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Understanding infant feeding practices, relations to the health clinic and experiences of receiving conflicting advices: A qualitative study with Somali mothers living in Oslo

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Summary

Background

Appropriate feeding practices are of fundamental importance of growth, development and health of infants and young children. There is limited knowledge on infant feeding practices among Norwegian born infants to immigrant parents.

Method
The study used a grounded theory approach in conducting in-depth interviews with 15 Somali mothers. The first interviews were conducted when infants were six months and a follow-up interview was conducted when infants were one year. Mothers were purposively selected using a multi-recruitment strategy. The inclusion criteria were that mothers should originate from Somalia, live in Oslo or nearby counties and have a six-(±two)-month-old infant born in Norway.

The master thesis
The master thesis is written in form of an introduction and article. In the introduction part, the background, methodology and methodology discussion will be presented. The results and discussion will be presented in the article. The article is written in accordance with the guidelines of the scientific journal "Maternal & Child Nutrition".

Findings
The findings show that exclusive breastfeeding was less common among the mothers, due to early introduction water, formula and early introduction of tastes of solids. Breastfeeding duration was generally short, only two of the mothers were still breastfeeding at 12 months. At four months, tastes of solids were commonly introduced, and homemade food was considered superior to commercially prepared infant food. The mothers described a stressful atmosphere at the health clinics, and time constraints among the health nurses were an issue of concern. Information about introduction of solids was regarded as insufficient, as it was commonly given in form of written brochures and booklets. The mothers reported about receiving infant feeding advice from their social network that were in conflict with the information provided at the health clinic, however, the public health nurse was considered as the most reliable source of information.

Conclusion
This study presents knowledge about Somali mothers' infant feeding practices that directly could guide discussions with these families. These findings also suggests that the health clinic has a major opportunity to promote appropriate infant feeding to immigrant Somali mothers, as it appears that the information provided at the health clinic is viewed as trustworthy.

Key words: *Somali mothers, Immigrant, Infant feeding, Information, Qualitative, Interview*

Sammendrag

Bakgrunn
Det finnes lite forskning på spedbarnsernæring blant norsk-fødte barn av innvandrerforeldre. I Norge er det gjort landsomfattende kostholdsundersøkelser blant spedbarn i alderen 6, 12 og 24 måneder. Denne undersøkelsen inkluderte ikke spedbarn født utenfor Skandinavia. InnBaKost-prosjektet ble startet i April 2012, med et mål om å samle inn data om spedbarnsernæring blant norskfødte barn av innvandrerforeldre. Innvandrermødre fra Irak og Somalia ble valgt til å delta i undersøkelsene på grunn av høy fødselsrate i Norge. Målet med denne studien er å generere kunnskap om Somaliske mødres praksiser rundt spedbarnsernæring og deres opplevelse av helsestasjonen samt råd relatert til spedbarnsernæring.

Metode
Grounded Theory ble brukt i innsamlingen av dybdeintervju med 15 somaliske mødre. De første intervjuene ble samlet inn når mødrenes barn var seks måneder gamle. I denne studien har vi gjort oppfølgingsintervju med de samme mødrene da barna var 12 måneder. Mødrene ble rekruttert ved formålsbestemt utvalg ved hjelp av multi-rekrutterings strategi. Inklusjonskriteriene var at mødrene var født i Somalia, bo i Oslo eller i nærliggende kommuner og ha barn på seks (+- to) måneder gamle barn født i Norge.

Masteroppgaven
Denne masteroppgaven er skrevet i form av en innledning og artikkel. Innledningen består av en lengre introduksjon/bakgrunn og metode i tillegg til metodediskusjon. Resultatene og resultatdiskusjonen blir presentert i artikkelen. Artikkelen er skrevet i henhold til retningslinjene til det vitenskapelige tidsskriftet "Maternal & Child Nutrition".

Resultater
Funnene viser at fullamming var mindre vanlig blant mødrene. Varigheten ble avbrutt av tidlig introdusering av vann, morsmelkerstatning og smaksprøver av fast føde. Mødrenes ammelengde var kort, da kun to av femten mødre fremdeles ammet ved 12 måneder. Ved fire måneders alder hadde de fleste barna blitt introdusert for smaksprøver av fast føde, og mødrene foretrakk å gi barna sine hjemmelaget mat framfor ferdigkjøpt barnemat på glass.

Mødrene beskrev atmosfæren på helsestasjonen som stressende og tidsmangel blant helsesøstrene ble uttrykt som bekymringsverdig blant mødrene. De fleste mente at informasjonen om innføring av fast føde var mangelfull, da informasjonen vanligvis ble gitt i form av brosjyrer og oppskriftshefter. Mødrene opplevde å få motstridende råd fra sitt sosiale nettverk og helsestasjonen i forbindelse med spedbarnsernæring. Helsesøster ble derimot ansett som mest troverdig da de ga informasjon basert på forskning og at de hadde best kunnskap om hvordan spedbarnsernæring bør være i Norge.

Konklusjon
Denne studien bidrar med verdifull informasjon om somaliske mødres spedbarnsernæring som direkte kan guide diskusjoner med disse familiene. Funnene foreslår at helsestasjonen har en viktig rolle i promoteringen av skikkelig spedbarnsernæring til innvandrer mødre fra Somalia, da informasjonen gitt er ansett som troverdig.

Nøkkelord: *Somaliske mødre, Innvandrere, Spedbarnsernæring, Informasjon, Kvalitativ, Intervju*

List of figures and tables

Definitions

Complementary feeding/weaning: When breast milk no longer is sufficient to secure the nutritional needs of the infants. Recommendations to start timely complementary feeding at six months alongside breastfeeding.

Exclusive breastfeeding: Only breast milk and no other liquids or foods.

Primiparous: mother of one child

Multiparous: mother of two or more children

Immigrant: Persons born abroad of two foreign-born parents and four foreign-born grandparents.

Norwegian born to immigrant parents: Persons born in Norway of two foreign-born parents and four foreign- born grandparents.

The terms “a few”, “some” and “most of” will be used in this thesis in order to describe the approximate number of mothers sharing opinions

A few = one to three

Some = four to six

Half = seven to eight

Most of = nine or more

1 Introduction

Appropriate feeding practices are of fundamental importance of growth, development and health of infants and young children. During the first two years of life, a child grows fast and the nutritional needs changes rapidly (Scott, Campbell, & Davies, 2007). Early established dietary habits appear to set a foundation for food choices later in life. (Schwartz, Chabanet, Lange, Issanchou, & Nicklaus, 2011).

According to both Norwegian and international infant feeding recommendations, infants should be exclusively breastfed for the first six months of life (Brown, 2000). Breastfeeding alongside introduction of other feeds from six months is recommended, and continue for one year or longer. Breast milk is uniquely superior for infant feeding, as it secure the infant nutritional needs in the first six months of life (Eidelman et al., 2012; Gartner et al., 2005). Research has provided evidence of breastfeeding being protective against a wide range of infectious diseases, as well as having a positive effect on cognitive development (Eidelman et al., 2012). Breastfeeding influences the infant growth and has also been associated the later risk of obesity in adulthood (Eidelman et al., 2012; Gillman et al., 2001; Jenum et al., 2013; Owen, Martin, Whincup, Smith, & Cook, 2005). In Norway, recommendations include giving infants vitamin D supplementation from the age of four weeks (Hay et al., 2011; Lande et al., 2003).

The nationwide nutritional surveys "spedkost" and "småbarnkost" conducted information about feeding practices among Norwegian infants aged 6, 12 and 24 months (Øvreby, Kristiansen, Andersen, & Lande, 2009). The results showed that the majority of the infants were fed according to the national recommendations for infant feeding. These surveys did not include children with mothers born outside Norway.

There is limited knowledge about the infant feeding practices among Norwegian-born infants to immigrant parents. However, a quantitative study of Pakistani, Turkish and Somali immigrant mothers and their Norwegian-born infants reported about a low percentage of exclusive breastfeeding at six weeks compared to ethnic Norwegians (Madar, Stene, & Meyer, 2009). Madar et al. (2009) also measured a low vitamin D status among the infants in same study. Wandel, Fagerli, Olsen, Borch-Iohnsen, and Ek (1996) compared weaning

patterns of immigrant born infants to ethnic Norwegians. They found that the duration of exclusive breastfeeding was particularly short among Turkish infants compared to Norwegians. Early introduction of infant formula and cow's milk was also common in this group. A higher prevalence of iron deficiency and a higher intake of sugar compared to ethnic Norwegians were also found in the same study (Wandel et al., 1996).

In April 2012, The InnBaKost-project started with the goal to study the diet and infant feeding practices among immigrants living in Oslo. The InnBaKost-project has chosen to focus on Somali and Iraqi mothers living in Oslo, due to being the two minority groups with the highest birth rate in Norway. The InnBaKost-study is divided in two main parts: a quantitative and a qualitative part (figure 1). The collections of quantitative data on the mothers' infant feeding practices are reported through 24-hour recall interviews, where quantities of different food are being measured. The present study is part of the qualitative part, which aims to get a deeper understanding about the Somali and Iraqi mothers' infant feeding beliefs and practices. I have chosen to focus on the Somali mothers in this thesis.

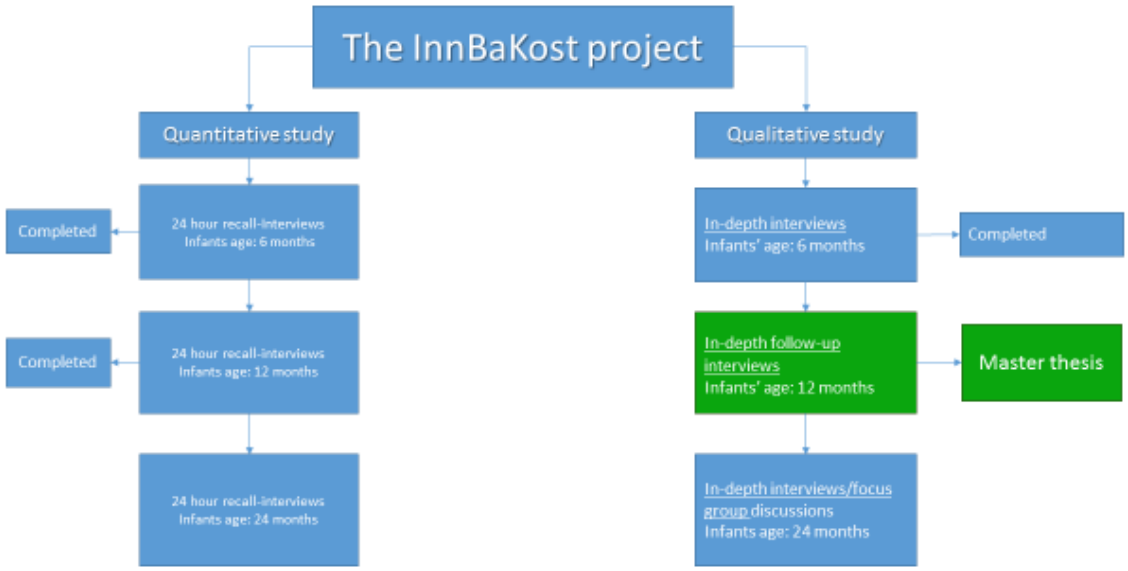

Figure 1 Overview of the InnBaKost-Project

1.2 Aim of the study

The aim of this study is to generate knowledge about infant feeding practices of Somali mothers and to get a better understanding of how they experience the nutrition communication at the health clinics. A better understanding of the Somali mothers' infant feeding practices could provide valuable knowledge for developing approaches for practicing culturally sensitivity in health and nutrition communication.

2 Background

2.1 Immigrants health in Norway

Immigrants accounted for 12 % of the total population in Norway as per 1 January 2014, while Norwegian-born to immigrant parents accounted for 2 % (SSB, 2014).

Migration is often associated with changes in dietary habits, nutrient intake and physical activity influenced by the process of westernization (Abebe, 2010). This has led to an increased risk of chronic diet- and lifestyle-related diseases among some ethnic minority groups compared to their country of origin and the majority population (Abebe, 2010; Holmboe-Ottesen & Wandel, 2012; Madar et al., 2009). Several studies have reported about changes in food habits after migration to Norway; changes in meal pattern, an increase of unhealthy dietary compounds and a decrease in healthier foods from their country of origin. (Fagerli, Lien, & Wandel, 2005; Mellin-Olsen & Wandel, 2005; Wandel, Råberg, Kumar, & Holmboe-Ottesen, 2008).

There is limited knowledge about immigrant mothers' experience of receiving nutrition-related information at the health clinics in Norway. However, one Norwegian study of immigrant women in antenatal care found that nutrition related information was sparse, and that the information provided by health workers caused confusion as the information was incongruent with their original food culture (Garnweidner, Pettersen, & Mosdøl, 2013).

2.2 Somalis in Norway

In 2014, there were 35 912 persons with Somali background in Norway, which makes Somalis the third largest immigrant group in Norway (SSB, 2014). Somalis started coming to Norway in the mid-1980 with an increase after the collapse of the Somali state in 1991. However, the largest group of immigrants from Somalia arrived in the 2000's and later (Horst, 2013). Almost all Norwegian-Somalis came to Norway as refugees, or for family reunification with those who had already settled as refugees. The majority of Norwegian-Somalis reported coming from cities, most apparently from areas around Mogadishu and along the coast in the south (Horst, 2013). First generation Somalis is one of the immigrant groups with the shortest time of residence in Norway. Somalis in Norway are also young, with 80 percent being under 40 years old. Children of Somalis are similarly young, with 80 percent being younger than ten years old (Horst, 2013).

The fertility rate among Somali women are high. In 2006, first generation Somalis gave birth to an average of 3,7 children (Government, 2009). Half of the Somali population is part of large households with five or more people, whereas one out of five lives alone (Horst, 2013). In the next section, I will give a short introduction of the traditional Somali diet and infant feeding practices.

2.3 Somali diet and infant feeding practices in Somalia

The majority of Somalis are Sunni Muslims and the Islam religion dictates which foods are allowed (*halal*) and which are forbidden (*haram*) (Haq, 2003). The main staples are milk, sorghum and maize, meat and/or beans. Rice and pasta is also common staples among Somalis and sugar and vegetable oil or ghee (clarified butter) are commonly used in cooking (Haq, 2003).

In Somalia, infants are breastfed, although exclusive breastfeeding until the age of four months is not common (FAO, 2005; Green, Lee, Parfrey, & Zemaitis, 2012). To the majority of caregivers, exclusive breastfeeding does not exist, as exclusive breastfeeding means giving breast milk and water with some sugar alone without any soft or solids (Mwaura & Moloney, 2008). Prolonged breastfeeding will continue until the child is two years old, as stated in the Quran (Green et al., 2012; Mwaura & Moloney, 2008).

Early introduction of cow or goat's milk in addition to breastfeeding have been reported to occur from birth to three months (Green et al., 2012; Haq, 2003). It is also common to give additional water during the first months. Most infants are introduced to solid foods before four months of age. Cereal-based porridge (sorghum, maize) with milk and family foods are commonly the foods first introduced. Most children are introduced to soft food in form of potatoes, biscuits or porridge after the third month of life (Haq, 2003). In households where there is difficulties accessing milk, the milk is often replaced with tea or porridge after the third month. A lack of variety in complementary diets was also noted (Mwaura & Moloney, 2008).

After migration to a more affluent country, the traditional diet and lifestyle have undergone a major change in the west (Green et al., 2012). According to a study done on the Somali population in the UK, a high-fat/high sugar diet, with refined carbohydrates is common among the Somali population (McEwen, Straus, & Croker, 2009). Overweight and obesity are a major concern for the western Somali population, however, according to Blom (2008), the Somali population in Norway is one of the healthiest immigrant group in Norway. These statistics are suggested to be in relation to their relatively young age compared to other immigrant groups living in Norway, which could be a factor influencing the statistics.

2.4 Multicultural competence in dietary counselling

It is well established that culture has a strong influence on an individual's food intake, attitudes and behaviours (Curry, 2000; Harris-Davis & Haughton, 2000). For health workers counselling in nutrition, this requires knowledge of culturally relevant foods and food habits and the ability to use this to promote desirable health and behaviour changes. Multicultural competence is the ability to discover the culture of each patient/client and effectively adapt interventions to her or him (Curry, 2000). The growing number of immigrants with different cultures and beliefs, forces health care practitioners to recognize the importance of culture in their interactions with clients (Harris-Davis & Haughton, 2000). A study conducted with immigrant diabetes patients in Oslo, showed that advices from the health worker was experienced as inadequate, because it was not based on the patients food-cultural background (Fagerli et al., 2005). Basing nutritional advice on the current diet of the patient is pivotal in health promotion. Skills that enhance care providers' abilities to recognize different cultural values, beliefs and practices are likely to lead to more successful treatment outcomes

(Bonder, 2001). Showing knowledge of and respect for an individual's food practices and customs and building a trusting relationship can help health workers facilitate changes in the eating and exercise patterns of their patients and clients (Curry, 2000).

3 Methodology

3.1 Qualitative, in-depth interviews

Qualitative, in-depth interviews were used to conduct the material for this study. Qualitative research is appropriate when we want to seek deep understanding and/or explore a social or human problem (Dahlgren, Emmelin, & Winkvist, 2004). According to Dahlgren et al (2004), qualitative researchers share a common perspective on the world, based on ontological and epistemological assumptions that influence the process of research. The ontological assumption in qualitative research is that realities are subjective, multiple and socially constructed. The epistemological assumption includes a view on how knowledge is generated, and the relationship between researcher and informant is emphasized as essential in the research process. The researchers pre-understanding, expectations, and biases must be taken into consideration. This perspective influences the process of research; Qualitative research is inductive, bound to time and context and follows an emerging design (Dahlgren et al., 2004).

Individual in-depth interviews are widely used by health care researchers to explore the participants perceptions of and experiences related to health and health care (DiCicco-Bloom & Crabtree, 2006). Features of qualitative interviews is that they entail a high level of participation on behalf of the informant. Open-ended questions are asked to encourage the informant to speak with their own words. Qualitative research relies on in-depth interviews as the aim of qualitative interviews is to access people's own perspectives (Dahlgren et al., 2004) .

An in-depth interview was a suitable approach when we wanted to explore the participants' perceptions and experiences about the aims of this thesis. Previous studies based on qualitative in-depth interviews have provided valuable insights into immigrants' experiences in relation to diet and health care (Bulman & McCourt, 2002; Fagerli et al., 2005; Lisa Maria Garnweidner, Terragni, Pettersen, & Mosdøl, 2012).

3.2 The Grounded Theory approach

The Grounded Theory approach was used as a strategy in this study. Grounded Theory offers a systematic way of transforming collected data into a more abstract form of information. Dahlgren et al (2004) describes this techniques in six distinct steps, which involves; (1) Data collection; (2) Documentation; (3) Open coding; (4) Selective coding; (5) Theoretical coding; (6) Integration. One of the goals of doing grounded theory is to discover something new and to generate new theories (Dahlgren L 2004). Hence, this method of investigation was chosen since little empirical data exist on issues surrounding young child feeding practices and beliefs among immigrant Somali mothers.

The master student followed five out of six steps; we did not follow the sixth step because it was to advance for this master thesis. In the following sections, the steps of Grounded Theory will be described further. (3.2 – 3.4)

3.3 Recruitment and sampling of the mothers

This is a follow-up study in an on-going project, which was initiated with mothers when their infant was six month of age. In the recruitment of the mothers, the researchers from the six-month study used a purposive sampling. The inclusion criteria were Somali mothers, born outside Norway with infants at six months of age, born in Norway. The recruitment was achieved by using a multi-recruitment strategy, which included visits to the health clinic, activity centres, women cafés organized by the Red Cross and by getting access to names of mothers through the National Population Registry [Folkeregisteret]. A multi-recruitment strategy has been suggested to be effective in recruitment of immigrants (Hussain-Gambles et al., 2004). The technique of snowball sampling was also used, which means that the participating mothers were used as a resource for getting in contact with other mothers who matched the inclusion criteria (Dahlgren et al., 2004). Fifteen mothers were recruited in the six-month-study.

When the mothers' infants had reached the age of 12 months, it was time to conduct the follow-up interviews. The researcher from the first part of the study created a list of contact information on the participating mothers, which we contacted by phone and scheduled up for

follow-up interviews. Nine out of fifteen mothers agreed to do the follow-up interviews, whereas six mothers did not have the opportunity to attend. In that occasion, we recruited six new Somali mothers of one-year old infants to participate in the study based on the principle of saturation. These mothers were recruited through snowball sampling.

3.4 Data Collection – Interviewing the mothers

Data collection is the first step in doing Grounded Theory in qualitative research (Dahlgren et al., 2004). As mentioned initially, we used in-depth interviews to collect the data for the study.

A semi-structural interview guide was developed before conducting the interviews. In a semi-structured interview, the largest part is guided by a list of questions or issues to be explored, but the exact wording or the order of the questions is not determined in advance (Merriam, 2009). The interview guide was made flexible enough to allow inclusion of emerging topics. The main topics of the interview guide was; introduction of family food; attitudes to food and drinks with high content of sugar; the husbands and other relative's expectations regarding the child's diet; opinions related to the child's health and wellbeing and the child's preferences in foods.

At the time of the six-month study, the interview-guide focused on the mothers' experiences with breastfeeding. In the follow-up study with infants at twelve months, we focused on the mothers' experiences with complementary feeding and on the mothers' perception of getting nutrition-related information from different sources. In the interviews with the six newly recruited mothers, we did a prolonged interview, and included questions from the six-month study regarding breastfeeding in order to evaluate all the participating mothers more or less at the same level.

The interviews took place at the researchers' workplace FAFO, at the mothers' home or in a café. In the beginning of the conducting phase, the project leader was the main interviewer. Eventually the master student conducted the interviews by herself with the support of a student working on the Iraqi part of the study (n=4). The interviews lasted from 40 minutes to one hour and 40 minutes. A tape-recorder was used during the interviews, and the mothers were informed about the procedures used to secure their anonymity. The mothers received a gift-card with a value of 150 NOK as a gratitude for their participation.

The majority of the interviews were performed in Norwegian, whereas only one of the Somali mothers needed an interpreter. A Somali interpreter assisted in this interview, and the conversation was interpreted consecutively. An interpreter manual was given to the interpreter with information about the InnBaKost project, the role of a good interpreter and general guidelines on professional behaviour, courtesy and discretion during the interviews.

3.5 Data analysis – Transcription and coding

After each interview, the recordings were transcribed verbatim. This is the second step in the Grounded theory approach, referred to as *documentation* (Dahlgren et al., 2004). According to Merriam (2009), verbatim transcription of recorded interviews, provides the best database for analysis. Data analysis is the process of making sense out of the data, which involves interpretation of the information provided by the informants (Merriam, 2009)

In this study, the *Open Code 4.01* program was used as a tool for coding the generated data. This program was developed to follow the steps of the Grounded Theory methodology (Dahlgren et al., 2004). *Open coding* is the third step in Grounded Theory and is the first close, line-by-line examination of the data (Draucker, Martsolf, Ross, & Rusk, 2007). The aim of open coding is to characterise important information in the material (Dahlgren et al., 2004).

469	I2: Har du begynt å gi henne andre type mat og drikke	Familiemat, grønnsaker, intro mat, potetmos, smake	INTRO/BARNEMAT
470	bortsett fra den grøten?	Familiemat, grønnsaker, intro mat, potetmos, smake	INTRO/BARNEMAT
471	K: Nei, nå sånn prøvesmaker mat liksom ikke veldig	Familiemat, grønnsaker, intro mat, potetmos, smake	INTRO/BARNEMAT
472	mye da, krydret og salte bare sånn finger smake da sånn	Familiemat, grønnsaker, intro mat, potetmos, smake	INTRO/BARNEMAT
473	forskjellige ting da	Familiemat, grønnsaker, intro mat, potetmos, smake	INTRO/BARNEMAT
474	I2: Hva da?	Familiemat, grønnsaker, intro mat, potetmos, smake	INTRO/BARNEMAT
475	K: For eksempel litt sånn potetmos og sånt, og litt	Familiemat, grønnsaker, intro mat, potetmos, smake	INTRO/BARNEMAT
476	mer grønnsaker som har moset og sånt sånn at hun finger	Familiemat, grønnsaker, intro mat, potetmos, smake	INTRO/BARNEMAT
477	smaker. Og det er det jeg har prøvd men jeg har ikke prøvd	Familiemat, grønnsaker, intro mat, potetmos, smake	INTRO/BARNEMAT
478	noe annet enda	Familiemat, grønnsaker, intro mat, potetmos, smake	INTRO/BARNEMAT

Figure 2 Example from coding

The data analysis began with reading, taking notes and comment on the interview transcripts collected in the study. The data were analysed using the constant comparative method, which involves comparing one segment of data (table 1.) with another to determine similarities and differences. The segments were further clustered into categories. This is the fourth step of doing Grounded Theory, the step called *selective coding* (Dahlgren et al., 2004; Merriam, 2009). I then chose to go through the material again, now knowing better what to look for. Further, I tried to find connections between the different categories, which are the fifth step in Grounded Theory, called *theoretical coding*.

I chose to include the nine interviews from the six-month-study, which I based the follow-up interviews on, in my thesis. I did this because the topics discussed in the first and second interview were somewhat overlapping, which meant that if the topic had been discussed in the first interview; it would not always be discussed as profound in the follow-up interview. I chose to do this in order to get a better understanding of the mothers' infant feeding practices and to be able to explore the transition from breastfeeding to complementary feeding among these mothers.

3.6 Ethical considerations

The Regional Committees for Medical and Health Research Ethics (REK) approved the InnBaKost project. The ethical aspects are of high relevance in this study. Longitudinal, qualitative interviews involve prolonged, close and personal involvement. The mothers were informed that the participation was voluntary and that they had the opportunity to resign from the study at any time. The mothers were given an informed consent to sign in advance the interviews. Confidentiality was secured by not revealing name and other information that could reveal the mothers' identity in the transcribed interviews. The study was carried out in accordance to the Helsinki declaration (Goodyear, Krleza-Jeric, & Lemmens, 2007).

4 Methodology discussion

A qualitative approach was chosen to achieve the aims of the study. Qualitative research is useful when the goal is to seek deep understanding about a phenomenon (Lietz & Zayas, 2010). The goal of this study was to get in-depth knowledge regarding the infant feeding practices among immigrant Somali mothers. Interviews are a good strategy to generate such information (Dahlgren et al., 2004).

4.1 Trustworthiness

Lincoln and Guba have identified criteria for establishing trustworthiness of qualitative research studies (Lincoln & Guba, 1985). A study is trustworthy if steps are taken in the research procedures to ensure the perspectives of the research participants are authentically gathered and accurately represented in the findings. To address the issue of trustworthiness, four concepts are established: credibility, transferability, dependability and confirmability.

In qualitative research, there are potential for the researcher or the study procedures to exert an impact on the participants thereby changing the findings of the study. *Credibility* refers to the degree to which a study's findings represent the meanings of the research participants (Baxter & Eyles, 1997; Lietz & Zayas, 2010). In order to enhance credibility, researchers focus on respondent selection procedures, interview practices and strategies for analysis (Baxter & Eyles, 1997).

The participants

Initially, the goal was to do follow-up interviews of 15 mothers interviewed when their infants were six months old. Of the fifteen Somali mothers who participated in the six-month study, we only managed to do nine follow-up interviews. Six mothers from the six-month study did not have the opportunity to participate. Based on the principle of saturation, we recruited six new Somali mother of one-year-old infants.

Of the six mothers who dropped out of the study, three had short time of residence in Norway and were in need of an interpreter. A shorter time of residence in Norway could make the mothers have stronger ties to their country of origin feeding traditions. As the mothers did not speak Norwegian fluently, other challenges regarding nutrition communication could have been discovered.

In order to get sufficient information from the six newly recruited mothers, we did a prolonged interview and asked questions from both the first and second part. Recall bias should be accounted for among these mothers. Due to time constraints, we were not able to get as detailed information about the newly recruited mothers as the mothers who were interviewed twice.

After this thesis is submitted, the plan is to write a scientific article based on the results from the six-month study of the Somali mothers and the results from the follow-up study. In that occasion, the six mothers who dropped out after the first interview will be included in the analysis, and the sample will consist of 21 mothers; The 15 from the six-month study and the six newly recruited

Prolonged engagement

Prolonged engagement involves conducting multiple interviews or spending extended time observing participants to achieve a complete look at the experience. By doing this, thick description will be provided and data saturation could be secured (Lietz & Zayas, 2010) The benefits of follow-up interviews is to provide the researcher an opportunity to clarify or elaborate topics poorly covered in the first interview. Since I did not conduct the first interviews, I carefully read the transcripts of the six-month interviews, to be as prepared as possible for the follow-up interview. I found that being well prepared made it easier to converse with the mothers, because I was able to follow-up on discussed topics from the first interview.

Another benefit of doing follow-up interviews is the opportunity to build trust (Lincoln & Guba, 1985). Before the interviews, I ensured the mothers that their anonymity will be secured and emphasised that their participation and contribution were important for the project (Lincoln & Guba, 1985). I did my best to make the interview situation relaxed and not to formal to make the mother feel comfortable during the interview.

Pre-knowledge of the master student.

Despite the fact that I am an educated nutritionist, I did not have much knowledge about infant feeding in the beginning. I also lacked experience with childbirth and infant feeding, because I do not have children on my own. Nor could I relate to the Somali community. According to Dahlgren et al. (2004), having somewhat pre-knowledge during interviews could help to identify follow-up questions. Since I was part of a bigger project, I did not feel

comfortable conducting the interviews on my own, because of insecurity of not being able to get the right information from the mothers. In that occasion, the project leader of the InnBaKost-project conducted the first interviews, while I acted as an active listener/second interviewer and asked follow-up questions if I felt that something was unclear. After having participated in a few interviews, I felt more ready to do interviews on my own. At that time, my pre-knowledge about infant feeding had grown and I felt more confident in the interview situation.

The interview situation

As mentioned initially, the project leader and I conducted the first interviews, but as I got more responsibility and started conducting interviews on my own, I got support by a fellow student during the interviews. Being more than one interviewer has been suggested to achieve more successful interviews (Murray & Wynne, 2001). Since I was an inexperienced interviewer, I found having the support of the fellow student as very helpful.

During the interviews, an audio-recorder was used to capture all the words of the mothers. Using an audio-recorder means that the researcher can concentrate on the topic and the dynamic of the interview (Kvale, 1996). The words, tones and pauses are recorded in a permanent form that can be returned to repeatedly for listening. After each interview, the interviews were transcribed verbatim before conducting the next.

Most mothers in this study spoke Norwegian fluently. However, some mothers had moderate Norwegian skills, which became apparent during the interviews. Questions asked by the researchers were not always understood. One of the researchers did interviews speaking her native language (Swedish), and the dialect of the master student (moldenser) is somewhat different from the dialect spoken in Oslo. This could have caused misconceptions of the researchers' questions. In most situations we were able catch this and could reword our questions. However, there is a possibility that the mother had given us "wrong" answers due to not understanding the question.

Some of the mothers brought their infant with them to the interview, which often created a lot of background noise such as babbling and crying (as infants usually do), which made the recordings sometimes hard to transcribe. I tried to solve this by transcribing the interviews directly after interviewing the mothers, in order to be able to remember much of what were said during the interviews. However, not every word was remembered, and valuable

information might have been lost in transcription. Another researcher could have relisten the audio-recordings in order to enhance the credibility of the transcriptions, but this was not done in this study.

Member check has been described as the most crucial technique for establishing credibility (Lincoln & Guba, 1985). Member checks involves seeking feedback from the research participants. Due to time constraints, this was not possible to implement in this process.

Transferability refers to the degree to which the findings are applicable or useful to theory, practice and future research (Lietz & Zayas, 2010). The findings in this study may not be generalizable to all immigrant Somali mothers, but may be applicable in similar settings as the one in this study. The six newly recruited participants further enhanced the transferability and credibility of the findings, because their experiences and perceptions were similar to the ones interviewed in the first part. Other studies of immigrant Somali mothers' infant feeding practices further supported the findings in this study, which suggests that these findings could be applicable in other settings concerning Somali mothers and infant feeding practices.

Dependability refers to the degree to which the research procedures are documented allowing someone outside the project to follow and assess the research process (Lietz & Zayas, 2010). One way to make decisions and change along the way is to provide detailed documentation throughout the research project. After each interview, I wrote a short report about the interview. This was helpful during the data analysis and I also believe that it would be helpful in the next round of interview, as there is a new student taking over.

Confirmability refers to the ability of others to confirm the findings (Lietz & Zayas, 2010). Since we were two researchers conducting the interviews, we were at least two persons who could confirm the findings. Since I was the only one transcribing the interviews, there could have been biases on by behalf. Even though I went back and forth through the audio-recordings, it might be possible that words have been written wrong. It might have been a good idea for another researcher to go through the recordings in order to confirm what has been said during the interview. Since we did follow-ups, the mothers were able to confirm or disconfirm sayings from the first part of the study. Member checking, audit trials and peer debriefing. These strategies allow collaborators external to the research team an opportunity to evaluate or confirm the research procedures.

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6 The article

Understanding infant feeding practices, relations to the health clinic and experiences of getting conflicting advices: A qualitative study with Somali mothers living in Oslo

By Julianne Lyngstad

Abstract

The objective of this study was to generate knowledge about infant feeding practices of Somali mothers and explore how they experience the nutrition communication at the health clinic, towards developing approaches for practicing cultural sensitivity in health and nutrition communication. In-depth individual interviews with 15 Somali mothers with one-year old infants living in Oslo were conducted. The findings show that exclusive breastfeeding was less common among the mothers, due to early introduction water, formula and early introduction of tastes of solids. Breastfeeding duration was generally short, only two of the mothers were still breastfeeding at 12 months. At four months, tastes of solids were commonly introduced, and homemade food was considered superior to commercially prepared infant food. The mothers described a stressful atmosphere at the health clinics, and time constraints among the health nurses were an issue of concern. Information about introduction of solids was regarded as insufficient, as it was commonly given in form of written brochures and booklets. The mothers reported about receiving infant feeding advice from their social network that were in conflict with the information provided at the health clinic, however, the public health nurse was considered as the most reliable source of information. This study presents knowledge about Somali mothers' infant feeding practices that directly could guide discussions with these families. These findings also suggests that the health clinic has a major opportunity to promote appropriate infant feeding to immigrant Somali mothers, as it appears that the information provided at the health clinic is viewed as trustworthy.

Key words: Somali mothers, Immigrant, Infant feeding, Information, Qualitative, Interview

Introduction

Appropriate infant feeding practices are of fundamental importance of growth, development and health of infants and young children. In the two first years of life, a child grows fast and the nutritional needs changes rapidly (Scott, Campbell, & Davies, 2007). According to both Norwegian and international breastfeeding recommendations, infants should be exclusively breastfed for the first six months of life and continue prolonged breastfeeding up to one year. In Norway, recommendations on exclusive breastfeeding include giving infants vitamin D supplementation from the age of four weeks (Hay et al., 2011; Lande et al., 2003).

Research has provided strong evidence that breastfeeding decreases the incidence and/or severity of a wide range of infectious diseases, as well as being associated with a positive effect on cognitive development (Gartner et al., 2005). Studies have also provided evidence about a relationship between breastfeeding and a reduced risk of obesity (Eidelman et al., 2012; Gillman et al., 2001; Owen, Martin, Whincup, Smith, & Cook, 2005). Infants will require additional food together with breastfeeding from the age of six months, in order to secure the needs for energy and nutrients and to enable the transition from milk feeding to family foods (Agostoni et al., 2008; Brown, 2000; Scott et al., 2007).

There is limited knowledge about the infant feeding practices among Norwegian-born infants to immigrant parents. However, a quantitative study of Pakistani, Turkish and Somali immigrant mothers and their Norwegian-born infants reported about a low percentage of exclusive breastfeeding at six weeks compared to ethnic Norwegians (Madar, Stene, & Meyer, 2009). Madar et al. (2009) also measured a low vitamin D status among the infants in same study. Wandel, Fagerli, Olsen, Borch-Iohnsen, and Ek (1996) compared weaning patterns of immigrant born infants to ethnic Norwegians. They found that the duration of exclusive breastfeeding was particularly short among Turkish infants compared to Norwegians. Early introduction of infant formula and cow's milk was also common in this group. A higher prevalence of iron deficiency and a higher intake of sugar compared to ethnic Norwegians were also found in the same study (Wandel et al., 1996).

Immigrants accounted for 12 % of the total population in Norway per 1 January 2014, while Norwegian-born to immigrant parents accounted for 2 % (SSB, 2014). Somalis are the third largest immigrant group in Norway (SSB, 2014) and they stared coming to Norway in the mid-1980 with an increase after the collapse of the Somali state in 1991. However, the largest group of immigrants from Somalia arrived in the 2000's and later (Horst, 2013). Almost all

Norwegian-Somalis came to Norway as refugees, or for family reunification with those who had already settled as refugees. The first generation of Somalis is one of the immigrant groups with the shortest time of residence in Norway. They are also a young group, with 80 percent being under 40 years old. Children of Somalis are similarly young, with 80 percent being younger than ten years old. The fertility rate among Somali women in Norway are high with an average of 3,7 children per woman in 2006 (Government, 2009). In addition, there are also reported about many single parents among immigrant Somalis, particularly single mothers (Government, 2009).

Multicultural competence in health care is the ability to discover the culture of each patient and effectively adapt interventions to respond adequately to the patients' needs (Curry, 2000). Skills that enhance care providers' abilities to recognize different cultural values, beliefs and practices are likely to lead to more successful treatment outcomes (Bonder, 2001). Demonstrating multicultural competence in dietary counselling requires sensitivity to cultural differences and knowledge of culturally relevant foods and food habits and the ability to use it to promote desirable health and behaviour changes. The growing number of immigrants in Norway has been regarded as a challenge to the health care system, including the public health clinics. The public health clinic it the most important arena within preventative health work for children in Norway, as the encounter between parents and health care workers during routine pregnancy and the early childhood years. This gives the health clinic an unique opportunity to work preventative with the health of the population (Government, 1995).
The aim of this study is to generate knowledge about infant feeding practices of Somali mothers and to get a better understanding of how they experience the nutrition communication at the health clinics. A better understanding of the Somali mothers' infant feeding practices, could provide valuable knowledge for developing approaches for practicing culturally sensitivity in health and nutrition communication.

Materials and methods

This is a follow-up study in an on-going project, which was initiated with mothers when their infant was six month of age. This article is based on the findings from both the six-month study and the follow-up study.

Approach and sample

The Grounded Theory approach inspired the strategy used in this qualitative study. Grounded Theory offers a systematic way of transforming collected data into a more abstract form of information (Dahlgren L 2004). This method of investigation was chosen since little empirical data exist on issues surrounding infant feeding beliefs and practices among immigrant Somali mothers living in Oslo.

In the recruitment of the mothers, the researchers from the six-month study used a purposive sampling. The inclusion criteria were Somali mothers, born outside Norway with infants at six months of age, born in Norway. The recruitment was achieved by using a multi-recruitment strategy, which included visits to the health clinic, activity centres, women cafés organized by the Red Cross and by getting access to names of mothers through the National Population Registry [Folkeregisteret]. A multi-recruitment strategy has been suggested to be effective in recruitment of immigrants (Hussain-Gambles et al., 2004). The technique of snowball sampling was also used, which means that the participating mothers were used as a resource for getting in contact with other mothers who matched the inclusion criteria (Dahlgren, Emmelin, & Winkvist, 2004). Fifteen mothers were recruited in the six-month-study.

When the mothers' infants had reached the age of 12 months, it was time to conduct the follow-up interviews. The researcher from the first part of the study created a list of contact information on the participating mothers, which we contacted by phone and scheduled up for follow-up interviews. Nine out of fifteen mothers agreed to do the follow-up interviews, whereas six mothers did not have the opportunity to attend. In that occasion, we recruited six new Somali mothers of one-year old infants to participate in the study based on the principle of saturation. These mothers were recruited through snowball sampling.

Data collection

A semi-structural interview guide was developed before conducting the interviews. At six-months, the interview-guide focused on the mothers' breastfeeding practices and attitudes. In the follow-up interviews at 12 months, the interview guide included; introduction of family food; attitudes to food and drinks with high content of sugar; the husbands and other relative's expectations regarding the child's diet; opinions related to the child's health and wellbeing and the child's preferences in foods.

In the interviews with the six newly recruited participants, we did a prolonged interview where we also asked questions from the six-months-study regarding breastfeeding in addition to the questions listed in the interview guide of the twelve-months study. Only one of the mothers needed an interpreter in this study. A Somali interpreter assisted in the interview and the conversation was interpreted consecutively.

The interviews took place at the researchers' workplace, at the homes to the participants or in a café in Oslo. The participants signed an informed consent ahead of the interviews. The interviews lasted from 40 minutes to one hour and 40 minutes and the mothers received a gift-card as a gratitude for their participation after the interviews.

Data analysis

The recordings of the interviews were transcribed verbatim after each interview. This process is done to make the collected data more available for analysis (Dahlgren, 2004). The *OpenCode* program was used to facilitate the coding and interpretation of the collected data (Dahlgren et al., 2004). The nine interviews from the six-month-study, which I based the follow-up interviews on, were included in the analysis. This was done in order to get a deeper understanding of the mothers' infant feeding practices and to investigate the changes that occurred during the infants' first year of life.

Ethical considerations

The Regional Committees for Medical and Health Research Ethics (REK) approved the InnBaKost project. Confidentiality was secured by giving the participants a coded name and other information that could reveal the participants' identity was not transcribed in the interviews. Every participant got a coded name, and the interview recordings were deleted at the end of the study. The transcribed anonymous interviews were stored to further research. The study was carried out in accordance to the Helsinki declaration.

Results

Characteristics of the participating mothers

Fifteen Somali mothers aged between 22 – 35 years participated in this study. Nine of the mothers were follow-ups from the six-month study, and six were newly recruited for the second part of the study. The mothers' time residing in Norway ranged from 3 – 26 years, and their age at the time of arrival was between 1 and 20 years old (tab.1). Nearly all the mothers were married and most of them had more than one child. Half of the mothers had primary or secondary education and the other half had education at tertiary level. All of the participants lived in municipalities of Oslo and Akershus. One participant required an interpreter during the in-depth interview.

Table 1 Characteristics of the participating mothers

Fictive Name	Age of the mother (years)	Number of children	Years in Norway	Marital status	Education level	Occupation
Ayanna	25	2	18	Married	Secondary	Employed
Nadifa	25	2	-	Cohabitant	Tertiary	Student
Aba	33	5	19	Married	Secondary	Student
Bahari	35	4	21	Married	Tertiary	Employed
Desta	23	2	22	Married	Tertiary	Student
Eidi	24	3	10	Married	Secondary	Unemployed
Fanta	23	1	3	Married	Primary	Housewife
Efia	29	1	15	Married	Tertiary	Student
Hanifa	24	3	8	Married	Primary	Employed
Gasira	31	3	14	Married	Tertiary	Employed
Ife	27	1	26	Married	Tertiary	Employed
Hisani	22	1	21	Married	Tertiary	Student
Farashuu	32	4	13	Separated	Secondary	Student
Jasmina	31	4	11	Married	Primary	Housewife
Idili	30	5	20	Married	Secondary	Student

Early disruption of exclusive breastfeeding

In this study, all of the mothers had breastfed their infants for some period. However, most of them had not breastfed exclusively. A common practice among the mothers was to introduce water early in addition to breastfeeding, due to the belief that breastfeeding made the infant thirsty. A few mothers also said they gave water during summer but not during winter because of the warmer temperature and the infant would need the extra fluid. Idili, a young mother of five, told us about the practice of giving water:

> *"Shall I tell you one thing? It is a bit funny, but we give water very early, we do. In Norway, they say there is no need for water during breastfeeding, but we say the opposite: When you breastfeed, the child gets thirsty. That is what they say in Somalia (…) I have always given some water"*
>
> *- Idili, 30 years, multiparous, 2nd interview*

Early introduction of formula was also a common practice that interfered with the exclusive breastfeeding duration. There were several reasons for supplementing breastfeeding with formula, but the most common rationale was the mothers' perception of the infant not being satisfied after being breastfed:

> *"I breastfed him, but it was not enough for him. He screamed and cried as if he wanted more, so I gave him (formula)"*
>
> *- Aba, 33 years, multiparous, 1st interview*

Breastfeeding in public was also an issue of concern for some mothers. The Islamic tradition to keep body parts covered when together with strangers made it challenging to breastfeed. The feeling of embarrassment was also emphasised. While a few mothers solved this by finding a public toilet or dressing room to secure privacy, others found offering formula to be more convenient. Some of the mothers considered the use of breast pump as a lot of work, and therefore did not use it to prepare breast milk in a bottle.

Despite the fact that most of the mothers had lived in Norway since they were children or adolescents, some mothers said they believed that living in Norway was more demanding compared to the life in Somalia. The mothers referred to that in Somalia one had a large support system of family and friends, whereas in Norway this was lacking. According to these mothers, everyday life was stressful and breastfeeding was difficult to manage during the day.

The mothers therefore resorted to formula feeding, as they experienced it to be more convenient. Many of the participating mothers shared this young mother's belief about how their current life situation influenced their infant feeding practices:

> *"It might be because they (in Somalia) have time and have a lot of people around to help out. I believe that is the reason (for breastfeeding longer in Somalia). For example, I have three kids, I stress and I do not manage to breastfeed all the time… Therefore I give formula"*
>
> *- Hanifa, 24 years, multiparous, 1st interview*

A few mothers had had problems with breastfeeding their previous infants and due to such experience lacked motivation to breastfeed. Further, the availability and price of formula in Norway was also a contributing factor that made formula feeding more convenient than breastfeeding.

Breastfeeding duration

The breastfeeding duration varied among the mothers. Of the nine mothers who participated in the six-month study, three of them had already quit breastfeeding at that time. The mothers who were still breastfeeding (n=6/9) were asked how long they planned to breastfeed their infant, and they planned on an average to breastfeed for one-year. At the time of the 12-month interview, three of the six mothers had breastfed for their planned duration. Only two of the 15 mothers were breastfeeding their infant at 12 months.

Rationales for stopping breastfeeding

The mothers' rationales for stopping breastfeeding varied, but most common explanations were that the infant refused to breastfeed and/or the mothers perceived they had too low breast milk production to satisfy their infant. The mothers said they had tried several remedies to increase their milk supply without effect. A few of the mothers said that production of milk varied among women, and some mothers were not able to feed their infant on breast milk alone:

> "I know that I do not produce enough milk, because I have seen others who breastfeed their child and… We are different, some have a lot of milk and some do not…"

- Eidi, 24 years, multiparous, 1st interview

Introduction of solids

At the infant's age of four months, most of the mothers had introduced other feeds than breast milk to their infant. When the mothers perceived that the infant was not getting satisfied with milk only, they started offering solid foods. For the mothers who exclusive breastfed the longest, giving food at four months was a factor interrupting duration of exclusive breastfeeding. Another reason was that the mothers wished to start accustom their infant to new tastes. The mothers commonly started giving small feeds of baby porridge in the process of weaning. Most mothers gave baby porridge from the supermarket and one of the mothers said that it was because it was enriched with vitamins essential for infants:

> *"I cannot make the porridge from scratch. If I could, I would make it myself, but because it is enriched with iron and such and I cannot make it. That is why I choose "Nestlé". Long live Nestlé! (Laughter)"*
>
> *- Bahari, 35 years, multiparous, 1st interview*

Homemade superior to commercially prepared infant food

As the infant got accustomed to other feeds than porridge, most of the mothers said they gave their infant homemade complementary food to commercially prepared food. Homemade complementary food was fresh, had a better taste and was considered being superior for the infant than the commercially prepared food. The main issue regarding commercially prepared food was related to the trust in quality and freshness.

> *"No, the (commercially prepared) infant food, I do not think it is good. You do not know how long it has been there (in the shelf of the supermarket) (…) It is better that he eats the food I make, because it tastes much better and he gets better vitamins, right… Fresh food."*
>
> *- Aba, 33 years, multiparous, 2nd interview*

However, some mothers gave commercially prepared food because it was perceived as more convenient. A few mothers also preferred giving commercially prepared food because they believed it was best for the infant:

"I did not like the taste, but since it is designed for children, I give it (commercially prepared food) to him. That it is best for him"

- Fanta, 23 years, multiparous, 2nd interview

Common for the mothers who preferred giving their infant commercially prepared food, were their short residence of time in Norway.

Preparation of the infant's first food

The homemade complementary food usually consisted of boiled and mashed vegetables such as potatoes and carrots together with fish or, as the infant got teeth, halal meat.

"I started giving her mashed vegetables… I usually boil potatoes and carrots for a very long time, and then I mash it before I give it to her. She really enjoys it"

- Hisani, 22 years, primiparous, 2nd interview

Pasta and rice were also important commodities added the infants' homemade complementary food. Some of the mothers emphasised the importance of variety in the diet and were therefore consistent when giving their infant different vegetables and protein sources during the week.

The common practice was to prepare food for the family and take a small portion out before seasoning the family's dinner. It was not common to add spices at six months among the mothers. Reasons were that spices were not good for infants and that the food should stay natural. Some mothers used herbs such as coriander in their home-prepared infant food, but avoided hot spices such as chilli. However, some of the mothers said they used to add small amounts of salt or bullion in the infant food to add flavour.

"I add herbs such as coriander, red pepper and garlic, but I stay away from the strong kinds. She (the infant) gets the same food as the family, but I usually take out a portion for her before I season. She only gets the herbs, the coriander, garlic and a pinch of salt. Not too much salt, just to add some flavour"

- Desta, 23 years, multiparous, 2nd interview

At 12 months, the use of spices was more common among some of the mothers as the infants were starting to eat the same food as the rest of the family.

"Earlier, I only gave mashed vegetables without any salt or spices, but (as she got older) I started to season her food little by little. She liked it"

- Ayanna, 25 years, multiparous, 2nd interview

Bread with spread

Bread was commonly given, as the infant was old enough to eat by itself. Bread was easy to bring when going out, and in addition, some mothers emphasized the importance of the infant learning to eat bread before starting kindergarten.

"The one-year-old in the kindergarten, I promise you, they will eat bread. They will learn it there (in the kindergarten), and that is a good thing"

- Idili, 30 years, multiparous, 2nd interview

The mothers' choices of bread spread for their infants were often "mackerel in tomato sauce", "prim", caviar in a tube, chicken liver pate, and cheese and halal meat spread.

"She eats slices of bread with all kinds of spreads, "prim", "mackerel in tomato sauce", mostly everything"

- Desta, 23 years, multiparous, 2nd interview

The importance of halal

All of the interviewed mothers said their family only ate halal food. For the few mothers who preferred giving their infants commercially prepared infant food, it was challenging due to the reduced selection of variety involved with not choosing the ones containing meat. However, these mothers often solved this by choosing the vegetarian infant food.

"I give the one (commercially prepared infant food) with only vegetables, I do not give (the ones containing) meat"

- Gasira, 31 years, multiparous, 2nd interview

Most of the mothers said that eating by Islamic rules was not a concern due to the availability of halal-meat in Oslo and in our neighbor country Sweden.

Consumption of sugar

Most of the mothers said that their infants were too young to be given sugar. Most of the primiparous mothers stated that they were very strict about giving candy and sugar due to believing that candy unhealthy.

> *"Soda and juice? I want to wait (to give the infant) for as long as possible, (…) it contains a lot of sugar and e-materials and I want to wait. Maybe two, three years… four maybe (laughs)*
>
> *- Eifa, 29 years, primiparous, 2nd interview*

It was more common among the multiparous mothers that their infant had tasted candy, and that the infants' older siblings were commonly eating candy. Most of the mothers had sweets available at home at all times

> *"I have it (candy) at home, but I only give them two times a week. To the oldest, not him (the infant)… Not yet, but I will (give candy to the infant)*
>
> *- Eidi, 24 years, multiparous, 2nd interview*

These mothers said that they tried to make restrictions regarding sugar intake, but they often found it difficult. Some blamed their husbands' habit of buying sweets, even though they were against it. Some had the same problem with other family members, which was often expressed as being frustrating.

> *"Every time my brother and family visits, they will buy him candy. (…) I argue with them; don't give candy, don't give chocolate, don't give him anything. But they give him… I know they do…"*
>
> *- Hanifa, 24 years, multiparous, 2nd interview*

Perceptions of the health clinic

Most mothers said they experienced the atmosphere at the health clinics as stressful and that lack of time was a common concern. Some mothers said that the public health nurses were mainly concerned with measuring height and weight to make sure that they had a normal growth instead of talking to the mothers about infant feeding. Some mothers said that they were seldom asked about their current infant feeding practices.

"I somehow felt that they just checked (the infant), I felt that it was much like that, he was very big, so I felt that they checked him out, and then they said, "Yes, you have nothing to worry about". But what if he had had nutrient deficiencies…"

- Nadifa, 25 years, multiparous, 2nd interview

The primiparous mothers were generally more satisfied with the service provided at the health clinics than the multiparous mothers were. The primiparous mothers appeared to be more active at the health clinic, and the mothers who actively brought up their concerns to the public health nurse appeared to be more pleased than those who did not. For instance, there were mothers who were less satisfied, complaining about having to ask the public health nurse for the information they needed.

Infant feeding advice

According to the mothers, the information provided about breastfeeding varied. Some said that they got good information about both exclusive breastfeeding and breastfeeding in general; however, the term exclusive breastfeeding was unfamiliar for most of the mothers. One mother said that she had been asked if she "just breastfed", but the term exclusive breastfeeding was never mentioned. Some mothers had received information regarding introduction of water, others could not recall that water had been a topic at the health clinic

"No, not as I recall, water has not been mentioned at all"

- Ayanna, 25 years, multiparous, 1st interview

Some mothers with low milk supply said they got advice on how to increase their breast milk production and help with different breastfeeding techniques. Some found this useful, and others found that the advices did not work:

"It is not just to drink a lot. It is not, I have tried"

- Eidi, 24 years old, multiparous, 1st interview

However, two of these mothers said they had experienced this as breastfeeding pressure. These mothers had sufficient milk supply, but said that they found breastfeeding challenging

and wanted to quit because of their infants perceived refusal to breastfeed. The quote below illustrates the mothers' experience of getting breastfeeding advice:

> *"I felt an enormous pressure to breastfeed by the health clinic and it was a bit like breastfeed, breastfeed, breastfeed. In a way you felt like a failure if you could not do it."*
>
> *– Nadifa, 25 years, multiparous, 1st interview*

Most of the mothers had started giving small feeds of solids when their infants were four months old. A few of these mothers said they did this because the health clinic had given such advice. The mother quoted below, felt that giving solids to infants at four month was too early, but stated that the public health nurse at the health clinic had told her that it was OK:

> *"At the health clinic, they say that you can start with taste-samples from four months (of age)"*
>
> *- Ayanna, 25 years, multiparous, 1st interview*

Most of the mothers said that they were not satisfied with the information provided about complementary feeding at the health clinic. Brochures and booklets written in Norwegian were usually the information given, and the public health nurse spent little time talking about infant feeding. One mother, who did not speak Norwegian, called for Somali translated brochures and others did not even read them. Some found the brochures useful, but still expressed that it would be useful if the public health nurse could give them more advice regarding complementary feeding:

> *"I wish that the public health nurse could tell me which food I should give at four months, six months and so on, and not just give me a brochure. The brochure is very general, it does not say much about the different stages (of introduction of solids)"*
>
> *- Hisani, 22 years, primiparous, 2nd interview*

Nearly all mothers reported giving their children cod liver oil [tran] or vitamin D supply, and said it was a recommendation from the health clinic. The mothers also knew about the importance of supplementing their infants' diet with vitamin D; due to the lack of sunlight in Norway and that vitamin D was good for the bone health.

Conflicting advices and reliable source of information

In addition to the health clinic, most of the mothers retrieved information from the Internet and received information from their social network such as friends and family members. The latter was especially common among the mothers. The infant's grandmother was considered as having much knowledge about infant feeding, because of having previous experience with infants. However, most mothers said that they had experienced getting conflicting advices related to infant feeding from their Somali network and the health clinic. Early introduction of water was according to some mothers, part of the Somali culture and often advised by the grandmothers:

> *"Among Somalis, it is common to give the child water, and my mother told me; you should give water too"*
>
> *- Bahari, 35 years, multiparous, 1st interview*

Another commonly given advice from the Somali network was supplementing breastfeeding with formula, due to the belief that breast milk was not enough to make the infant grow well enough and gain weight:

> *"They (Somalis) think that breast milk does not have enough (nutrients)… The composition of fat and all it is not enough. Therefore the infants must be provided with formula to gain weight."*
>
> *- Bahari, 35 years, multiparous, 1st interview*

According to some mothers, many Somalis favoured "chubby" children. Being "chubby" was regarded equal to being healthy. Even when the infant was developing in accordance with the growth charts at the health clinic, the Somali network would state that the infant was too thin. Some of the mothers experienced this as very confusing, and the quote below illustrates one mother's experience of getting conflicting advices:

> *"It was two different worlds, I recall. In Norway, the only truth was to breastfeed, right. Among the Somalis, the baby ought to be fat and that made me really confused at that time. That's why I started reading and get more knowledge, and that made me eliminate all that nonsense"*
>
> *- Bahari, 35 years, multiparous, 1st interview*

The quote above also shows how the mother chose to handle getting conflicting advices, through reading and gaining knowledge in order to be better suited to take decisions regarding infant feeding for her child.

The most trustworthy source of nutrition-related information

Regarding information about infant feeding, most of the participating mothers found the information provided at the health clinic as most suitable for their infants. As some of the mothers said, the health clinics gave information based the life in Norway, and due to this, the advices from the Somali network did not appear as useful as those given at the health clinic did:

> *"I mostly take the advices provided by the health clinic. Because they are Norwegians, born and raised in this country and they know what to give to the child as my child is growing up here…"*
>
> *- Fanta, 23 years, primiparous, 2nd interview*

Some mothers also said they trusted the health clinic because they believed they based their advices on research in contrast to the Somali network that often gave advice based on own experience:

> *"I feel like the health clinic and the hospital follow some recommendations, sort of a manuscript, and that they give me information based on what is in it… My network gives advice more based on their experience, right, but it is not said that their experience will work for me."*
>
> *- Desta, 23 years, multiparous, 2nd interview*

A few of the mothers' husbands were also concerned with getting information regarding infants from the health clinic and not from their Somali network:

> *"I try to ask (her mother), but my husband is very aware; "You have to ask the ones who knows, the ones who have knowledge" he tells me all the time. (…) According to him, the doctors and the nurses at the health clinics are the ones with knowledge."*
>
> *- Efia, 29 years, primiparous, 2nd interview*

Which information source to trust, was further strengthened if other source of information supported the information provided. The quote below illustrates this in a good way:

> *"My mother meant that I should start giving him water when he was three months old, and the nurse at the health clinic told me that I should not give water. I believed that the health clinic was right, because I had also read about it elsewhere."*
>
> *- Bahari, 35 years, multiparous, 1st interview*

Discussion

In this in-depth qualitative study, we have managed to get an insight in immigrant Somali mothers infant feeding practices and how they navigate between different sources of information concerning breastfeeding and introduction of complementary foods. What follows is a summary of the findings obtained; they are not intended to be generalized to the whole Somali population living in Norway, but to document the experiences of the mothers in the sample.

Stressful lifestyle and lack of support system in Norway

The mothers reported about time constraints due to a stressful lifestyle in Norway. The lack of support system of friends and family appeared to be an influencing factor on the mothers' breastfeeding duration and a reason for formula feeding. Migration to a country without an establishment of support system has been identified as an important factor for some immigrant women to abandon breastfeeding (Pak-Gorstein, Haq, & Graham, 2009). Traditionally in Somalia, mothers spent the first forty days after birth at home breastfeeding exclusively (the Umol Bah). This period permits family and friends to support the mother and infant on bonding and breastfeeding (Pak-Gorstein et al., 2009). The Somali mothers studied by Steinman et al. (2010) also reported about a decrease in breast milk production due to lifestyle changes.

Some of the mothers perceived their milk supply to be low, which often resulted in supplementing breastfeeding with infant formula. A study done by De Carvalho, Robertson, Friedman, and Klaus (1983) suggests that true or perceived low milk supply is a major cause of early breastfeeding failure and that low milk supply is best treated by frequent breastfeeding to stimulate the milk production (De Carvalho et al., 1983; Hartmann, Cregan, Ramsay, Simmer, & Kent, 2003). The mothers in this study had tried several remedies to

increase their production of breast milk without luck, and considered the use of breast pump as tiring. Therefore, the mothers gave their infant formula, which may have caused the mothers' milk supply to decrease further, due to the lack of stimulation. These findings suggests that breastfeeding should be encouraged among the mothers with perceived low milk supply, and a strategy might be to explain the mechanisms in an easy way so that the mother understand why.

If the mothers low milk supply is true or perceived, is not possible for us to recognise. However, research has provided evidence that stress is an influencing factor on lactation in mothers (Hartmann et al., 2003). The mothers reported about having a stressful lifestyle in Norway, which could have made the production of milk to decrease. Offering the infant formula or other feeds would further decrease the infant stimulation of the breast to lactate, which again will lead to lower milk supply by the mother.

Breastfeeding in public

Breastfeeding in public was an important religious aspect that influenced the mothers' breastfeeding practices. The Islamic tradition to keep body parts covered when in front of nonfamily members can cause Muslim women to offer formula to their infants (Pak-Gorstein). Embarrassment was also mentioned among the mothers in the present study, which is a factor that other studies have related to breastfeeding abandonment (Pak-Gorstein et al., 2009). Some of the mothers who managed to breastfeed when out in public solved this by finding a private spot for her to breastfeed her infant. Strategies to solve this problem among Muslim mothers should be promoted; one strategy might be to use a nursing cover, which cover up both the breasts and the baby and the mother could breastfeed in public without showing skin.

Early disruption of exclusive breastfeeding

Early introduction of water, infant feeding formula and solid foods, were factors causing the majority of the mothers to leave exclusive breastfeeding early. According to a study of Somali mothers' infant feeding practices, exclusive breastfeeding is non-existing in most parts of Somalia. The term exclusive breastfeeding was reported to be equal to giving breast milk and water with sugar, without any soft or solid foods (Mwaura & Moloney, 2008). Giving water early was common among the mothers in this present study, whereas sugar-water was not. Most of the mothers in the present study, said that they had never heard about the term "exclusive breastfeeding", and the ones who had, believed that it was giving water and small

tastes food was included. Low incidence of exclusive breastfeeding has been reported in other studies of immigrant Somali mothers (Cruz, Nguyen, Wandel, & de Paoli, 2014; Madar et al., 2009).

Some mothers in this study mentioned the value of "chubby" infants among many Somalis. This was an important factor for supplementing breastfeeding with other feeds because some mothers believed that breast milk was not enough to secure the infants growth. According to Steinman et al. (2010), chubbiness is linked to health, strength and beauty among a group of Somalis in the US. "Fat and healthy" is how Somali parents wants their children to be, even to be overweight or obese by western standards (Haq, 2003). These findings are consistent with other research done with Somali mothers (Hill, Hunt, & Hyrkäs, 2012), and should be taken seriously. An increased weight during infancy and early childhood is a risk factor for obesity (Owen et al., 2005) and weigh-related complications in adulthood (Dietz, 1998).

A smaller social network in Norway, issues with public breastfeeding, the belief of a low milk supply and the value of chubby children all contributed to the mothers mixed feeding practices for their infants. In order to promote and encourage breastfeeding in the Somali population in Norway, public health workers will need to deal with these perceptions.

Introduction of solids

Most of the mothers in this study reported that they started offering their infant tastings of solids at the infant age of four months, alongside breastfeeding. For some mothers, introducing tastes of solids at four months disrupted exclusive breastfeeding. This was done because the mothers felt that their infant was not satisfied with milk alone and that they wanted to accustom their child to new tastes. According to Mwaura and Moloney (2008), early introduction of solids is common in Somalia as soft food in form of potatoes or porridge are introduced to most children before four months (Mwaura & Moloney, 2008). These findings are also consistent with results found in a review study done by (Schmied et al., 2012).

In the present study, most of the mothers said that they preferred giving their infant homemade complementary food to commercially prepared food. Studies conducted with Somali mothers in the US showed similar attitudes towards commercially prepared infant food (Pak-Gorstein et al., 2009; Steinman et al., 2010). The homemade complementary food was fresh and superior to infants, and the mothers often used fresh vegetables in their cooking. Fish, especially salmon was, according to the mothers, regularly given the infants. A

high consumption of vegetables and fish well known to be beneficial to health, and should be viewed as a positive trend in the diet of immigrant Somali mothers. The mothers who gave their infants commercially prepared food had concerns about whether the food contained meat or not and therefore chose to buy the vegetarian options. However, the recently launched halal-commercially prepared infant food could make infant feeding easier for these mothers, which are available in supermarkets in Oslo and nearby counties.

Consumption of sugar

Since the mothers' infants were only one year old during the interviews, most mothers said their infant was too young to be eating sugar at that age. However, the sugar consumption among the multiparous mothers' older children was discussed. A high consumption of sugar was reported among the infant's siblings, and a few mothers did not have problems giving candy to their children. However, other mothers were more concerned about their children's sugar intake. Some blamed their husbands or other family members for giving candy to their children, although the mother did not want them to. Primiparous mothers were often more careful with giving sugar to their infant than the multiparous. Offering complementary foods without added sugars and salt may be advisable not only for short-term health but also because the taste preferences in early life may set a foundation for children's later food choices (Agostoni et al., 2008; Schwartz, Chabanet, Lange, Issanchou, & Nicklaus, 2011). Parents can thus play a critical role in the development of food preferences, and should therefore be encouraged to give their children food with a low content of sugar and salt.

Infant feeding advice at the health clinic

Some mothers mentioned that introducing tastes of solids at four months was an advice given by the public health nurse. Some mothers disrupted exclusive breastfeeding at four months due to this, which is not according to the breastfeeding recommendations to exclusive breastfeed for six months. However, the recommendations in Norway is in a process of change; a prospective on going study suggests that infants should be introduced to solids such as wheat at four months to protect against development of celiac disease (Størdal, White, & Eggesbø, 2013). The research might be influencing the public health nurses to give such advice.

Stressful atmosphere and insufficient information regarding infant feeding

Some of the mothers experienced the atmosphere at the health clinics to be stressful, and that the public health nurse did not prioritize talking to the mothers about infant feeding practices. The mothers mostly got information about infant feeding through brochures and recipe booklets, which the mothers perceived as not being enough. Similar results were found in a study of immigrants in antenatal care in Norway, where it was reported about a small provision of nutrition-related information from health workers (Garnweidner, Pettersen, & Mosdøl, 2013). Some said that they had received the brochures, but did not read them. A report published in 2009 by the Government reported that Somalis in a small degree relate to written information, and that tailored information is necessary (Somalis in Norway, 2009). The brochures about infant feeding provided at the health clinic are written in Norwegian, and the mothers with short residence time in Norway, called for Somali translated brochures.

Conflicting advices

The mothers described getting conflicting information about infant feeding from their Somali network at the health clinic. Most of the mothers were encouraged to give water and formula to their infant in addition to breastfeeding, which was in conflict with the advice given at the health clinic. According to other studies done with immigrant mothers, it is not uncommon that conflicts occur between traditional beliefs and the dominant practices of the host country (Nielsen, Krasnik, & Holm, 2013; Schmied et al., 2012).

However, despite not being satisfied with the amount of information provided, the findings of this study show that most mothers perceived the information at the health clinics as the most reliable. This was grounded in the belief that the public health nurse knew the appropriate infant feeding practices in Norway, whereas the infant's grandmother only knew how to feed a child in Somalia. Nielsen et al (2013) found that immigrant mothers experienced the Danish health authorities as the most trustworthy source of information, as the mothers often appealed to the advices given from health workers in order to get through with health information to their cultural network.

Limitations

In this study, we did follow-up interviews with nine mothers, and in order to reach saturation, we recruited six new mothers. We performed prolonged interviews, and the mothers were interviewed retrospectively about their infant feeding practices from birth up until one year of

age. This might have led to recall-bias; it might have been difficult to remember their infant feeding practices from the early beginning. However, the findings from the newly recruited mothers could confirm the findings from the mothers who had been interviewed twice, and this further strengthen the findings in this the study. Only one of the mothers in this study needed an interpreter, as most of the mothers came to Norway as children and spoke Norwegian fluently. Although we tried to include a demographically diverse sample, the results might have differed if the more of the mothers had had shorter residence time in Norway.

Conclusion

The findings of this study addresses cultural traditions that influences the mothers' infant feeding practices as well as the mothers perceptions of the nutrition-related information provided at the health clinic. It is apparent that exclusive breastfeeding during the first six month should be further encouraged among Somali mothers. The public health nurses was considered a trustworthy source of nutrition-related information and therefore has a major opportunity to influence unhealthy nutrition-related behaviour and beliefs in this group. Time constraints at the health clinic were one of the reasons the mothers felt they did not get enough information about infant feeding. A few extra minutes during the first consultation to establish the mother's basic knowledge about infant feeding and to map potential cultural influences could prevent conflicts and resources in the future.

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7 Appendices

Appendix 1: Request to participate in the InnBaKost-project and consent form

Appendix 2: Background information sheet

Appendix 3: Interview guide 1 (six-month study)

Appendix 4: Interview guide 2 (12-month study)

Appendix 5: Interview guide 1 and 2 (short version)

Appendix 6: Interpreter manual

Appendix 7: REK-approval

Appendix 1: Request to participate in the InnBaKost-project and consent form

Forespørsel om å delta i InnBaKost-prosjektet

Vil du være med på et forskningsprosjekt som ser på kosthold blant barn med innvandringsbakgrunn?

Dette er et spørsmål til deg om å delta i en forskningsstudie. Fafo skal gjennomføre en undersøkelse av kostholdet blant 6 måneder gamle spedbarn med innvandringsbakgrunn. Undersøkelsen gjennomføres i samarbeid med Universitet i Oslo, Høgskolen i Oslo og Akershus, Nasjonal kompetanseenhet for minoritetshelse og Nasjonalt kompetansesenter for amming. Hovedformålet med undersøkelsen er å øke kunnskapen om kostholdet blant sped- og småbarn med innvandringsbakgrunn og å få et bedre grunnlag for å forebygge kostholdsrelaterte helseproblemer i denne aldersgruppen.

Hvem søker vi?
Vi søker kvinner med barn på 6 måneder som har innvandringsbakgrunn fra Somalia/Irak. Mødrene skal være født i Somalia eller Irak.

Hva innebærer studien?
Dersom du vil delta i studien, ønsker vi å intervjue deg en gang om barnets kosthold når barnet ditt er 6 måneder gammelt og vi vil også vite noe om ditt møte med helsestasjonen. Du vil møte en prosjektmedarbeider som vil utføre intervjuet. Du kan velge om du vil bli intervjuet på norsk eller ditt morsmål. Du trenger bare å svare på de spørsmålene du selv er komfortabel med. Samtalen vil vare omtrent en time og du kan selv velge et passende sted og tidspunkt.

Det er ønskelig at barnet deltar videre på oppfølgingsstudiene når barnet er henholdsvis 1 og 2 år gammelt. Du vil få dekket reiseutgifter til og fra intervjuet. Deltar du på alle intervjuene vil du motta et pengehonorar.

Hva skjer med informasjonen om deg?
Intervjuene vil bli tatt opp som lydopptak, men navnet ditt og annen informasjon som gjør at du vil kunne bli gjenkjent vil ikke bli tatt opp. Det er kun prosjektleder og prosjektmedarbeider knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg for å kunne utføre oppfølgingsstudiene. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres. Lydopptakene og navnelistene vil videre bli slettet når studien avsluttes. All informasjon du gir vil bli behandlet konfidensielt.

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få konsekvenser for deg. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte Marina de Paoli, Fafo, tlf. 22 08 86 52/91 62 64 63. Du kan også skrive en e-post til **mdp@fafomail.no**

Ytterligere informasjon om studien finnes i kapittel A

Ytterligere informasjon om personvern finnes i kapittel B

Samtykkeerklæring følger etter kapittel B

Kapittel A- utdypende forklaring av hva studien innebærer

Bakgrunnsinformasjon om studien
Barnets kosthold tidlig i livet er av stor betydning for barnets helse og utvikling. I løpet av de to første leveårene vokser barnet og barnets ernæringsbehov forandres raskt. Det er tidligere utført kostholdstudier på barn med norske foreldre for å få kunnskap om kostholdet blant disse barna. Det foreligger imidlertid lite kjennskap til kosthold og ammepraksis blant barn med innvandringsbakgrunn. Tidligere studier som har sett på kosthold og ernæring blant barn med innvandringsbakgrunn har ofte kun fokusert på enkelte næringsstoffer eller ikke vært representative når det kommer til utvalgsstørrelse og populasjonsgrupper. Flere og flere studier dokumenterer hvor stor betydning kostholdet tidlig i livet har for utvikling av overvekt og andre sykdommer senere i livet og viser dermed hvor viktig det er å undersøke kostholdet blant barn. Det er også manglende kunnskap på helsestasjonen om tradisjonell barnemat og barneoppdragelse bland innvandrerbefolkningen hvilket kan svekke rådgivningssituasjonen ved møtet med kvinner av innvandrerbakgrunn på helsestasjonen.

Denne studien er en del av et større forskningsprosjekt som heter InnBaKost– Kosthold og ernæring blant barn med innvandringsbakgrunn fra Somalia og Irak – En kvalitativ studie Formålet med InnBaKost-prosjektet er å øke kunnskapen om kosthold og ammepraksis blant barn med innvandringsbakgrunn fra Somalia og Irak. Dette er ønskelig for å kunne utvikle verktøy og strategier for å forbedre ernærings- og helsesituasjonen blant denne målgruppen, og for å kunne kan ta mer hensyn til eventuelle kulturelle faktorer for å forbedre møtet og rådgivningssituasjonen på helsestasjonen.

Studien gjennomføres som intervju ved bruk av intervjuguide av kvinner med 6 måneder gamle barn med innvandringsbakgrunn fra Somalia og Irak. Barna vil bli fulgt opp når de er 1 og 2 år gamle. Kvinner som er født i Somalia og Irak, og som er innvandret til Norge, vil bli spurt om å delta. Inklusjonskriteriet er at barnet er friskt og ikke har en sykdom/tilstand som krever at barnet går på et spesielt kosthold.

Intervjuene gjennomføres av en prosjektmedarbeider og du kan selv velge om du vil utføre intervjuene på norsk eller ditt morsmål. Samtalene vil vare i ca 1 time hver gang. Dersom du ønsker å delta, vil du få spørsmål knyttet til disse temaene:

- Ammepraksis
- Hva slags mat barnet får
- Barnets høyde, vekt (på grunnlag av det som er registrert i barnets helsekort) og generelle helsetilstand
- Generell bakgrunnsinformasjon som f.eks. morens alder, språk, utdanning, yrke, og høyde og vekt, samt familiesammensetning.
- Din opplevelse av møtet og nytteverdien av helsekontroller på helsestasjonen.

Studien innebærer ingen medisinske undersøkelser eller målinger.

Tidsrom
Vi ønsker å gjennomføre første intervju når barnet er 6 måneder gammel og ønsker å starte høsten 2012. Deretter vil du bli kontaktet igjen etter 6 måneder (våren 2013) og det siste intervjuet vil bli gjennomført når barnet er to år (våren 2014), med 2-4 uker mellom første og andre kostintervju.

Mulige fordeler
Dersom du deltar i studien vil du være med på å sette fokus på kosthold og helse blant barn med innvandringsbakgrunn fra Somalia og Irak og hvilke eventuelle tiltak som kan settes i gang for å forbedre helsen deres. Det kan også lede til at samarbeidet med helsestasjonen blir bedre.

Mulige ulemper
En mulig ulempe med å delta i studien kan være at noen synes det er uvant eller privat å snakke om spørsmål som handler om ammepraksis, mat og helse. De som deltar trenger imidlertid bare å svare på spørsmål de føler seg komfortable med. Du trenger ikke oppgi grunn for å avstå fra å svare på enkeltspørsmål og det vil ikke få følger videre i prosjektet.

Kompensasjon
Dersom du deltar vil du kunne få dekket reiseutgifter til og fra intervjuene. Deltar du på alle intervjuene vil du motta et pengehonorar.

Annet
Dersom det gjøres endringer i hvordan studien gjennomføres underveis vil de som deltar få beskjed om dette så raskt som mulig. Du vil da kunne vurdere på nytt om du er villig til å delta i studien videre.

Kapittel B – informasjon om personvern

Personvern
Opplysninger som registreres om deg er alder, familiesammensetning, fødeland, språk, utdanning, yrkesstatus, hvor lenge du har bodd i Norge, høyde og vekt. Det vil være en separat navneliste med kontaktinformasjon for at vi skal kunne oppsøke deg til oppfølgingsstudiene når barnet er 1 og 2 år gammelt. Informasjonen vil bli lagret på Fafo under tilsyn av prosjektlederen. Det blir ikke gjort noen kopling mot andre registre som kan ha opplysninger om deg. Fafo ved administrerende direktør er databehandlingsansvarlig.

Informasjonen som registreres i studien skal kun brukes slik det er beskrevet i forhold til hensikten med studien. Alle opplysninger vil bli behandlet uten navn, fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter opplysninger om den enkelte deltaker sammen. En liste vil koble koden sammen med ditt navn. Denne listen vil oppbevares atskilt fra andre opplysninger i studien. Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Denne listen vil slettes når alle intervjuene er ferdige. Ved det første intervjuet vil deltakerne bli spurt om telefonnummer slik at de kan kontaktes før neste intervju. Også listen med telefonnumre vil slettes når alle intervjuene er gjennomført. Lydopptakene vil bli oppbevart til prosjektslutt år 2016.

Det vil ikke være mulig å identifisere den enkelte kvinne når resultatene av studien publiseres. Navn på helsestasjonen kvinner sogner til eller hvor samtalen har blitt gjennomført vil heller ikke komme fram. Alle som vil behandle opplysningene har taushetsplikt.

Rett til innsyn og sletting av opplysninger om deg og sletting av prøver
Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Annet
Studien er delvis finansiert gjennom forskningsmidler fra Norges Forskningsråd. Fafo er prosjekteier og ansvarlig for oppbevaring og håndtering av data. Det anses ikke som relevant å forsikre deltagere i

prosjektperioden. Resultatene fra studien vil bli publisert. Deltagerne har rett til å få informasjon om hvor resultatene blir presentert og publisert.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)

Appendix 2: Background information sheet

InnBaKost-prosjektet

Bakgrunnsinformasjon til intervju

Dato:

Intervjusted:

Tilstede:

Navn på intervjuer:

Navn (informant):

Navn på barnet:

Alder (informant):

Utdanning:

Yrke:

Sivilstatus:

Antall barn:

Alder på barnet/barna:

Bosted:

Barnets fødselssted:

Barnets høyde og vekt ved fødsel:

Barnets høyde og vekt ved siste kontroll på helsestasjonen:

Andre observasjoner:

Oppfølgingsintervju

Dato:

Sted:

Intervjuer:

Tilstede på intervjuet:

Barnets høyde og vekt ved 1 års kontrollen:

Annen informasjon:

Appendix 3: Interview guide 1 (six-month study)

Intervjuguide

Dybdeintervjuer av mødre med spedbarn i 6 måneders alderen med innvandringsbakgrunn fra Somalia og Irak.

Tema og hovedspørsmål

Intervjuguiden har som mål å dekke følgende tema:

- Å bli en forelder: Overgangen til å bli mor og forelder.
- Amming: Holdninger og erfaringer i den første 6 måneders perioden.
- Spedbarnsernæring i den første 6 måneders perioden.
- Kommunikasjon om spedbarnsernæring på sykehuset etter fødsel.
- Kommunikasjon om spedbarnsernæring på helsestasjoner før fødsel og i den første 6 måneders perioden.
- Motstridende verdier og praksis relatert til spedbarnsernæring.
- Familienettverkets rolle med hensyn til spedbarnsernæring.
- Rollen som andre sosiale nettverk har til spedbarnsernæring.
- Vurdering av måten amming/spedbarnsernæring har foregått.
- Fremtidsplaner i forbindelse med spedbarnsernæring.

Nedenfor er en liste over spørsmål. Hovedspørsmål og hovedmål for studien er å samle informasjon om syn, opplevelse, kunnskap og praksis i forbindelse med spedbarnsernæring hos målgruppen. I tillegg utforske deltakernes erfaring med helsestasjon og helsepersonell.

Introduser deg selv og fortell hva vi er interessert i. Sørg for at de har forstått at du ikke er fra helsevesenet. Fortsett med å spørre om barnet – hans/hennes navn– kommenter utseende på en positiv måte – og få dialogen i gang.

Åpningsspørsmål

Kan du fortelle meg litt om deg selv?

Finn ut: Hvor er du født, når kom du til Norge, andre slektninger – familienettverk – som bor i Norge, hvor bor du, hva gjør du nå

Barn (hvor mange barn, hvor ble de født)

Kan du fortelle om ditt siste svangerskap? (siste født og tidligere svangerskap).

Hvordan var opplevelsen å føde ditt sist fødte barn? (hvis han/henne er med mor) Finn ut: Hva slags fødsel og sted og grunner til at du valgte å føde slik.

Hvis mor har fått barn før spør om tidligere erfaring med fødsel

Hva var dine forventninger til det å bli mor? Hvordan så du det for deg? Var du avslappet til morsrollen eller var du litt redd for det ukjente?

Innledende spørsmål

Hva slags mat får spedbarn vanligvis i Somalia/Irak av deres mødre?

Hva slags mat fikk du som spedbarn?

Hva er (familiens) tradisjonene knyttet til spedbarnskost i hjemlandet? Hvordan påvirker disse tradisjonene spedbarnet får mat? Er det andre ting som du tror påvirker spedbarnskost i praksis (i ditt hjemland eller i Norge). Kan du være snill å gi meg noen eksempler.

Følger du noen av disse tradisjonene i Norge? (barneoppdragelse og spedbarnskost)

Overgang spørsmål

Tar ektemenn eller mødre/svigermødre tradisjonelt del i tema relatert til fødsel, barnets helse og spedbarnsernæring? Forklar. Spør om deres erfaring.

For mødre som også har født i deres hjemland: Har det vært noen forandringer siden du kom til Norge i forhold til deltakelse av ektemann/besteforeldre til barnet rundt tema å føde, barnets helse og spedbarnsernæring? Hva er dine personlige erfaringer?

Hva slags støtte får du fra din ektemann/besteforeldre til barnet i forbindelse med barnets/barna helse og mat som du gir ditt barn/barna? På hvilken måte? Forklar.

Gir din ektemann/barnets besteforeldre råd om barnet/barnas helse, amming og spedbarnskost? Er det andre familiemedlemmer som gir deg råd om dette? Hva synes du om rådene du får og hvordan kan du relatere deg til deres råd?

Er det andre som gir deg råd om barnet/barnas helse, og hvordan du ammer eller hva slags mat du gir barnet/barna dine?

Hovedspørsmål

Hva er din erfaring med amming med ditt barn/barna?

For mødre som har flere barn: Har det vært noen endringer i amming eller spedbarnskost siden ditt første fødte? Hvis ja, hva slags forandringer og hvorfor?

Hvis du skulle snakke med en nybakt mor om amming, hva slags råd ville du ha gitt henne?

<u>Innføring av amming</u>

Hva slags mat/drikke fikk barnet rett etter fødsel? Når var ditt barn plassert mot brystet for å amme etter fødsel? Finn ut: årsaker til umiddelbar eller forsinket amming, hvis forsinket spør hva var det første som ble gitt til spedbarnet og årsaker til dette.

Fikk ditt barn den første melken (colostrum)? Finn ut: Hvis noe av melken ble presset ut, årsaker til denne praksisen (hvis noe av det ikke ble brukt) og tradisjonell tro/syn om colostrum (råmelk).

Ga du eller noen andre barnet annen pre-lacteal mat? Hvis ja, hva slags væske/mat (vann, sukkervann, salt, kumelk, grøt, andre type mat) og hvor lenge. Finn ut: grunner for dette.

Kan du fortelle om omgivelsene og støtten du fikk da du begynte å amme? Hvis ingen støtte gitt, finn ut: hva slags type støtte mor hadde ønsket å få og fra hvem.

Hvordan var din erfaring med amming i de første 6 måneden perioden?

Nåværende ammepraksis

Ammer du ditt barn nå? (J/N)

Hvis ja: hva slags mat/drikke har du gitt barnet ditt fram til nå? Får barnet andre type drikker/mat i tillegg til brystmelk?

For mødre som fortsatt ammer: hvor lenge planlegger du å amme?

Hvis mor fortsatt bare ammer (presiser om hun kun fullammer, i.e. uten tillegg av andre type væsker inkludert vann og mat) undersøk varighet av fullammingen, når og hvorfor andre type væsker og mat vil bli introdusert. Spør hvilke type fastføde/væsker. Undersøk grunner til hennes praksis og kulturelle syn.

Hvis moren ammer delvis (amming med andre type væske) når fikk barnet annen væske enn brystmelk? Finn ut hva slags type væske. Undersøk varigheten av fullammingen. Når vil du introdusere fastføde og hva slags type mat vil du gi barnet? Finn ut grunner for hennes praksis og kulturelle syn.

Hvis *moren praktiserer blandet spedbarnsernæring* (brystmelk med fastføde, drikke og morsmelkerstatning) Når planlegger du å introduserte andre type matvarer og drikke? Hva slags type mat/væsker? Undersøk varighet av fullammingen. Finn ut grunner til hennes praksis og kulturelle syn. Finn ut erfaringer med introduksjon av andre type matvarer/drikker.

Hvis nei: Hva slags mat/drikke ga du til barnet fram til du sluttet med ammingen? Spør om hva slags matvarer/væske hun har gitt barnet. Finn ut grunner for hennes praksis og kulturelle syn. Finn ut om hennes opplevelse med introduksjon av andre matvarer/væske.

Har det vært noen problemer knyttet til ammingen? Finn ut om mangel av brystmelk. Hvis ja, hva har du gjort? Hva har du blitt fortalt med hensyn til det å øke brystmelk produksjonen og hva gjorde du?

Hvordan har din opplevelse med amming vært og har det variert over tid?

Hvis ikke ammet i det tatt: Hva slags mat har barnet fått fram til nå? Spør henne om bruk av morsmelkerstatning, kumelk, andre typer spedbarns mat og grunner til at hun har valgt dem. Finn ut grunner til hennes praksis og kulturelle syn.

Sjekk om du har presisert nok om:

- Blandet mat (morsmelk, andre matvarer og erstatning) - grunner
- Praksis til fullamming (det trenger mye presisering for å finne ut hvor eksklusiv fullammingen har vært eller er)
- Ingen amming (morsmelkerstatning, kumelk) – grunner
- Innføring av andre matvarer (hva, når, hvordan, hvorfor, ritualer)
- Blandet kost (morsmelk med andre matvarer og erstatning) – grunner
- Mors grunner til kostholdspraksis: finn ut tradisjonelle praksis.

Kan du fortelle meg om negative og positive grunner som har påvirket din amme praksis?
Finn ut:

- kommentarer fra familie og venner
- råd gitt av helsepersonell eller andre
- arbeid og familie relaterte problemer
- sykdom hos spedbarn

Rådgivning

Hva slags type informasjon om amming/spedbarnsernæring kan være nyttig for deg?
Hvem mener du vil være den passende personen til å gi informasjon om amming?
Hva slags hjelp/støtte trenger du med hensyn til ditt barns kosthold?
Hvem mener du er den beste personen som kan gi deg råd om amming og hva slags mat du bør gi barnet ditt?

Tjenester på helsestasjon

Hva er din nåværende erfaring med helsestasjon?

ingen tidligere barn: hva er din tidligere erfaring med helsestasjonen (hvis noen)?

Hva slags råd har du fått fra helsesøster/andre helseomsorgsarbeidere) med hensyn til spedbarnskost og barns/barnehelse? Hva slags ernæring relaterte råd har du fått?
Hvem gir deg råd om amming?

Hvordan opplever du måten helsesøster snakker til deg om spedbarnsernæring og helse til småbarn?

Hva har de sagt om oppstart av amming, "pre-lacteal feeds" og bruk av colostrums/ (råmelk)? Hvem har fortalt deg om optimal lengde på fullamming og amming generelt? Hva har du blitt fortalt om spedbarnsernæring/tilleggskost? Hva slags råd har du fått angående oppstart av tilleggskost og tilleggskost som du bør gi? Hadde dette rådet vært nyttig for deg?

Hvordan oppfatter du råd om ernæring og helse gitt til deg av helsesøster? Snakker de til deg om amming, pre-lacteal feeding, weaning og tilleggskost?

Hvor nyttig er informasjonen som du har fått om spedbarnsernæring? Synes du informasjonen var lett eller vanskelig å forstå eller var det vanskelig å følge rådene? Vet du om andre måter å gi mat til ditt barn som er bedre enn rådene som du har fått fra helsestasjonen? Fikk du råd om å ikke følge den tradisjonelle spedbarnsernæring praksisen som du har fra hjemlandet? Hvis så, fortell meg om det.

Har du deltatt i noen spesiell ernæringsprogram eller andre helse program på helsestasjon?

Slutt spørsmål (Alt tatt i betraktnings spørsmål (sammendrag spørsmål / avsluttende spørsmål)
Har du noen spørsmål eller forklaring til noe vi ikke har nevnt om amming?

Har du noe mer du ønsker å tilføye?

Henvisning til et oppfølging intervju etter 6 måneder og 18 måneder.

Appendix 4: Interview guide 2 (12-months study)

Intervjuguide

Dybdeintervjuer av mødre med spedbarn i 12 måneders alderen med innvandringsbakgrunn fra Somalia og Irak.

Tema og hovedspørsmål

Intervjuguiden har som mål å dekke følgende tema:

- Amming: Holdninger og erfaringer i de første 12 månedene
- Introduksjon av barnemat og ved 6 til 12 måneders alder. Holdninger og erfaringer
- Viktig: informantens kunnskap om norsk «barnemat»
- Måltider i familien: Hvordan er de organiserte? Barnets deltakelse - får barna den samme maten som voksne? Hvis det er forskjeller, hva består forskjellene i? Eller er den ikke krydret?
- Informasjon og råd om barnemat på helsestasjonen i den første 12 måneders perioden.
- Motstridende verdier og praksis relatert til amming og barnemat.
- Familienettverkets rolle med hensyn til amming og barnemat.
- Rollen som andre sosiale nettverk har til amming og barnemat.
- Vurdering av måten amming/spedbarnsernæring har foregått frem til oppfølgings intervju nr. 2.
- Planer i forbindelse med barnemat - nå og fremover.
- Mat i barnehagen - ideer om hvilken mat skal de ha med seg?

- HUSK! Skriv inn: tran, kostnader og praksis i hjemlandet med hensyn til morsmelkerstatning, gi melk om natten

Nedenfor er en liste over spørsmål. Hovedspørsmål og hovedmål for studien er å samle informasjon om syn, opplevelse, kunnskap og praksis i forbindelse med barnemat og ernæring

hos målgruppen. I tillegg er det å utforske deltakernes erfaring med helsestasjon og helsepersonell.

Introduser deg selv og fortell hva vi er interessert i. Sørg for at de har forstått at du ikke er fra helsevesenet. Fortsett med å spørre om barnet – hans/hennes navn – kommenter utseende på en positiv måte – og få dialog

Åpningsspørsmål

Kan du fortelle meg om hvordan det har gått siden vi sist snakket mht amming, barnemat, søvn, sykdom etc.

Følg også opp på info du har fra siste intervjuet.

Innledende spørsmål

Kan du fortelle meg litt om hva du har gitt og gir barnet av mat?

Kan du fortelle meg om hva ditt barn har spist og drukket i løpet av dagen? (Morgen, når han/hun våkner, mitt på dagen, mellommåltider, middag, mat/drikke om kvelden før han/hun legger seg, mat om natta)

Er dette mat som barn vanligvis får i Somalia/Irak??

Husker du – eller har du blitt fortalt - hva slags mat fikk du som barn?

Hva er (familiens) tradisjoner knyttet til barnemat i hjemlandet? Hvordan påvirker disse tradisjonene den maten du gir ditt (spesielt sistfødte) barn? Er det andre ting som du tror påvirker hva du gir av barnemat i praksis (i ditt hjemland eller i Norge). Kan du være snill å gi meg noen eksempler.

Følger du noen av disse tradisjonene i Norge? (barneoppdragelse og spedbarnskost)? Er det viktig for deres Somaliske/Irakiske identitet å gi barnet mat som er typisk fra deres hjemland? Er det noe mat som du mener er spesielt viktig å gi til ditt barn som er bra for hans/hennes helse?

Hva slags mat gir du barnet som du mener er norsk? Deltar du i barselgrupper, åpen barnehage eller samlingssteder for mødre hvor dere spiser sammen og gir råd til hverandre? Er det også norske mødre og barn der? Hva synes du om maten de norske mødrene gir barna sine? Bruker du samme type mat?

Er det viktig for dere å gi norsk mat for å integrere barnet/dere selv i norsk kultur og identitet?

Overgangsspørsmål

Måltider i familien

Kan du fortelle hvordan måltidene er organisert i din familie? Hvilke måltider spiser dere sammen? Når, hvem deltar, hva spises der, er det felles mat eller ulike mat for barn og voksne? Hva er «barnemat»?

Spørsmålet er blir stilt lenger ned Snakker dere sammen i familien om maten? Og snakker dere sammen om maten til barnet? Snakker du med din ektemenn eller mor/svigermor om barnets helse og maten du gir til ditt/dine barn? Hvem er ansvarlig for å kjøpe inn mat, tilberede og mate barnet? Ser du noen forskjeller på denne arbeidsfordeling i Norge sammenlignet med ditt hjemland?

Spiser dere ofta ute? Hvor spiser dere? Hva bestiller dere for barnet? Hvorfor dette? (valg av mat) Take away mat? (pizza, hamburger, pommes frites, kebab, brus, milkshake, is, nuggets??

Fredags/lørsdagskos? (potetgull, godteri, sjokolade, brus etc.)

Gir din ektemann/mor eller svigermor råd om barnet/barnas helse, amming og barnemat? Er det andre familiemedlemmer som gir deg råd om dette? Hva synes du om rådene du får og hvordan kan du relatere deg til deres råd?

Er det andre som gir deg råd om dine/ditt barns helse, og hvordan du ammer eller hva slags mat du gir dem?

Hovedspørsmål

<u>Nåværende ammepraksis</u>

Ammer du ditt barn nå? (J/N) Spør hvor lenge hun fullammet (for å sammenligne med info vi fikk ved første intervjuet)?

Hvordan kan du oppsummere din erfaring og praksis knyttet til amming frem til nå?

For mødre som fortsatt ammer: hvor lenge planlegger du å amme?

Hvis mor fortsatt ammer prøv og finne ut hvor ofte og hvor mye? Spør hvis hun gir barnet morsmelkerstatning eller kumelk? type fastføde/væsker. Undersøk grunner til hennes praksis og kulturelle syn.

Hvis nei: Hva slags mat/drikke ga du til barnet fram til du sluttet med ammingen? Finn ut grunner for hennes praksis og kulturelle syn. Finn ut om hennes opplevelse med introduksjon av andre matvarer/væske.

Hvordan har din opplevelse med amming vært siden vi sist traff deg?

Har det vært noen problemer knyttet til ammingen etter det første intervju? Finn ut om mangel av brystmelk. Hvis ja, hva har du gjort? Søkte du råd noe sted – hvor? Hva har du blitt fortalt med hensyn til det å øke brystmelk-produksjonen og hva gjorde du?

Hva mener du er best for barnet: morsmelkerstatning eller brystmelk? Hvorfor synes du det?

Tror du at kroppsideal (fine bryst etc) påvirker ammelengden hos irakiske/somaliske kvinner i Norge? Hva tror du er grunnen til at somaliske/irakiske kvinner ammer kortere enn mødrer som bor i Somalia/Irak? Hvordan har din erfaring vært med amming med ditt barn/barna? Har du følt press fra noen på å gi morsmelkerstatning (NAN) derfor slutter de å amme tidligere?

Bruker ditt barn smokk? Når, hvor lenge og hvorfor? Tilsetter du noe honning på smokken? Irakisk: Har kommet frem i et intervju at barnet får tørket spiserør fra sau, som de steker i ovnen med litt salt. Dette blir brukt som smokk, årsak: smokk inneholder ukjente kjemikalier.

For de mødrene som ammet eksklusivt i 4-6 måneder/eller bare lenge: hør om hvordan dette tas i mot i det irakiske/somalisk miljø?

<u>Innføring av mat</u>

Repetisjon: Hva var det første som ble gitt til ditt barn av mat og drikke? Ved hvilken alder? Mors grunner til kostholdspraksis: finn ut tradisjonelle praksis.

Har dere introdusert noe nytt til barnet siden sist gang? / Hva slags mat har barnet fått fram til nå? Spør henne om bruk av morsmelkerstatning, kumelk, andre typer spedbarns mat og grunner til at hun har valgt dem. Finn ut grunner til hennes praksis og kulturelle syn. (Probe for usunne og sunne produkter uten å nevne usunt/sunt ved navn: brus, kjeks, potetgull, pommes frites, godteri, kake, dessert, is, lokom (Irak), kumelk med tilsatt sukker (smaksatt melk, sjokolade, og sunn: jordbær, banan, annen frukt, yoghurt,… etc.)

Er det noen spesiell årsak til at du gir denne type mat? Finn ut erfaringer med introduksjon av andre type matvarer/drikker.

Hva liker barnet ditt å spise? Hva liker det ikke? Hvor mye bestemmer du hva ditt barn skal spise og hvor mye lar du ham/henne styre? Innføring av andre matvarer (hva, når, hvordan, hvorfor, ritualer)

Er det mat som du pga din religion eller kultur ikke kan gi til ditt barn? Hva er årsaken til dette?

Får barnet ditt vann, saft, brus, juice, morsmelkerstatning, kumelk, te, sukkervann og brystmelk (pumpet)? Annen væske? Får de det via flaske eller kopp?

Gir dere barnet mat fra ferdigglass kjøpt i butikken eller hjemmelaget? Hva slags ferdigmat? Hva inneholder den hjemmelagde maten? Krydder, salt, pepper, kjøtt, kylling, fisk, grønnsaker, frukt.

Gir dere te til barnet? Gir dere fortsatt te til barnet? Hva slags type te? Har dere sukker, melk, honning i teen? Hvor ofte? Eksempler som har blitt nevnt av informantene: Kamillete, marimia (sterk lukt, ser ut som kvister, lysegrå, parfymesmak), nobat (ser ut som krystaller, safran og sukker). Alle disse typer te blir gitt når barnet har luft eller vondt i magen.

Gis honning? På smokk, flaske, i te osv

Lokom (dessert, legges i en tøy bit som barnet får og kan sutte på)

Hvor handler dere mat inn mat? Mest «innvandrerbutikker»? Handler dere i Sverige? Hvorfor?

For mødre som har flere barn: Har det vært noen endringer i amming eller barnemat sammenlignet med dine eldre barn? ? Hvis ja, hva slags forandringer og hvorfor? Det her blir også spurt i første intervju men vi følger opp og sjekker.

Hvis du skulle snakke med en mor om amming og barnemat, hva slags råd ville du ha gitt henne basert på dine erfaringer? (Dette skulle blitt spurt om ved 1. intervjuet, se om hun sier det samme.)

Kan du fortelle meg om hva som har påvirket din ammepraksis og hva du gir ditt barn å spise? Finn ut:

- kommentarer fra familie og venner
- råd gitt av helsepersonell eller andre
- arbeid og familie relaterte problemer
- sykdom hos spedbarn

<u>Mødrenes syn på optimal barneernæring og rådgivning.</u>

Hva legger du i begrepet ”sunn mat”, og hvor viktig syns du dette er i forhold til ditt barns kosthold?

Hva er dine oppfatninger om hva som er den beste maten for små barn (med fokus på alder 6-12 måneder)? Hva synes du om den maten du har gitt til barnet ditt? Har det vært noen utfordringer i forhold til tid, økonomi eller barnets preferanser?).

Følger du med i media når det blir tatt opp saker om amming og barnemat?

<u>Barnehage</u>

Har barnet begynt på barnehage/barnepass/dagmamma eller besteforeldre?

Hvis ja: Når og hvorfor begynte barnet med det?

Hvor lenge er de i barnehagen (hel eller halv dag)?

Hva slags mat får barnet i barnehagen? Sender dere med matpakke (hva da?)

Har dere fått noen kommentarer på hva barnet kan ha med seg i barnehagen? (sukkerfri barnehage)

Hvis barnet ikke i barnehage: Hva er grunnen til det? (probe: Kontantstøtte)

Hvis mye hos besteforeldre/andre slektninger: Hva får de når de er hos dem? Er det noen konflikt i forhold til maten barnet får hos besteforeldre/andre slektninger?

Hvis besteforeldre/andre slektninger: Hva gir de? Eller har du gjort i stand mat på forhånd til barnet?

Rådgivning

Hva slags type informasjon om amming og barnemat har vært nyttig for deg?
Hvor har du fått denne informasjonen?
Hva slags hjelp/støtte trenger du med hensyn til ditt barns kosthold?
Hvem mener du er den beste personen som kan gi deg råd om amming og hva slags mat du bør gi barnet ditt?
Bruker du Internett for å innhente informasjon? Hvilke sider foretrekker du å bruke? Kan man stole på det man finner på Internett?

Tjenester på helsestasjon

Hva er din erfaring med helsestasjon frem til nå?

Hva slags råd har du fått fra helsesøster/andre helseomsorgsarbeidere med hensyn til barnemat, barneernæring og barns helse?
Hvordan opplever du måten helsesøster snakker til deg om barnemat og helsen til småbarn?

Hva har du blitt fortalt om spedbarnsernæring/amming/tilleggskost? Hva slags råd har du fått

angående oppstart av tilleggskost og tilleggskost som du bør gi? Hadde disse rådene/informasjonen vært nyttig for deg?

Hvordan oppfatter du råd om ernæring og helse gitt til deg av helsesøster? Synes du informasjonen var lett eller vanskelig å forstå eller var det vanskelig å følge rådene? Vet du om andre måter å gi mat til ditt barn som er bedre enn rådene som du har fått fra helsestasjonen? Fikk du råd om å ikke følge den tradisjonelle praksisen som du har fra hjemlandet? Hvis så, fortell meg om det.
Ville det vært en fordel om de på helsestasjonen snakket ditt morsmål? Og/eller har informasjon (brosjyrer, fakta-ark, internettsider) på ditt morsmål?

Har du deltatt i noen spesielle ernæringsprogram eller andre helseprogram på helsestasjon siden sist gang?

Slutt spørsmål (Alt tatt i betraktnings spørsmål (sammendrag spørsmål / avsluttende spørsmål)
Har du noen spørsmål eller forklaring til noe vi ikke har nevnt om barnmat og amming?Har du noe mer du ønsker å tilføye?
Henvisning til et oppfølging intervju etter 12 måneder.

Appendix 5: Interview guide (short version)

Svangerskap og fødsel	**Innføring av mat**	**Rådgivning**	**Barnehage**
- Hvordan var svangerskapet? (Siste og evt. Tidligere svangerskap) - Hvordan gikk fødselen?	- Nåværende ammepraksis - Første mat som ble gitt, årsaker. - Hvordan tilberedes maten? - Erfaringer med innføring av mat - Hva liker barnet å spise - Drikke (saft, juice, melk, vann) - Ferdigmat vs. Hjemmelaget - Frukt og grønnsaker - Somalisk mat vs. Norsk mat (årsaker, viktig å gi norsk mat?) *Hva ga du barnet ditt av mat i løpet av dagen i går? (24 t) + klokkeslett* **Mødre som har flere barn** - Endringer? - Erfaring over tid *Hva er det beste du kan gi barnet ditt av mat/hva er sunn mat for barnet ditt?*	- Info som har vært nyttig for deg - Hvor får du info og fra hvem? - Hvem vil du helst ha råd fra? Årsaker - Internett/aviser/bøker /ukeblader? - Spør du om du lurer på noe? - Spør noen deg om råd?	- Mat i barnehage - Matpakke? Hva sendes med? **Om slektninger passer på barnet** - Har mor kontroll på hva som blir gitt barnet?
Amming **Rett etter fødsel** - Når, hvordan - Råmelk? - Evt. Hvorfor ikke - Annen mat/drikke - Hjelp/støtte? Hvem/hvordan - Hvis ikke: Hva skulle du ønske? **Fullamming/eksklusiv amming** - Ja/nei? Evt. Hvor lenge - Årsaker til ja/nei - Når sluttet du? Årsaker - Annen mat/drikke (vann) **Problemer med amming** - Hvilke - Hva ble gjort for å få det til? - Råd i forhold til amming **Erfaring med amming**	**Måltider i familien** - Hvordan er de organiserte? Spiser dere måltider sammen? - Barnas deltagelse – samme mat som de voksne? - Forskjeller? Hvilke? Krydder?	**Helsestasjon** - Erfaringer - Benytter du deg av helsestasjonen? Hvorfor/hvorfor ikke? - Kostholdsråd/info - Lett/vanskelig å forstå helsesøsters råd? - Bedre råd fra andre? Ernæringsprogram/helseprogram **Mødre med flere barn** - Endringer fra første barn? Får du fortsatt informasjon eller forventer de at du kan det du skal kunne om mat og barn?	**Annet** - Kosttilskudd; tran, vit-D - Søtsaker (hvor ofte, hva, hvem gir?) - Bakervarer, boller, pålegg (syltetøy, nugatti, hapå) - Kafébesøk - Restaurantbesøk

Manual for tolk i

InnBaKost-prosjektet

FAFO 2012

FAFO

Fafo er en uavhengig stiftelse som forsker på arbeidsliv, velferdspolitikk og levekår, nasjonalt og internasjonalt. Fafo er stiftet av Landsorganisasjonen i Norge, Orkla ASA, Umoe As, Elkem ASA, Coop Norge, Sparebank 1 Gruppen, Fagforbundet og Telenor AS. Postadresse: Postboks 2947 Tøyen, 0608 OSLO. Besøksadresse: Borggata 2B. Telefon: 22088600, Telefax: 22088700

Forord

Denne manualen er en veiledning for tolk som deltar i InnBaKost-prosjektet i Oslo, høsten 2012. Manualen vil gi oversikt over retningslinjer som vil bli gjennomgått underopplæring av tolk.

Undersøkelsens bakgrunn og hensikt

Ammepraksis blant mødre med somalisk og irakisk innvandringsbakgrunn

Forskningsinstituttet FAFO skal gjennomføre en undersøkelse av kostholdet blant 6 måneder gamle spedbarn med somalisk og irakisk innvandringsbakgrunn. Undersøkelsen gjennomføres i samarbeid med Universitet i Oslo, Høgskolen i Oslo og Akershus, Nasjonal kompetanseenhet for minoritetshelse og Nasjonalt kompetansesenter for amming. Hovedformålet med undersøkelsen er å øke kunnskapen om kostholdet blant sped-og småbarn med innvandringsbakgrunn. I tillegg å få et bedre grunnlag for å forebygge kostholdsrelaterte helseproblemer i denne aldersgruppen.

Det er en mangel på informasjon om ammepraksis og spedbarnsernæring blant kvinner med innvandringsbakgrunn. Årsaken er ofte ekskludering av kvinnene i nasjonale amming og spedbarnskost studier. En studie som InnBaKost er viktig for å bedre kunnskapen på dette området. Undersøkelsen kan gi funn som vil være nyttig i utforming av strategier for å gi råd om amming og spedbarnsernæring til mødre med innvandringsbakgrunn. Helsepersonell vil muligens ha nytte av denne kunnskapen i møte med mødre med innvandringsbakgrunn. I tillegg til å bidra med økt kunnskap rundt ammepraksis og spedbarnskost.

Din rolle i prosjektet

Innsatsen til tolk vil være avgjørende for kvaliteten av datamaterialet. Nøyaktighet av oversetting av intervjuguide og tolk under intervju skal gi en best mulig beskrivelse over informantens oppfatning, holdning og syn rundt amming og spedbarnskost.

Samtidig vil dere få informasjon om mødrenes ammepraksis og spedbarnsernæring. Dette er et viktig prosjekt og vi håper dere er opptatt av at intervjuene gjennomføres på best mulig måte.

Personvern

FAFO har fått godkjent søknad fra Regionale komiteer for medisinsk og helsefaglig forskningsetikk (REK). REK er en komité som undersøker om prosjekter er i samsvar med forskningsetikkloven og helseforskningsloven.

Hvem skal intervjues?

Det er imidlertid lite kunnskap i forhold til kosthold og ammepraksis hos mødre med innvandringsbakgrunn. Tidligere studier som har sett på kosthold og ernæring blant barn med innvandringsbakgrunn har ofte kun fokusert på enkelte næringsstoffer eller ikke vært representative når det kommer til utvalgsstørrelse og populasjonsgrupper. Flere studier dokumenterer hvor stor betydning kosthold tidlig i livet har for utvikling av overvekt og andre sykdommer senere i livet og viser dermed hvor viktig det er å undersøke kostholdet blant barn. Det er i tillegg manglende kjennskap på helsestasjon om tradisjonell barnemat og barneoppdragelse blant innvandrerbefolkningen som kan svekke rådgivningssituasjonen ved møtet med kvinner av innvandrerbakgrunn på helsestasjonen.

I denne studien vil enkeltpersoner som oppfyller inklusjonskriteriene bli rekruttert til intervju. Inklusjonskriteriene er mødre med innvandringsbakgrunn fra Somalia eller Irak, barnet er 6 måneder gamle og at barnet er friskt og ikke har en sykdom/tilstand som krever at barnet går på et spesielt kosthold. Informantene har blitt rekruttert på forhånd

Hvordan være en god tolk under intervjuet?

I dette avsnittet skal vi beskrive hvilken fremgangsmåte som skal benyttes under intervju. Du vil på forhånd bli informert om når og hvor intervjuene skal foregå. Det vil tilsammen utgjøre omtrent 15 intervjuer av enkeltpersoner.

1) Presenter deg selv for informanten, fortell at du vil fungere som tolk under intervjuet. Og at du er et mellomledd, påpeke at samtalen er mellom intervjuer og informant.
2) Oversett direkte og nøyaktig, unngå unnlatelse av informasjon. Vi ønsker mest informasjon.

3) Unngå å gjøre forkortelser på det som blir sagt (forforståelse på ting, ikke ta det som en selvfølge at vi har kjennskap til det som blir sagt mellom deg (tolk) og intervjuobjektet
4) Unngå egne kommentarer og meninger.
5) Prøv å oversette fortløpende.
6) Vær oppmerksom på kroppsspråket ditt (vær nøytral i reaksjonen din, ikke gi uttrykk for om du er enig eller uenig med informanten.
7) Du har taushetsplikt.

Kvalitetskontroll

Under intervjuet er det viktig at spørsmålene som vi stiller blir riktig oversatt og formulert til intervjuobjektet, slik at vi får svar på det vi har spurt om. Etter intervjuene vil disse bli skrevet ordrett på data. Under transkribering kan uklare svar bli oppdaget underveis, vi kan dermed ønske oppklarhet fra deg.

Oppbygning av tillit hos informanten

I alle dybdeintervjuer er det viktig at tolken forsøker å skape tillit hos dem som skal intervjues. Dette gjelder spesielt når mødre med innvandringsbakgrunn skal intervjues, fordi mange av dem kan være usikre på hva opplysningene skal brukes til og til hvem som egentlig står bak undersøkelsen. De kan også være usikre på om tolken virkelig er den han eller hun gir seg ut for å være. For at intervjuerne skal kunne overbevise intervjuobjektene om hvem som står bak undersøkelsen vil intervjuerne bli utstyrt med:

1) Identifikasjonspapirer med bilde,
2) Et informasjonsbrev fra FAFO, og
3) Et kort med telefonnummer og navn på en av de prosjektansvarlige ved FAFO

1) Forklare nøye hvem han/hun er
2) Forklare hva som er hensikten med prosjektet.
3) Forklare hva FAFO er

4) Forklare at det er viktig for kvaliteten på prosjektet at alle som takket ja til å delta svarer på spørsmålene.

Vær oppmerksom på at personen sier ja til å bli intervjuet ikke behøver å bety at du har personens tillit. Tillit er viktig for å få så gode og oppriktige svar som mulig. En intervjuer må aldri forsøke å presse intervjuobjektene til å svare på en bestemt måte.

Dersom du får følelsen av at intervjuobjektet ikke gir helt sannferdige svar, kan du forsøke å på en vennlig eller spøkefull måte å peke på motsigelser i den informasjonen som du får. Dette må gjøres med varsomhet.

Generelle retningslinjer

1: Ikke bli aggressiv. Gi ikke intervjuobjektet følelsen av å bli kalt for løgner. Prøv heller å antyde at de husker feil, en å gi inntrykk av at du tror de holder tilbake informasjon.

2: Hvis det er klare motsigelser i svarene som avgis bør du høflig gjøre oppmerksom på dette. Du kan unnskylde deg med at du vil måtte forklare dette for prosjektansvarlig, eller at dataprogrammet ikke vil akseptere slike svar, og at du derfor må oppklare det.

Holdningsspørsmål

Intervjuguiden inneholder en del spørsmål om mødrenes kulturelle syn og praksis til spedbarnskost. Dette er spørsmål som ikke har noe riktig eller galt svar, og det er viktig at du som tolker ikke på noen måte gir utrykk for hva du selv mener.

Høflighet og diskresjon

En del av de spørsmålene som stilles kan virke nærgående og ubehagelige for intervjuobjektet. Det er viktig at du som tolker har en tilbakeholden rolle når disse spørsmålene stilles. Du må ikke gi inntrykk for overraskelse, misnøye eller fordømmende holdninger til de svarene som gis. Du bør for eksempel ikke riste på hodet eller smile av det som blir sagt.

Forklar hensikten med prosjektet hvis informanten spør

For å skape tillit hos intervjuobjektene vil du i mange tilfeller måtte forklare nøye om hva som er hensikten med undersøkelsen. Når du forklarer bør du huske følgende:

- Snakk klart og tydelig. Forsøk å unngå vanskelige ord og utrykk. Ikke snakk for fort, men hold en vennlig og profesjonell tone.
- Fortell at du arbeider for FAFO, som er en selvstendig forskningsstiftelse. Gjør klart at deltagelse i dybdeintervjuet er frivillig.
- Understrek at dybdeintervjuet er viktig for intervjuobjektet, fordi resultatene kan brukes til utarbeiding av tiltak for å forebygge kostholdsrelaterte helseproblemer blant spedbarn med innvandringsbakgrunn.

Profesjonell adferd

Når du skal ut og være tolk, forventes det at du opptrer profesjonelt. Det å være profesjonell innebærer en rekke faktorer:

1: Du må ha kunnskaper om InnBaKost-prosjektet, slik at du kan forklare hva som er hensikten med det. Du må også kjenne litt til FAFO.

2: Du må virke overbevisende i intervjusituasjonen. Dette innebærer at du må kjenne intervjuguiden så godt at du kan behandle det på en rolig og sikker måte. Du bør prøve å unngå å virke rotete og klønete, for eksempel å bla fram og tilbake i intervjuguiden og lete etter noe. Det er lurt å ha noen penner i reserve, slik at du slipper å låne.

3: Du bør opptre høflig. Forsøk å opptre rolig og vis respekt for private saker. Det gir et dårlig inntrykk å tygge tyggegummi, bite i penner osv.

4: Utseende og påkledning: husk på at det ikke er deg selv du presenterer i intervjusituasjonen. Kle deg ordentlig, unngå det ekstreme og påfallende. Bruk klær og sminke i nøytrale toner.

Appendix 7: Approval from REK

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Katrine Ore	22845517	28.06.2012	2012/957/REK sør-øst A

Deres dato:	Deres referanse:
22.05.2012	

Vår referanse må oppgis ved alle henvendelser

Liv Elin Torheim
Pb 2947 Tøyen

2012/957 Ernæring og helse blant barn med innvandringsbakgrunn

Forskningsansvarlig: Fafo ved øverste ledelse
Prosjektleder: Liv Elin Torheim

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst) i møtet 14.06.2012. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikklovens § 4.

Prosjektomtale
Denne studien er en del av et større forskningsprosjekt som heter InnBaKost– Kosthold og ernæring blant barn med innvandringsbakgrunn. Formålet med InnBaKost-prosjektet er å øke kunnskapen om kosthold og ammepraksis blant barn med innvandringsbakgrunn fra Somalia og Irak (mors fødested). Studiens resultater forventes å kunne benyttes til å utvikle verktøy og strategier for å forbedre ernærings- og helsesituasjonen blant denne målgruppen. Studien skal gjennomføres som intervju samt spørreskjemaer og "24-timers kostintervju" av kvinner med 6 måneder gamle barn. Barna vil bli fulgt opp når de er 1 og 2 år gamle. Inklusjonskriteriet er at barnet er friskt og ikke har en sykdom/tilstand som krever at barnet går på et spesielt kosthold. Studien er samtykkebasert og alle som deltar i hele undersøkelsen vil få fem flaxlodd. Prosjektets forskningsfil vil bli lagret avidentifisert og alle opplysninger som er samlet inn i prosjektperioden vil bli slettet i 2016.

Vurdering

Komiteen vurderer prosjektet som viktig forskning på barns helse.

Komiteen ber om at informasjonsskrivet som har tittelen "Invitasjon til å delta i en undersøkelse av kostholdet blant spedbarn med innvandringsbakgrunn" endres til forespørsel om å delta.. I samme informasjonsskriv bør det fremgå at det er mors fødested som er utgangspunktet for forespørsel om deltakelse. Komiteen ber også om at det ikke legges press på eventuelle deltakere til å være med i prosjektet fordi det vil gi best forskning. Forskningsdeltakere kan trekke seg når som helst fra en studie uten hensyn til prosjektets vitenskapelige verdi.

Vedtak
Komiteen godkjenner prosjektet på vilkår som beskrevet ovenfor, med hjemmel i helseforskningsloven § 9 jf. § 33. Revidert informasjonsskriv sendes komiteen til orientering.

Godkjenningen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet isøknaden, og i samsvar med de bestemmelser som følger av helseforskningsloven med forskrift.

Godkjenningen gjelder til 01.08.2015.

Forskningsprosjektets data skal oppbevares forsvarlig, se personopplysningsforskriften kapittel 2, og Helsedirektoratets veileder for «Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren».

Dersom det skal gjøres endringer i prosjektet i forhold til de opplysninger som er gitt i søknaden, må prosjektleder sende endringsmelding til REK.

Prosjektet skal sende sluttmelding på eget skjema, se helseforskningsloven § 12, senest et halvt år etter prosjektslutt.

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jf. helseforskningsloven § 10, 3 ledd og forvaltningsloven § 28. En eventuell klage sendes til REK Sørøst A. Klagefristen er tre uker fra mottak av dette brevet, jf. forvaltningsloven § 29.

Komiteens avgjørelse var enstemmig.

Med vennlig hilsen

Gunnar Nicolaysen
Professor

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Katrine Ore
Rådgiver