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Beliefs and Practices Regarding Solid Food Introduction among Latino parents in Northern California

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Abstract

Latino children are more likely to be obese than non-Hispanic white children, and feeding patterns that begin in infancy may contribute to this disparity. The objective of this study was to elucidate beliefs and practices related to the introduction of solids and solid food feeding in the first year of life among low-income Latino parents residing in Northern California. We conducted 26 semi-structured interviews that explored the timing of introduction of solids, selection of foods to serve to infants, feeding strategies, sources of information on solid food feeding and concerns about infant weight. We found that most parents relied on traditional practices in selecting first foods for infants and had a strong preference for homemade food, which was often chicken soup with vegetables. Parents generally described responsive feeding practices; however a minority used pressuring practices to encourage infants to eat more. Very few parents practiced repeated gentle introduction of unfamiliar food to increase acceptance. High calorie low nutrient foods were typically introduced at around 12 months of age and parents struggled to limit such foods once children were old enough to ask for them. Parents were concerned about the possibility of infants becoming overweight and considered health care providers to be an important source of information on infant weight status. The results of this study can be used to inform the development of interventions to prevent obesity in Latino children with similar demographics to our study population.

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Keywords

Latinos; infants; complementary feeding; feeding practices; obesity prevention

Introduction

Latino children are significantly more likely to be obese than non-Hispanic white children,[1] a disparity that emerges in infancy.[2] Among Latinos, children born to low-income families are at particularly high risk for obesity. For example, in a cohort study of low-income Mexican American mother-infant dyads living in Arizona, 36% of infants were found to have a weight-for-length ≥95th percentile by age 12 months per World Health Organization (WHO) growth standards.[3] Rapid weight gain during infancy is an important risk factor for childhood obesity, [4,5] and eating patterns that are associated with obesity often begin in infancy.[6] For example, the Feeding Infants and Toddlers study (FITS) examined dietary intake among infants and toddlers in the United States and found that 43% of 9-11 month olds had consumed a dessert or sweetened beverage on the day prior. Consequently, the first year of life may offer a window of opportunity for the prevention of childhood obesity.

Research on obesity prevention has only begun to focus on the infant period. Nonetheless, several infant feeding behaviors have emerged as either possible or likely contributors to childhood obesity. Infant feeding practices that may be protective against obesity include breastfeeding, [7] *responsive feeding practices* (meaning that parents identify and attend to the infants' signals of hunger and satiety) rather than *pressuring feeding practices*, [8] and avoiding high-calorie low-nutrient food and beverage choices.[9-11] In addition, the specific practice of gentle repeated exposure to previously rejected foods has been shown to increase infant acceptance of healthy foods such as vegetables.[12]

While the study of obesity prevention in infancy is still an emerging science, there are guidelines on infant feeding based on the best available evidence to date. For example, the American Academy of Pediatrics (AAP) *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents* advises exclusive breastfeeding for about the first six months of life and recommends that infants be introduced to solid foods when the infant is developmentally ready, which is typically between 4 to 6 months of age.[13] From 6 to 12 months of age, *Bright Futures* advises that caregivers introduce infants to a wide variety of nutritious foods including fruits, vegetables, whole grains, fish, poultry and meat and avoid introduction of high calorie low nutrient foods and beverages (chips, cookies, ice cream, sweetened drinks, etc.). *Bright Futures* also recommends that parents be counseled on responsive feeding practices and the practice of continuing to introduce healthy foods that were previously rejected. The Robert Wood Johnson Foundation Healthy Eating Research program recently convened an expert panel to develop feeding guidelines for children ages 0 to 24 months.[14] The panel report entitled *Feeding Guidelines for Infants and Toddlers: A Responsive Parenting Approach* also advises exclusive breastfeeding for the first 4-6 months of life followed by the introduction of solids and specifically emphasizes the importance of responsive feeding practices, repeated gentle exposure to healthy foods (such as vegetables)

to increase their acceptance, and avoiding foods and beverages rich in added sugars and sodium.

Two United States based intervention trials that promoted parental use of responsive feeding practices and the specific behavior of gentle repeated introduction of healthy foods resulted in lower weight gain in infancy.[8,15] However, these studies largely enrolled white mothers with a college education. Thus, the results may not apply to low-income Latino families. In order to develop effective interventions to promote optimal feeding practices among low-income Latino parents, it is important to understand parental beliefs and practices regarding infant feeding as well as parental supports and resources on this topic. Previous qualitative research has explored Latino mothers' beliefs regarding breastfeeding,[16-19] and one qualitative study with Latino parents in Massachusetts touched on beliefs and practices related to the introduction of solids among numerous other topics.[18] In addition, a study conducted in Northern California examined Latina mothers' beliefs regarding infant feeding through age 6 months, addressing both milk and solid food feeding practices.[20] There remains, however, a paucity of research offering an in-depth focus on Latino parents' beliefs and practices regarding the introduction of solids and solid food feeding throughout the first year of life.[21] The central objective of this study was to elucidate beliefs and practices related to the introduction of solids and solid food feeding in the first year of life among low-income Latino parents residing in Northern California. We used semi-structured interviews to address beliefs and practices regarding the timing of introduction of solids, selection of foods to feed to infants, use of responsive versus pressuring feeding practices, concerns about infant weight and growth, and sources of information on these topics.

Methods

Recruitment and Eligibility

Parents were eligible to participate if they identified as Latino and had a child between the ages of 4 and 24 months of age. Participants were recruited for the study in four community health centers in three different counties in the San Francisco Bay Area. All four recruitment sites were clinics that serve a low-income, publicly insured population that is primarily of Mexican and Central-American origin. Parents were informed about the study by medical assistants or health care providers during clinic visits and were referred to study staff if they were interested. They were then screened for eligibility and provided informed consent. We continued recruiting new participants until thematic saturation was reached (no new themes emerging).

Study procedures

Interviews were conducted in a private room in the clinic just after the clinic visit concluded and ranged in duration from 25 to 50 minutes. The interviews were performed by a bilingual researcher with previous qualitative experience in the language of the participants' choice (English or Spanish). Interviews were audiotaped and subsequently transcribed in original language for analysis. Parents were given a supermarket gift card as compensation for the time spent on the interview. The interview guide was developed by the research team which included two general pediatricians and a medical anthropologist with expertise in qualitative

research with Latino parents. The guide included a series of open-ended questions about beliefs and practices related to solid food feeding of infants as well as specific follow-up probes. Parents were asked to talk about when they first fed their infants solids, what foods they offered initially and then subsequently in the first year of life, what foods they considered to be the healthiest and what foods infants should avoid, how they determined how much to feed infants, concerns about their infants growth or weight, when and why they introduced high-calorie low nutrient foods and their sources of information about infant feeding. In reviewing the first five interviews, we noted that infants were being introduced to high calorie low nutrient foods such as dessert and fried foods around one year of age. While our planned focus was on infant feeding in the first year of life, we thought that the introduction of high calorie low nutrient foods was an area worthy of detailed exploration. Thus, we added questions to the interview guide that specifically asked about the timing and circumstances around the introduction of common high calorie low nutrient foods including ice cream, cookies, candy, cake, *pan dulce* (a sweet Mexican pastry), chips, and French fries. For parents who had not yet introduced these foods to their child, we asked when they planned to first introduce them. Parents were asked to focus their responses on their youngest child, but some also discussed experiences with older children. In addition, while the interviews focused largely on feeding during the first year of life, we found that the introduction of high calorie low nutrient foods spanned the infant and toddler period, and thus discussion of this particular topic explored toddler feeding practices as well. Parents also completed a brief demographic questionnaire. The interviews were completed between October 2013 and May 2014. Ethics approval for this study was granted by the Committee on Human Research of the University of California, San Francisco.

Analysis

Descriptive statistics were used to summarize the demographic data. The manuscripts were analyzed using a general inductive approach.[22] NVivo 10 software (NVivo qualitative data analysis Software; QSR International Pty Ltd. Version 10, 2012) was used to assist with coding. Two bilingual researchers (AB and KH) read each manuscript in its original language to identify emergent themes relevant to the study objectives along with illustrative quotes. Dr. Beck is a general pediatrician who conducts mixed methods research on obesity prevention in low-income Latino children. Her clinical work is divided between primary care pediatrics and treatment of pediatric obesity. Dr. Hoeft has a background in cultural anthropology and public health and has conducted multiple qualitative research studies with Latino parents of children under five exploring dental health and feeding practices. The researchers met regularly through this process to compare the themes and quotes. Differences were resolved through discussion and consensus. As new themes emerged, previous transcripts were reread and recoded. Three out of four authors (AB, KH, and JB) then met to discuss and revise the themes and representative quotes. The fourth author (JT) then reviewed the themes and representative quotes. For data reporting for this manuscript, we selected the most representative quotes for each theme and translated Spanish quotes to English.

Results

We conducted 26 interviews: 23 with mothers, 1 with a father, and 2 in which both mother and father were present for a total of 28 participants. Interviews were conducted in participants' primary language: 23 in Spanish and three in English. Three parents were born in the United States and all others were born in Latin America. We examined the coded transcripts to determine whether there were substantial differences in the themes by interviewee type (US born vs. immigrant) and interview language (English vs. Spanish). No major differences were observed, so all transcripts were retained for analysis. Table 1 describes the demographic characteristics of the participants.

In nearly all interviews (22 out of 26), parents reported introducing solid food to their infants between 4 to 6 months of age. There were four exceptions; two parents reported introducing solids at 3 months and two introduced solids at 7 months. Parents cited advice from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and from health care providers as the main reason for starting solids in the 4 to 6 month time frame, although a few parents also mentioned that they introduced solids when they perceived that their infant was interested in the food that other family members were eating. We identified a total of 11 themes in the following four categories: 1) *First foods* 2) *Infant feeding strategies* 3) *Introduction of high calorie low nutrient foods* and 4) *Concerns about weight*. The themes in each category are summarized in Table 2 with representative quotes illustrating each theme.

First foods

The majority of parents (19 interviews) reported serving their infants *traditional first foods* which was most often a homemade soup such as chicken or beef soup. Soups were prepared by cooking chicken or beef and vegetables in water. Parents would then puree broth from the homemade soups with soft cooked vegetables such as carrots, potatoes, and squash and serve the pureed mixture to infants. Some parents thought that infants could be served meat, rather than just broth, from a young age and would add bits of meat to be pureed along with the broth and vegetables, but others thought that young infants could not digest meat (even in a pureed form) and thus waited until 9 or even 12 months before introducing meat. Another common traditional food for infants was a broth made from beans. Parents would often start by just serving the broth and then later add actual pureed beans to the mixture. As with meat, some parents believed that young infants could be served pureed beans and lentils and others considered these foods hard to digest and thought that they should be introduced closer to one year of age.

A smaller subset of parents reported following *recommendations from WIC* in deciding what foods to introduce to infants. These parents typically offered their infants baby cereal as a first food followed by commercially prepared pureed fruits and vegetables provided to them by WIC. In addition, several parents noted the importance of serving infants *vegetables as a foundation for healthy eating*. Some were worried that infants would reject vegetables if they were served fruits before vegetables or that they would not eat vegetables later in life if they did not begin to eat them in infancy. Many parents considered vegetables to be the healthiest foods for infants. Finally, the majority of parents expressed a *preference for*

homemade baby food rather than store bought baby food because it was freshly prepared and free of preservatives or other "chemicals" which parents considered to be unhealthy. Even parents who reported serving their infants commercially prepared baby food considered homemade food to be the healthiest for infants. Several parents reserved prepared baby food for when they were out of the house, serving homemade food at other times. In addition, several parents reported that they did not use all of the baby food that WIC provided for them because of a preference for homemade food.

Feeding Strategies

The majority of parents (17 interviews) attended to their infants hunger and satiety cues in a way that would be classified as *responsive feeding practices*. Parents described identifying that infants were hungry from a variety of signals including mouth movements, appearing excited when seeing food, reaching for and pointing to food, or crawling towards their high chair or the refrigerator. Parents described knowing when infants were no longer hungry because the infant would spit food out, refuse to open their mouth, or push away spoons and plates. Several parents also mentioned that they were aware that infants have small stomachs and typically eat only a few tablespoons of food at a time, explaining that they had learned this information from WIC.

A minority of parents, however (9 interviews), reported using *pressuring feeding practices* to push their infants to eat when they were not showing interest in food. Some felt that their infants had to eat a certain amount of food in a day or consume a certain variety of different foods for the parent to feel that the infant had eaten well. A few parents noted that other family members did not agree with the coercive feeding practices and could acknowledge that these family members may have a valid point. Nonetheless, they continued to employ the pressuring practices due to anxieties about their child not being well fed.

Of participants who reported that their infant had rejected a particular food the majority of *parents did not continue to reintroduce foods that infants have rejected* (7 out of the 10 interviews in which parents reported food refusal). Rather, most noted that if infants refused a particular food more than once or twice, they would consider that the infant did not like the food and would no longer continue to offer it. There were three parents who did mention continuing to offer previously rejected foods and all noted that they had learned about this practice from WIC or a health care provider. Other parents, however, believed that their role was to determine which foods their infant liked and did not see themselves as having agency in shaping their infants' dietary preferences.

Introduction of high calorie low nutrient foods ("junk food")

Study participants reported that they considered most *high calorie low nutrient foods* such as cookies, cake, ice cream, chocolate, chips, and French fries to be *inappropriate for infants but appropriate for toddlers*, noting that they typically began introducing these foods at around one year of age, (although a few parents reported feeding ice cream and other sweets to infants as young as 8 months). Parents were concerned that if they introduced unhealthy foods at too young of an age, children may become accustomed to these foods and continue to crave them, preferring them over healthier foods. However, by 12 months, most parents

thought that infants were ready to eat the same foods as other family members including "junk foods." Many parents noted that their child had tried different unhealthy foods for the first time when they saw an older sibling or other family member consuming them and indicated that they wanted to try some. Parents did have concerns about the health effects of many junk foods, but the majority found it *challenging to deny children junk food once they were old enough to ask for it*. Parents also did not consider it possible to restrict children's junk food intake when children were being cared for by friends or other relatives, expressing that even if they asked other caregivers not to give their child junk food, their family members were unlikely to follow such a request. Participants who considered that it was possible to limit their child's intake of junk food described strategies that involved the entire household, namely limiting the frequency with which junk food was purchased and purchasing small quantities.

Concerns about weight

When asked what they thought about their infant's weight, most parents thought that their infants were at a healthy weight, but a number of parents were *concerned that their infants could gain too much weight* if parents did not monitor their diet carefully. For example, several parents (9 interviews) specifically mentioned that introduction of junk food in the first year of life could contribute to both childhood obesity and/or diabetes. In two interviews parents noted that allowing their infant to eat whenever they wanted rather than on a schedule could result in excess weight gain. For some parents concerns about weight stemmed from having an older child in the family who was overweight, while others noted hearing about the increase in childhood obesity from the news or from health care providers.

Nearly all parents *trusted health care providers' assessment of their child's weight* and many commented that they were confident that their child was at a healthy weight because they were told so by their child's primary care practitioner. A few noted that they had been concerned that their child was underweight but were reassured when a physician had explained to them that their child's height and weight were in the normal range.

Discussion

Our study revealed a number of parental beliefs and practices regarding the introduction of solids that have direct relevance to anticipatory guidance provided by health care providers and population-based programs serving Latino families with similar demographics to the study population. For example, many parents in our study served infants pureed homemade soups, prepared with vegetables, beans, beef and/or chicken as first foods. The Feeding Infants and Toddlers (FITS) Study, a national survey of infant and toddler dietary practices, found that Hispanic infants were more likely to consume soups compared to non-Hispanic white infants, suggesting that this practice may be widespread among Latino families.[23] Serving infants soups made with meat and vegetables exposes infants to a variety of vegetables from an early age. Furthermore, when pieces of actual meat are included in the purees, they constitute a source of iron which is a critical nutrient for breastfed infants.[13] Clinicians and public health practitioners should therefore encourage and support this practice. However, some parents in our study avoided actual meat and beans/lentils (even in

pureed form) until infants were closer to one year of age, preferring to just provide broth with soft cooked vegetables. Thus, practitioners should specifically encourage parents who prepare pureed soups for infants to include meat and legumes as a source of dietary iron and reassure parents that infants can digest pureed meats and beans.

Some parents reported relying on advice from WIC in determining which foods to introduce to infants. This finding is consistent with prior studies which have also reported that Latino parents consider WIC a trusted source of information on child feeding.[18,24] It is therefore important to carefully consider the role that WIC plays with regards to infant feeding practices in this population. Many parents decided to introduce solids in an appropriate window (4 to 6 months) based on advice from WIC that is consistent with current infant feeding guidelines. A concern, however, is that some parents may be following advice from WIC about appropriate content of solids at the expense of traditional practices. While infant cereal and commercially prepared baby food in jars offered by WIC are safe and nutritious, there are also benefits to introducing infants to their family's traditional diet from an early age and supporting parents' belief that homemade food is nutritious. Other studies with Latino parents of young children have also revealed a cultural preference for homemade food. A qualitative study with Mexican origin mothers of preschoolers found that mothers had a strong preference for serving their children fresh, natural food rather than packaged or store bought food.[25] In addition, two studies conducted with Latino parents about children's beverage intake both found that homemade beverages were viewed as healthy because they contained “natural” ingredients while store-bought beverages were viewed as unhealthy because they contained “chemicals.” [24,26] One policy strategy that could support Latino parents in maintaining healthy traditional infant feeding practices would be to allow parents to choose whether they wish to receive commercially prepared baby food from the WIC program or prefer instead to receive additional vegetables, fruits, and legumes which could be used to prepare food at home. In addition, education provided in WIC could reinforce the benefits of homemade foods for infants and young children.

Our finding that most parents reported responsive feeding practices is encouraging and consistent with the findings of Woo Baidal et al. who conducted focus groups with Hispanic origin women in Massachusetts and found that mothers believed that they were attuned to their infants hunger and satiety cues.[18] However, a minority of parents in our study did report pressuring infants to eat suggesting that education on the benefits of responsive feeding should be included in childhood obesity prevention efforts for Latino parents of infants. In addition, while parents in our study did believe that it was important to serve infants vegetables, they were mostly not aware that they could shape infants' taste preferences towards healthy foods through repeated introduction. This is consistent with a study of toddler feeding practices among Mexican American mother which also found that mothers did not engage in the practice of repeated introduction of unfamiliar foods and rather sought to determine which foods their child liked.[27] Similarly, a study of Mexican American mothers' decision making regarding which foods to offer children ages 3-4 found that mothers considered child preference to be an important factor in determining which foods they prepared and offered.[28] Given that parents in our study considered vegetables to be very important for infant health, interventions which educate parents on the strategy of

gentle reintroduction to increase infant vegetable intake could have a significant impact in this population.

Our results regarding the introduction of high calorie low nutrient foods suggest that the 12 to 15 month age range may be a critical period for nutrition education among Latino immigrant parents, as this was the time period in which many children began to eat foods with low nutritional value. Woo Baidal et al. also found that some Latino parents believed that children should be introduced to sugary foods around age one (or earlier) with the reasoning that infants needed to be exposed to different foods to develop their ability to taste different flavors. Parents in our study did not mention infant taste development as a reason to introduce high calorie low nutrient foods, but did appear to make a distinction between what was appropriate for infants versus toddlers; parents also reported significant struggles with limiting unhealthy foods once they were introduced. These struggles originated both from parental discomfort with denying children foods that they were requesting as well as feeling that it was not possible to place limits on foods that family members offered to children. Prior studies with Latino parents have also revealed tensions between mothers who wish to limit intake of unhealthy food and beverages and other family members who believe that children should be allowed to consume high calorie low nutrient food and beverages.[18,24] This is a particularly important point given that both indulgent feeding practices and household purchases of sweetened beverages and other foods containing sugar have been associated with weight gain in Latino toddlers.[29] Our results as well as those of prior studies suggest that Latino parents may benefit from support in moderating children's consumption of high calorie low nutrient foods including strategies for addressing this issue with family members and that targeting this education as infants approach age one may be most effective.

With regards to concerns about weight, our results are consistent with those of Woo Baidal et al. who found that Latino parents believed that infants could gain too much weight and disagreed with the notion that a chubby baby is a healthy baby.[18] However, Woo Baidal et al. also found that parents did not consider excess weight gain in infancy to be a problem as they expected that infants would grow out of being overweight. Parents in our study, however, did worry that unhealthy eating patterns in infancy could contribute to both obesity and diabetes. In contrast, a study of Latina mothers' beliefs about infant growth in a WIC population residing in Arizona by Valencia et al. found more concern about underweight than overweight.[30] While a study of Mexican American mothers of toddlers in Northern California found mixed views on the desirability of toddlers being chubby.[27] Differences among studies may reflect the cultural diversity of the populations studied, evolution in beliefs over time, and the impact of local educational efforts. We also found that parents in our study trusted health care provider assessments' of infant weight gain and expected such assessments at each visit. This was a finding of both Woo Baidal et al. and Valencia et al. suggesting that there is a strong basis for encouraging health care providers to discuss infants' weight status with Latino parents at each well child visit.

There are a number of important limitations to our study. First, nearly all participants were Spanish speaking immigrants from Mexico and Central America. Thus, our results are not generalizable to more acculturated Latino families or to those from other areas of Latin

America. In addition, as we recruited participants in a health care setting it is possible that certain results are not generalizable to families less engaged in the healthcare or social service system or were driven by social desirability bias (such as comments regarding parents' perception of information provided by health care providers). Finally, while we did reach thematic saturation, our sample size was small, and our results may not fully represent the infant feeding practices of Latino parents from Mexico and Central America.

Despite these limitations, our results have a number of implications for primary care and public health practitioners serving Latino families with demographics that mirror our study population. Interventions can be strengthened by reinforcing healthy traditional practices (such as serving infants homemade soups). Policy makers should be aware of the influence of the WIC program on infant feeding decisions in low-income Latino families and consider flexible approaches that support healthy traditional infant feeding practices, such as allowing parents to substitute additional fresh foods in lieu of jarred baby foods. Educational interventions on infant feeding for Latino parents should reinforce the benefits of responsive feeding, address potential negative effects of pressuring feeding, and educate parents on the technique of repeated gentle introduction of unfamiliar foods. Furthermore, in designing obesity prevention efforts for Latino parents, it may be important to consider the transition to toddlerhood as a high risk time for the introduction of unhealthy food and provide parents with strategies for limiting high calorie low nutrient foods. Finally, health care practitioners should feel comfortable communicating concerns about infant weight to Latino parents and should provide an assessment of infant weight at every visit.

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Table 1

Demographic characteristic of Latino parents in Northern California participating in a qualitative study on infant feeding practices n=28

Variable	Mean	n (%)
Age (years)	31.9	
Years in US	13.6	
Number of children<18 years in household	2.3	
Age index child (months)	11.6	
Family status		
Dual parent household		24 (92)
Single parent household		2 (8)
Mother employed outside the home		6 (23)
Parental Country of origin		
Mexico		10 (35)
Guatemala		8 (27)
Honduras		5 (19)
USA		3 (12)
El Salvador		1 (4)
Peru		1 (4)
Highest level of education		
≤6th grade		10 (36)
Some high school		3 (11)
High school graduate		15 (54)
Child health insurance		
Medicaid		26 (100)

Table 2

Themes with illustrative quotes

Theme	Illustrative Quotes
Category 1: First foods	
Traditional practices: soups as ideal first food	“My mother always taught me that soups are the best food for children, they're healthy and my preference is to give my children soups, either chicken soup or beef soup.” “I think that the best food for [babies] is soup that you make with vegetables.”
Recommendations from WIC: baby cereal and pureed fruits and vegetables	“They told me in WIC that I had to start with baby cereal. I started with just twice a day and now it's three times a day as he's 7 months now. The only other thing that I give him is pureed fruits and vegetables.” “She breastfed until 6 months and from there we started with cereal and Gerber…That's what I learned in WIC, that those foods were the best for her.”
Vegetables in infancy as foundation for healthy eating	“Well [I give him vegetables] because I want him to get more used to vegetables, because there are other children that don't like vegetables.” “Well the pediatrician and my mother always told me when you start to feed your baby,' always start with vegetables, like squash…because if you start with fruit, they will taste the sweetness and then won't want anything that isn't sweet.”
Preference for homemade baby food	“The best foods are what you make at home like soups, broth, and vegetables. My mother used to make chicken soup and mashed up the potatoes with the carrots and all that… I think that it's better than Gerber because you're cooking it. It's fresh.” “I think that it's better to cook for [babies] at home than to give them food from cans and jars with chemicals that have been sitting around for who knows how long.”
Category 2: Infant feeding strategies	
Responsive practices	“Sometimes if she eats, one, two, three or four spoonful's, I don't keep giving her more because she doesn't want any more. She spits out the food or doesn't open her mouth anymore.” “She usually knows when she's done. So I don't try to overfeed her.”
Pressuring practices	“There was a period that she ate well and then I don't know… There are times that she doesn't want to eat very much and I have to encourage her and sometimes force her because she has to eat something.” “My daughter ate a lot…and he's different. I have to chase after him while he is playing to give him the food…Sometimes I get very stressed because I worry that he is not eating well.”
Parents do not continue to reintroduce foods that infants have rejected	“I gave him broccoli and he didn't like it…I have only given it to him twice. I haven't tried much.” “There are things that [when he eats them] he makes a face. Then I try to give that food one more time and if he doesn't accept it I don't try again.”
Category 3: Introduction of high calorie low nutrient foods	
Parents consider junk foods inappropriate for infants but appropriate for toddlers	“Around a year is a good age [to introduce chocolate] because from a very young age, it wouldn't be good to get them in the bad habit of sweets.” “I think that around a year is when they can start eating sweets, but in moderation.”
Parents find it challenging to deny children junk foods once they are old enough to ask for them	“Well now he asks [for ice cream], he knows… He tells me that he wants ice cream… Because where I live, the ice cream vendors with the carts pass by. And every time they pass by he is outside and hears it and knows. And then he says ‘ice cream, ice cream,’ so I have to buy it for him.” “Since his brother eats well and eats his vegetables… we wanted to reward him with an ice cream. But it's impossible to prevent the [younger child] from seeing it… He would start to cry and make a big scene [if we don't give him ice cream].”
Category 4: Concerns about weight	
Concern that infants could gain too much weight	“So I try to let her eat a few puffs, and then I give her her bottle, like, 4 ounces of formula because somebody told me, ‘Don’t give her any more rice cereal unless you want her to get thicker and chunkier. It has no nutritional value in it, so you don't have to give it to her anymore,' so I stopped giving her the rice cereal. And now, I'm gonna try to wean her into the oatmeal cereal because they said it's better for her.” “Sometimes I have to hide the food…because he likes to eat a lot…and it makes me scared that he might [gain too much weight].” “I feed her at the same time as [the rest of] the family…Because if I feed her all the time, she will get used to [eating all the time] and could get fatter.”
Parents trust physicians' assessment of child's weight	“I think that she's very thin, but the doctor told me that she's okay…that everything's okay, normal for height and weight…I'm relaxed about it because if [the doctor] tells me that it's because they know, so I have calmed down.” “No, I have hardly [worried about her weight] because every time I bring her here they tell me her weight is okay. That's what I always ask and they always tell me her weight is okay for her age.”