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Feeding Practices in Cusco, Peru

Engaged Learning Final Report

April 2014

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Mentor: Dr. Carolyn Smith-Morris

Malnutrition

This summer I had the opportunity to volunteer in Cusco, Peru as part of an Engaged Learning Project. While in Peru, I worked at a center for malnourished children for three weeks starting July 1 to July 20th. In the process of my volunteer work, I observed and learned many things about children with nutritional concerns. I also observed the feeding practices used to combat childhood malnutrition.

“The term malnutrition essentially means “bad nourishment” “(Aguiar et al. 3). Malnutrition is a complex phenomenon that stems from various underlying determinants, including a lack of optimal feeding practices for infants and young children. It is also the largest risk factor in the world for disability and premature mortality among young children, especially in developing countries (Wondafrash et al 1). Peru is one of these developing countries that like many other countries such as South Asia and Sub-Saharan Africa, grapples with the problem of malnutrition. It is a common belief that poverty and a lack of available food and nutrients are the sole reason for malnutrition, however, “ equally important are caring practices, such as infant and young children feeding, and the family resources needed to provide that care”(Engle).

Feeding styles range amongst different countries. Some countries have one identifiable style of feeding, while others might have two or all three represented in their culture. Feeding practices consist of the interaction between the caretaker and the child, and regularly involve a distribution of power. “ Cultures range from those that sanction maximum control by caretakers to those that allow almost complete autonomy for infants.

The degree of control exerted varies intraculturally as well, according to characteristics of caretaker and/or characteristics of the child” (Dettwyler 697).

According to Engle three feeding styles have been identified: controlling, laissez – faire, and responsive. In a controlling style of feeding the caretaker has complete control of feeding time, and regulates when and how much the child eats. In a lasissez-faire style of feeding the balance of power is in favor of the child, with the child choosing when and what they eat with little encouragement from the caretaker. “ Finally, a caregiver with a responsive or interactive feeding style responds to the child’s hunger cues in reasonable time, feeds using strategies of encouragement and praise, feeds in an consistent manner, and feeds more actively when the child is recovering from an illness” (Engel 11).

During my internship one of my main responsibilities was assisting children during their feedings. I witnessed two of the three stages of feeding practices previously mentioned, however, the one that fully grabbed my attention was the “controlling” form of force-feeding. This feeding practice was very new to me and provoked me to research and learn about the reasons for the occurrence of such feeding practices.

General Information

The center that I worked at was called Madre Teresa De Calcuta and was a part of the government’s program, Centro De Vigilancia Nutritional. “ Peru’s government supports a multitude of programs that address the challenges of malnutrition in the country”(Aguier et al) one of these being the Peruvian Integral Nutritional Program. Not only are these programs focused on simply increasing the amount of food given to children but as stated by Messer ,“ Recent advances in nutritional policy have argued for a broader concept of nutritional security, one that incorporates both food quantity and quality and of nutrition

as “ food, health, and care” (Intra-household 1675).The goals of Madre Teresa fall in line with the goals of the Peruvian Integral Nutrition Program. As said by Aguiar :

“There are four primary components of PIN: (1) food assistance with a focus on foods rich in iron and vitamin A; (2) Education for mothers and caretakers that includes balanced nutrition for children, hygiene practices such as hand washing, and exclusive breastfeeding; (3) Capacity development for the regional and local governments and civil society that includes development of integrated health and nutrition planning; and (4) Monitoring and evaluation through establishment of base line measurements and integrated information systems between local governments, regional governments, the Ministry of Health, and the Ministry of Education” (23).”

Madre Teresa De Calcuta followed all four steps of the PIN program in an effort to combat childhood malnutrition. The current problem of malnutrition was discussed on the Municipalidad Provincia del Cusco website:

Children treated at this center [Madre Teresa De Calcuta] reached 37% of acute malnutrition and 41% of chronic malnutrition, worrying figures that reflect current issues in food. From managing chaired by Mayor Luis Florez Garcia we are determined to reverse these figures , implementing the monitoring centers , where authority , health professionals , as parents themselves are involved in ensuring proper growth for our children” (Municipal del Cusco) .

The direct mission of the center as written on its advertising pamphlet was to: “ Give attention to the psychology of children and the parents of families.” The director also told

me that the main focus was to teach the children to be receptive to food, and to teach the parents how to give the children food. (Appendix A)

Madre Teresa De Calcuta served children from the age of six months, up to the age of three years old. Many of the children were still being breastfeed and were currently being weaned to accept solid foods. As said by Moore, “ Children are particularly vulnerable [to malnutrition] from the age of 6 months, when they begin to require foods additional to breast milk” (Moore 1917).

Although the center was centered off the main square, Plaza de Armas, it served mainly the families of the outskirts of Cusco. Many of the mothers and fathers walked for several miles to deliver their children to the center before going to work at their shops or the locket market. In one case Juana, a mother of a one year old, stayed with a relative in town some days in order to deliver her child Anthony to the center.

The center opened in April 2012 and started with only educating mothers on the proper food to feed their families and cooking lessons. A year later it evolved into a childcare facility. “ The Peruvian Ministry of Health has found that a mother’s education level is associated with child malnutrition, with malnutrition rates decreasing with a mother’s education level...More directly, lack of education often points to scarcity of knowledge about health issues (particularly malnutrition), and reluctance to turn to health care services to deal with their health issues” (Aguiar et al. 10). Classes are still given to the mothers at least once or twice a month, and the parents of the children are still very involved with the daily activities of the school. Parents are required to feed their children breakfast as well as to clean the center at the beginning and end of the day.

The two women that I had the most contact with were the director of the school, Kornia, and the cook Luz. Korina was very involved in the daily events of the center; she was in charge of the interworkings of the school and making sure that it was in compliance with governmental guidelines. She was also the main disciplinarian of the center and overseer of the parents. There was also a psychologist that frequented and a teacher, Maria that was present at meal times. I was informed that a nutritionist provided the weekly list of foods to be served to the children. A weekly food list was readily available however; I never had the pleasure of meeting the nutritionist or dietician. (Appendices B)

How the children came to be at the center varied, but the general process was that the children were referred to the center after being identified as underweight at birth, or post a sick visit from the doctor. Many young children in Peru suffer from severe diarrhea that can become terminal. In many instances these cases are onset by parasites that the children are exposed to after being weaned off of breast milk. "The existence between an inverse relationship between breast-feeding and morbidity from diarrheal and possibly, other diseases is strongly indicated by the evidence from less developed countries"(Brown 31). Juana told me that her son Anthony who was being weaned off of breast-milk was sent to the center after he became very ill and lost a significant amount of weight. She took him to the doctor and the doctor referred her to the center. After being sent to the center the parents had to go through a registration process that included them being examined by a doctor employed by the government, who would determine if the child needed to be enrolled into the program. If the child was to be enrolled into Madre Teresa then the parents would have to agree to help with the upkeep of the center, as well as a few other duties that were required of them. The program also required routine house checks by the

nutritionist, to ensure that the parents were following the dietary guidelines that were taught to them. As said by Pelto, “ The inappropriateness of providing nutrition and health education without also addressing family and community needs for food, healthcare, and infrastructure development is now widely recognized by agencies, national governments, and nongovernmental organizations (1301)”.

Prior to being enrolled in the center the children appeared to be very thin when compared to plump faces of other children their age. While at the facility the children’s weight and height were monitored weekly, and their food intake was also monitored very closely to make sure that they were improving physically and gaining weight compared to when they arrived. As said by Messer, “ Anthropological research has shown that fatness is particularly favored at certain life stage: during infancy and female adolescence” (Small 40).

Stunting is also a common indicator of malnutrition and health deficiencies. As discussed by Bose et al., “ Two of the internationally recommended indicators [of malnutrition] most commonly used are child stunting (low height-for-age) and underweight (low weight-for-age) (73).” Peruvian children suffer greatly from stunting as found by a Tufts University Policy report that stated: “ In 2002 25.4% of all children under five [In Peru] suffered from stunting” (Aguier 13). Stunting has also proved to further cause other developmental long-term effects. As mentioned by Pelto, “ Children who experience growth faltering, manifesting as low height and weight for age, also tend to be developmentally delayed as assessed through measures of psychomotor and cognitive performance” (1300). A biweekly record of the children’s weight and height were kept in a notebook operated by Maria.

My Duties

I would report to work Monday through Friday from nine am to two pm. Many days I would come in at eight am to help the cook Luz cut vegetables and wash dishes for breakfast. My usual duties included helping Luz prepare food, playing and supervising the children, and feeding the children snack and lunch. I also sometimes helped feed the children breakfast if the parents were unable to do so. During my stay I implemented three nutritional activities, which consisted of: a vegetable and fruit coloring activity, an educational sing along, and a fruit salad for snack. Every Monday and Friday the children were weighed and their height was measured. At the beginning of class one week I assisted the director with these measurements and recorded the information into the weekly log.

Food and Preparation

The feeding time was very strict and controlled. The cook prepared every meal that the children received, besides one occasion where a birthday party took place and the children had cake and flan. Everyday Luz would carefully weigh the food and determine the portion size that a child was to receive based on the height, weight and former weeks portion of food. All the information was kept in a notebook and was updated daily after every meal. If a child had a problem finishing their food or finished their food quickly the day before, then adjustments would sometimes be made at the discretion of the nutritionist or the director. I witnessed one occurrence where a child finished their food quickly for two days straight, and therefore they increased his portion. However, in my experience there were very few times that the portion was reduced due to the child not being able to finish.

As soon as I arrived at the center at nine AM, usually the children were finishing up eating their breakfast fed to them by their parents, as required by the center's rules.

Breakfast was normally the easiest feeding time of the day, which might be in part to their parents feeding them or in part to them being hungry after not having a complete meal the night before. The director told me that many of the families did not have a kitchen in their homes and many times children only received papa fritas, or french fries, for dinner. Most of the children and their parents lived in poverty, and therefore the children did not have balanced meals. As said by Boise, "It has now been well established that poverty is the main underlying cause of malnutrition and its determinants (73.)". As by Aguiar, "the most direct way poverty contributes to chronic malnutrition is by limiting individual's ability to purchase food in adequate amounts or variety" (8). Dietary complexity has been used as one of several ways to compare diets of rich and poor both qualitatively and nutritionally..." (Principles 234). The breakfast usually consisted of yogurt or a grain such as quinoa made to an oatmeal like texture. The children ate vast amounts of quinoa, which is in relation to it being a staple in the Peruvian diet due to its affordability and accessibility. "The consumption of quinoa is related to the ease of obtaining it, and is influenced by socioeconomic group, regional location of families, and cost." (Macedo 222). Many days they also had a fruit to compliment the meal such as a banana or an orange. The children readily received the breakfast apart from a few who might not necessarily want to eat it. After eating and saying goodbye to their parents, the children played with toys and watched children's videos until their eleven AM snack time.

Snack usually consisted of fruit, left over yogurt or oatmeal from breakfast, spleen, or cow's blood mixed with a grain. It appeared as though the children's snack was heavily dependent on receiving food high in iron. The children's receptiveness of the snack was based on what the snack was, for example the cow blood which the children named "

chocolate” was a favorite and served with oranges, and was always readily received. Some snacks were not as well received however and resulted in the food giver to sit at the table until the child finished or until the director decided that the child truly was not hungry. After snack the children would play once more until it was time for lunch.

Lunch was difficult for the majority of the children. Many times it would consist of meat such as fish or chicken. It also consisted of other parts of animals such as chicken liver or lung. Sometimes it would take an hour or longer for a child to finish their meal, and they were forced to sit at the table until they finished it or until they got sick (which occurred on numerous occasions. When I asked Korina, the director, why the majority of the children refused lunch she stated that they were not use to receiving food. She said that since the children were not use to eating anything but french fries or nothing at all, it might feel “weird” on their stomachs. Another cause of the children’s inability to eat could be the reason that they were sent to the center in the first place, malnutrition, or any parasites that they might have contracted from being weaned off of breast milk. In an article by Dettwyler she labeled the “lack of a normal appetite, disinterest of food, or refusal to eat” as anorexia. She went on to say that “Many factors can contribute to anorexia in young children including a monotonous diet, chronic malnutrition, specific mineral deficiencies, disease, anxiety, intestinal parasites, and sores in the mouth” (684).

Different Feeding Habits

In the center much emphasis was placed on the preparation of the food and providing complementary foods to nourish the children, but as expressed by Pelto, “In addition to providing complementary foods that meet nutritional requirements, feeding practices (particularly frequency of feeding, and feeding style to ensure intake) are

determinants of adequate growth” (1300). From research it is clear that “ appropriate child feeding practices and behaviors of parents have a positive effect on growth of infants and young children” (Wondafrash et al 2). Therefore it is pertinent to identify and analyze the type of feeding practices implemented in a center where growth is fundamental. In her article analyzing good child nutrition, Engle identified the three good components of complementary feeding:

1. Adapting the feeding method to the child’s psychomotor abilities;
 2. feeding responsively. Including feeding when the child is hungry, encouraging a child to eat, recognizing possible low appetite, balancing child versus caregiver control of eating, and using an affectionate or warm style of relating to the child during feeding and
 3. Creating a satisfactory feeding situation by reducing distractions, developing a consistent feeding schedule, and supervising and protecting children during eating,
- During lunch is the time where I observed the most difference in feeding practices.

As stated previously there are three commonly observed feeding practices of caregivers. They are controlled feeding, laissez-faire, and responsive. At the center different caregivers applied different tactics, for example Maria and the psychologists readily applied responsive feeding practices, while Korina frequently applied a controlling form of feeding behavior. The laissez-faire form of feeding I never observed at the center.

Maria and the psychologist normally had a responsive style to feeding. Wondafrash et al. defined the responsiveness feeding style in their article as “a condition in which the caregiver is in close proximity to the young child during the meal and responds to a child’s hunger cues in a reasonable time” (2). The caretakers were very patient with the children during mealtime and usually waited for the child to signal when they wanted food. If the

children were having a hard time eating the food then Maria and the psychologist would try to encourage them by singing songs and giving them positive enforcement. They would make airplane noises and make the child feel as though he/ or she had a hand in the feeding. Another tactic was to divert the child's attention by taking the child out of the feeding room or by letting them play with a toy. Moore et al. described such a practice in the article when they said: " Two common strategies reported by mothers were to divert the child momentarily and to follow the child around with a plate of food until the child would take a mouthful" (1921). In the research of Moore et al. responsive feeding had the best long-term effects on the child. As stated by Moore et. al: " Responsive feeding practices incorporate the components of caregiving that are known to promote physical, mental, and social development more generally" (1918). Some of the feeding styles expressed by Maria and the psychologists could be seen as controlling behavior, for example pretending to eat themselves or by providing rewards for finishing food such as a toy or desert. As stated by Dettwylier , " Rewards are often used in the context of control of food consumption...Mothers or other caretakers may pretend to eat themselves, reward the child with smiles or praise for eating, or play age-appropriate food games"(1989). Although some of the behaviors by Maria and the psychologist could be considered as controlling the majority of the feeding practices that they displayed were responsive.

The feeding behaviors of Maria and the psychologist was very different than the behavior of the director. Korina had a completely controlling style of feeding behavior. Wondfrash defines the controlling feeding style as " When a caregiver has complete control of when, and what, and how much the child eats, and includes restriction and force-feeding the child"(2). If the responsive behavior of Maria and the psychologist did not work then

the director would come in and use an authoritative voice to where the children were receptive to eat. The director would simply say “open your mouth” or “eat” and force the food into the children’s mouths. If the children spit out the food she would just recollect the food into the spoon and enter it back into the child’s mouth until they ate it. This behavior was then expected of all the workers due to feeding time taking too long and the children not being receptive to the food. As mentioned before the proportions that the children were supposed to eat were weighed out exactly in accordance to the child, and therefore the child consuming all of the food was very important to the workers at the center. Even if a child got sick and vomited their food, I witnessed it being re-fed to the children. I witnessed children’s vomit being re-fed to them twice and at least two other instances of children becoming sick when being force-fed. Feeding time particularly lunch did not appear to be a happy time for the children, many of whom did not even want to sit at the table when it was announced that it was lunch time. A few parents came during lunchtime to assist in feeding. The children were no more receptive to their parents, but there was much less instances of force-feeding. However, if the workers, and in particular the director witnessed that the child was not eating, then she would “teach” the parents how to introduce the children to be susceptible to food by once again force feeding them. Force-feeding was very hard for the parents and many times I witnessed the parents eating the food themselves or sneaking the remaining food to the kitchen to avoid the director. In Engle et al.’s article they discuss how a controlling form of feeding as well as force feeding could provide damage to the health of the child. In the article they say: “When too much control is in the hands of the caregiver, force-feeding, or continued and even intrusive

pressure on children to eat is seen, which may lead eventually to inability to monitor food intake, and to obesity”(Engle et al. 27).

At no time at the center did I observe laissez faire form of feeding. Laissez-faire was defined by Wondafrash as “ the caregiver makes little effort to encourage eating; feeding is not encouraged even when the child may be marginally nourished” (2). I found it interesting that in Wondafrash et al.’s study they found that the laissez faire feeding style was most frequently found in Peru and Guatemala because this is not what I observed.

Relation To Course Work and Studies

I believe that many of the things that I learned while in Cusco were closely related to the subjects I have studied in both my major and my minor at SMU .My major in International Studies and my minor in Cultural Anthropology have both taught me more about different cultures and their foodways. As said on the Dedman college website: “The International and Area Studies Major provides students with the opportunity to design an interdisciplinary program of study that facilitates an understanding of the human experience in a global perspective, while at the same time allowing them to develop in-depth knowledge and expertise in a specific geographical area.” The geographical area that I have studied while at SMU is Latin America, so having the opportunity to work in the location that I have learned so much about was an invaluable experience. I was able to come in to contact with many of the places that I have learned about in textbooks and to talk to people in which I have learned about from documentaries and books. A co-requisite of my major is two years of study of a foreign language in which I chose to study Spanish. My Spanish language skills were very important to my work in Peru, because no one at the center spoke fluent English. I was able to communicate with the parents and the workers

and ask them questions about the children and their lives. On one occasion I was actually invited into one of the mother's homes, Juanna, which gave me a really authentic experience of how her, her husband, and child, Anthony lived.

My minor in cultural anthropology has taught me many things about observing other cultures and learning about the ways of other people. Classes such as Introduction to Cultural Anthropology taught me about different food ways in various cultures. I believe that if I did not see documentaries such as *A World of Food: Tastes and Taboos in Different Cultures*, I might have reacted differently when seeing the children eating foods such as cow blood or spleen, and I most definitely would not have tried it myself. Instead of seeing the food as "taboo" I inquired about the health benefits of eating that particular food and in doing so learned a lot about the different nutritional benefits.

Classes such as South American Indians taught me about the availability of food in the Urubamba Valley mountain range such as many of the potatoes and tubers. I learned a lot about the importance of grains like quinoa, as well as the importance and historical significance of coca tea. I also learned about the makeup of the Cusco environment and the lack of arable land. I was taught a lot about the people who occupy Cusco, more specifically the history of their ancestors, and some of their values and customs. Such knowledge proved to be valuable in developing relationships with the workers and the parents at the center.

The class Latin America People Places and Power further expanded my knowledge of the history of Latin America and also helped me to understand how the people of Cusco related to me as an African American. Many times I was asked if I was a "morena" or if I was a "mestiza", questions that would have offended me if I did not know the history of mixing

races in Latin America. The most important thing that I learned from my cultural anthropology minor is how to use an anthropological perspective while observing other cultures.

Conclusion

Working at the center was truly a learning experience, and a great asset to my education. I learned a lot about the different type of feeding practices that exist in childcare and also the long-term effects that these practices have on the children. It was evident to me that the all of the workers at the center deeply loved the children and the children loved them in return. None of the acts by the workers were ever done in anger, and even Korina showed a vast amount of patience during feeding time. The controlled form of feeding I witnessed was not of malicious intent but rather a concern that the children would not get their proper portion of food, and possibly go hungry for the night. Although the program is new and not completely developed, I believe that the center is a valuable asset to defeating the problem of malnutrition in Peru.

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Appendices

**MUNICIPALIDAD PROVINCIAL DEL
CUSCO**

**CENTRO DE VIGILANCIA
NUTRICIONAL**

“MADRE TERESA DE CALCUTA”

Brinda servicio de alimentación para niños en estado de desnutrición a menores de 3 años desde los 6 meses de edad.

Atención psicológica a niños y padres de familia

REQUISITOS:

- Cartilla de Vacunación (fotocopia)
- D.N.I. de los padres (fotocopia)

HORARIO DE ATENCION: 8:00 am – 3:00 pm.

Para mejor información estamos en Calle Resbalosa S/N – (a media cuadra de la calle Suecia)

- VACANTES LIMITADAS -



(Appendix A)

	Monday	Tuesday	Wednesday	Thursday	Friday
Breakfast	Oats with oranges and bread with cheese	Zambito Wheat with cookies	Sweet potatoes	Maize porridge	Pineapple pie with milk punch
Additional (snack)			Spleen	Spleen	
Lunch	Tarwi cream soup with anchovies	Lentils with ground meat meatballs	Scrambled lung with rice	Mashed quinoa with chicken heart stew	Sautéed chicken liver with rice
Drink	Purple corn juice	Lemonade	Star fruit juice	Coconut juice	Passion fruit

(Appendix B)