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Policy Brief

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Child Care Behaviours and Outcomes of Professional Mothers in Accra[i]

BACKGROUND

Maternal education and related income have been major contributing factors to improved child survival. However, recent research evidence indicates high levels of child malnutrition and poor health across all income or wealth quintiles (Gwatkin et al. 2000 cited by Oppong 2004) and educational categories (UNICEF 2006) in the developing world. According to the 2008 Ghana Demographic and Health Surveys (GDHS)[ii], on the average, 13.9% of all the children under five years of age from all backgrounds in Ghana was underweight. The percentages recorded for children of mothers in the highest income category (8.6 percent) and those with secondary or higher educational status (6.8 percent) was also high. Well over a tenth (14.4 percent) of children of mothers with the highest wealth status was stunted (too short for their age). This policy brief is on the adverse effects of maternal education and occupation associated with care behaviours among highly educated professional mothers in the city of Accra.

CONCEPTS

Child care has been identified as an important determinant of children's nutritional and health status and as a major factor that either enhances or negatively impacts nutrition and health of children (Garza 1995). Child care has been defined basically as behaviours such as breastfeeding, determining when a child is ready for supplementary feeding, weaning and choosing appropriate weaning food(s), among others (Berggren et al. 2006).

Differences in care giving behaviours account for differences in nutritional and health status of children and also for what is referred to as "positive deviants" among children (Zeitlin et al. 1990). These are children of households/mothers with little material resource for child care, for example food. However, the children have good health and nutritional status because of optimal care behaviours of their mothers.

Traditionally, mothers are primary care givers to children with support from extended family members and siblings. Such traditional practices of child care, just like many other traditional ways of living, have however been threatened mainly by participation of mothers in the paid labour force

(Folbre 2004, Oppong 2012, Baatar 2012, Badasu 2012). The drive to achieve gender equality in employment opportunities has adversely affected child care. While higher female labour force participation has been lauded by all progressive societies, it has come at a cost to child care; and this demands creative public policy instruments to address it. But not all societies have adequately given attention to it.

METHODS

The study was part of a research on care practices and behaviours associated with the nutritional and health status of children of Ewe migrants in Accra for a doctoral thesis that was completed in 2009. It was carried on three broad clusters of residential areas: low, middle and high income residential areas of the city of Accra. The results of the component of the study on high income residential areas where professional mothers with tertiary education were selected are discussed in this paper. They include Legon, East Legon, Dzorwulu, Korle Bu (residential area of nurses and medical doctors). A total of
50 children were selected in these high income residential areas for the study. Both quantitative and qualitative research approaches were used for the study. The results discussed in this policy brief are from the descriptive statistical analysis of the data.

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE CHILDREN AND THEIR MOTHERS

The 50 children were all under five years of age. Thirty percent (15) of them were infants, under one year while 70% (35) were aged one to four years. They were made up of 23 boys and 22 girls.

The mothers were aged between 26 and 47 years. The main occupations of the mothers included the following: health workers (medical practitioners, pharmacists, radiologists, and nurses), tertiary level teachers, finance and data management specialists, administrators, marketing officers, librarians and catering officers. Apart from four of the mothers who were single parents, all were married and living with their husbands, the fathers of their children. Co-residence of the children and their parents was expected to provide opportunity for the fathers to provide some care for their children. But, like the mothers, the fathers were professionals who hardly had time to help with child care activities.

WORK AND CHILD CARE BEHAVIOURS

Location of work place was found to be an important factor associated with the ability of the mothers to combine maternal activities with work. This was critical as the mothers are entitled to only three-month maternity leave. A little over a quarter of the mothers worked from home so they did not face the same constraints on child care s a result of occupational demands as the others (Table 1). Among those who worked outside home, the ease of travel to and from work was very crucial with respect to breastfeeding young infants aged below six months. Over half of all the women working outside the home found it difficult to visit home during working hours to breastfeed or provide them with some care. Long hours of travel to and from work prevented them from even enjoying fully the half-day work benefit stipulated by the government for lactating mothers with infants aged below twelve months.

Table 1 Location of Workplace of Mothers and/or Caregivers, Percentage

Location of Workplace	Percent
Home	27.1
Outside home but nearby	-
Outside home, far away and difficult to drop by during working hours	52.1
Outside home, far away, but easy to drop by during working hours	6.3
Temporarily unemployed or on maternity leave	10.3
Unemployed	2.1
Other (Variable)	2.1
Total	**100.0**

N= 50

Source: Field Work 2004

Mothers who could have continued exclusive breastfeeding after resumption of work from a three-month maternity leave were unable to do so. They leave home early, spend long periods daily in vehicular traffic to and from work. The typical working day and work schedule of the mothers differed considerably. Health workers, for example, had long schedules; some worked 14 hours regularly and others were often away for 48 hours or more on duty. Teachers in tertiary institutions had more flexible hours than all others. On the other hand, they also indicated that their workload prevented them from having what they considered to be adequate time for child care.

Delegated Maternal care

As a result of demanding occupations, the mothers delegated some of their maternal care activities to house helps and/or their own mothers and other relatives. Some depended on day care centers. In all, 15 of the mothers had house helps on a permanent basis. Two of them had two house helps, including medical practitioner who had three children aged four years two years and two months.

All, the house helps, except three, were teenagers and young adults aged between 14 and 23 years who were inexperienced with child care.

Exclusive Breastfeeding Practices

The duration of exclusive breastfeeding among the women with secondary or higher education is shown on Table 2; and is compared with those with lower levels of education in the total study population. As can be observed from Table 2, the lowest rate of exclusive breastfeeding was found among mothers with university education who are all among the professional mothers.

Table 2 Duration of Exclusive Breastfeeding by Mother's level of Education, Percent

Level of Education	< 6months	6 months	Total
None	42.9	57.1	**100.0**
Primary	57.1	42.9	**100.0**
JSS/Middle	53.2	46.8	**100.0**
SSS	47.8	52.2	**100.0**
Vocational/Technical	37.5	62.5	**100.0**
Polytechnic/Teacher Training	61.1	38.9	**100.0**
University	67.9	32.1	**100.0**
Total	**55.2**	**44.8**	**100.0**

N= 172

Source: Field Work 2004

HEALTH AND NUTRITIONAL OUTCOMES

Pregnancy Outcomes

In-depth interviews with the professional mothers were done to find out what the health and nutritional outcomes of the maternal and occupational strains were among them. Mothers who delivered their babies preterm blamed this on their demanding jobs. The lowest birth weight of a 1 kilogramme was recorded by a mother with university education who also attributed an earlier pregnancy loss to stress from work. She cited long period of time spent in traffic daily to and from work as a major source of stress..

Nutritional and Health Status

The nutritional status (from weight and height measurements taken of the children) and health status (prevalence of malaria and diarrhoea) of the children was not as good as expected, especially among the children who attend day care. Their mothers noted that their children had malaria and diarrhoea more frequently than before they started attending day care facilities. These are the commonest causes of ill health among children in Ghana. The mothers attributed the frequent malarial attack and diarrhoea experienced by their children to several factors, mostly eating habits of the children and sanitation at the day care centres.

Many mothers noted that as the children are rushed to the day care facility in the mornings they fail to eat breakfast well. Moreover, their eating habits are such that they need a lot of supervision when they take other meals at school. This, is not adequately provided since the child-care giver ratio is quite high. Overtime, they become undernourished and have low immunity.

Diarrhoea is attributed to some unhygienic practices among the children and care givers at the day care facilities and these were observed in two day care facilities that were visited. For example, hand washing is not done effectively due to lack of sinks. In some day care facilities, the children washing in bowls filled with water one after another. The number of sinks were inadequate, the children crowded around the sinks.

CONCLUSION AND POLICY RECOMMENDATIONS

Time constraints to child care among the professional women arising from working outside home; inadequate supply of social infrastructure, particularly transport network; long distances that have to be made to work affected the child care behaviours of the professional mothers negatively. The health and nutritional status of the children were affected by these constrains despite the financial resources available to the mothers for providing the food and other needs of the children. Short maternity leave and delegated maternal activities also negatively affected the provision of care to the children.

The following policies are recommended for addressing constrains on child care provision among the professional mothers in Accra and elsewhere in Ghana where similar experiences may exist:

- Increase maternity leave up to at least six months.
- Institute flexible schedules for working mothers that can reduce maternal and occupational role conflicts, for example, allowing lactating mothers to avoid travelling to and from work during peak hours until their infants are 12 months old.
- Providing day care facilities near work places to ensure that lactating working mothers can breastfeed their children when on break.

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[1] The results of the last GDHS carried out in 2014 are yet to be published.

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