showed them how to cook impacted the foods that they fed their children currently. In two of these cases, the participants altered the foods when they offered them to their child to make them more conducive to the foods they believed their children should eat. For example, one participant feeds her daughter a pescatarian diet based on her own diet and another participant ensures to not give her son foods with oils and spices to prevent him from having potential stomach issues based on her experience with her previous children.

- [Discussing her family’s beliefs] Honestly, I just thought it was a little stupid. I never really understood it, if the kid needs to wake up, the kid needs to wake up. I don't feel like
over-stuffing them to the point that they are extremely full and uncomfortable is going to help the matter. And I'm a very hands-on parent, if my kid is awake, they need me for something. I don't know, I just feel like it creates bad eating habits from a very young age. Gluttony, I don't like it.

- I mean, I think I feed my kids when they're hungry, they can have leftovers, like I don't ration or kids can only have this or not that, we all eat the same thing. I substitute if someone doesn't want something. So, it's not, you know like some cultures, if you don't eat, you're just going to be hungry kind of thing. I don't do that. Yeah.

**Question Five: What signs, if any, do you use to determine or to know that your child is hungry? What signs do you use to tell you that your child is full? How often do you use these signs to know that your child is hungry or full?**

The participants were asked about the signs they used to determine if their child is hungry or full—each question was asked once at a time. All participants (n=8) indicated that they used signs to determine their child’s hunger status. Many of the participants (n=6) used verbal communications (such as the child asking for snacks and/or saying that they are hungry) with their child to determine whether they were hungry. All participants besides one (n=7) mentioned that their child gets cranky, cries, and/or cries when they are hungry. Two participants had snacks that were easily accessible to their infants through older siblings or simply being in an accessible place, so they used their child getting snacks as an indication towards them being hungry. Two participants also used the time that they last fed their child as an indication on whether their child would be hungry soon. One mother gave many different signs that she used to determine whether her child was full or not, such as eyeing what is being eaten, reaching hand
out towards food, smacking lips, making a sucking motion with his mouth, and clenching his fists.

- *Usually, if it's been more than three, four hours, I typically would try to feed them then, because I know that's ... I use myself. I know I'm hungry, usually, by that point, so I figure that they might be hungry, too.*

- *He's fussy. He'll give you that like he want to fight with you, he's hungry. And he will say goo-goo. Whenever he says goo-goo, I know he's hungry.*

When discussing the signs the parents used to determine if their child was full, all participants stated that their children would stop eating when they were full. A couple participants (n=2) mentioned their child would start to play with the food. Two participants also mentioned their children would throw their food on the floor when they finish eating. Three participants used their child walking away from the table as a common sign that their child was full. Four participants stated that their child verbally communicated their fullness by saying they were full or that they were done with their food. Half of the participants also stated that their children would close their mouths and/or turn their head away from the food once they were full.

- *Oh, she'll just become very uninterested. So, she'll get up and walk away at this point. Back then, she'll just continually turn her head like, "No, I'm not interested anymore."*

- *She'll roam away from her plate. That's her big thing. Getting up and roaming away or she'll say no. Something like, if she's eating off of my plate or something, if I keep trying to feed her, she'll tell me no. And most of the time it ends with the you eat. So, she's not hungry.*

As a final part of the question, the participants were asked “How often are the signs used to know that the child is hungry or full?” All the participants (n=8) said that these signs were used
either every day or all the time. A common response to the question of why the signs were used every day or all the time was that the participants knew the signs worked because of their consistency (n=3) and how they work for the participant (n=3) as the child typically becomes complacent after they are given a food item when they are hungry, or they have their food taken away from them once they are full. Two participants mentioned that they know the signs are working because the weight gain their child is experiencing is appropriate, as confirmed by the child’s pediatrician.

- It’s if she’s not starving. Because I mean, I don’t know. They just seem to work, I guess. The communication between us is there. I understand. And our weight gain is appropriate.
- Well, because honestly, I mean, I serve meals at certain times but if she’s telling me that she’s hungry, I’m going to feed her. And I know that she’s done when she’s throwing her food all over the place.

Question Six: Do you think the media influences your feeding practices or how you feed your baby?

Most of the participants (n=5) indicated that the media did not influence the foods they fed their children when they were asked, “Do you think the media influences your feeding practices or how you feed your baby?”. Three participants mentioned they did not believe the media influenced them because they did not keep up with celebrities, watch TV shows with commercials, or listened to the radio frequently while two participants believed they knew not to believe anything that is stated in the media. Two of the participants who mentioned media having an influence on the foods they fed their children specifically mentioned social media having an
influence on the foods their children ate, specifically based on seeing different ways a child could be fed and what not to feed their child versus what was fine to feed their child. Few participants (n=2) mentioned the media messages being promoted in WIC as an influence on what they fed their children. For example, one participant worked directly at WIC, so she had felt the social media posts that she made for the program may have had a subconscious influence on what she fed her children. As a final point of interest, one participant mentioned Netflix documentaries having an impact on what she fed her child as she wanted to ensure her child was eating healthier foods instead of the negative ones mentioned in the documentary.

- *I think the media has allowed me to see a different way of bringing children than I was exposed to growing up, which is just focusing on this mental and emotional understanding of what it's like for children and their own age and development and their own understanding of things. It's exposed me to that perspective I didn't have prior to. And that's helped me to basically have these habits that I'm trying to form now with him, so that we have healthy associations with eating.*

- *No. I can't think of anything that would influence me that I've seen on the media. Because I don't really watch TV. I don't listen to the radio. If I watch something, it's on Netflix and there's no commercials there, so...*
Chapter Five: Discussion

The purpose of the study was to determine the social and cultural factors influencing complementary feeding practices of young African American mothers between the ages of 18 to 30 years old. Four main trends were observed over the course of the interviews. Pediatricians and other health professionals played a prominent role in early feeding decisions of the participants. The participants’ culture impacted their feeding decisions in interesting ways. The participants all practiced responsive feeding as they paid attention to their child’s feeding cues mainly to determine the time to begin complementary feeding and to tell whether their child was hungry or not. Lastly, many participants stated that the media did not influence the decisions they made with feeding their children.

Trend One: Pediatricians and other health professionals played a prominent role in early feeding decisions

The majority of participants introduced solid foods at 6 to 7 months of age. Two women introduced foods at five months of age, but this was under the guidance of their child’s physician. In this study, most participants mentioned their pediatrician as a source of knowledge when asked where they received information on how to feed their child and who gave advice on how to feed their child. Regarding complementary feeding and the timing of the introduction of solid foods among African American women, there seems to be mixed results in the literature. For example, Hart and Drotar (2006) examined complementary feeding practices among African American women with infants from 6-18 months of age in a Midwest urban care clinic. The study found that many of the women introduced solid foods prior to six months and were not following the guidelines set by their pediatricians and the American Association of Pediatrics (AAP) on how to feed infants. About 34% of mothers in this study introduced solids before four
to six months of age and 48% introduced water and juice before four to six months of age. Additionally, the mothers in this study believed doctors recommended introducing solid foods and beverages before six months, further showing a disconnect in the information received by these mothers compared to established recommendations. Hart and Droter (2006) suggested that there is a lack of understanding among mothers between what the doctor recommends for them to feed their child and what the mother feels is best. Factors such as a lack of education among the mothers, miscommunication between mothers and doctors, and mothers receiving conflicting information from family members were also seen as large factors that influenced the results in this study. Other studies found that mothers lacked nutritional information and introduced complementary feeding earlier than recommended for similar reasons (Underwood et al., 1997, Daly et al., 1998; Bronner et al., 1999, and Briefel et al., 2004). It is also important to note that previous studies were based on African American women who were low-income and had low education rates, however, the majority of women studied in this study had some college experience or were college graduates, increasing the likelihood that they would follow what the pediatrician informs them because of their educational background.

However, a study by Monterroso, Pelto, Frongillo, and Rasmussen (2012) among women in Mexico to understood complementary feeding patterns found similar results as our study. Although the population of women is not similar to the one studied in our study, it is important to note that the women in Mexico also used the advice they received from their child's pediatrician and nurses to determine whether it was time for their child to eat solid foods. They also reported that health professionals also gave information on when to start feeding and what types of food to prepare for their children. The results from our study may have resulted because
information from health professionals have become more accessible through increased telehealth visits (Suran, 2022).

There is a lack of research on African American mothers and their complementary feeding practices. This is an area where additional research is needed among diverse groups of African American women. Additional studies are needed to examine the association between complementary feeding practices and socioeconomic status.

**Trend Two: Culture emerged in interesting ways among the participants**

Broadly, culture is defined as the set of beliefs, practices, and symbols that are learned and shared by a group of people; culture forms a system that binds people together and shapes views on the world and ways in which they live life (Braff & Nelson, 2020). Even with this definition, culture is a complex construct to define, especially to individuals who are not asked about their culture frequently. For this reason, participants understood the concept of culture in interesting ways, which had an impact on the early feeding decisions they made for their children's food. Some participants indicated their culture did not have an influence on their complementary feeding practices stated that they simply ate what they wanted to and did not feel a strong connection towards eating any cultural dishes. Based on the information received in this study and the complexity of culture, there seems to be a need for more research on the link between culture and complementary feeding among young African American mothers. This will help researchers get a more in-depth look at what they would define as culture and then learn about what feeding practices and beliefs impact the foods they give their child.

Despite not all of the participants acknowledging the impact that their culture as African American women could have on the foods that they fed their children, culture was still mentioned in a few of the interviews. As an example, one participant mentioned culture in the
context of religion in her decision not to feed pork products to her child. She gave an example of how the lines between religion and culture can be blurred. And, because of this, some people may consider their religion as a part of their culture. The participant in question did not directly associate her religion with her culture, however, and stated that she did not believe her culture had an influence on food choices. American culture was mentioned by two participants. One participant specifically mentioned Southern influences on the foods she fed her child. Then, the other participant discussed how American culture consisted of influences from numerous different cultures, so she fed her child numerous different foods based on these cultures. The participant specifically used tacos (Mexican) and Alfredo (Italian) as some examples of foods that she cooked for her daughter based on the cultural diversity present in the United States. Additionally, one participant mentioned her husband’s culture influencing the food choices she made for her children in that she wanted to ensure that her children were being fed foods that were a part of her husband’s culture and were consumed frequently in his upbringing. A further note of interest is that a participant discussed how her Nigerian culture impacted the foods she fed her child because she fed her child many meats, vegetables, and foods with spices in them compared to other more bland and sweet foods. So, while there were conversations about culture present, more in-depth details or explanations on the phenomena of culture was needed.

The literature supports that culture has an impact on the foods that African American mothers decide to feed themselves and their young children. For example, one study by DeVane-Johnson et al. (2018) found that culture and traditions contributed to how women made infant feeding decisions and the women were able to acknowledge the impact culture had on their decisions. In DeVane-Johnson et al. (2018) study, the women commonly noted that their cultural background influenced their decisions towards breastfeeding, especially through messages
passed on from family members, which were more likely to discourage breastfeeding. Interestingly enough, in the current sample of women for this study, they all reported to have started off with breastfeeding their child although two women did mention, outside of a cultural context, that their family members did encourage them to bottle feed their child instead and discouraged breastfeeding in front of the family. DeVane-Johnson (2018) also mentioned that culture’s impact on infant feeding practices was understudied in African American mothers, making it imperative to conduct research on this topic to give further understanding of the results found in her own study. This would be especially important because Devine-Johnson predominantly focused on breastfeeding rather than complementary feeding practices as in our study. Other studies further support the impact culture has on the feeding choices African American mothers make for their children in regard to breastfeeding (Green et al., 2021; Obeng et al., 2015). However, studies on culture impacting the choices African American mothers make in regard to complementary feeding are not as common, meaning that this is an area where more in-depth research should be conducted in the future.

**Trend Three: Responsive feeding occurred often as the participants used cues to determine whether their child is hungry or full**

Responsive feeding is when a parent identifies and appropriately responds to a child’s fullness and hunger cues (Finnane et al., 2016). According to Finnane et al. (2016), responsive feeding is known as one of the more positive ways to feed a child as it does not create unhealthy associations with food. All the participants in the current study practiced responsive feeding and mentioned several cues that they used to tell whether their child is hungry or full and stated that they used these cues every day. Participants mentioned that they were confident in their feeding cues as their children were gaining the proper amount of weight. In a randomized control trial
about family-based obesity prevention Thompson et al. (2019), examined the feeding practices of 429 African American mothers to see how many mothers practiced responsive feeding over the other feeding techniques (laissez faire - child does not have a restriction on food quality or quantity and parent is uninvolved in feeding; pressuring - child is forced to eat all food; restrictive - child is limited on the foods they eat; indulgence - child does not have a restriction on food quality or quantity, but the parent is involved in what the child eats). African American mothers in this study practiced responsive feeding at a high rate, similar to what was found in this study. However, Thompson et al (2018) study also examined the other feeding styles in relation to complementary feeding and found that mothers also had high rates of restrictive feeding practices based on amount and diet quality. Indulgent and laissez faire feeding styles were the least common of all the feeding styles mentioned among this group of parents. Thompson et al (2018) found an association between responsiveness and income, in that lower income mothers were more responsive than higher income ones. They suggested that this may have been due to the mothers participating in programs such as WIC. WIC provides information and food packages to low-income women and could have provided women with the knowledge to know how to feed their children more properly. As the current study directly studied low-income mothers, this finding from Thompson could support that the involvement of participants in our study with WIC could explain the high usage of responsive feeding.

Several studies (Sacco et al., 2007; Spruijt-Metz et al., 2006; Hughes et al., 2005) have examined the infant feeding styles of low-income African American mothers. Results showed that most mothers followed a restrictive feeding style in contrast to the more responsive feeding styles described in Thompson et al (2018) research and our study. However, these authors did not mention whether participants were involved in WIC and other programs. Most of the mothers
in our study were involved in WIC and similar programs. Feeding practices, because of the strong implication they have on the future of children and their weight status, are important to understand, especially as more negative feeding styles in infants are associated with negative adult feeding behaviors.

**Trend Four: Media did not influence the decisions participants made with feeding their children**

A majority of the participants in the study stated that the media did not influence the decisions they made with regards to feeding their children. The mothers in our study were between the ages of 18 to 30, it was expected that they would be more connected to the media. This was a surprising finding. This contrasts from the common anecdotes that young adults are highly impressionable and are likely to follow media trends rather than use their own experiences to form their choices. In the participants who said the media impacted their food choices, one participant clearly pointed out that it would be easy for her to say the media did not impact her child’s food choices, but she acknowledged that media could cause a subconscious or subliminal impact on her feeding decisions. This would be an interesting trend to evaluate for further research because potentially, if probed further, more participants could have reflected on the subconscious impact media may have on their choices. Media is incredibly prevalent in the world we currently live in so although it is easy to say that one does not follow exactly what the media says, there could be certain aspects to media that one follows without realizing it.

Social media was a prevalent source of media used among the participants in the study. Whether the mothers believed the media influenced their feeding decisions or not, a majority of mothers mentioned social media in some capacity during their interviews, supporting the idea that younger generations are more connected to the media than ever and can be subconsciously
and consciously impacted through this medium. A participant cited social media as being helpful in seeing other ways that children are raised while another participant found social media to be filled with negative information that was not backed by research. The negative presence of media could be an influence itself within these mothers to not feed their child a certain way rather than conforming to how media shows children being fed. However, none of the participants mentioned this in their interviews, making this an area that could be examined in the future.

Similar results were found in the literature. Byslaska-Davies (2005) conducted a study of 20 pregnant and postpartum women in Massachusetts to learn more about how the media impacted perceptions of infant feeding among the women studied. The women in this study had an age range of 26 to 38 (with the mean age being 32.1), and, similarly to the women in this study, these women described that their infant feeding choices were not influenced by the media and were instead influenced by their healthcare providers and family members. Although the women in the Byslaska-Davies (2005) study described media as being more prevalent in their lives as seen through public opinions, commercials, and celebrities, they still believed that the media did not influence their decisions. They preferred to listen to individuals that knew them rather than impersonal media sources. It is also important to mention that this study had an emphasis on breastfeeding, so it did not directly examine complementary feeding. Furthermore, there were not any African American participants in the study. Based on the current literature review, in the United States, there are not many studies about African American women and the media in relation to the decisions women made with complementary feeding their children. Most of the studies conducted on the media’s impact on complementary feeding were conducted in foreign countries, indicating that this could be an area that should be studied more in the United States because of how prevalent the media is in the country. This is an area where more research
can be conducted to see how media impacts the way mothers see foods and decide to feed their children. Considering the study results once more, it seems that the results that occurred in our study were similar to other research in the literature that determined women were not impacted by what they saw in the media and did not use the media to inform their child’s feeding patterns.

Conclusion

The focus of this study was to determine the social and cultural factors that influenced complementary feeding among young African American mothers, aged 18 to 30, with infants who were six to 24 months old. The findings of this study demonstrate that the complementary feeding choices made by participants were more impacted by influences, such as pediatricians and other healthcare professionals, rather than more indirect sources, such as the media. The findings also showed that young African American mothers may feel a disconnect between their culture and the foods they choose to offer their child. Furthermore, the study found that the participants were prone to responsively feeding their child and paid attention to hunger and satiety cues often. With all these trends in mind, the current study has laid a foundation for more research to be conducted on factors influencing complementary feeding practices among young African American mothers in the future.

Limitations

The study sample was small, only consisting of eight women, so it is difficult to generalize the results to a wider population. There was also limited time in recruitment for the study, which contributed to the small sample size. The small sample size can also be attributed to how African American women, especially young African American women, can be a difficult population to reach in terms of research. Initially, the project was meant to focus on young African American women ages 18 to 25, but the study age range had to be expanded to 30 due to
the lack of women ages 18 to 25 showing interest in the study. This could be considered a limitation because the larger age group could mean that we may have young women who may be experiencing different complementary feeding challenges. For example, an 18-year-old may have different challenges than a 30-year-old woman. Furthermore, a majority of the participants were college educated, and this prominence of education could have potentially skewed the results towards being more homogenous compared to if the participants had more diverse educational backgrounds. There also could have been the potential of social desirability bias among the participants as they could have provided responses that they thought the interviewer wanted to hear.

**Implications and Future Work**

The implications of the study surrounding complementary feeding practices of young African American mothers with infant children should be considered in future research. The study suggests that pediatricians are a trusted resource among mothers and should be utilized more often in the spread of important information. Additionally, the study suggests media is not seen as a trustworthy source, so putting messages in the media about complementary feeding may not be as beneficial as giving this information to the mothers through their pediatricians directly.

Studying the culture of African Americans in relation to their complementary feeding practices would be insightful as young African Americans have a unique cultural experience compared to other Americans that could be further studied in terms of how their cultural experiences impact the foods they feed their children. Also, the media’s impact on complementary feeding could be studied in more detail as well to build a stronger argument for whether the media’s impact on the foods mothers choose to feed their child. The period of
complementary feeding can have a life-long impact on parents and children, so it is imperative to get a closer examination on the factors that influence parents when they make their complementary feeding decisions. This study yielded information that could lead to the development of culturally appropriate interventions and could inform policy decision.
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## Table 2. Interview Questions and Responses

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<th>Interview Question</th>
<th>Participant Responses</th>
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| 1. Explain when was the first time you introduced solid foods to your child?     | ● At six months…  
● Yeah, she was around seven months.  
● Around seven months.  
● I believe he was five months.  
● I want to say six months.  
● I think he was about seven months.  
● Around six months.  
● I introduced solids at about five and half months of age and I tried puréed baby food first, vegetables. |
| a. Why did you choose to introduce solid foods at this time?                      | ● The research says that it's [the introduction of solid foods] between four and six months.  
● Not really, only it was just the right age. And then also he was showing signs of being ready to eat solids. … Reaching for regular food, being hungry more often….  
● I made it a point to exclusively breast feed until the six-month mark and then start introducing solids after.  
● I think because her pediatrician said by that time she should be eating solid foods.  
● Because he didn't want to take any bottle at all. So, all he wanted was only breast milk. And at that time, we went to a doctor appointment and that's when the doctor told me that I can start giving him not that much, but just a little bit.  
● Well, she had already started budding teeth. So, she had two teeth. And she was more reaching towards my food versus just wanting to nurse.  
● So, her daycare also stated, like, "Hey, we can start introducing her to solid food if you're interested," around that six-month mark. |
| b. What foods were introduced? | Cereals, pureed fruits and pureed vegetables …
|                               | Yeah, she started doing a lot of food purées. So, I made a bunch of food purées with fruits and vegetables.
|                               | Pretty much table foods, whatever we eat.
|                               | Sweet potatoes and veggies. Sweet potatoes, carrots and stuff like that.
|                               | Sweet potatoes, green beans, apple sauce. This is all pureed. […] Also scrambled eggs, breakfast sausage. Not really bread. And then the side of like a cheese, or deli ham, or something like that.
|                               | He had the fruit cups, the Gerber purees, but he was already eating food. It would be a variety of food, but it would already have been chewed up for him or cut up and softened. So, it wasn't necessarily a puree, but it could be whatever I'm eating.
|                               | Started off with the rice, the powdered rice mixed with breast milk. And then after that, eventual- just the cans of baby food, different types.
|                               | Pureed fruit, soft foods, mashed potatoes, eggs, scrambled eggs, ice cream.
| c. Why did you introduce these particular foods? | I figured they were baby friendly. He could easily swallow it. No choking hazard, easily accessible…
|                                            | Well, one, I wanted to make sure that there wasn't a ton of sugars, preservatives, and stuff which is why I started to make them all at home myself instead of buying the stuff that was in the jar. But secondly, they taste

...Because I had WIC at the time too, that's when they start giving you solids on your WIC card, as well. That was also something that added to just knowing that, yeah, it was definitely time for solids.
yummy.
- She has two older brothers, and they eat table foods. So, it's might as well just fix three little plates.
- I didn't want to really focus on the sweet stuff because I know when they're little and you introduce them with the sweet stuff, they will always want to eat the sweet stuff, not other food like healthy food and stuff like that.
- I think it's promoted more. Like sweet potatoes, green beans, and definitely the apple, apple sauce. Because you always see that at the grocery store in the baby section.
- I wanted him to get introduced to a variety of flavor from the beginning so that it wouldn't impact him potentially being a picky eater, which sometimes those things you can't really avoid no matter what you try, but I just wanted to introduce him to a variety of flavors and spices and stuff.
- I know for the cereal, we started that because the doctor was a little concerned for his weight. He was slow weight gain. So, she wanted me to add cereal a couple times a day to, I guess, add on some extra calories or something.
- Baby didn't have to chew them; they could just swallow them. They wouldn't choke on them.

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<th>d. Are there foods you avoid feeding your child?</th>
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<td>- I don't think so, other than actual food that requires chewing. I didn't give him anything that I would eat.</td>
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<td>- Yeah, I've been reading a bunch of stuff about additives in rice cereal that I wasn't comfortable with feeding my child, so I opted out of it.</td>
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<td>- No. Just nothing with honey on it [due to the risk of botulism].</td>
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<tr>
<td>- Yeah, anything that has nuts on it, so I just threw it away. I think it was</td>
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because he was too little to try that. I don't know. That's how I feel. I feel like it was too early to give him those type of food.

- Meats, unless... Obvious things like that, [unless a] deli type of meat. But, a whole chicken wing, or no, I'm not doing... No, that's too much. Or like ground beef, and... No, no. I try to stay away from the fried stuff too, like fries or whatever.

- I didn't want to do too many fruits and sweet foods. I wanted to introduce mostly savory foods. There was definitely no sugar. I tried to pay attention to what has high fructose corn syrup or processed sugar, no candies or desserts or those types of sweets.

- No, not really. Because I think pretty much the only food that he could eat during that time, which is the rice and the baby food, was generally, I guess safe for kids to eat. So, I didn't really have any concerns.

- Any choking hazards, popcorn, grapes, and hot dogs.

2. Are there individuals who influence the way you feed your baby?

- ...The reason why I say no is because I know that, typically, it's starting to be and some of the mom communities are starting to be frowned upon to give your kid jar food, but for me, I don't have an issue with it, so I just give them whatever I can.

- Yeah, definitely. My husband.

- [No] ..Because I already been through that. She's my third. So, my first son, we had issues with him in formula intake and he wasn't gaining weight properly off of breast milk. So, my grandma did tell me he can eat food. So, it was one of those things like, "Oh, okay." And my great grandma showing me how to feed a little baby solid foods. But then I had two more
- kids after that. So, it was- I got it.
- I feel like there's not one particular person that influences, it's just I will collect various information and then I just make up what's my best judgment. So, for example, I consulted with a lactation consultant, but I didn't do every last thing that she said. I used that coupled with maybe advice from my mom, coupled with advice from other moms who were moms who have young children the same age as mine, not just my mom's information from back in her time, but that was also still helpful. So just using all of that combined together wholistically to try to make my own decision using my own judgment.
- [No] Basically. Cause I'm the only one in the home that prepares the meals.

| a. If so, who are these individuals? | Moms2Be Parenting Program.  
| | His doctor was the one that first tell me to introduce him to veggies and stuff like that.  
| | My mom, because when I'm at work she watches her all day.  
| | My husband. |

| b. What advice have you received from these individuals? | I've received a lot of advice from them, things such as when you're introducing solids, introduce one, maybe one flavor, one item, one fruit, one food item for a couple of days, just to make sure there isn't an allergic reaction. Then if there is, at least you know where you can tie it back to.  
<p>| | Yeah, we definitely use more hands as opposed to utensils around here just because that's how he was raised. And we tend to usually eat like my daughter and I, we usually share a plate of food when we eat just because they're used to a sharing culture where everybody gets one plate, and everybody eats off of it. |</p>
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<th>3. Where do you get information on how to feed your baby or infant?</th>
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<td>• The only time somebody gave advice on that was when the pediatrician was like, &quot;By this time it should be, I don't know, baby foods, then solid foods, then try to branch her out more with nut items, or dairy items to see if she's allergic or lactose, or something like...&quot;</td>
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<td>• What to feed him, when to feed him.</td>
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<td>• Sometimes, I'll look online, but that's not really something I take too much, unless it's a website that I feel might be a legitimate website. But for the most part, again, dieticians, from Moms To Be or pediatrician. If I have a question, I'll ask pediatrician, if I needed to. I don't really like to take advice from other parents just because, what might work for them, might not work for me.</td>
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<td>• Usually from the pediatrician</td>
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<td>• I guess just life. Because I probably shouldn't feed them half the stuff I feed them all the time. But I do. But of course, the doctor's office in WIC gives you a base or a standard of what baby should be having and at what stages they should be having them at.</td>
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<td>• His doctor. And I use my own personal life, and my friend.</td>
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<td>• At the beginning, I guess you could say that I just ask my mom and my sister. Because my sister has three kids, and my mom obviously had children too.</td>
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<td>• I'm no longer on social media actively now, but for from maybe a few months ago before I stopped being on so actively, there's the Solid Starts Instagram page is really helpful. They give a lot of advice about how you should cut food, different ways to serve it. Not just physical things like that, but the mental aspect of the child eating.</td>
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| 4. Culture is defined as the set of beliefs and practices that a common group of people follow. Talk to me about how your culture influences the foods you feed your child? | • So, like I said, that sheet that I get from the doctor's office and then from the pediatrician herself, and then I do a lot of online research, like Pinterest and I watch YouTube videos, TikTok videos, oh wait a minute... TikTok videos. I'm in like different groups on Facebook. So, I try and just use a lot of online resources.  
• Online resources, the AAP, WHO, Allergy Institute, the CDC, the FDA.  

• No. Sometime, occasionally, we'll have ... because it is a very common cultural practice for us to eat together, like in one bowl, like sit down together, eat together, but that doesn't always happen. But sometimes I do try to implement that, too, because that is a culture thing. That's how I grew up. We would all eat together in the same bowl. If it's something that I know that they'll like, we'll typically just eat together, but if not, they usually just eat Western style, which is just everybody has their own plate, their own serving, and just sit at a table and eat.  
• So culturally, we don't eat pork or any pork products so that's definitely a huge factor when we're feeding our kiddos. Other than that, I don't think there's really anything culturally that influences the way that we feed the kids.  
• When I was growing up, I remember seeing my aunt feed my cousins and she was always saying how she had to add in rice cereal to their formula bottles, even when they were super young so that they could be full and sleep through the night. It's not something that I've ever personally participated in, but that's definitely been a thing, culturally in my family.  
• Based upon what we eat, we don't
eat... I don't know. We're not African. So, we don't eat a lot of African dishes. We just eat what we normally would eat. I don't know. Not saying that we don't try new foods. We definitely try new foods. But it's not a daily thing.

- My grandma showed me how to cook, so I just cook my meal just like I always do, but for him, it's kind of different because my meal will have spice, oil and stuff like that. But when I'm preparing his meal, it's always with unsalted butter and that's it, nothing else.

- I guess it's American culture, so the eggs, sausage, maybe a waffle or pancake, or piece of toast. I guess that is American. And then lunch, it's light too. But then dinner, it could be like when I was eating meat. It could be burger and fries homemade, or it can be meatloaf, mashed potatoes and vegetables. It could be fried fish, since I've been eating a lot of fish. I do fry it, because it do taste better. I guess just like an American diet, I guess. Oh, and then also of course holidays, like Easter, Thanksgiving, definitely Thanksgiving, and Christmas.

- I think in our culture, there's a lot of meats. There's a lot of vegetables, a lot of different kinds of spices and that kind of thing. And I think for me, he pretty much eats everything just because he was exposed to that early.

- Yeah, I would say I am... I don't know. I was raised kind of Southern, I guess you would say, like as far as foods. So, I tend to make a lot of things that are influenced by Southern and dishes and things like that.

- I don't think it does. I don't have a very strong culture. I mean, my mom is white, so I don't really have any real strong cultural influence from her
5. What signs, if any, do you use to determine or to know that your child is hungry?

- Now that they're a little bit older, if they keep asking for random snacks ... First of all, if it's been a while ... First, usually, let's say if it's been more than three hours since the last time they had a decent meal and I know that they're constantly asking, "I want candy. I want this," like random, like they just keep asking for snacks. Then sometimes, too, when they get a little bit cranky as well, those are usually good indications to me that okay, we're passing mealtime now.
- Well, at the age she's at right now, she'll pretty much have a freaking attack if she's hungry. She's yelling, screaming she wants food, so at this point she can tell me. Back at the six, seven-month mark, also crying.
- She'll go get something. But we have a little snack drawer for the kids where they can go into it.
- Right now, she climbs into the chair. But if we're not home, she gets super whiny, and that's when I know
- So, he would just eyeing what I'm eating. He would reach his hands out. That's just now. He could smack his lips when he was younger. It could be anything like making a sucking motion with his mouth. There's just a certain kind of cry that I know that's a hunger cry when he was younger like newborn. Other signs could be the timing because after a while of tracking, okay, I'm starting to learn certain patterns. Okay, every three hours or every this or that kind of thing.

| a. What signs do you use to tell you that your child is full? | They'll just stop eating or start playing with the food, throwing it and ... yeah. Now that he's old enough, he'll just say, "I'm full." He won't say I'm |

because I'm not white, I guess.
hungry, but he'll tell you, "I'm full."
- Oh, she'll just become very uninterested. So, she'll get up and walk away at this point. Back then, she'll just continually turn her head like, "No, I'm not interested anymore."
- She typically will take her plate and put it in the trash.
- He's going to spit the food out or the milk, he's going to spit it out. He's not going to open his mouth. He's going to close his mouth, no matter what you do, he's not going to open it.
- Now she'll just throw her plate on the ground. Before, she'll just stop eating it, if I were to spoon feed her. But now, she just throws it on the ground.
- Sometimes he also could just, he will wipe the table, if he has a tissue and he will put his cup into his bowl. And I know that he's done eating. Sometimes he'll be like all done and he will say that.

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<th>b. How often do you use these signs to know that your child is hungry or full?</th>
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<td>- [All mealtimes] Because I found that it's a good indicator as to when they're hungry and when they're full. It works for me.</td>
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<td>- [Every day] Well, because honestly, I mean, I serve meals at certain times but if she's telling me that she's hungry, I'm going to feed her. And I know that she's done when she's throwing her food all over the place.</td>
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<td>- [All the time] It's just because of the consistency of the signs.</td>
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<th>6. Do you think the media influences your feeding practices or how you feed your baby?</th>
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<td>- I feel like, if I didn't know better, it would. It definitely would. I can see because, sometimes with ... Let's say I'm on social media. Sometimes, the way the algorithms are set up, you watch one video of something, all of a sudden, you're getting a flood of the videos. I feel like, honestly speaking, if I weren't someone who knew better,</td>
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it would have a huge influence on it. But to answer your question, no, just because I feel like I know better. Yeah, just because I feel like I know better, it doesn't have an influence on me.

- [No] Because I don't really watch TV. I don't listen to the radio. If I watch something, it's on Netflix and there's no commercials there, so...
- I don't think so. But probably it does. I don't... I think the media is a subconscious thing. It does more than what we think it does. So, we could be like, no. But subconsciously, it influences us more than what we believe. So, I could say no, but subconsciously, probably...
- So, I would say yes, only at the beginning because at the beginning you get WIC, and everything was... Everything was Gerber, all the formula was Gerber. I would get the formula just for backup if I really, really needed it, but I never used it. But I noticed everything was Gerber.
- I think the media has allowed me to see a different way of bringing children than I was exposed to growing up, which is just focusing on this mental and emotional understanding of what it's like for children and their own age and development and their own understanding of things. It's exposed me to that perspective I didn't have prior to.
- [No] Cause I just think the Media puts... When it comes to food, I think the Media puts unrealistic expectations.