Infant feeding practices of Iraqi mothers residing in Norway

*In-depth interviews with Iraqi mothers of six months old infants*

Joanna Rose Hermo Cruz

Master thesis
Department of Nutrition
Faculty of Medicine

UNIVERSITY OF OSLO
June 2013
Infant feeding practices of Iraqi mothers residing in Norway

In-depth interviews with Iraqi mothers of six months old infants in Norway

Supervisors:
Margareta Wandel
Marina de Paoli

Master thesis in Nutrition
University of Oslo

By:

Joanna Rose Hermo Cruz
Joanna Rose Hermo Cruz

2013

Infant feeding practices of Iraqi mothers residing in Norway

Joanna Rose Hermo Cruz

http://www.duo.uio.no/

Trykk: CopyCat, Oslo
Acknowledgement

My two last years in the master program nutrition, has come to an end with this master thesis. I have been working with the master thesis for about a year, and I have realized I am taking with me a great experience and more knowledge on infant nutrition. I am very thankful to have been a part of the project InnBaKost. It has been an exciting learning process putting theory to practice.

This thesis is the result of one year hard work. However, this would not have been possible without the discussions throughout the process with my fellow master student/researcher Camilla Nguyen and my two supervisors through this process, Marina de Paoli and Margareta Wandel. I want to thank my two supervisors for the support, feedback and for always being available. In addition, I want to thank Fafo, where I have spent thousands of hours writing and doing literature search, for giving me a space to write and read. I also want to thank the interpreters for the assistance in recruitment and interviews. Last but not the least, I want thank all the Iraqi mothers, who participated in the study.

Oslo, June 2013

Joanna Rose Hermo Cruz
Executive summary

There is an increasing immigration to Norway. The fifth largest immigrant group is the Iraqis. Immigrants constitute about 13% of the total population in Norway. It has been further reported that Iraqi women are among the immigrant groups with the highest number of births compared to ethnic Norwegian women. Although infant feeding practices of Norwegian mothers has been well documented, no previous studies have reported infant feeding practices among Iraqi mothers in Norway.

The Norwegian recommendations on infant nutrition are in line with WHO’s recommendation on breastfeeding and complementary feeding. Exclusive breastfeeding is advised to be maintained until the infant is six months old, and gradually introduce complementary food at this age. The breastfeeding should be maintained up to one year of age. Breastfeeding in Iraq is a common infant feeding practice. A majority of Iraqis are Muslims, and the Quran recommends mothers to breastfeed for two years if possible.

Studies have suggested that the breastfeeding practice may be influenced by the immigration to a new country. This has been referred as acculturation of breastfeeding practices. The breastfeeding prevalence may have increased or reduced in the new country. Several factors may influence the mother’s infant feeding decision. In order to investigate and describe the Iraqi mothers infant feeding practices of their six months old infant, the InnBaKost study was developed. The experience and potential barriers to their choice of infant feeding practice have also been explored, and how they perceive the information given to them by the Iraqi network and health clinic.

This thesis is based on the results from qualitative in-depth interviews with 14 Iraqi mothers with the help of a semi-structured interview guide, and an interpreter when necessary. The qualitative approach of the data collection and analysis was conducted according to the Grounded Theory. The mothers were recruited from various places such as “Folkeregisteret”, health clinics and the snow-ball method. All the interviews were digitally recorded. The interviews were further transcribed verbatim in Norwegian and transferred to the software program OpenCode, where the transcripts were coded. The relevant codes were further clustered and transformed to categories, and further attempted to be connected to each other.
The main findings in the study were that the mothers practiced predominant breastfeeding, and introduced liquids (milk formula, water, sugar water) before the infant’s first month of age. Milk formula was perceived as an easy option, when challenges occurred. The main challenges mentioned were that the mothers felt their milk was not enough, breastfeeding in public and plans to go back to school or work. According to the mothers water was a necessity for the infant and sugar water was perceived as a pain relief for stomach ache. The advices on water and sugar water were given by their mothers and mothers-in-law. The mothers perceived their own mothers and mothers-in-law as trustworthy persons because of their previous experience with children. Some mothers also mentioned language and their mothers or mothers-in-law to be more available than the health clinic as the reasons for why they trusted them more. The recommendations on complementary food from the health clinic were also followed by the mothers. They introduced typical Norwegian infant foods such as porridge and mashed vegetables. They also added the Iraqi soup to the infant meals, which consisted of vegetables, some added rice and sometimes meat and seasoning.

The majority of the mothers had a positive experience with the health clinic. The mothers who felt they did not have enough milk were advised to use milk formula at the hospital and/or at the health clinic. A few of the mothers mentioned that there was a stressful environment in the health clinic. This could have made the mothers hesitant to ask questions at the health clinic, because it seemed like they had limited time for each mother.

Their own mothers, mothers-in-law and the health clinic seem to be important information sources for the Iraqi mothers. However, information from different sources may be confusing for the mothers. The Iraqi mothers seem to need more information on sugar water, water and exclusive breastfeeding. Information from this study can be valuable in improving counseling of Iraqi mothers at the health clinic. In this way the public health nurse will have a better knowledge what they should emphasize when giving advice or inquire the Iraqi mothers about at the health clinic. The findings in this study, can be helpful in knowing which areas should be targeted, in advice-giving to the Iraqi mothers. In addition, develop relevant strategies to improve the knowledge on liquids during the first six months of the infant.
# Table of contents

1. Introduction ............................................................................................................................ 1

2. Background ............................................................................................................................ 2
   2.1 Immigration ................................................................................................................... 2
   2.2 Health challenges among children of immigrant background ..................................... 3
   2.3 Norwegian recommendations on breastfeeding and complementary food ............. 4
   2.4 Breast milk and breastfeeding ...................................................................................... 5
   2.5 Complementary food .................................................................................................... 7
   2.6 Breastfeeding practice in Norway and Iraq ................................................................. 8
   2.7 Acculturation and influential factors on breastfeeding ................................................ 9
   2.8 InnBaKost ................................................................................................................... 10

3. Objectives ............................................................................................................................. 11

4. Methodology ........................................................................................................................ 12
   4.1 Study design ................................................................................................................... 12
   4.2 Ethical considerations .................................................................................................... 12
   4.3 Recruitment and participants ...................................................................................... 13
   4.4 Different recruitment sources and channels ............................................................... 13

5. Data collection ...................................................................................................................... 14
   5.1 Interview situation and interview guide ......................................................................... 14
   5.2 Interpreter ....................................................................................................................... 15

6. Data analysis ........................................................................................................................ 16
   6.1 Transcribing and coding ................................................................................................. 16

7. Results ................................................................................................................................ 17
   7.1 Study sample .................................................................................................................. 17
   7.2 Breastfeeding ............................................................................................................... 19
      7.2.1 Duration of breastfeeding ....................................................................................... 21
      7.2.2 Exclusive breastfeeding ......................................................................................... 23
      7.2.3 Predominant breastfeeding .................................................................................... 24
      7.2.4 Challenges in breastfeeding .................................................................................. 28
   7.3 Complementary food ....................................................................................................... 30
      7.3.1 Complementary feeding ......................................................................................... 30
   7.4 Information sources ......................................................................................................... 32
7.4.1 Mother and mother-in-law ................................................................. 32
7.4.2 Hospital ......................................................................................... 33
7.4.3 Health clinic ................................................................................ 34
7.5 Conflicting messages and practices .................................................. 36
8. Discussion ......................................................................................... 37
  8.1 Methodology discussion ................................................................. 37
  8.2 Result discussion .......................................................................... 44
9. Conclusion ....................................................................................... 54
References .......................................................................................... 57
Appendixes: ......................................................................................... 63

List of tables

Table 1 ................................................................................................. 18
Table 2 ............................................................................................... 20
Clarification of terms

**Primiparous**: A woman who has only given birth to only one child.

**Multiparous**: A woman who has given birth to two or more children.

**Exclusive breastfeeding**: The time period when the infant only receives breast milk, in addition to vitamins, minerals and medicines.

**Predominant breastfeeding**: In this practice, breast milk is the predominant source and other liquids such as water, sugar water and milk formula have been introduced.

**Complementary food**: This implies that all types of food and other liquids have been introduced to the infant at any time.

**Complementary feeding**: The infant is given complementary food.

In the result chapter: Proper definitions on few, some, half and majority have been provided, in order to know how many mothers it has been referred to:

- Few (1-3)
- Some (4-6)
- Half (7-8)
- The majority (>9)
1. Introduction

Norway is a multicultural society with different ethnic groups. The population of immigrants and those born in Norway to immigrant parents have increased since the end of the 1960’s. Around half of the immigrants come from Asia, Africa and Latin America. According to Statistic Norway (SSB), the current population in Norway constitutes of 593 321 immigrants, which is about 13 % of the total population (SSB, 2012, 2013a). In 2010 and 2011, it was reported that Iraqi women were one of the two groups with the highest number of births in Norway among non-western immigrants. However, there is limited knowledge on Iraqi mothers’ infant feeding practices in Norway. There have been two national dietary surveys with a study sample of Norwegian young children aged six months, one year and two years of age. The surveys were “Spedkost” and “Småbarnskost” and were conducted in 2006-07 (Øverby, Kristiansen, & Frost-Andersen, 2008, 2009). However, in these studies infants and young children of immigrant mothers born in another country than Norway were excluded. In addition, previous studies on infant/child feeding of immigrant groups conducted in Norway have several limitations: the focus has been on specific nutrients (iron and vitamin D) a small sample size and/or selected population groups studied was limited (Arsky, 1996; Brunvand & Brunvatne, 2001; Madar, 1997; Madar, Stene, & Meyer, 2009; Solem, 1982; Wandel, Fagerli, Olsen, Borch-Iohnsen, & Ek, 1996). Thus, there is a lack of knowledge on how immigrant parents’ of infant and young children feed their infants and young children.

The mothers’ choices of infant feeding practices are influenced by many information sources. This is a matter that should be explored, because breastfeeding practices and choice of complementary food is of great importance for the child’s development and well-being (Horta, Bahl, Martines, & Victora, 2007). The Norwegian recommendation on breastfeeding is to breastfeed exclusively for six months and introduce complementary at this age (Norwegian Directorate of Health, 2001). The benefits of breastfeeding have been thoroughly documented; therefore it is important to investigate the breastfeeding practices of immigrant mothers to identify potential challenges (Horta et al., 2007).

The health clinic is the institution which has the main task to inform the mothers about infants care in Norway. The health clinic follows the Norwegian recommendations on nutrition for infant and young children in their advice giving to mothers. However, one study showed that breastfeeding patterns differ among immigrant groups in Norway, in terms of duration of exclusive breastfeeding and introduction of complementary foods to infants (Kumar & Wandel, 2006).

Due to the lack of knowledge about breastfeeding and complementary feeding practices among immigrant mothers living in Norway, the project “InnBakost” was developed. The project has focused
on the two immigrant groups, Iraqi and Somali mothers. The project is divided into two parts, one qualitative and one quantitative part. This thesis is a part of the qualitative sub-study of “InnBakost” and its objective is to describe the Iraqi mothers’ feeding practice of their young infants. In order to understand infant feeding practices among participating Iraqi mothers’ the study investigated their feeding practices, intention to the feeding practice, experiences with the health clinic and hospital and influences from family and other information sources.

2. Background

2.1 Immigration

SSB’s definition of an immigrant is a person who is born abroad by two immigrant parents (SSB, 2012). An increasing immigration to Norway from countries in all regions of the world has been reported throughout the last five decades. An immigration ban on labor migration was introduced in 1974 with the justification that integration problems with the immigrants already living in Norway should be solved before letting any new immigrants into the country (SSB, 2013b). Since the immigration ban was introduced, the majority of immigrants from third world countries have been refugees and asylum seekers, in addition to those seeking family reunification with labor migrants and other immigrants already present in Norway. There was a rapid increase of asylum seekers, from the early 1980s to the mid-80s (SSB, 2013b).

A recent report by SSB focused on the largest immigrant groups in Norway. In this report, it was documented that the reason for growth in these immigrant groups were high immigration, high fertility and many new arrivals of women in childbearing age (SSB, 2013b). Since 2000, the number of people originating from Iraq more than doubled in Norway. According to a recent SSB statistic, the Iraqi is the fifth largest immigration group constituting of 27 827 Iraqis living in Norway in 2011 (SSB, 2013b). Around two percent of the Iraqi immigrants arrived before 1989 and most of them (75%) have arrived in the two recent decades. The total fertility rate (TFR), expressed as children per woman were for the Iraqi women 4.29 in 1999, and decreased to 3.57 in 2008. The TFR for Iraqi women is above the national average of the ethnic Norwegian women which is 1.80-1.88 from the same time period (SSB, 2013b). Women from Iraq and Somalia have the highest fertility rates in Norway.
The majority of immigrants and second generation immigrants have a strong tendency to marry within the group, although there are some groups that differ somewhat from this pattern (SSB, 2013b). The level of education is in most cases higher for second generation immigrants than others. Employment of immigrant women is far lower than it is for Norwegian women. Young immigrants and especially second generation immigrants have much higher employment rate than older immigrants.

Even though Pakistanis are still ranked as the largest immigrant group in Norway, the increasing numbers of immigrants from Iraq and Somalia are predicted to surpass the Pakistanis within a few years. The reason for this prediction is that the Iraqis and Somalis have higher numbers of births; higher net immigration and those who are arriving are in childbearing age. The highest concentration of immigrants lives in Oslo (SSB, 2013a). An ordered excerpt from SSB from last year was requested on how many Iraqi women lived in Oslo and counties outside Oslo. From this excerpt, there were 3311 Iraqi women from the age of 15 to 49 living in the two municipality Oslo and Akershus.

2.2 Health challenges among children of immigrant background
Potential challenges have been documented to the diet and nutrition of infants and children with immigrant background. This included high prevalence of anemia and iron deficiency (Arsky, 1996; Brunvand & Brunvatne, 2001; Madar, 1997; Solem, 1982; Wandel et al., 1996), vitamin D deficiency (Brunvand & Brunvatne, 2001; Madar et al., 2009), early introduction of milk formulas or cow’s milk (Wandel et al., 1996) and high intake of sugar (Antonsen, 2000; Madar et al., 2009; Wandel et al., 1996).

By the time they reach adulthood, some immigrant groups are more prone to type 2 diabetes and obesity (Abebe, 2010). Many health challenges have been identified in the adult ethnic minority population in Norway. This includes elevated prevalence of obesity, in particular among women from Pakistan and Turkey (Kumar, Meyer, Wandel, Dalen, & Holmboe-Ottesen, 2005), high rates of type 2 diabetes mellitus (Jenum, Holme, Graff-Iversen, & Birkeland, 2005), and vitamin D deficiency (Holvik, Meyer, Haug, & Brunvand, 2005). The increasing documentation shows that nutrition at an early stage may influence the development of these health problems in adulthood (Koletzko, 2005). Therefore it is crucial to improve the diet of infants and young children. This may be one of the key strategies for reversing the increasing social gradient in health between socio-economic groups in Norway (Marmot et al., 2010).
2.3 Norwegian recommendations on breastfeeding and complementary food

The Norwegian recommendations for infant feeding encourage mothers to breastfeed exclusively for six months and thereafter gradually introduce complementary food with continued breastfeeding (Norwegian Directorate of Health, 2001). Complementary food is defined as other food and liquids which is consumed by the child except for breast milk (WHO, 2008). In addition, breastfeeding should be maintained throughout the child’s first year. (Norwegian Directorate of Health, 2001). Norwegian recommendations on infant feeding are in line with the World Health Organization’s (WHO) recommendations (WHO, 2003). According to the Norwegian infant feeding recommendations, some children may require solid foods before six months of age, but the introduction should not occur earlier than four months of age. Children, who are not breastfed, can be introduced to complementary foods at four to six months of age. In cases where breastfeeding is not possible or there is a need for other milk in addition to breast milk, milk formula should mainly be used until 12 months of age (Norwegian Directorate of Health, 2001). Infants are also recommended by the Norwegian health authorities to receive a teaspoon (5 ml) of vitamin D supplements in the form of cod liver oil (tran) which is equivalent to 10 microgram of vitamin D, from four weeks of age. This is the recommended daily intake of vitamin D for infants and young children. Infants who are not given this oil should be given vitamin D drops. Norwegian recommendations further recommend that honey should not be given to infants under the age of one year, because of the risk of infant botulism.

Exclusive breastfeeding for six months will ensure that the infant will achieve optimal development, growth and health (WHO, 2003). However, there is a disagreement on what the optimal duration of exclusive breastfeeding should be. The ongoing discussion is on whether the recommended length of exclusive breastfeeding could be shortened to four months (Fewtrell et al., 2007). The duration of exclusive breastfeeding should be considered, if the infant is born prematurely, residence (developing / developed countries) and if the nutritional content of breast milk is adequate for the infant (Fewtrell et al., 2007).

The Norwegian Directorate of Health is currently working on revising the recommendations of infant feeding and is expected to be finished by 2013, the last one was published in 2001.
2.4 Breast milk and breastfeeding

A mother produces colostrum the first days after giving birth. It is described as a yellow thick substance. Colostrum is recommended to be given to the infant, because it is a rich source of nutrients and can rebuild the immune system, while enhancing cell growth and tissue repair. It is an essential nutritional supplement that protects and promotes health for the infant (Uruakpa, Ismond, & Akobundu, 2002). By giving colostrum is the initiation of breastfeeding. The term breastfeeding can be divided into exclusive and predominant breastfeeding. According to WHO’s definition, exclusive breastfeeding is when the infant only receives breast milk, in addition to vitamins, minerals and medicines. Predominant breastfeeding is defined as breast milk as the predominant source and other liquids such as water, sugar water and milk formula (WHO, 2008).

As mentioned earlier, there is scarce knowledge on infant and child feeding practices among immigrant parents. Earlier studies on breastfeeding practices among immigrant groups living in Norway show variations between the different groups. One study on Turkish parents showed that they introduced milk formula or cow’s milk to their infants earlier than Norwegians parents did (Wandel et al., 1996). Another study that compared breastfeeding duration among Norwegians and Pakistanis, found no difference (Arsky, 1996). A study conducted by Pak-Gorstein et al. (2009) acknowledged specific cultural beliefs and practices that possibly could have an effect on infant feeding practices of immigrant mothers, such as discarding colostrum, delayed breastfeeding initiation and giving prelacteal foods (Pak-Gorstein, Haq, & Graham, 2009).

Breast milk is the best nutrition for the infant. The composition and quantity of breast milk is accustomed to the infant needs, and varies for each feed, time of the day and breastfeeding duration (Norwegian Directorate of Health, 2001). Breast milk contains a number of substances that promote absorption from the intestine, contributes to the physiological maturation of the small intestine and promotes the infant's immune system. The content of these substances in the breast milk is adapted to the child's growth and development (Norwegian Directorate of Health, 2001). Breast milk also contains enzymes and amino acids which are important for absorption of fats in the intestine, as well as various growth factors and hormones that influence and regulate the physiological maturation of the small intestine (Norwegian Directorate of Health, 2001). Factors in breast milk (including white blood cells and large amounts of secretory IgA) protect the infant against absorption of antigens with adverse effects (Norwegian Directorate of Health, 2001). Breast milk contains immunologically active substances, and numerous studies have shown that breastfeeding is associated with reduced risk of infections caused by bacteria and viruses. In industrialized countries, it is shown that breastfeeding protects against diarrhea, ear infection and respiratory infections, and is associated with shorter disease
course (Norwegian Directorate of Health, 2001). There is evidence that breast milk has a positive effect in terms of cognitive (mental) development. The reason for this may possibly be that the breast milk contains long-chain omega-3 fatty acids (n-3 fatty acids), although it is difficult to establish a causal relationship (Norwegian Directorate of Health, 2001). Breastfeeding in infancy has been associated with reduced risk of respiratory diseases, overweight later in childhood, and with a favorable risk profile in relation to cardiovascular disease in adults (Norwegian Directorate of Health, 2001).

A meta-analysis showed that the absence or short duration of breastfeeding is related to mothers who smoke, limited information or advice given by health professionals (Wijndaele, Lakshman, Landsbaugh, Ong, & Ogilvie, 2009). Additionally, that infants who are frequently baby-sat by family members are breastfed for a shorter period and introduced earlier to complementary food compared to infants in parental care (Betoko et al., 2013).

An intervention study from Brazil managed to delay the introduction of milk formula and complementary foods by giving counseling session in the maternity ward and the home of the breastfeeding mothers (de Oliveira, Giugliani, Santo, & Nunes, 2012). The introduction of milk formula was delayed by almost two months, and occurred at five months of age instead of three months. The authors also mentioned that evidence suggests that milk formula that is introduced before four months of age is associated with greater mortality, hospitalization due to respiratory illnesses, incidence of ear infection, asthma, eczema and type 1 diabetes and 2 diabetes. It has been estimated that 30% of the cases of type 1 diabetes could have been avoided if 90% of the infants were not given cow’s milk before three months of age (Gerstein, 1994). An early introduction of cow’s milk can also cause intestinal microhemorrhages that reduce iron reserves (Jiang, Jeter, Nelson, & Ziegler, 2000; Ziegler et al., 1990). For each month that cow’s milk is consumed by the infant, it is estimated that hemoglobin levels fall by 0.2 g/dl (Male, Persson, Freeman, Guerra, & Hof, 2001). Simultaneously, introduction of milk formula in early stages of the infant’s first half of their first year negatively affects the duration of breastfeeding (Santo, de Oliveira, & Giugliani, 2007).
2.5 Complementary food
As mentioned earlier, WHO defines complementary feeding as any food and liquid given to the infant while they are still being breastfed (WHO, 2008). This term is reserved to describe the feeding of breastfed infants from six months of age and beyond. Substitutes to breast milk such as cow’s milk and milk formula are defined as a complementary food to emphasize and encourage breastfeeding (Fewtrell et al., 2007).

Eating habits and behaviors from the start can later decide preferences and habits related to food (Betoko et al., 2013). As mentioned earlier, complementary food should be introduced gradually, while the young child is still being breastfed. It is recommended that new food should be introduced by six months of age with small portions of one food item at a time for tasting, and the portions can be increased gradually (Norwegian Directorate of Health, 2001).

Complementary food should provide extra energy and iron for the infant. It may be appropriate to begin with a thin porridge or mashed potato/vegetables, which can be mixed with breast milk/milk formula. The vegetable/potato mash can eventually be added with small bits of meat and fish, mashed fruit and berries can also be given (Norwegian Directorate of Health, 2001). Sugar or salt should not be added in the infants’ food. As mentioned earlier, children who receive milk formula and are not being breastfed, can be introduced to complementary food from they are four to six months old. From six months of age the child should be gradually accustomed to a varied diet (Norwegian Directorate of Health, 2001). Iron enriched porridge is recommended for one to two meals per day for a period of a few weeks with gradual introduction of small amounts. To ensure a balanced intake of nutrients, the diet should not solely be based on commercially manufactured porridge (which is nutrient-enriched), but varied with for example bread and other foods mentioned above (Norwegian Directorate of Health, 2001). Breast milk should be given before the meal to maintain milk production until the time you want to step down with breastfeeding.

However, early introduction of complementary food into an infant’s diet is common (de Oliveira et al., 2012). A study suggested that adolescent mothers were particularly susceptible to the early introduction of foods into their infants’ diets, and that grandmothers had an influence on this behavior (de Oliveira et al., 2012). Several studies showed that early complementary food introduction was correlated to young mothers, low maternal education, higher birth weight, low socioeconomic status and infant gender (Betoko et al., 2013; Wijndaele et al., 2009). The preparation of food for the infant can be a challenge when time limit is an issue, such as when the women go back to work. When women work for long
hours outside home, this may result in a reduced time spent preparing meals and increased use of ready-prepared foods (Betoko et al., 2013).

On the other hand, there were studies that suggested that it was possible to reverse the trend of early introduction of complementary food. The study by de Oliveira and co-workers (2012) also achieved preventing early introduction of complementary foods before four months. Delaying consumption of complementary food was favorable for the infant considering that early introduction was associated with child and adult obesity and allergic diseases (Wilson et al., 1998; Wu & Chen, 2009). In the study by Oliveira and co-workers, (2012) the intervention began to lose its effect when the infants reached the age four months, and at six months there were no difference between the control and intervention groups in the consumption of complementary foods (de Oliveira et al., 2012). The authors suggested that counseling sessions or maternal education should be provided for the mothers beyond the fourth month of life (de Oliveira et al., 2012).

2.6 Breastfeeding practice in Norway and Iraq

According to the two Norwegian national studies on infant feeding «Spedkost» and «Småbarnkost» 95% of the infants were breastfed at four weeks of age, and by six months 80% of the mothers were still breastfeeding (Øverby et al., 2008). This showed that Norway has a high breastfeeding rate compared to other western countries (Yngve & Sjostrom, 2001). In both of these studies, immigrant mothers were excluded from the study. The reason given was that the immigrants were not representative in relation to sample size and the group studied (Yngve & Sjostrom, 2001).

Breastfeeding action has been established and developed in Norway, such as The Baby-Friendly Hospital Initiative (BFHI), “Nasjonalt kompetanesenter for amming” and “Ammehjelpen”. The BFHI was launched in 1991 by UNICEF and WHO to ensure that all maternities were centers for breastfeeding support. A maternity facility would be designated as BFHI, when the ten steps to support breastfeeding were implemented and when no free or low cost breast milk substitutes are accepted (UNICEF & WHO, 1991). The BFHI was launched in Norway in 1993, with the aim to increase breastfeeding rates and improve the interaction between mothers and infants. The focus was on helping mothers to breastfeed without too much effort (Hansen et al., 2012). “Nasjonalt kompetanesenter for amming” can be translated to National Competence Centre for breastfeeding and was established in 1999. It was established after the implementation of the WHO/UNICEF global initiative BFHI in Norway from 1993 to 1996. The National Competence Centre for breastfeeding prioritized improving and spreading knowledge, by contributing to research and disseminate knowledge to the health services (Rosenberg & Nylander, 2005). “Ammehjelpen” is translated to breastfeeding help in English, which
have worked to protect and promote breastfeeding since 1968. Their goal is to give all mothers help and support to breastfeed as long as they want, considering what is best for the infant and the mother’s health (Ammehjelpen, 1968), and they work to promote the necessary knowledge about breastfeeding among health professionals.

In Iraq, breastfeeding was almost universal and was considered the normal way to feed infants and young children (Ameer, Al-Hadi, & Abdulla, 2008). Iraq is one of the seven countries where 100% of facilities have been designated as BFHI (Philipp & Radford, 2006). However, there is limited information on how many Iraqi mothers practice exclusive breastfeeding for six months. A study reports that Iraqi mothers have limited knowledge about how long exclusive breastfeeding should last and when the introduction of complementary foods should occur (Ameer et al., 2008). The reason for this could be that the knowledge among medical professionals in Iraq on breastfeeding was limited (Al-Nassaj, Al-Ward, & Al-Awqati, 2004). Another study shows that the prevalence of exclusive breastfeeding was low and that early introduction of complementary food is common among Arab mothers (Muhsen, Masarwa, Guttman, & Cohen, 2011). Most Iraqis belong to the religion Islam, and the holy book of Islam, the Quran, recommends mothers to breastfeed their infant for two years if possible (verse 2:233) (Shaikh & Ahmed, 2006).

2.7 Acculturation and influential factors on breastfeeding

The maternal infant feeding attitude and behavior could be influenced by what is considered acceptable in her culture (Swanson & Power, 2005). The duration of breastfeeding may vary, one aspect may be the length of stay in the new country (Choudhry & Wallace, 2012). A study from the United States showed that first generation immigrants, regardless of race or ethnicity breastfeed more frequently than those born in the United States with an immigrant background (Celi, Rich-Edwards, Richardson, Kleinman, & Gillman, 2005). In contrast, one study showed that women from South Asia had the lowest duration of breastfeeding among women in the UK. There are often groups with low social status who breastfeed less (Choudhry & Wallace, 2012).

Influential factors such as subjective norms (people’s views) have been identified as important determinants of initiation and continuation of breastfeeding and giving milk formula in a bottle (Swanson & Power, 2005). A woman’s decision to breastfeed or use milk formula is influenced by what is acceptable or desirable in the society, the mothers are open to social and cultural influences. The decision to breastfeed is guided by mothers’ underlying attitudes, skills, abilities and beliefs, but also by perceptions of what other people think of duration of breastfeeding, breastfeeding in public, if it is good or bad for the mother and/or infant etc. (Swanson & Power, 2005). Many mothers stop breastfeeding
before six months, because they encounter challenges and difficulties to breastfeed exclusively (Dennis, 2002). Studies showed that women who were young, had low income, belonged to an ethnic minority, had no support to breastfeed, worked full time, decided to breastfeed during or late in pregnancy were more likely to have negative attitudes towards breastfeeding and to have low confidence in their ability to breastfeed. These mothers were more likely to discontinue breastfeeding early (Dennis, 2002).

A study by Manstead et al. (1983) suggested that subjective norms were more important for primiparous than multiparous mothers (Manstead, Proffitt, & Smart, 1983). For first time mothers, subjective norms may determine their choice regarding whether to breastfeed or use milk formula, as they have no earlier experience and they may lack confidence in the decision to breastfeed. Therefore, they might be more likely to pursue or consider others’ opinions in making her initial choice, in comparison with women who already have previous experience with breast- or bottle-feeding (Swanson & Power, 2005). A study compared breastfeeding practices of mothers after birth. The findings indicated that mothers who breastfed perceived more social pressure to do so than mothers who gave their infant milk formula. The mothers that gave milk formula felt more social pressure to bottle-feed (Swanson & Power, 2005). The opinions of the mother’s partner, her own mother, midwives/nurses in regard to the initiation and continuation of breastfeeding or bottle-feeding were significant (Swanson & Power, 2005).

2.8 InnBaKost
This study was part of a project called “InnBaKost” which stands for “Innvandrer Barns Kosthold”, and can be translated to immigrant children diet in Norway. It is a three year project funded by the Norwegian Research Council. The aim of InnBakost is to learn more about infant and young child feeding practices of mothers with immigrant background. The participants were of Somali, Iraqi and Kurdish backgrounds and were living in Norway. “InnBaKost” consist of a quantitative and qualitative part. This thesis was related to the qualitative part and focused on mothers with Iraqi and Kurdish backgrounds. These mothers will further be referred to as Iraqi mothers in the thesis.

The qualitative part of InnBaKost project is a longitudinal in-depth study and will follow the Iraqi mothers during a three year period. The mothers were informed in the first interview that they will be interviewed two more times, when the young child is one and two years old. This thesis includes the results of the first data collection of interviewing Iraqi mothers of infants aged six months (+/- two months). The qualitative part of the study was interested in collecting data about breastfeeding and complementary food practices of the mothers. The data collection was performed through qualitative in-depth interviews, which were regarded as the most appropriate for collecting relevant data about the target group.
3. Objectives

The main objective for this thesis was:

To generate knowledge about diet and infant feeding practices of Iraqi mothers living in Norway, their experience with the health clinic and their perception of information given from different sources.

The following sub-objectives were addressed:

1. To describe Iraqi mothers infant feeding practice.
2. To explore factors that influence mothers’ infant feeding choices and practices (how they breastfeed and its duration, choice and time of introduction of complementary foods).
3. To explore how mothers experience and deal with the food culture from their country of origin and the one in Norway with regards to how they feed their children.
4. To explore the mothers’ experiences with health clinics in general and more specifically with regards to advice-giving on young child feeding practices and the diet of young children.
5. To explore the potential conflict of advice-giving from health clinics and others.

Three terms have been included in the thesis in defining the different infant feeding practices. As mentioned earlier, these terms are: exclusive breastfeeding, predominant breastfeeding and complementary feeding. In the term exclusive breastfeeding cod liver oil has been included, because Norwegian health authorities recommend this for the infant from four weeks of age. The infant was still considered exclusively breastfed even with this supplement. The time when introduction of liquids, tasting portions or complementary foods were introduced separately or together have been seen as the time the exclusiveness of breastfeeding stopped. Predominant breastfeeding is defined according to WHO's definition as other liquids such as water, sugar water and milk formula (WHO, 2008).

There is a disagreement on breastfeeding definitions of infant feeding practices (Noel-Weiss, Boersma, & Kujawa-Myles, 2012). It is recommended and regarded as safe to introduce infants to complementary food at four to six months of age (EFSA, 2009; Norwegian Directorate of Health, 2001). Even though the term complementary food is reserved for the food that is introduced after six months, it has been included in this thesis and used to explain any food and liquids that have been introduced to the infant at any time, aside from breast milk.
4. Methodology

4.1 Study design
In depth interviews were carried out with the help of a semi-structured interview guide on 14 Iraqi mothers of infants aged six months (+/-two months). The interviews were conducted by the author of this thesis and/or the project leader. The participants were offered to use an interpreter in either Arabic or Kurdish during the interview, and seven of the mothers accepted this offer. The participants were recruited from the counties Oslo, Akershus, Østfold and Vestfold. The interviews were conducted at the participants’ home (n=8), in the health clinics in Oslo (n=2) or in a café near home or a nearby center (n=4). All the interviews were digitally recorded and conducted from October 2012 to March 2013. Each interview lasted approximately 30 minutes to one hour. All the mothers received a gift card valued 150 NOK to a baby shop as an incentive for participating in the project. The mothers living outside Oslo were given 150 NOK in cash.

A qualitative approach was chosen in order to describe the Iraqi mothers’ infant feeding practices and their experience towards information given by their health clinic and influential people. This approach allowed us to take the perspective of the informants by obtaining in-depth information about their practice through their perceptions, opinions and experience (Dahlgren, Emmelin, & Winkvist, 2007). The focus was on a smaller number of informants to gain a deeper understanding. The aim of qualitative analysis was to conceptualize the meaning of the phenomena and human action, which in this case was issues related to breastfeeding and complementary food practices (Dahlgren et al., 2007). The approach implemented in the study was based on Grounded Theory, to describe a phenomenon in a substantive and concrete way (Dahlgren et al., 2007).

The master student took part in the recruitment, data collection and analysis. The master student received training in conducting interviews and how to use the software program OpenCode.

4.2 Ethical considerations
The InnBakost project was granted ethical approval from the Regional Committees for Medical and Health Research Ethics (REK) in September 2012, with full accordance to the Helsinki declaration.

Before each interview the mothers were informed about the InnBaKost project, that their participation was voluntary and that data collected would be treated confidentially. They also received written information with equivalent information in Norwegian (appendix 1). A longer version which contained more information about the study, voluntary participation and a statement of informed consent was also handed out (appendix 2). This was carefully explained to the mothers to ensure that they understood
what they were giving their signed consent for. The mothers were also given the opportunity to read the information by themselves. The signed consents were obtained from all the mothers before the interview started. Their signed informed consent protected the mothers by guaranteeing that the information they give out will be treated confidentially and cannot be traced back to them.

Each participant was given one code name which was used in naming the transcription of data, sound files and coding. The logs were filled out by hand before an interview started, and later destroyed right after converting the information electronically. All potentially identifying material has throughout the data collection and analysis process been treated in a strictly confidential matter. The material has been stored in a password protected laptop with the limited access to one authorized researcher and others in the project if needed.

4.3 Recruitment and participants
Due to problems that were encountered in the recruitment process, recruitment was conducted from various relevant places in reaching the Iraqi mothers. A purposive sample has been recruited through a multiple recruitment strategy. The criteria for participating were that the mother should have Iraqi parents, she should be born in another country outside Norway, immigrated to Norway at some point and that her infant was six months (+/- two months) of age and healthy. Reaching the mothers was a challenge because it was hard to locate them by name and little previous knowledge on places where they gathered. In addition, the criteria on the age of the infants was originally six months and was changed because of time limit and difficulties in finding Iraqi mothers with infants in the specific age group.

4.4 Different recruitment sources and channels
All parents, including those with an immigrant background, visit health clinics regularly for health check-up, growth monitoring and vaccination of their infants (Norwegian Directorate of Health, 2003). Based on that all mothers come to the health clinics, this would be an importance in reaching all Iraqi mothers in Norway. The study sample has been recruited through the first five health clinics in Oslo who agreed to participate in the InnBakost project (Grunerløkka, Grønland, Grorud, Romsås and Østensjø). One additional health clinic (Sagene) did not want to be included in the study, however the opportunity to recruit in their waiting room was given if needed. The health clinics were contacted beforehand to obtain information when Iraqi mothers with infants in the specific age group had an appointment. A few health clinics were able to give us this information before our visits (n=2). The public health nurses mentioned that it was a challenge to identify Iraqi mothers by name.
Multiple relevant sources have been applied in the search for Iraqi mothers. The snowball sampling method was also used in a small scale in the recruitment process, through friends of friends and interpreters (n=5). An ongoing recruitment was also in progress in the quantitative part of the InnBaKost project, some of the mothers were asked to join the qualitative part (n=4). An application for permission from REK to recruit from “Folkeregisteret” was granted after the study started. “Folkeregisteret” is the national population register in Norway and comprise key information about every individual who are or have been a resident in Norway. A list of the names and address of Iraqi mothers who had an infant from six months (+/- two months) at the time of data collection was given, a confidential declaration was signed by the researcher and interpreter. With this information a search for the potential informants’ number was done by an interpreter (n=3).

In addition, we contacted various organizations and associations for further dissemination of the project that could possibly benefit the recruitment. Several visits were made to such places; women groups, cafés and activity centers organized by Red Cross. Open kindergarden and the mosque were also visited. We also tried to recruit participants by advertising for InnBaKost during our visits to different places. An ad for participation in the study was hung up at relevant places such as mosques. There was no one who contacted us through these methods.

5. Data collection

The Grounded Theory has provided a systematic approach of the analysis of collected data. This was conducted by transforming collected data into a more abstract form of information (Dahlgren et al., 2007). The five steps to the systematic way from the Grounded Theory that had been used were: data collection (1), documentation (2), open coding (3), selective coding (4) and theoretical coding (5). These steps are presented further in this chapter and the analysis chapter together with how it was done in the study.

5.1 Interview situation and interview guide
One of the project leaders conducted the first interviews to ensure the quality of the interview, and that all the topics and questions in the interview guide were covered. The author of the thesis was present during these interviews as part of her research training. She took over the interviewing, first with guidance from the project leader, and then by herself. During five of the interviews the husband of the mothers was present in the interviews. A log was filled out before each interview. The logs contained practical information about the informant and the interview (appendix 3) (Dahlgren et al., 2007).
Additional field notes were taken by the author of thesis when the interviews were conducted by one of the project leaders.

As mentioned earlier, a Norwegian semi-structured interview guide (appendix 5) and a digitally recorder were used during the interviews, this is the data collection which is the first step in the Grounded Theory approach (Dahlgren et al., 2007). The interview guide was developed in English and Norwegian. The Norwegian interview guide was the updated version, and it was translated from the English interview guide (appendix 4). The purpose of the interview guide was to give an overview over the topics to be covered and suggested questions (Dahlgren et al., 2007). A semi-structured interview guide allowed additional questions to be made to follow-up the mothers answers. At the same time it was flexible to unexpected themes that may emerge during the interview, thus some questions were added during the interviewing process. In this way the interview guide was neither an open conversation nor a closed conversation with a questionnaire (Kvale & Brinkmann, 2012). The interview guide focused on the mothers’ knowledge, perception and understanding in relation to the infants’ feeding, exclusive breastfeeding and complementary feeding, experiences from health station and advices given from family and others.

5.2 Interpreter
The interpreter played an important role in the interview setting in obtaining knowledge and experiences from the Iraqi mothers, when language was a barrier. There were three interpreters that were used in the interviewing process. The interpreters were used with the mothers who were not fluent in Norwegian or English. Three interviews were conducted in Kurdish, four in Arabic with the assistance of an interpreter. The rest of the interviews were in Norwegian. An interpreter manual was developed and introduced to the interpreters before they started to work. The interpreter manual contained useful information that was meant as guidance on how to act during an interview and what role they had as an interpreter (appendix 6). It also included brief information about the “InnBakost” project. The interpreters also got feedback on their performance after being a part of the interviews.
6. Data analysis

6.1 Transcribing and coding
The interviews and the analytic methods are based on some of the principles of the Grounded Theory (Dahlgren et al., 2007). The purpose of the Grounded Theory is to develop a theory, however this was not the intention of this thesis. The Grounded Theory involves a systematic approach to the analysis of qualitative data aiming for discovery. This approach was recommended in exploring a subject where little previous research has been done (Dahlgren et al., 2007). As there was little existing empirical data on the studied topics, this approach was chosen in data collection and analysis.

The sound files for each interview were transcribed verbatim in Norwegian and then transferred into the software program OpenCode version 3.6.2.0 for coding. The procedure of organizing the transcripts in OpenCode was the second step in Grounded Theory, and called documentation (Dahlgren et al., 2007). The author of the thesis transcribed and coded the interviews.

The transcription was the initial phase of analysis (Kvale & Brinkmann, 2012). In the next interview, one could make small changes by adding necessary new questions if this was needed. After each transcription was completed, a quality control of the transcription was made by listening to the sound files a second time to ensure that everything was included. After the transcription of each interview, they were further coded in OpenCode, before the next interview if this was possible. This process was called open coding, which is the third step in the Grounded theory approach. In this step the transcripts were gone through by giving a specific or several codes that described the meaningful sentences that emerged in the data material (Dahlgren et al., 2007). The fourth step, selective coding was done by further analyzing the transcriptions. This was done by printing out each interview which was gone through again, the decision on which codes were important was done by clustering and transforming them to categories (Dahlgren et al., 2007). The categories were: breastfeeding, complementary food, formula, changes in infant feeding and current infant feeding and possible influence. The fifth step of the analysis was theoretical coding, which attempts to find connections between the codes or emerging categories (Dahlgren et al., 2007).

The last step is integration, which is to attempt to connect own findings with an existing theory. This step has not been included in the analysis. The reason for this was that it required more time and was considered too advanced for a master thesis.

In addition, to get an overview of the large data, a matrix was developed. The matrix gave an overview of the mothers’ practice, including introduction of formula, complementary food and liquids. In this process, relevant quotes from the mothers were also extracted from the transcriptions and further used in
the results to highlight the different important topics. Meaningful quotes that were extracted were related to influences to the mothers infant feeding practices, the barriers to what has been recommended to them from the health clinic and the Norwegian recommendations for infant feeding. The quotes were translated from Norwegian into English in the best possible way without losing its meaning or been taken out of its context. The translations were done by the author of the thesis, and then further assessed by one of the project leaders. The statements are presented in the result chapter, these are marked in italics.

7.0 Results
The chapter will start out with a brief description of the mothers (table 1), and further present the results with relevant quotes divided in the topics breastfeeding, complementary foods, information sources and conflicting challenges. Explanations in parentheses have been added in some of the quotes for the reader to understand what the mothers are talking about. In this chapter proper definitions on: few, some, half and majority have been provided. These words will be used when referring to how many mothers it is talked about, in order to make it easier for the reader to understand. The following numbers of mothers are included in the parenthesis: few (1-3), some (4-6), half (7-8) and majority (>9). The mother’s fiction name and the age of the infant have been added at the end of the quotes.

7.1 Study sample
The study sample consisted of 14 Iraqi mothers (table 1). The mothers included in the study have been given a fiction name to remain anonymous. The mothers’ were between 21 to 40 years old, and the majority was in their mid-twenties. Half of the mothers were first time mothers. The mothers’ work situations are described in the table below as employed, housewife and student. However, all the mothers were on maternity leave at the time of interview. All but one of the participants were married and born in Iraq. The one exception was of Iraqi origin, but born in Iran and cohabiting with the infant’s father. There was no requirement for the mothers to have good knowledge of the Norwegian language, as we used an interpreter during interviews if necessary. The table below has been arranged according to how many years in Norway the mothers have lived.
Table 1. Informants

<table>
<thead>
<tr>
<th>Fictitious name</th>
<th>Age</th>
<th>Years in Norway</th>
<th>Number of children</th>
<th>Education</th>
<th>Work situation</th>
<th>Age of the infant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belen</td>
<td>25</td>
<td>2</td>
<td>1</td>
<td>Secondary</td>
<td>Housewife</td>
<td>8</td>
</tr>
<tr>
<td>Sayran</td>
<td>28</td>
<td>4</td>
<td>1</td>
<td>Not given</td>
<td>Employed</td>
<td>9</td>
</tr>
<tr>
<td>Evin</td>
<td>28</td>
<td>4</td>
<td>1</td>
<td>Not given</td>
<td>Housewife</td>
<td>6</td>
</tr>
<tr>
<td>Hana</td>
<td>25</td>
<td>4</td>
<td>1</td>
<td>Tertiary</td>
<td>Student</td>
<td>7</td>
</tr>
<tr>
<td>Rihan</td>
<td>29</td>
<td>4</td>
<td>1</td>
<td>Tertiary</td>
<td>Housewife</td>
<td>6</td>
</tr>
<tr>
<td>Shayan</td>
<td>33</td>
<td>4</td>
<td>2</td>
<td>Tertiary</td>
<td>Housewife</td>
<td>6</td>
</tr>
<tr>
<td>Aisha</td>
<td>21</td>
<td>8</td>
<td>2</td>
<td>Secondary</td>
<td>Student</td>
<td>6</td>
</tr>
<tr>
<td>Aylin</td>
<td>32</td>
<td>10</td>
<td>3</td>
<td>Secondary</td>
<td>Student</td>
<td>5</td>
</tr>
<tr>
<td>Dilare</td>
<td>40</td>
<td>10</td>
<td>6</td>
<td>Tertiary</td>
<td>Housewife</td>
<td>7</td>
</tr>
<tr>
<td>Jasin</td>
<td>25</td>
<td>11</td>
<td>1</td>
<td>Secondary</td>
<td>Employed</td>
<td>8</td>
</tr>
<tr>
<td>Ronya</td>
<td>25</td>
<td>16</td>
<td>1</td>
<td>Tertiary</td>
<td>Student</td>
<td>6</td>
</tr>
<tr>
<td>Elmira</td>
<td>28</td>
<td>21</td>
<td>2</td>
<td>Tertiary</td>
<td>Employed</td>
<td>6</td>
</tr>
<tr>
<td>Asmira</td>
<td>30</td>
<td>21</td>
<td>2</td>
<td>Tertiary</td>
<td>Employed</td>
<td>4</td>
</tr>
<tr>
<td>Freshta</td>
<td>26</td>
<td>22</td>
<td>2</td>
<td>Tertiary</td>
<td>Employed</td>
<td>5</td>
</tr>
</tbody>
</table>

The mothers had lived in Norway from 2 to 22 years. There were six mothers who had recently arrived to Norway (≤4 years). Three of these were not fluent in Norwegian, and had their husband present and participating in the interviews. It was either the mother who wanted their husband to be there or the husband who insisted on being present during the interview. The reasons could possibly be of security, insecurity with Norwegian and having unknown people coming into their home. The husbands had been in Norway for a longer period and were more fluent in Norwegian. An interpreter was present during these interviews. There were also other mothers in the study sample who had their husbands present, but in these interviews the mothers answered the majority of questions. It seemed that these mothers had their husband present for security and taking care of the infant while interviewing the mother. All in all, there were five interviews, where the husband was present.

The remaining three of the six mothers who had recently arrived in Norway, spoke almost fluent Norwegian. These mothers had a tertiary education from Iraq. Interpreters were present during the interview, but were hardly used.
Four of the mothers have lived in Norway from eight to eleven years. They could speak Norwegian, but accepted the offer to use an interpreter during the interviews, except for one. Three of the mothers were multiparous and one of them had the highest number of children (six children) among the Iraq mothers.

Four of the mothers arrived as children and have lived in Norway for longer period (16-22 years). They were fluent in Norwegian and the majority of them had a tertiary education. The mothers who have stayed for over 20 years were multiparous, except for two who was primiparous.

The infants were four to eight months old. Due to problems encountered in recruiting and limited time, one infant who had exceeded the age criteria six months (+/- two months) was included in the study.

7.2 Breastfeeding

Half of the participating mothers were still breastfeeding at the time of interview. A brief summary of the mothers in the study is presented with the focus on breastfeeding practices (table 2). The term from start has been used in the table below, in describing when liquids (milk formula and water), tasting portions or complementary foods have been introduced from right after birth to the first month of the infant. The liquid/food, in addition to breastfeeding, that was first introduced to the infant is noted in the practice column. The mothers had mentioned several reasons for their practice, but the main reason for the mothers’ choice of practice have been presented in the table below. The column for the main reason was the mothers’ explanation for their practice.

According to the table below, the majority of the mothers have practiced predominant breastfeeding, as they introduced water, sugar water and milk formula to the infant. Five mothers had practiced exclusive breastfeeding from two to five months, before introducing any food or liquids. The discontinuation of breastfeeding, the introduction of complementary food and liquids have been provided (appendix 7). The mothers stopped breastfeeding from 40 days to six months of age. The introduction of complementary food was done from three to six months of age, while liquids were given from right after birth to six months of age. The table below has been organized according to their infant feeding practice in an alphabetical order.
Table 2. An overview of the Iraqi mothers breastfeeding practice.

<table>
<thead>
<tr>
<th>Fictional name</th>
<th>Practice</th>
<th>Main reason</th>
<th>Still breastfeeding?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hana, 25</td>
<td>Exclusive breastfeeding for 4 months</td>
<td>Inadequate breast milk production</td>
<td>Yes</td>
</tr>
<tr>
<td>Shayan, 33</td>
<td>Exclusive breastfeeding for 4 months</td>
<td>Advice from health clinic and doctor</td>
<td>Yes</td>
</tr>
<tr>
<td>Aisha, 21</td>
<td>Exclusive breastfeeding for 5 months</td>
<td>Good for the infant</td>
<td>Yes</td>
</tr>
<tr>
<td>Jasin, 25</td>
<td>Predominant breastfeeding from start (formula)</td>
<td>The infant did not want to breastfeed</td>
<td>No</td>
</tr>
<tr>
<td>Belen, 25</td>
<td>Predominant breastfeeding from 2 months (formula)</td>
<td>The breast was too hard, and painful while breastfeeding</td>
<td>Yes</td>
</tr>
<tr>
<td>Aylin, 32</td>
<td>Predominant breastfeeding from 2 months for 2 weeks (formula)</td>
<td>Inadequate breast milk from 2 months</td>
<td>Yes</td>
</tr>
<tr>
<td>Sayran, 28</td>
<td>Predominant breastfeeding from start (formula and sugar water)</td>
<td>No particular reason and the infant did not want to breastfeed</td>
<td>No</td>
</tr>
<tr>
<td>Elmira, 28</td>
<td>Predominant breastfeeding from start (formula and water)</td>
<td>Inadequate breast milk production and the infant needs water</td>
<td>Yes</td>
</tr>
<tr>
<td>Evin, 28</td>
<td>Predominant breastfeeding from start (formula and water)</td>
<td>Delayed milk production and need of liquid</td>
<td>No</td>
</tr>
<tr>
<td>Asmira, 30</td>
<td>Predominant breastfeeding from start (formula and water)</td>
<td>The infant was constipated</td>
<td>No</td>
</tr>
<tr>
<td>Ronya, 25</td>
<td>Predominant breastfeeding from start (formula, sugar water and water)</td>
<td>The infant had stomach ache and need of liquid</td>
<td>Yes</td>
</tr>
<tr>
<td>Rihan, 29</td>
<td>Predominant breastfeeding from start (sugar water)</td>
<td>The infant had stomach ache</td>
<td>No</td>
</tr>
<tr>
<td>Dilare, 40</td>
<td>Predominant breastfeeding and complementary feeding from start (sugar water and meals)</td>
<td>Inadequate breast milk production</td>
<td>No</td>
</tr>
<tr>
<td>Freshta, 26</td>
<td>Predominant breastfeeding from start (water)</td>
<td>Advice from the mother</td>
<td>No</td>
</tr>
</tbody>
</table>
7.2.1 Duration of breastfeeding

The initiation of the breastfeeding started when the infant received colostrum, which all the mothers stated they had given to their infant. A majority of the mothers’ said that breastfeeding and giving the colostrum was a common practice in the home country. One mother stated that giving colostrum and breast milk was also promoted in the home country. She had received information on the importance of colostrum and breast milk from the hospital in Norway after giving birth. However, this was something she knew from before:

“This (colostrum) was something the nurse had explained, but I knew this from before and this is widely known in Arabic countries, it (colostrum) contains nutritious substances and this I know. Although there are conflicts (war) in the home country, this is something we (Iraqis) try to promote that breastfeeding is important, and that bottle is a no go....and it (breastfeeding) is very critical from birth to six months that you should breastfeed, even though they (mothers who have stopped breastfeeding) say they have not tried you should try as best as you can” Aylin, five months old infant.

As the quote above illustrates, it may seem that giving colostrum and breastfeeding was a common practice in Iraq. Although there are conflicts in their home country it does not appear to affect the focus on breastfeeding. The mothers were asked how common it was to breastfeed in Iraq and what the usual duration of breastfeeding among Iraqi mothers was. A majority of them stated it was a common practice to breastfeed for one year. Their own mothers encouraged them to breastfeed:

“For us (Iraqis), it is not a rule but the longer you breastfeed the better it is. Most (mothers) breastfeed for a year or two. That is what is normal for us” Elmira, six months old infant.

“One year, that is the standard (duration of breastfeeding)” Shayan, six months old infant.

“It (feeding practices in Iraq) is mostly breast milk. My mom says it all the time that I should breastfeed. We (Iraqis) recommend that you should breastfeed for two years. Breast milk is quite common to give the child” Ronya, six months old infant.

“... We (Iraqis) are used to it (breastfeeding). Everybody does it, mom does it” Aisha, six months old infant.

In general, it seems that a majority of Iraqi mothers breastfeed, because it was common and a part of their culture. Breastfeeding appeared to be a widely known infant feeding practice in their home country. The mothers’ were all Muslim, and were religious to various degrees. Half of the participating mothers mentioned that advices for breastfeeding were quoted in the Quran. They told that the Quran recommended mothers to breastfeed for two years. However, it does not seem as this was something they were forced to do. The mothers appeared to have thought about their own breastfeeding situation, when considering if it was possible for them to breastfeed for two years. The mothers mentioned
teething and inadequate milk as challenges in breastfeeding, which may be a problem if they continue to breastfeed for two years. The quotes below illustrate this:

“...In my religion we (Iraqis) prescribe that the children have to get two years of breastfeeding from the mother. But you know, right now she (the infant) has teeth and when I breastfeed her it really really hurts...” Hana, seven months old infant.

“...You breastfeed until the breastfeeding is done, until you do not have any milk and that is up to two years, but it (the Quran) does not say you have to breastfeed for two years, but close to two years...It is preferred to breastfeed for two years, because this is the period where the milk plays an important role...” Aylin, five months old infant.

The citations above also illustrate that breastfeeding was a common practice and part of their culture. Some mothers mentioned that even though the Quran recommended mothers to breastfeed for two years, it did not seem to be a rule for them. In addition to religious motivations, mothers also mentioned teething and milk production as reasons for the length of time they decided to breastfeed. The quotes above may also illustrate that the mothers thought that two years was far too long to breastfeed, and can be a challenge. Their own mothers have recommended them to breastfeed for one year, and they may perceive this as an achievable duration. Seven of the mothers stopped breastfeeding from 40 days to five months after birth; the majority of them had decided to stop at three months. The mothers who stopped breastfeeding early, practiced predominant breastfeeding with the introduction of milk formula before the breastfeeding stopped. The introduction of milk formula was initiated between after birth and three months. The most common reasons for this given by the participating mothers were: discomfort while breastfeeding, the infant did want to suck or inadequate breast milk production. Some of the mothers who practiced predominant breastfeeding had given the infant water right after birth. The introduction of both water and milk formula were considered as the time when the exclusive breastfeeding stopped.
7.2.2 Exclusive breastfeeding

Only three of the mothers’ had breastfed exclusively for four to five months. These three mothers were of Iraqi-Iraqi (Arabic) origin. Two of these mothers were multiparous. The three mothers planned to keep breastfeeding for one year; they mentioned it was because it was good for the infant. One of the mothers who had exclusively breastfed her infant, explained why she did this: “Everybody says that breast milk is very good for them (infants), that they become strong and get strong bones and teeth. She (first born) I have not breastfed as much. She does not have very nice teeth, she has problems with her teeth” Aisha, six months old infant.

Aisha decided to exclusively breastfeed her last born, because of the experience from her first born who have developed bad teeth. It seemed that she blamed herself for not having breastfed the first born like she is planning to do for her last born infant. It was important for the three mothers to breastfeed exclusively because they wanted their infants to grow strong and healthy. Further, they had not experienced any major challenges in breastfeeding exclusively. These infants had no problem sucking the breast, the mothers had sufficient breast milk and two of the mothers had positive experience from their first born: ”...She (the infant) was very good at sucking and everything went well with breastfeeding” Hana, seven months old infant, “I had a lot of milk, and I felt that it was a waste to throw away the milk, so then I just continued” Aisha, six months old infant and ”No, there were no problems (breastfeeding the last infant) I had experience from my first child, I breastfed her (first born) until she was six months so there were no problems” Shayan, six months old infant.

A few minor challenges have been stated by two of the mothers regarding exclusive breastfeeding: ”I also thought it was very tiresome, but I breastfeed because it is good for her” Aisha, six months old infant and ”No it is not tiresome, but I have to be near her all the time” Shayan, six months old infant.

Although two of the mothers did mentioned that it was tiresome to breastfeed, they still maintained breastfeeding exclusively.
7.2.3 Predominant breastfeeding

**Milk formula**

A majority of the mothers’ had practiced predominant breastfeeding, which meant they had introduced liquids before it was recommended (n=11). Eight of the participants introduced milk formula as one of the first liquids to the infant as early as from right after birth to two months old. Seven mothers had discontinued breastfeeding from 40 days to six months. The main reasons for providing milk formula to the infant were: relentless to breastfeed, delayed milk production or inadequate breast milk production. This may suggest that the mothers who introduce water or milk formula at an early age are more likely to stop breastfeeding earlier than recommended. In addition, half of the mothers were of Iraqi-Kurdish origin. They introduced milk formula in the first month of the infant.

One mother felt that the infant did not get enough milk from her, and asked for advice from a public health nurse, and the nurse had recommended her to give milk formula. After two weeks with milk formula, the mother decided to quit giving milk formula and begin breastfeeding again. The reason for this was that she felt that she had enough milk and maintained breastfeeding exclusively until the infant was four months old.

“I was recommended to give milk formula and I gave this to my youngest for two weeks and it was a combination of breastfeeding and milk formula for two weeks. Then I felt I had enough milk, and decided to stop with the milk formula” Aylin, five months old infant.

In this case, the use of milk was temporary to overcome a period with not enough milk. However, the recommendation by the public health nurse to begin with milk formula when the mothers had challenges with breastfeeding could also be futile for breastfeeding duration. One mother also mentioned that the infant did not want her breast any longer, after she had give milk formula in a bottle. She said it was painful when the infant suck her breast.
**Water and sugar water**

Five of the mothers introduced water as the first liquid this was the reason for why the exclusivity of breastfeeding stopped. There were also mothers who had given water, even though this was not the first thing they introduced. Some of these mothers had been recommended by relatives to give water to their infant, even though according to the official recommendations, this is not necessary before the infant was six months old. Elmira was advised to give water by her parents and parents-in-law and their reason was: “The children needs it, it is not enough with milk only”. Even those who were well aware that there was no need for the infant to drink water gave it anyway:

"My mom always told me that I should give water to her (the infant), even though there is no need for it from the start, she (the infant) still gets water...” Freshta, five months old infant.

“I started giving water regularly when he (the infant) was three weeks old. They say maybe here (Norway) that the child does not need it, but both of my children have been given water. It is almost as if they (her children) know the difference between water and milk. They become very thirsty when I put just a little on the lips. I noticed that he (the infant) drank and drank (from the infant’s lips). I only gave him a little, maximum one teaspoon, especially when they (my children) are so small” Elmira, six months old infant.

"...We (myself and my husband) try to force her (the infant), because she gets food she has to have water. We have been in contact with the health clinic. As long as she receives breast milk it consist of water, but I do not believe it is enough, is it?...” Ronya, six months old infants.

It seems like the mothers trust the advice giving from their family, especially about giving water. In addition, the multiparous had previous experience that giving water to an infant has not been harmful. Even though breast milk does contain water, the mothers did not seem to be convinced that breast milk was enough. Those who had lived in Norway for many years (16-22 years) gave water from birth. This advice was given from relatives, a few of the mothers used it as a “medicine” mixed with sugar for stomach ache, or they gave water alone to prevent constipation.

Four mothers mentioned they gave water with sugar at an early age (<1 month) for stomach ache. This was either purchased in the pharmacy or made at home with ordinary sugar. The advice for this practice was in a few cases given by the health clinic, but it often came from the mothers and mothers-in-law or other relatives.”Yes, it was from my mother-in-law, but I asked at the doctors. They said it is enough with breast milk. But yes, my mother-in-law says that sugar water is good to prevent gas and other things in the stomach, because she (the infant) cries sometimes and such and I did not know what to do...It is ordinary sugar, but it is just a little. Just a little, they say that about air and the infant become a little calmer”. Rihan, six months old infant.
One mother told that she gave water and sugar to the infant two days after birth. She explained that her breast milk was three days delayed after birth: "I gave it (sugar water) because I felt that my child did not get enough, so I gave water and sugar, we (Iraqis) use it for pain when the child is in pain and it helps with the pain. It is not ordinary sugar, it is a type of sugar which they import from Iran... the people at the health clinic suggested to give milk formula but I did not want to do that, I thought it was enough with water and sugar” Dilare, seven months old infant.

It seems that this mother believed that sugar water was better than milk formula. Even though milk formula was recommended to the infant due to the situation, the mother chose to not follow this advice.

A few of the mothers mentioned an alternative medicine, which they gave the infant to relieve stomach aches. They called it nobat or qund, and it consisted of saffron and sugar: "Yes, it is sugar, it is a special sugar, but I do not know what kind it is. It is not ordinary sugar”. Nobat or qund was shown to us by one of the mothers. It looked like crystals with a slightly yellow color. It is prepared by having "one small piece in a bottle with hot water..." Ronya said it contained sugar but stated: "It is better than sugar”. The advice about giving nobat or qund came from the parents or parents-in-law.

"When she (the infant) has stomach ache my mom says that it might be gas in the stomach. This will help for the pain and other things, because I have tried it for myself when I have my period and stuff, and when I try, it helps a lot. So, when I gave her this (nobat/quand) it helped she sleeps nicely and does not cry” Jasin, eight months old infant.

"They also say it (nobat/qand) is very good for the children. It gives a bit warmth to the body and so on. In addition to air too (prevent)” Rihan, six months old infant.

These mothers trusted the advice from their parents or parents-in-law to give nobat and qund, and they trusted them because they had more previous experience with care of children. In addition, the mothers have tried it for themselves and they believe it works both for themselves and their infant.
Other remedies

Another remedy that was mentioned as an alternative medicine for stomach ache was marimia/mirimia. The mothers described it as herb, and it was shown to us by one of the mothers. It was grey and it looked like dried short twigs. The herb was offered to us to taste, and had a strong taste. The mothers said marimia/mirimia was prepared like tea, boiled in hot water. The mothers who gave it to the infant stated the following reason: “... I always use it for her (infant) when she has stomach ache”. In addition to stomach ache it was also used for ”diarrhea”. Not all of the mothers who mentioned it, used it, but they knew it was used and given to infants. The tea could also be served to adults with honey for the same purpose. One mother explained when she used marimia/mirimia:

"I use it now when she (the infant) coughs or is in pain coughing and for nothing else. It is like tea, it is special and comes from Syria or Iraq. We put it in water and give it to her” Hana, seven months old infant.

According to the quote above, the mother used it to soothe the infant’s throat, when the infant had symptoms of a cold. A few other mothers mentioned that this practice was done for the same reason.

According to a few mothers, chamomile tea had also a similar “soothing” effect as marimia/mirimia. The explanation to why this was given to children was: “It was for the stomach ache” and ”...when she is very ill or a bit tired. A couple of days ago she (the infant) had mucus, she got it then”. Chamomile tea was not used by all of the mothers who mentioned it, but a few had considered using it or had heard about someone else who had used it. One mother, who gave it, did this when the infant was five months old.

One mother used Pepsi as an alternative medicine for stomach ache. When asked if there was something else she did for stomach ache, she explained she presses out the juice from pomegranate and grapes, and gave it to the infant. The reason given for this practice by the mother, was it is good for digestion and stomach ache. Another example she mentioned was placing a meat bone in the food, while the food was being prepared, and then take out the bone when the dish was done. She believed that the bone gave lots of nutrition in the food for the infant. The mother felt that this practice worked well for her infant, and believed that this was not common to do in Norway. The same mother explained that she did not agree with the recommendation from the health clinic to give the infant oatmeal porridge or vitamin D drops, she did not think it worked. The reason for this was that the mother’s second youngest infant got a bad immune system, after following the advice of giving oatmeal porridge and vitamin D drops. She felt that the advices from the health clinic regarding what kind of food one should give the infant, needed improvement.
Some of the mothers mentioned alternative practices that were common in Iraq, but which they did not follow in Norway. One mother mentioned a tea made from anise, this tea was prepared by boiling anise in water. However, this was not given to the infant by the mother. The reason was that she had tasted it, and said it tasted horrible, which was considered as healthy for the infant and a common practice to give infants in the home country. Another mother mentioned a practice she had heard about, but did not do, which was to give the infant the leftover water from boiled rice. This mother said that this was a common practice in Iraq, and was done to make the infant fat.

7.2.4 Challenges in breastfeeding
The mothers who were still breastfeeding were asked for how long they were planning to do so. Some of them stated one year, but a few argued that it could be a challenge since they plan to go back to school or work soon. A few of the mothers were considering starting with milk formula. The mothers seemed unsure for how long they could breastfeed, as they were planning to go back to school or work. A few of the mothers mentioned that it was both inconvenient and tiresome to breastfeed:

"I do not know, I think until August (breastfeeding duration) because I'm starting college, so it can be a bit difficult to breastfeed... It (breastfeeding duration) is going to last for a year. Or I could try to pump a little and so on, but I do not know". Rihan, six months old infant.

"I think if I start looking for a job, or have something else to do, it (feed the infant) could possibly be easier for the father with milk formula and or else I have to pump and that is tiring” Shayan, six months old infants.

As mentioned earlier, it is common to breastfeed for at least one year in Iraq, and the mothers confirmed this. One mother explained why it was possibly easier to breastfeed longer in the home country: “...I breastfed her for two years but I felt tired since I was working. It is not that many who work there (Iraq), and then it is ok (to breastfeed)” Elmira, six months old infant.

According to the mothers it may be easier to breastfeed for longer periods in their home country, because of the fact that the mothers in Iraq do not work. Some of them also stated that mothers with infants and young children get more help in Iraq. Another challenge mentioned by the mothers was that breastfeeding in public was embarrassing:

“Yes, when I go to the mall and other places it is difficult to breastfeed...” Rihan, six months old infant.
"...I think it has become modern to give the bottle and there are so many who resort to the bottle because it is embarrassing to breastfeed outside home. There are many disadvantages but that is how it is...Yes, because it is embarrassing. I think there are many who think it is difficult, I have many girlfriends who have given the bottle pretty early because they cannot breastfeed in public. They think it is uncomfortable and they wear veils and are all covered up. Then it looks silly, so then they give the bottle. There are many who also have incomplete information on milk formula, they almost think it is healthier than breast milk, and they say they spare themselves (showing the breast), and it gives them more freedom”. Elmira, six months old infant.

The bottle is possibly seen as the solution to avoid taking of clothing in order to breastfeed when being outside the home. The mother may seem uncomfortable when they are usually covered up and they have to show their breast in public in order to breastfeed the infant.

Those four mothers, who introduced milk formula early (≤2 months), gave these reasons related to their infants: “he did not want to suck on the breast”, “it was painful”, “She did not want my breast any longer after we had used bottles” and “she somehow was not satisfied”. After advice from the hospital and health clinic the four mothers introduced milk formula. A few of the mothers said they had experienced challenges with the initiation of breastfeeding. These mothers believed that the infant did not get enough breast milk when they had delayed milk production, and asked for milk formula at the hospital. One mother stated that her insufficient milk production and vitamin deficiency were some of the reasons for why she felt the breast milk was not enough for her infant:

"The reason for why I stopped breastfeeding was because the last child did not want breast milk because it was difficult for her, I had little milk in the breast, and vitamins and iron deficiency, and so there was very little milk in the breast, so it was hard for me to pump it out or for the child to suck the milk out of the breast, so she did not want it any longer. So, when she was two months I started to give her milk formula in a bottle. She was then two months, she did not want milk from the breast but preferred the bottle and from when she was 40 days. I started giving her tasting portions of food, and then it was ordinary food, vegetables and meat, I made to a soup. And when she was four months she regularly got soup which I prepared at home” Dilare, seven months old infant.

In the quote above, the mother mentioned that the infant was relentless to breastfeed; therefore she started to introduce milk formula and tasting portions early. These were also the reasons stated by the participating mothers, that the breast milk was not enough, and for that reason they gave milk formula. Even a mother who managed to breastfeed exclusively was considering giving milk formula, because she believed it would be easier for her:

"I thought about giving her milk formula, but I talked to the doctor and he recommended me that if there was no problem I should just continue to breastfeed, that is much better. But I thought it was easier with milk formula, but I did not give her any milk formula” Shayan, six months old infant.
Although she had considered giving the infant milk formula, she continued to breastfeed after advice from the doctor. The bottle or milk formula may seem as an easier practice for other mothers also. This practice was considered or carried out by the mothers, because they did not need to worry about losing their freedom. They can move around, not having to show their breast, and they can plan to go back to school or work.

7.3 Complementary food

7.3.1 Complementary feeding
Predominant breastfeeding stops when complementary food was introduced to the infant. The infant feeding practice was then referred to as complementary feeding in this thesis. Many of the mothers have let the infant taste food from the age four to six months, which was the advice given at the health clinic. According to the mothers, the portions given were very small and considered as tasting portions. Almost all the mothers followed this advice, except for one who had introduced complementary food in the form of tasting portions when the infant was only 40 days old. The majority of mothers had just introduced tasting portions by the time of the interview. They were gradually making the infant used to food by four to six months of age, and planning to eventually give a bigger meal to the infant. A few of the mothers mentioned that they thought the infant was too little to be given food. Therefore they gave the infant tasting portions to make him/her used to food:

"No, I think she is too small for it, but our main course for dinner today is rice and soup, and she is then allowed to taste the soup" Freshta, five months old infant.

As the quote above illustrates, a few of the mothers showed concern in giving the infant food, because they thought that infant was too small for regular food. They were cautious and only gave tasting portions. It was usually from what the family was eating for dinner.

According to the mothers, the health clinic recommended oatmeal porridge as the first meal for the infant. The majority of the mothers gave this porridge, which was easy to prepare and needed only to be mixed with hot water. Most of the mothers had at the time of interview recently introduced other meals to the infant, besides porridge. The majority of the participating mothers had infants, who were five to seven months old infants, which is when complementary food was introduced.

A majority of the mothers also gave home-made infant food, and only two of the mothers regularly used the ready-made infant food. These two mothers stated that the food was liked by the infants, in contrast to the rest of the mothers who said that their infants did not like the ready-made food from the store.
The mothers who gave home-made food stated their infant preferred this type of food, and they seem to like the assurance that comes with knowledge of what the food contained.

The four mothers who had stayed longest in Norway gave ready-made oatmeal porridge. Two of them combined giving both homemade and ready-made porridge, while the other two mothers gave ready-made food from a glass jar and ready-made oatmeal porridge. The two mothers who only gave ready-made food were planning to return to other commitments in the near future (studies and work). It seemed that time and the transition to regular meals for the infant was important for them. One mother who had lived in Norway for 16 years said the following when she was asked about how the feeding practices for young children in Iraq was:

"I do not think you are asking the right person right now. But here in Norway I use whatever is available here. I think it (the practice in Iraq) is ordinary food, which you have mashed, but today there is food in the stores like here (Norway)" Ronya, six months old infant.

It may seem that the mothers who have arrived in Norway as children were more open to adapt to the infant feeding practices in Norway, because they were unsure or did not trust the infant feeding practices in Iraq. In addition, this is the only practice they know of. It could also possibly be that mothers who were eager to go back to work or had to go back to school, had less time to prepare food.

Some of the mothers mentioned that they had received a booklet from the health clinic, which had simple suggestions on recipes and what kind of food they could give the infant from four months to one year of age. The majority of the mothers started out with mashed vegetables like potatoes, carrots and broccoli when their infant was four to six months of age. Some had also tried different fruits such as apple, orange, grapes, pomegranate and banana. These fruits were given to the infant to suck on or the juice was pressed out for them to drink. Half of the participating mothers combined the complementary food with breast milk, and the other half used milk formula. When the mothers were asked to describe a typical meal for their infant, some said that they were careful with the infant’s food by just adding a few ingredients, like mashed vegetables. Other mothers had almost introduced everything, and the infant ate just about whatever the family did.

A majority of the mothers gave their infants hot soup with vegetables and meat, which was common for Iraqis to eat for dinner. A few also added rice in this soup. Some modifications to the typical Iraqi soup was done for the infant, such as less salt or no salt, no meat/ a little meat mashed or put in a blender. The mothers made the Iraqi soup for the whole family but set aside a small portion for the infant before adding other ingredients for the rest of the family. One mother explained what the Iraqi soup contained
and how she prepared it. She would usually make a big portion that would last for a week for the infant:

"There are vegetables and meat and I prepare this in a pot. This is for a week which I divide. Usually it is different vegetables some meat and sometimes fish but that is seldom, as I am afraid there might be bones (from the fish) ... When I make it I just put it in a bowl and cover it with plastic wrap and then I put it in the refrigerator and every time I am going to give food to the infant, I take out from the bowl and boil it in hot water and give it (to the infant)" Dilare, seven months old infant.

Prepping a big portion for the infant that will last for a whole week made it easier for the mother to save time.

7.4 Information sources
In the search for information about what to give the infant, some mothers mentioned different information sources they would seek for advice during the pregnancy and after. Some of the mothers would verify information they had read on the internet with the health clinics. The internet or books were not primary sources of information among the participating mothers. They mainly trusted and used the information they got from their mothers, mothers-in-law, the hospital and health clinic.

7.4.1 Mother and mother-in-law
Many of the mothers chose to combine the information from the health clinic with their mother’s or mother-in-law’s advice. The explanation for this was that they spoke the same language and they have more experience.

"... I listened to my mother. She is not only my teacher but she has also three children and she knows everything. I get the advice from the health clinic that I should breastfeed and give food, and what kind of food I should give. But all the (useful) information I get is from my mom and mother-in-law” Hana, seven months old infant.

"... she (my mother) has much more experience than I have, I have learned a lot from her. She has given many good advices, like that the infant can get some more ordinary food than this (oatmeal porridge) after he (the infant) has turned six months” Belen, eight months old infant.

The quotes above may illustrate, that the mother showed great respect and trust for their mothers. Therefore, they listened to them and took their advice, because they have gone through the same experience and managed it. The mothers who breastfed exclusively appreciated their mothers’ opinion, and combined this source of information from books or internet they had read or heard from the health clinic. The reason mentioned for why they listen to their mothers was also their previous experience with children.
"... she has a lot more experience with children than I have" Aisha, six months old infant. In the interview she said that her mom had five children including her, but she also trusted the advice given by the health clinic as well: "I call up here (health clinic) and if I do not get hold of them I go to my mom. If I ask mom and she does not know, then I come here. That is how I do it" Aisha, six months old infant.

"My mom is the best (source of advice), maybe it is because she speaks Arabic, and she understands how it is with a baby, and what I should do with for example gas in stomach. She has explained many times about it and I have learned which is good" Hana, seven months old infant.

One reason given to why they resorted to their mothers and mothers-in-law was that they were easy to get hold of and/or are someone they frequently see. Some of the parents or parents-in-law were not living in Norway; the mothers spoke to them regularly by phone or internet.

7.4.2 Hospital
All of the mothers knew about colostrum, and had been informed about this at the hospital. They also stated that the infant had received most of the colostrum. A few of the mothers encountered problems in giving the colostrum, because of delayed milk production. According to the majority of the mothers, the hospital was good at informing about colostrum, as this seemed to be a part of the hospital procedure.

The majority of the mothers had a positive experience with giving birth in a hospital. However, one woman had given birth to her two youngest children in a hospital in Norway, and told about the bad experience she had with the last born:

"...the time when I gave birth to the second youngest I felt much safer. Things were better then, I was offered support, like an interpreter, who explained everything throughout the whole birth process, what was going on and so on. I did not get that with the last born, and I was very scared..." Dilare, seven months old infant.

Only a few mothers told about their negative experience with the hospital, which were mostly related to the staff. One of the stories was that the staff had left her newborn baby in the reception without guidance. The multiparous felt that they were better taken care of at the hospital, when they had their first child. However, the three mothers who had breastfed exclusively seemed to have had a positive experience with the hospital.

The mothers who had breastfed exclusively, said that they had been given a good and detailed procedure and help regarding breastfeeding in the hospital. These mothers told us what kind of information they had received at the hospital after giving birth:
“When I was pregnant with my first child I was very afraid and I thought about how life was going to be with her. But when I gave birth at Bærum hospital they helped me a lot and they taught me lots of things, how I should hold her, breastfeed and bath her. I was very happy, and after that when I was discharged from Bærum hospital it was all back to normal and very good with her and everyone”

Hana, seven months old infant.

“I received a lot of help…. We (my husband and me) learned how to hold the baby and have the breast inside the mouth. The baby should have their mouth open and have the breast inside the mouth and let it, and the baby should be breastfed for 20 minutes...”

Aisha, six months old infant.

As the quote above illustrate, the mother was concerned on how life would be as a mother as this was her first child. However, with the help and advice on how to care for the infant at the hospital the mother’s concerns disappeared. The mothers who breastfed exclusively were able to give detailed descriptions on what advices they had been given from the hospital. It is also important to remember that the mothers did not encounter any major challenges, which is a significant reason to why they have managed to breastfeed exclusively.

7.4.3 Health clinic

When the mothers were asked if they had heard about exclusive breastfeeding the majority of the participants were not familiar with the term. However, they had been informed that breastfeeding was good for the infant and should be maintained until four to six months by their health clinic. The mothers with the quotes below have not heard about exclusive breastfeeding, but describe what was told about breastfeeding by the health clinic

“`They said I should give her my own milk, but that’s all, and if it’s not enough then I can use something else”’ Sayran, nine months old infant.

“`They said I can breastfeed for over six months, but not less than six months”’ Belen, eight months old infant.

“`Just that it is good if you breastfeed, it is better that you breastfeed than give milk formula”’ Jasin, eight months old infant.

The quotes above may illustrate that the health clinic may not use the term exclusive breastfeeding, when explained to the mothers. It seemed that the mothers were well informed by the health clinic, that breast milk is beneficial and the optimal practice. However, they appeared not to use the term exclusive breastfeeding.
One mother expressed that she felt pressured to breastfeed by the health clinic: "Yes, but as said before, they (health clinic) recommended that I should breastfeed for at least four months. They also said this at the hospital. But they cannot go around forcing people (mothers) to breastfeed. If they do not want to, they cannot begin to insist doing that, it is of course my choice. But they also say that it is beneficial for the children so therefore you should do it" Ronya, six months old infant.

Three mothers practiced exclusive breastfeeding as mentioned before. However, two of these mothers revealed that they had not heard about exclusive breastfeeding. They told us what had been said about breastfeeding:

"...she (the public health nurse) said I have to breastfeed her. They (health clinic) said I had to breastfeed her so I continued to breastfeed her" Hana, seven months old infant.

"Yes, she (the public health nurse) said she recommended six months (of breastfeeding) and after that I could decide if I wanted to quit breastfeeding. But she recommended that I should breastfeed her for six months" Shayan, six months old infant.

These two mothers, who had exclusively breastfeed, received similar advice as the rest of the mothers from the health clinic on exclusive breastfeeding. They were advised to continue breastfeeding, since they did not have any problems with breastfeeding. The mothers who breastfed exclusively were motivated to so, because of recommendations from family, health clinic and hospital. These mothers who had a positive experience with the health clinic and/or hospital had a support system influencing them to breastfeed exclusively. One of these mothers also mentioned that the advice to breastfeed exclusively was given by both the health clinic and her mother.

The three mothers who breastfed exclusively were content and trusted their health clinic, in regard to the help and information they had received on care of the infant. Two of them explained why: "I am very pleased. Yes they (health clinic) help out and they are very good to us. If I need help or information they give it to me and I am very happy with the health clinic" Hana, seven months old infant and "I collect information from the family but I trust the public health nurse the most because she is educated in the field" Shayan, six months old infant.

A majority of the mothers’ trusted and had a positive experience with the health clinic and were satisfied with the information given. Only a few of the mothers mentioned brochures they had received at the health clinic. The reason may be that only a few considered this as important information or that it was not handed out to them. A few mothers had also noticed that the staff at the health clinic can be stressed and have a limited time for each mother. The mothers said it felt like they were only there for the infant to get measured, weighed and vaccinated. This was also observed during the recruitment
process at the health clinic. This perception of the health clinic could make the mothers hesitant to ask the health clinic questions.

7.5 Conflicting messages and practices
Although many of the mothers trusted the advice they had received from their mothers or mothers-in-law, some chose to not follow all of the advices given. Some were also explicit that they avoided the infant feeding practices from the home country and refer them as “out of date”:

“Yes, my mom has actually not said too much but she asks if I have done this or that, but my dad recommended that I should give water to her (infant), and I said no dad her stomach is still very little I do not want to do that when the child is like that” Shayan, six months old infant.

“... She has seven children and I have great respect for her, she has a lot of experience, but I do not know. I thought about being more modern and ask the health clinic...” Rihan, six months old infant.

It seemed that early introduction of water to the infant was a common practice both in Iraq and in Norway among the mothers. However, some of the mothers in this study seemed to not follow the advice because they have heard that water is not necessary or they were skeptical to the practices in Iraq. One of the mothers stated her reason for not following the infant feeding practices from Iraq:

“It is because of people who study the same as you for example, they do research on what is best. I base my practice on knowledge and research, I think that is what you can trust, rather than using your child as a guinea pig and just try it out on your child” Shayan (33).

This mother has chosen to follow the advice from the health clinic, because she perceived the information from the health clinic as trustworthy. The mothers followed the advice from the health clinic in introducing food and what type of food. The health clinic recommended mashed vegetables as a start for the infant. The majority of the mothers followed this advice. Most of the mother made something they called Iraqi soup, which consisted of vegetables and soup with sometimes rice or meat. They also received recommendations from family on infant feeding practices from the home country such as giving for example water, tea, nobat/qund and marimia/mirimia to the infant.

One mother of six children did not trust or follow the recommendations from the health clinic. According to this mother, the reason given was that the child born before the youngest got a bad immune system after following the advices given by the health clinic. She had only followed the advice from the health clinic with this child. The other children were born in Iraq, except for the two last born children who were born in Norway. The mother decided to practice what she had done with the older children born in Iraq with the last born. The mother had also introduced fruit a bit too early according to
the health clinic: “She (infant) received fruit when she was two months, I was scolded by the midwife”
Dilare, seven months old infant.

The same mother of six introduced food quite early too. She was asked what the reaction of the health clinic was to her practice, and she said what the public health nurse has said:

“Oh, it is dangerous you should not do that, you should do this and this. I said to her I am a mom of six children. Listen to me, I have tried it a numerous times. There are a lot of problems for the child lalalalala(the nurse said). She (the public health nurse) does not listen to me and I do not want to listen to her” Dilare, seven months old infant.

This mother has a lot of experience, and seemed confident in her practice. Another mother gave bread or cookies dipped in tea to their infant as a meal. She explained that this is a common practice in Iraq. The majority of the mothers were aware of this practice, even though they did not do it. The mothers who did not give tea were asked if they have heard or seen this practice. The majority of them answered yes. It does not seem like there is a particular reason to why tea was given. The tea given by the one mother was ordinary black tea with some sugar and was a part of the infant’s meal, for example breakfast.

8. Discussion

8.1 Methodology discussion
As mentioned earlier, there has been done no previous research on Iraqi mothers’ infant feeding practices in Norway. Therefore, a qualitative approach has been chosen to answer the main objective and sub-objectives.

A main strength in qualitative methods is that it can generate abundant data, which reflect the participating mothers’ point of view. Qualitative methods are used when we want to understand a phenomenon, on how it varies under different circumstances and why. The phenomenon in this case, was infant feeding practices among Iraqi mothers. To understand the phenomena, it was important to obtain how mothers’ perceived infant feeding practice, their experience with infant feeding and their point of view of this practice (Klepp, 1997). A disadvantage in qualitative method was that the method was resource-demanding, time-consuming and the number of participants was limited. Due to the time limit and the challenges in recruiting the participants, pilot interviews with the interview guide were conducted on another ethnic group, the Somali mothers. The author of the thesis was present on one pilot interview of a Somali mother. In addition, the first interviews were seen as training, when one of
the project leaders conducted them. These interviews were also included in the final data material, due to difficulties in recruiting the Iraqi mothers.

It was unfortunate that interviews of public health nurses were not implemented in this study. As this could have given an overview over what kind of information was given out to the mothers and what was understood by the Iraqi mothers. However, the present study has managed to capture the perception of the mothers on the advice given from the health clinic. In addition to their intention behind their infant feeding practice, this can benefit the Iraqi mothers in the future.

A saturation of information was achieved, in terms of that predominant feeding seemed to be a common practice among Iraqi mothers in Norway and was obtained from the interviews. However, a few mothers mentioned common infant feeding practices, which could have been further explored with some more interviews. Unfortunately, the time limit of the master thesis had to be considered.

**Preknowledge**

Prior to when the InnBakost started, literature search on the themes such as breastfeeding, complementary food and immigrant groups was done. The research was done to develop the project description for the master thesis. This may have developed a preknowledge for the author of the thesis. Preknowledge is referred as preconception by Malterud (1996). The preknowledge is described by Malterud (1996) as the backpack we bring into the research project before it has started. The content of the backpack may determine and influence how data is collected and analyzed. The backpack of the author of the thesis consisted of absence of experience with children and no precious contact with the Iraqi community in Norway prior the study. In addition to a nutrition background, this may have increased the curiosity in learning more on these topics, but at the same time the no experience with infant feeding can be a disadvantage in the interview. More experience in infant feeding, may possibly have influenced the questions asked, going in to depth on challenges related to breastfeeding and understanding the experiences of the mothers.

**Interview situation**

The interviews were conducted at a place and time which was suitable for the mothers. A majority of the mothers preferred to have the interviews at home, which was easier for them. Because it was difficult to get in contact with Iraqi mothers with an infant in the specific age group, it was a greater chance the interview would take place if time and place was chosen by the mother. Since, many of the interviews were conducted in the mothers’ home could perhaps have had a positive effect, considering that they might have been more comfortable and relaxed during the interview. The infant or children
were present during most of the interviews. The interviews lasted for approximately 30 minutes to one hour. The interviews conducted with the help of an interpreter lasted for a longer time. In some of the interviews the children became restless or the mothers were in a hurry. Therefore, when it was time to end the interview, the most important questions were prioritized. Most of the interviews covered the important topics.

The mothers were informed that the interview would be recorded, before it started. The mothers did not appear to be nervous because of the recorder. Those who seem uneasy at the start of the interview seemed to forget about it during the interview. The use of a digital recorder was an advantage, which gave the opportunity to hear through the interviews and enabled the interviewer to fully concentrate on what the mother was saying. This made it easier for the interviewer to listen actively. This was favorable in order to achieve listening and understand the Iraqi mothers’ choice of practice in context with their infant feeding practice. Active listening was important in order to master the technique in asking questions during the interview. Active listening is the interviewer’s ability to listen to what the informant is saying (Kvale & Brinkmann, 2012).

The data in this study was collected retrospectively, and were dependent on the mothers’ memory. Most of the interviews were done at four to eight months after birth. The time of interview may be seen as reliable and valid for the Iraqi mothers to estimate breastfeeding initiation and duration. According to Li and co-workers (2005) retrospective interviews on initiation and duration of breastfeeding can be seen as reliable, when the interviews are conducted three years or less after birth. The present study may be reliable on recall of food, because most of the introduction of food was recently introduced to the infant.

Kvale & Brinkmann (2012) mention asymmetrical relation between the interviewer and informant as a possible methodical challenge, considering the background of the interviewer and that the interviewer controls the interview. The awareness of the author’s nutrition background may have affected the mothers’ statements regarding what type of food they gave. However, this did not seem to affect what the mothers told us. Before the interview or during the recruitment, the mothers were informed that we were only interested in knowing how their infant feeding practices were. It is therefore important that the interviewer should reflect over the asymmetrical relation, even though one try to have an open understanding (Kvale & Brinkmann, 2012). However, it was not an option to not mention the author’s background, because the mothers had the right to know what was studied.

The first three interviews were held by one of the project leaders, and being present and observing at these interviews were a form of training on how the interviews should be conducted. The author of the thesis had some previous experience from the bachelor thesis and modules from school in conducting
interviews. The other interviews were conducted by the master student with the help of the interview guide and at some cases an interpreter.

**Interpreter and translations**

The use of interpreter was necessary in some of the interviews due to language barriers between the interviewer and the Iraqi mother. Qualitative studies that use an interpreter during the research process are described as cross language research (Temple, 2002). In order to improve the quality of care by health care professionals, studies on immigrant groups background and culture should be represented with the help of interpreters to capture much needed information (Esposito, 2001; Yach, 1992).

The use of only a few interpreters in the present study gave the opportunity for the interpreter to become familiar with the research process, and to be aware of the type of information needed from the interviews, which was necessary in qualitative work (Adamson & Donovan, 2002). A training or induction process is usually recommended in order for an interpreter to understand her/his role in the study (Edwards, 1998). This was done in the present study, where the interpreters received a booklet with information about the project and the role of an interpreter in the interviews. By this way, the interpreters were sensitive to the research topics, aims, aware of their role and the confidential matter of the interviews. It was helpful to have the interpreter present, in case the interviewer forgot to go in to depth at some topics. In this way the interpreter could remind the interviewer to cover topics, which had not been fully covered during the interview.

The credentials and experience of the interpreters may have affected the quality of translations and the analysis process (Adamson & Donovan, 2002; Edwards, 1998). The trustworthiness of interpreters translations were at some times questioned. This occurred in a few interviews where the Iraqi mothers’ would speak for a long time and the translation was short compared to how long time the mother had spoken. To avoid that the interpreter had to translate too much, if the mother was talkative, was to interrupt and ask what the mother said. This could have possibly disturbed the natural flow in the conversation, but was done to make sure all information was translated by the interpreter and obtained by the recorder.
The Iraqi mothers

When recruiting the mothers several challenges were encountered: finding Iraqi mothers with an infant in the specific age group (six months), identify the Iraqi mother or infant by name at the health clinic, finding gathering places and difficulties in recruitment from the health clinics. Luckily, the challenges were surpassed when new recruitment strategies were used: “Folkeregisteret”, snowball-method, recruiting mothers who had participated in the pilot study of the quantitative part of InnBaKost. The challenges in recruiting may have resulted in a heterogenic group, because the mothers were recruited from various places mentioned above. Half of the mothers were multiparous, there was a wide age specter, years in Norway and half of the mothers spoke Norwegian. It is important to ensure that the selection strategies elicit informants who has the information about the phenomena one wish to explore (Malterud, 1996). Therefore, it was critical to reflect around the choice of the selection and what effect this potentially has had on the findings. A potential selection bias among the participating mothers did not seem to have occurred, because the mothers were not over interested in infant nutrition or the gift card we offered. However, they were interested in helping the study and participated, they were recruited through the use of snowball method.

Along in the interviewing process, it was discovered that Iraqis can be divided into Iraqi-Kurdish or Iraqi-Iraqi (Arabic). Since, this was discovered while the recruitment of mothers was on-going; all Iraqi mothers who agreed to participate in the study were included. These mothers were included because of the limited time regarding the deadline for handing in the master thesis. This may be considered as a weakness in the present study, as two groups are represented. However, there were no big differences observed among the two groups, and both groups were equally represented in the group of Iraqi mothers.

Transcription and analysis

The author of the thesis transcribed all of the interviews, except for one. The analysis of the data was conducted alone by the author. As mentioned earlier, the study followed the five steps in Grounded Theory when data was collected and analyzed, and is further discussed below.

The first step in the Grounded Theory approach is data collection. The analysis already began at this stage, and results in follow-up questions. After listening and going through the interviews, it was obvious that some of the interviews may lack in follow-up questions on some topics. However, during the interviewing process the follow-up on interesting issues became easier, as well as being independent and breaking away from the interview guide.
The next step was documentation, which involved transcribing the interviews and transferring them to the software program OpenCode for coding. Transcribing the interviews was at some cases a challenge when the sound files had a lot of sounds in the background, the microphone was too far away from the mother or the mother spoke to low. However, in most cases the author of the thesis was present during the interview, and therefore had an idea on what was said when some parts of the sound file was unclear. The interviews were transcribed verbatim in Norwegian and analyzed by the same person, the author of thesis. The transcriptions were further transferred in the OpenCode for coding.

After the transcriptions were transferred in OpenCode for coding, the third step was Open coding (3). Each sentence was then given one or more codes, which described the sentence. The codes were later clustered and transformed to categories, and given a name which described the codes. This process was called selective coding (4). An advantage to this step was that the codes were systemized, which made it easier to get an overview over the different categories in the transcripts. A potential disadvantage that may have been present in this process was determining which codes should be removed and which ones that should be kept. In addition, the categories may have already been decided unintentionally. Valuable information can have possibly been lost in this process.

In the last step theoretical coding (5), the codes and categories were connected to each other in order to discover new concepts. This step made it possible to detect potential connection between statements of the mother. Preknowledge may have an important role when attempting to connect different codes and categories with each other. The author of the thesis may lack the experience and the preknowledge when attempting to connect codes and categories together.

The interviews were gone through many times, by listening to them and by reading the transcripts. In this process, relevant statements were extracted from the text. To get an overall overview on the data of the mothers a matrix was developed. This made it easier to have an overview over the important topics, as well as to develop tables; appendix 7 has been developed from this matrix.

The interviews were originally conducted in Norwegian, but since the thesis is written in English, relevant quotes from the transcriptions had to be translated. The translations of the quotes were performed by the author of the thesis, and further approved by the project leaders.
Trustworthiness

In conducting qualitative studies, trustworthiness of the results is important to consider. Trustworthiness of the data collection and results can be addressed according to four different aspects; credibility, transferability, dependability and confirmability (Dahlgren et al., 2007).

Credibility is the truth value of the study’s findings. This means if the study have answered the research questions, which was aimed to be captured through the interviews with the mothers (Dahlgren et al., 2007). In order to ensure the quality of the data, the mothers were contacted by phone if some topics were unclear. It was also beneficial to provide a mutual understanding between the informant and interviewer by giving a summary of what the interviewer have understood based on the informants statements, which is defined as dialogical validation (Malterud, 1996). It also strengthens the sound file and transcription, in case the recorder did not catch what was said or the sound quality of the file was bad. Information from previous interviews were also used, by verifying the information from these interviews in the later ones, one example is how they describe common practices in the home country. In addition, a debrief after some of the interviews were done to discuss the interview, information obtained and further observation that could be important in interpreting the findings (Adamson & Donovan, 2002). The use of triangulation, when using several methods could have enhanced the credibility of the results. By conducting interviews or focus group discussions of public health nurses and Iraqi mothers could have increased the trustworthiness of the results. Unfortunately, this was not done in first data collection of the project, and might have supplemented the findings from the interviews.

Transferability is another aspect to the trustworthiness of the results. This is to which extent the knowledge can be transferred to other people in similar contexts (Dahlgren et al., 2007; Malterud, 2003). A useful keyword in describing transferability is context, in assessing the transferability to similar phenomenon. It is important to ask, can the findings be applicable outside the context it was obtained from, and in which contexts? (Malterud, 1996). The group of mothers who participated in this study consisted of various degrees of integration, various length of living in Norway, various educational level and primiparous/multiparous Iraqi mothers. The findings from the participating Iraqi mothers were a specific group studied, and cannot be applicable to other immigrant groups. However, the findings might be applicable to other Iraqi mothers in Norway. Within qualitative methods the purpose is not to generalize, but to say something on the understanding of phenomena in the context (Kvale & Brinkmann, 2012).
Dependability is related to the issue of consistency of the interviews. This refers to the ability of the researcher to account for the constantly changing conditions of the phenomenon studied. The conditions can be the interaction with study participants and for the entire research process carried out (Dahlgren et al., 2007). In the present study, the first interviews compared to the later interviews may have been different. As one of the project leaders conducted the first interviews, and the author of the thesis did the other interviews. The interviews were conducted consistently in the later interviews, where the interviewer was no longer dependent on the interview guide. The dependability may have possibly increased along the interviewing process. Another issue that may have affected the dependability of the project was the recruitment process. As the recruitment places where changed along the way, this may have reduced the dependability in relation to the recruitment process. However, the change in recruitment process may have been positive for obtaining a heterogenic group of Iraqi mothers.

The last aspect was confirmability. This aspect addresses the neutrality of the data. The confirmability may have been a weakness in this study, due to the fact that the analysis was done independently by the author of the thesis. A fellow researcher should have gone through the data collected, and if the research was confirmable the researcher should be able to find the same conclusion as the author of the thesis.

8.2 Result discussion

Breastfeeding

The mothers perceived breastfeeding as a common infant feeding practice in Iraq. In addition, they mentioned that breastfeeding is recommended for two years by the Quran. Since, it is seen as a common practice in the home country and recommended in their religion, it may be part of their culture and in shaping their motivation and intention to breastfeed. Many of the mothers in the study stated one year as the common duration of breastfeeding, although only four mothers stated they were planning to breastfeed for one year.

The mothers’ perception of breastfeeding may have come from their own mothers, mother-in-laws and reading the Quran. In addition, it has been acknowledged earlier that there is high breastfeeding prevalence in Norway (Øverby et al., 2008). The combination of the mothers’ perceptions on breastfeeding and the Norwegian influences can be expected to result in high breastfeeding prevalence among Iraqi mothers living in Norway. One study suggested that women who were originally from a country where breastfeeding was common can have a drastic drop in their breastfeeding rate after arriving in a new country, where breastfeeding rate was lower (Choudhry & Wallace, 2012). Thus, the
possibility of influencing the breastfeeding practice negatively by migration to Norway compared to other western countries may be reduced.

However, only half of the participating mothers were still breastfeeding. This may indicate an acculturation in shorter breastfeeding duration. A part of the explanation can also be that the age criterion was wide, so that some of the children were more than six months of age. However, some mothers started to give milk formula very early (≤2 months). It also seemed that mothers who had introduced milk formula or water from start (from birth to one month) were more likely to have stopped breastfeeding before the time of interview (table 1).

Breastfeeding is nutritious for the infant, and a longer breastfeeding duration has been positively associated with delayed introduction of complementary food (Betoko et al., 2013). In addition, breastfeeding also reduces the risk of many diseases of the infant and mother (Kristiansen, Lande, Øverby, & Andersen, 2010). As mentioned in the background, some immigrant groups were more prone to diabetes type 2 and obesity. The long term benefits have been reported to reduce the risk of these diseases that some immigrants encounter (Chung et al., 2007). Therefore, mothers of immigrant background should be encouraged and motivated to breastfeed longer in order to prevent these diseases.

Norwegian mothers with six months old infants have a high prevalence on breastfeeding (80%) (Øverby et al., 2008). A low exclusive breastfeeding prevalence at six months (9%) was also documented among the Norwegian mothers from “spedkost” (Øverby et al., 2008). The prevalence of mothers who breastfeed exclusively in Iraq is unknown (Ameer et al., 2008). In the present study, only three of the mothers’ breastfed exclusively, these mothers were of Iraqi-Iraqi origin (Arabic). These mothers said they did this practice because it was good for the infant and they seemed not to have encountered any decisive challenges. However, the maternity leave system in Norway support the possibility and facilitate breastfeeding among all mothers during the infant’s first year of life (Kristiansen et al., 2010). It is unknown if this system have only benefited breastfeeding duration of Norwegian mothers. Therefore, Iraqi mothers should also be able to breastfeed exclusively for six months or breastfeed for a longer period.

However, there were a few mothers who had part time jobs and some were housewives. These mothers did not receive paid maternity leave. Of the five mothers who were housewives, three had stopped breastfeeding. The mothers may have possibly wanted to go back to school or work earlier, than the other mothers who had paid maternity leave. Thus, research on immigrant mothers such as Iraqi mothers is needed to understand potential reasons for differences in breastfeeding practices. This kind
of research may facilitate the development of effective breastfeeding promotion strategies, where all mothers are reached and benefited.

**Challenges in breastfeeding**

Half of the mothers had stopped breastfeeding at the time of the interview. These mothers stated three main reasons for discontinuation of breastfeeding: discomfort while breastfeeding, the infant did not want to suck or inadequate breast milk, similar reasons were identified among Norwegian mothers (Øverby et al., 2008). This may indicate that these problems are common among mothers who are breastfeeding. However, a study from Australia claimed that mothers have a tendency to perceive their breast milk as insufficient (Scott, Binns, & Arnold, 1997). The mothers in the present study seemed to feel guilt of not being able to provide their infant with enough breast milk. This may have resulted in the early introduction of milk formula. Counseling and information on breast milk may be needed to motivate and to give the mothers a positive perception of their breast milk production. Studies from Norway and other countries have reported that low maternal age and the level of education were consistently related to shorter duration of exclusive breastfeeding and breastfeeding (Betoko et al., 2013; Kristiansen, Lande, Øverby, & Andersen, 2010). In the present study, however, there seemed to be no association on maternal age or education.

A few of the mothers have mentioned that breastfeeding outside the home is a challenge. The mothers in this study were all Muslims to various degrees. The religion Islam emphasizes the mother’s privacy and modesty when breastfeeding, where parts of the body must be covered at all times from those who are not close family members (Shaikh & Ahmed, 2006). A few of the mothers perceived this as an important aspect, which may have resulted to the early introduction of milk formula for the infant. The reason may have been, that milk formula was easier to use outside the home and available in every supermarket.

A challenge that may affect the breastfeeding duration also, was an early return to work outside home (Betoko et al., 2013). However, the mothers in the present study were still on maternity leave and most stated that they were not planning to go back to work before the infant was one year old. In the present study, the majority of the mothers were either employed or students. Milk formula may have been considered as an option, when the mother had to go back to their commitments. By making the infant used to milk formula before they have to go back to work or school, would make it easier for the mother to be away from the infant. The mothers mentioned that the mothers in Iraq breastfeed for up to one year, and are able to breastfeed because they do not work and they get help from their family. It may be
easier for the mothers in Iraq to focus on the infant and breastfeeding, because they are then more available for the infant.

**Predominant breastfeeding**

**Milk formula**

The problems with breastfeeding stated by the mothers, have possibly led to the early introduction of milk formula among the Iraqi infants. The challenges the mothers encountered have been solved by introducing other alternatives (milk formula and complementary food) to provide the infant with the nutrition it needs. The mothers, who encountered problems with breastfeeding and did not get adequate help, were possibly more likely to introduce the child to predominant breastfeeding or complementary feeding earlier. In the present study, a majority of mothers introduced supplements such as sugar water, water and milk formula at when the infant was below three months of age, which was also found in another study among mothers in Iraq (Ameer et al., 2008). It has been reported that early introduction of milk formula affects the duration of breastfeeding negatively (de Oliveira et al., 2012). Milk formula in a bottle may also lead to the infant developing a different suck, which can be uncomfortable for the mother while breastfeeding (Giugliani, do Espírito Santo, de Oliveira, & Aerts, 2008). This was stated by one of the mothers, as a reason why she stopped breastfeeding. It also seemed that introducing milk formula to the infant was more common among the mothers who were Iraqi-Kurdish, since they all introduced milk formula in the first month. Most of them practiced predominant breastfeeding, in the way that they would mix breastfeeding and give the bottle or stopped breastfeeding. Some of them stopped breastfeeding early.

In a study on Iraqi mothers in Iraq, 35% believed that breast milk alone was not enough to feed their infant (Ameer et al., 2008). The reasons were mainly related to the mothers’ health, such as deficiency of vitamins and/or illness. Therefore, a majority (79%) of the mothers started to give supplements at three to six months of age (Ameer et al., 2008). However, there were some mothers (13,1%) in that study that introduced supplements from birth to three months of age (Ameer et al., 2008). This may show that it is common among Iraqi mothers to introduce supplements such as water, sugar water and milk formula early.

As one intervention from Brazil showed, the introduction of milk formula can be postponed by improved counseling in the maternity ward and at the home of the mother until the infant is four months of age, (de Oliveira et al., 2012). The introduction of milk formula was delayed for almost two months, and was introduced at five months instead of three months of age. The mothers in this study may need
more information on how to stimulate milk production and how to breastfeed, in order to increase the 
prevalence of breastfeeding among Iraqi mothers living in Norway.

**Early introduction of water**

Almost all the infants were introduced to water early, from birth to the first month of age. This practice may be common among Iraqi mothers. The prevalence of this practice among Norwegian infants was not as high (14% <3 months) (Øverby et al., 2008). In the present study, the mothers stated that the infant needed water, as the reason for why they gave it to the infant. Even the mothers, who were aware that there was no need for water, gave it anyway. The similar reasons have also been documented among Turkish mothers, where the mothers believed their infants needed water and other supplement when they felt they did not produce enough milk (Ertem, 2011). In the present study, this advice was often given by their mother or mother-in-law, as it was among the Turkish women, elderly women (grandmothers and mothers) had beliefs that the infants needed water (Ertem, 2011). The intention of giving water may be in accordance with what the Turkish mother thought of water. They did not perceive water as a supplementary food, but as a necessity for the maintenance of infant health (Ertem, 2011). A potential underlying challenge in the present study may be that the mothers felt pressured to follow the advice from their mothers. The mothers have stated that they trusted and respected their own mothers’ advice, because of their experience with children. The introduction of water has caused the exclusivity of breastfeeding to stop, along with other practices which is common among Iraqi mothers. The mothers seemed to not see any harm in introducing a little water.

**Sugar water**

Nearly half of the mothers had introduced sugar and sugar water early (≤1 month), which was a common practice in Iraq. One study from Brazil, suggested that poor sucking of the infant was associated with early introduction of water, herbal tea and milk formula (Giugliani et al., 2008). In the present study, however, this practice was not related to sucking problems, but seemed to be related to the belief that sugar water and herbal teas had a medicinal effect. The use of herbal teas was also found to be a common practice among Turkish and Arab mothers (Abdulrazzaq, Kendi, & Nagelkerke, 2009; Ertem, 2011).

Some of the mothers had introduced sugar water of some kind in the first month after birth. Early introduction of sugar water was common in an Iraqi study where more than half of the mothers had introduced sugar water early especially to jaundiced infants (Ameer et al., 2008). A study from Saudi Arabia reported that mothers who initiated breastfeeding late, gave sugar water, tea and milk formula as
alternatives (Amin, Hablas, & Al Qader, 2011). These two studies did not explain why the mothers gave sugar water to their infant. In the present study, the mothers’ reason for giving sugar water was to relieve stomach ache of the infants. Another study from United Kingdom showed that sugar water has also been used for pain relief of newly born infants, despite the fact that it has been claimed that it may not be an effective pain relief (Slater et al., 2010).

In this study, the advices on giving sugar water have been given from family members, which can also indicate that it is a common practice in the home country. The Norwegian recommendations on infant nutrition do not recommend any sugar to be added in the infant’s food (Norwegian Directorate of Health, 2001). However, a few of the mothers have claimed that the health clinic had advised them to give sugar water (purchased at the pharmacy) to relieve infant’s stomach ache. As mentioned before, the mothers follow the advice from their mothers and mother-in-law, because they consider them to be a trustworthy source of information. Sugar water seems to be a practice which is common in Arabic countries. The mothers in the present study may have felt pressured to follow this advice because it came from their mother or mother-in-law. Most of the mothers also perceived the health clinic as a trustworthy source of information. However, some of the mothers have overlooked the official recommendations, and given sugar to the infant. Sugar intake at an early age can increase the risk of overweight and obesity at an early age (Siega-Riz et al., 2010). The mothers may have not understood or they may not have gotten any advice on water and sugar or the advice may have been unclear or conflicting at the health clinic. The mothers in the study could speak Norwegian to various degrees. The level of Norwegian language skills could have determined the understanding of the information and advice received.

Complementary food

A low maternal age and the level of education have been consistently related to an early introduction of complementary food (Betoko et al., 2013). Even though the mothers in this study have introduced other liquids earlier than recommended, the majority followed the advices from the health clinics regarding introduction of complementary food. They were recommended to let the infant taste food at four to six months of age by the health clinic. However, the recommendation on introducing tasting portions of complementary food before six months of age should only apply to the infant who receive milk formula and are not being breastfed (Norwegian Directorate of Health, 2001). Some of the mothers had introduced milk formula and were not breastfeeding any longer, and had therefore been advised by the health clinic to give complementary food at four months. However, it seemed that the advice on introducing complementary food at four months was given to almost all the participating mothers. Even the mothers who had managed to breastfeed exclusively had received the same advice. According to the
mothers’ statements, they were advised by the health clinic to give milk formula when they felt they did not have enough milk.

Early introduction of complementary food prior to four months of age have been a concern, for developing food allergy and intolerance (Prescott et al., 2008). The introduction should occur between four to six months of age, since current evidence suggests that tolerance to food allergens appears to be driven by early and regular exposure (Prescott et al., 2008). According to the same research, delayed exposure, beyond six months, may also increase the risk of food allergies. The continuation of breastfeeding could promote tolerance and have protective effects during the period when complementary feeding is initiated (Prescott et al., 2008). However, the European Food Safety Authority (EFSA) does not consider introduction of complementary food from four to six months to impose any adverse health effects, such as infections, excessive weight gain, allergy or obesity (EFSA, 2009).

**Ready-made food**

All the mothers introduced ready-made oatmeal porridge as the first food to the infants, which was advised from the health clinic. This was also a common practice among the Norwegian mothers (Øverby et al., 2008). The booklet from the health clinic, which some of the mothers mentioned they have received, contained recipes on home-made food such as oatmeal porridge (Norwegian Directorate of Health, 2012). Since, the ready-made porridge was recommended by the health clinic, and it seemed to be the easier option for many of the mothers who followed this advice instead of making the porridge by themselves. The majority of Iraqi mothers did not use any other ready-made food than the porridge, and the reason given was that the infant did not like it. There were only two mothers who mentioned that they purchased the ready-made infant food in a glass jar, which their infant liked. One of the mothers stated it was easier and she argued why spend any time making food when the infant liked it. This practice was regarded as time-saving for the mothers, which these mothers may have appreciated. One of these mothers was a full time student, and the other wanted to make the infant used to food by the time she started to work again. The two mothers may have wanted to make the infant use to food, before they went back to their commitments outside the home, in order to make it easier for them to leave the infant at home. Another underlying reason for their practice could be inadequate cooking skills (Betoko et al., 2013)
**Home-made food**

After introducing porridge as the first food, the mothers gradually began to introduce other foods at about four to six months. The home-made infant food which was prepared consisted mostly of mashed vegetables. Some similarities to the Norwegian mothers in giving mashed vegetables and fruit or mashed berries to the infant at six months of age were also proven among the mothers in the present study. These practices are the common infant feeding practices in Norway, and was recommended by the health clinic and health authorities on infant nutrition (Norwegian Directorate of Health, 2001). The majority of the mothers seemed to have adapted this practice as well. Another home-made food was the Iraqi soup, which consisted of meat, vegetables and some seasoning. A few of the mothers mentioned they added a little salt in the Iraqi soup, which was given to the infant. But the majority did not add any salt or seasoning. Salt is also not recommended to add in the infant’s food (Norwegian Directorate of Health, 2001).

**Information sources**

**Mothers and mothers-in-law**

Half of the participating mothers were mothers for the first time. It has been argued that primiparous are more susceptible to people’s opinions in making the initial choice, compared to multiparous mothers (Swanson & Power, 2005). In addition, they may need more information and support. Many of the mothers went to their own mothers for advice, and trusted them because they had previous experience. A study from Ireland on first time mother showed similar findings, that both their mothers and mothers-in-law were their primary sources of appraisal support (Warren, 2005). Appraisal support was related to confidence and informational support in infant feeding practices. However, there is some evidence that the mothers verify the advice from their own mother with another source they see as trustworthy (Hauck & Irurita, 2003). This was also stated by some of the participating mothers in the present study, where the mother would check the information she got from their mother with the health clinic. It seemed as some of the mothers trusted the advice from their own mothers the most, because they had more experience. It has been suggested that when the grandmother of the infant intervene with the practice of the mother, can be positive to prolong the breastfeeding duration. This have been seen as positive, when support from health professionals are absent (Reid, Schmied, & Beale, 2010).

A few of the mothers did not want to follow the advice from mothers and mother-in-law, as these advices was considered to be out of date. Some of the mothers stated that they wanted to be more modern in their infant feeding decisions. It may seem like these mothers were more open to the advice
given from the health clinic. In addition, they were more likely to disregard advice from the family. As a part of the modernization, mothers today may rely more on information from their friends, professionals and the media, compared to elders who are less likely to be seen as authorities in giving advice for infant feeding (Lamm, Keller, Yovsi, & Chaudhary, 2008).

**Hospital**

According to the mothers’ statements, they were satisfied with the help they had received on breastfeeding at the hospital and had an overall positive experience with the hospital. In addition, the mothers who practiced exclusive breastfeeding had a positive experience at the hospital and had been given a detailed procedure on how to breastfeed. It seemed like a positive experience with the hospital and with the information given, made these mothers secure on how they should breastfeed. Since the guidance from the hospital was given in detail, this could have made it easier for the mothers to breastfeed. This was in contrast to the results from a Canadian study, where they found that immigrant mothers were more likely to experience hospital practices detrimental to breastfeeding success than Canadian-born mothers (Loiselle, Semenic, Côté, Lapointe, & Gendron, 2001). All the participating mothers stated they had been given advice on breastfeeding at the hospital. The advices from the health clinic were more emphasized by the mothers. This may be because they visit the health clinic more frequently than the hospital.

According to the mothers’ statements, they had been given advice to give milk formula when they felt their infant did get enough breast milk. It may seem that the nurses at both the hospital and health clinic are quick to advice the Iraqi mothers to give milk formula, when challenges related to breastfeeding are encountered. A study on challenges and successes to the BFHI in Norway also reported this tendency (Hansen et al., 2012). Among the Ten Steps to Successful Breastfeeding developed by WHO/UNICEF, step six was discovered to be the most challenging for the Norwegian hospitals. Step six was on the use of supplements, and it was registered that the most common reason for giving milk formula were babies who were still crying after being breastfed. This was seen as an acceptable “social” medical reason for use of milk formula (Hansen et al., 2012). Instead of supplements being an exception for calming babies, it seems to be the usual solution. A crying breastfed baby is most certainly not crying for breast milk substitutes, but is probably crying for something else (Hansen et al., 2012). Some of the mothers in the present study stated that their infant had received milk formula at the hospital. This practice may have been a disadvantage in remaining the breastfeeding exclusive. The hospital should focus more on guiding the mothers and give advice on maintaining the breast milk production. It has been pointed out that young mothers are open to adopt healthier infant feeding practices when they are guided and
encouraged to do so (de Oliveira et al., 2012). Breast milk production is usually adequate, it is therefore important to focus on motivating the mothers in order to prolong the breastfeeding (Scott et al., 1997).

**Health clinic**

A majority of the mothers showed trust in the health clinic by following the advice given there. A study suggested that immigrant mothers are more likely to get professional breastfeeding support in the local community (Loiselle et al., 2001). However, there were some of the mothers who trusted their own mothers more than the health clinic. The health clinic was possibly visited once a month or less by the mothers. A few mothers mentioned that it was easier to get in contact with their own mother or mother-in-law. They may think it is tiresome to go back and forth to visit and ask questions. They could also possibly be hesitant to call because of language barriers. Therefore, the mothers go to their own mothers for advice, by talking to them they can avoid misunderstandings and do not need to go out to the health clinic. It seemed that the Iraqi mothers considered their mother and mother-in-law as trustworthy persons, from whom they can get relevant advice on infant feeding practices.

Some of the mothers also mentioned that the public health nurses at the health clinic, seemed to be in a hurry and it was sometimes a stressful environment. A study from the United States identified similar non-supportive behaviors among the public health nurses, where the mothers stated they sensed that the nurses were in a hurry (Hong, Callister, & Schwartz, 2003). In the present study, this may have caused the mothers to be more hesitant to ask questions, because they might sense that the public health nurse does not have the time to neither listen nor answer. Potential misunderstandings or limited information may have lead to an early introduction of complementary food by the mothers.

Only a few mothers mentioned that they had received brochures at the health clinic. However, it was also possible that information was handed out to the Iraqi mothers, and they may not have read it. According to Kumar & Viken, persons with an immigrant background did not see the existing information material handed out as relevant to them (Kumar & Viken, 2010). This can possibly result in lack of information in infant feeding practices, and might be the reason to why only half of participating mothers’ breastfed for a short time or why they introduced water and sugar water at an early age. In addition, language may also be a barrier regards to understand what is written and said in the brochures or what the public health nurses are saying. Information such as how to stimulate milk production could have been of much help, since some of the mothers have stated insufficient milk as a reason for introducing milk formula.
It may possibly be difficult for the public health nurses to help the mothers, when they come to them for advice on insufficient breast milk. The public health nurses may feel obliged to come up with a fast solution to the problem; this may be the reason for why they recommended milk formula. Around half of the mothers mentioned they were afraid that their infant did not get enough milk, and may have seemed impatient and wanted a fast solution when contacting or consulting the health clinic about their perception that they did not have enough breast milk. They may not be patient enough for the health clinics to help them with advices on how to stimulate breast milk production, because of the stressful environment at the health clinic, the public health nurses may not have time to sit down and explain the procedure carefully. Studies on mothers with a different ethnicity are important, to understand their infant feeding. This should be done with the combination of obtaining information on common infant feeding practices and how they perceive the information given here by the health clinics. These types of studies may improve compliance with the recommendation among all groups by understanding their culture and reduce inequalities in infant feeding practices (Kristiansen et al., 2010). In the present study, the mothers seemed to experience the health clinic as a reliable and a trustworthy information source. A study from Ireland showed that first time mothers considered the informational support that were given from both public health nurses and maternal mothers as equally good (Warren, 2005). Findings from an Irish study reported also that their own mothers and the health clinic seemed to have a great influence on mothers’ final infant feeding practice. This may suggest that mothers or mothers-in-law should be added in some of the counseling sessions at the health clinic.

9. Conclusion

When immigrants arrive in the new country, new practices are discovered and may be explored and combined with the practices from their country of origin. The attempt to combine the practices from their home country with new practices can be conflicting and confusing, especially when information and advice is given from various sources. The advices and information from various sources can form the basis of the mothers’ choice of the infant feeding practice. In addition, to influences and challenges related to own experience.

Breastfeeding was perceived as a common practice by the participating mothers. This perception seemed to come from that it is a common infant feeding practice in Iraq and recommendations from the Quran. Their mothers and mothers-in-law seem to be a great importance for the Iraqi mothers, and some followed their advice. One should be aware, that mothers and mothers-in-law have strong influence on mothers infant feeding practices. They were the ones to encourage prolonged breastfeeding. On the other hand, early introduction of liquids occurred after advices from their mothers and mothers-in-law.
(≤1 month). This included early water and sugar water introduction (ordinary sugar and nobat/qund), to
the infant. Different types of herbal teas (marimia/mirimia, black tea and chamomile tea) were
introduced when the infant was older. According to the mothers, they gave water after the advice from
their family, especially by their mother or mother-in-law. This practice of early introduction of liquids
should be targeted. One solution to counteract such practice could be to develop a brochure on the
disadvantages of giving water and sugar water, ideally a brochure of this kind should be in Arabic or
Kurdish. This brochure should be gone through carefully with the mother. The majority of mothers
practiced a predominant breastfeeding, this may indicate that mothers and mothers-in-law can have a
positive and negative effect on the infant feeding practice. Another strategy could be to invite mothers
or mothers-in-law to the first control at the health clinic, in order to minimize the possibility of the
discontinuation of exclusive breastfeeding.

The mentioned challenges in breastfeeding were: discomfort while breastfeeding, the infant did not
want to suck and inadequate breast milk production was to introduce milk formula. This was introduced
after the advice from the hospital or the health clinic. The mothers were concerned that their breast milk
was not enough, and gave milk formula in addition to their breast milk. Many of the mothers regarded
this practice as an advantage, because she can avoid showing the breast in public and she can go back
sooner to other commitments. However, this may have resulted in discontinuation of breastfeeding and
continuing to give the bottle. In order to avoid these challenges, it can be beneficial for the mothers to
receive advice on how to make breastfeeding a comfortable experience, how to help the infant to suck,
stimulate breast milk production and suggestions on how to make it possible to breastfeed in public.
Since, the majority of the mothers in the study were first-time mothers, it is suggested that compulsory
classes for immigrant first-time mothers should be developed, where these challenges are taken into
account.

The Iraqi mothers also perceived sugar water and herbal tea as a remedy for relieving stomach ache.
The advice to give sugar water and herbal teas to their infant also came from their mothers or mother-in-
law. Sugar is not recommended to be added in any food for the infant. This advice should possibly be
more emphasized at the health clinic among immigrant mothers, due to the reason that they are possibly
more prone to diabetes type 2, overweight and obesity in adulthood. These infant feeding practices may
be common in Iraq, but have caused the exclusivity of the breastfeeding to stop earlier than
recommended.

In relation to complementary food, the mothers followed the health clinic’s advice in introducing this at
four to six months of age. This should not have been applied to all the mothers according to the
Norwegian recommendations on infant nutrition, but were still recommended to them. The mothers
seem to have adapted many of the typical Norwegian infant feeding practices. They gave porridge as the first meal as recommended and they followed the advice on giving mashed vegetables. The majority gave their infant home-made food. The complementary food was not only inspired from the Norwegian recommendations but also influenced by practices from the home country. Iraqi soup, which was also included in the infant’s meals, was common to give the infant and was similar to the mashed vegetables recommended by the health clinic.

Iraqi mothers need more information on how to maintain the milk production, as only a few in this study managed to breastfeed exclusively in study, while the majority of the participating mothers practiced predominant breastfeeding. Predominant breastfeeding may have been unintentionally practiced because of lack of information on exclusive breastfeeding. Information from this study can be considered as valuable in improving counseling of Iraqi mothers at the health clinic. With this information the public health nurses are aware of the practice these mothers may have. It can also make the nurses attentive to what they should emphasize when giving advice or inquire when they have appointments of Iraqi mothers at the health clinic.

The InnBaKost project is still on-going, where the qualitative part is in the process of the second data collection. The data from the second and third collection from the qualitative combined with the quantitative part, will be able to establish the Iraqi mothers further practice when the young child is one and two years old. These studies will further improve our knowledge on these mothers infant and young child feeding practice. The findings in this study will be valuable in the attempt to improve the counseling of immigrant mothers at the health clinic.
References


SSB. (2013b). Norway's population groups of developing countries' origin Change and integration (Vol. 10/2013): Statistics Norway


Appendix 1:
InnBaKost 2012-2013
Oslo, september 2012
Undersøkelse av kostholdet blant barn med innvandringsbakgrunn

Forespørsel om å delta i InnBaKost-Prosjektet/InnMorBarn-prosjektet

_Vil du være med på et forskningsprosjekt som ser på kosthold blant barn med innvandringsbakgrunn og rådgivningssituasjonen på helsestasjonen?_

Dette er et spørsmål til deg om å delta i et forskningsprosjekt. I Norge har det tidligere blitt gjort undersøkelser for å se på kostholdet til norske barn, men det har ikke vært mulig for barn med innvandringsbakgrunn å delta på disse undersøkelsene. Vi som arbeider i InnBaKost/InnMorBarn-prosjektet ønsker derfor å undersøke kostholdet til barn med innvandringsbakgrunn og hvordan mødrene til barna erfarer møtet med helsestasjonen. Dette er viktig informasjon for å forstå hva barn spiser og drikker, hvilke matvarer som blir gitt og om det er noen kulturelle forskjeller og hva som påvirker invandrerbarns kosthold. Denne undersøkelsen kan dermed være med på å øke kunnskapen om barns kosthold og bidra til å forebygge kostholdsrelaterte helseproblemer, samt forbedre møtet med helsestasjonen.

_Hvem søker vi?_
Vi søker kvinner som har innvandret fra Somalia og Irak og som har barn født i Norge på 6 måneder. Barna vil bli fulgt opp ved 6, 12 og 24 måneders alder.

_Hva innebærer undersøkelsen?_

Du vil bli kontaktet igjen når barnet er omkring 1 år, og du vil da bli intervjuet to ganger om hva barnet har spist og drukket dagen før intervjuet. De to siste intervjuene vil være når barnet er omkring 2 år.

_Frivillig deltakelse_
Det er frivillig å delta og du kan når som helst trekke deg fra undersøkelsen. All informasjon du gir vil bli behandlet konfidensielt.

Prosjektet er et samarbeid med forskere fra Fafo, Universitetet i Oslo, Høgskolen i Oslo og Akershus, Nasjonal kompetanseheten for minoritetselte og Nasjonalt kompetansesenter for amming, og det er delvis finansiert av Norges Forskningsråd.

Har dere noen spørsmål kan dere ringe prosjektleder Marina Manuela de Paoli på telefonnummer 91626463. Dere kan også skrive en e-post til mdp@fafomail.no. På forhånd takk for hjelpen og vi gleder oss til et godt samarbeid!

Med vennlig hilsen

Marina de Paoli
Prosjektleder
Appendix 2:

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?


Hva skjer med informasjonen om deg?

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


Studien gjennomføres som intervju ved bruk av intervjuguide av kvinner med 6 måneder gamle barn med innvandrindebakgrunn 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 familiessammensettning.
  - 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 comfortable med. Du trenger ikke oppgi grunn for å avstå fra å svare på enkeltspørsmål og det vil ikke få følger videre i prosjektet.

**Kompensasjon**

**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.


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
Samtykke til deltagelse i studien

Jeg er villig til å delta i studien

.configav prosjektdeltaker, dato)

Jeg bekrer å ha gitt informasjon om studien

(Signert, rolle i studien, dato)
Appendix 3:

InnBaKost-prosjektet

Bakgrunnsinformasjon til intervju

Dato:
Intervjusted:
Tilstede:
Navn på intervjuer:
Navn (informant og kode):
Navn på barnet:
Alder:
Yrke:
Utdannelse:
Sivilstatus:
Antall barn (& alder):
Bosted:

Barnets fødselssted:
Barnets høyde og vekt ved fødsel:
Høyde og vekt ved siste kontroll på helsestasjonen:

Annen informasjon:

Andre observasjoner:
Appendix 4:

Interview Guide

In-depth interviews with mothers immigrated from Somalia or Iraq with six-months old children

Issues and Key Questions

The interview guide aims to cover the following key themes:

- Becoming a parent: transition towards motherhood and parenthood
- Breastfeeding: attitude and experiences in the first six-months period
- The mother’s infant feeding practices in general in the first six-months period
- Communication about infant feeding at the hospital after birth
- Communication about infant feeding in the health clinic (‘helsestasjon’) before birth and in the first six months
- Conflicting values and practices related to child feeding
- The role of family network with regards to feeding the child
- The role of other social networks with regards to child feeding.
- Evaluation of how breastfeeding/infant feeding has proceeded
- Plans for the future in terms of child feeding

Below is a list of questions which will serve to guide the study. The key question and main objective for the study is to gather information about perceptions on target beliefs and practices with regards to infant feeding as well as to explore participants’ experiences with the ‘helsestasjon’ and their health care providers.

Introduce yourself/ourselves and tell them what we are interested in. Make sure that they have understood that you are not from the health system. Continue by asking about the child – his/her name – comment on his/her appearance in a positive way – and start to get a dialog going.

Opening question (to get the dialogue going)

Can you tell me something about yourself?

Probe for: where were you born, when did you come to Norway, other relatives –family network- living in Oslo, where do you live, What do you do now)

Children (how many children, born where)

Can you tell me about your pregnancy (last born and previous).
Can you tell me about your giving-birth experience with your last born child/this child (if he/she is with the mother) Probe for: Mode and place of delivery and reasons for choosing to give birth in this way.

If the mother is not primipara ask about previous giving-birth experiences,

Can you tell me about your expectations and how you imagined it would be to become a mother. Were you relaxed about this role or a bit scared of the unknown?

**Introductory questions**
How do mothers traditionally feed their small infants in Somalia/Iraq?

Do you know something about how you were fed?

What are the (family) traditions of feeding a small child from where you come from? How do these traditions still influence how a small child is fed? Are there other influencing factors which you think influence infant feeding practices (in your home country and in Norway). If you can, please give me some examples.

Are you still following/keeping some of these traditions with regards to child rearing and infant feeding while in Norway?

**Transition questions**
Are husbands or mothers/mothers-in-law traditionally taking part in issues related to giving birth, child health and infant feeding? Please explain. Ask about their own experience.

*For mothers who also have given birth in her home-country: Has there been any changes since you came to Norway with regards to the participation of husband/mother/mother-in-law in issues related to giving birth, child health and infant feeding? What is your personal experience on this?*

In your family what kind of support does your husband/mother/mother-in-law provide in your family with regards to your child/ren’s health and how you feed your child/ren? In what way? Explain.

Does your husband/mother/mother-in-law give you advice about your child/ren’s health and how you breastfeed/feed your child/ren? Are there any other family members who give advice on this? What do you think about them giving you advice and how do you relate to their advice?

Are there other persons who give you advice about your child’s/ren’s health and how you breastfeed/fed your child/ren?

**Key questions**
What is your over-all experience with breastfeeding your last-born child (and your older children)?
For mothers who have more than one child: Has there been any changes in the breastfeeding/infant feeding practices since your first born child? If yes, what changes and why?

If you were to advise a mother with a newborn infant on how to breastfeed what would you tell her?

**Initiation of breastfeeding.**
How did you feed your child right after birth? When was your baby put to your breast to begin feeding after giving birth? Probe for reasons for immediate or delayed breastfeeding, if delayed breastfeeding ask what was the first item given to the infant and reasons for this practice.

Did you feed your child the very first milk (colostrum)? Probe for if some of the very first milk was squeezed out. Probe for reasons to this practice (if part of it was not used) and customary beliefs about colostrums.

Did you or someone else give your child any pre-lacteal feeds? If yes, what kind of liquid/food (water, sugar-water, salt, cow’s milk, porridge, other type of foods) and for how long. Probe for reasons for giving pre-lacteal feeds.

What was the setting and what support did you receive when you initiated breastfeeding? If no support received, probe for what kind of support mother had wished to get and from who.

How was your experience of breastfeeding in the first six months period?

**Current breastfeeding practices**
Are you currently breastfeeding your child? (Y/N)

*If yes:* How have you been feeding your baby up to now? Do the child get other drinks/food in addition to breast milk?

For women who are still breastfeeding: For how long are you planning to breastfeed your child?

If the mother is still *only* breastfeeding (probe if she is strictly practising exclusive breastfeeding, i.e. no addition of any fluids including water and foods) investigate about duration of exclusive breastfeeding and when and why liquids and foods will be introduced. Ask what type of food/liquids. Probe for reasons for her practices and cultural beliefs.

If the mother is partially breastfeeding (breastfeeding with other liquids) ask her at what (infant) age she introduced other liquids. Probe for what kind of liquids. Investigate about the duration of exclusive breastfeeding. Ask her when she will introduce foods and what type of foods she will give the infant. Probe for reasons for her practices and cultural beliefs.

If the mother is practising *mixed feeding* (breast milk with other foods, drinks and supplements) ask her what (infant) age she introduced other foods/liquids. Ask what kind of foods/liquids. Investigate about the duration of exclusive breastfeeding. Probe for reasons for
her practices and cultural beliefs. Probe for her experiences with introducing other foods/liquids.

*If no:* How did you feed your child until you stopped breastfeeding? Ask what kind of foods/liquids she has been given her child. Probe for reasons for her practices and cultural beliefs. Probe for her experiences with introducing other foods/liquids.

Were there any problems related to breastfeeding? Probe for not enough milk. If yes, what have you done? What were you told with regards to increasing breast milk production and what did you do?

How has your overall breastfeeding experience been and how has it varied over time?

*If not breastfeed at all:* How have you been feeding your child? Ask her about use of formula, cow’s milk, other type of infant food and reasons for choosing them. Probe for reasons for her practices and cultural beliefs.

Check that you have probed enough for:

- Mixed feeding (breast milk with other foods and supplements) – reasons
- Exclusive breastfeeding practices (it needs a lot of probing to really find out how exclusive exclusive breastfeeding is)
- Not breastfeeding (formula, cow’s milk) - reasons
- Introduction of other foods (what, when, how, why, rituals),
- Mixed feeding (breast milk with other foods and supplements) – reasons
- Mothers’ reasons for all methods of feeding. Probe for customary practices.

Can you tell me about discouraging and supportive factors that has affected your breastfeeding practices? Probe for:

- comments from family and friends
- advice given from health care providers or others,
- work and family related problems
- infant sick

**Advice-giving**

What kind of information regarding breastfeeding/infant feeding may be helpful for you?

Who would be the appropriate person to provide the information on breastfeeding?

What help/support do you need with regards to feeding your infant?

In your opinion, who is the best person to advise you about breast feeding and how to feed your child?

**Services at the health station**

What is your current experience with the ‘helsestasjon’?
Not primipara: What is your previous experience with the ‘helsestasjon’ (if any)?

What kind of advice have you received from ‘helsesøster’ (other health care workers) with regard to infant feeding practices and child health? What nutrition related advice have you received.

Who gives advice about breast feeding?

What are your experiences with how and when ‘helsesøster’ talks to you about infant feeding and young child health?

What did they say about initiation of breastfeeding, pre-lacteal feeds and the use of colostrums? Who told you about optimal length of exclusive breastfeeding and breastfeeding in general? What have you been told about infant feeding in general/complementary feeding? What have you been told about when to begin with weaning foods and what type of weaning foods to give? Has this advice been useful to you?

How do you interpret and understand the nutrition and health advice given to you by ‘helsesøster’? Do they talk to you about breast feeding, pre-lacteal feeding, weaning and complementary food?

How useful is the information that you have been given about infant feeding? Did you experience that the information was easy or difficult to understand and/or was it difficult to follow the advice given? Did you know of other ways of feeding your child that is better than the advice received from ‘helsestasjon’? Did they give any advice against traditional infant feeding practices that you have from your mother country? If so, tell me about it.

Have you participated in any special nutritional programme or any other health programme at the ‘helsestasjon’?

Ending questions (All things considered question/summary question/Final question)

Do you have any question or explanation about something we did not mention about breast feeding?

Is there anything else you would like to add?

Referral to a follow up interview after 6 months and 18 months.
Appendix 5:

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.
- Spedbarnsvern i den første 6 måneders perioden.
- Kommunikasjon om spedbarnsvern på sykehuset etter fødsel.
- Kommunikasjon om spedbarnsvern på helsestasjoner før fødsel og i den første 6 måneders perioden.
- Motstridende verdier og praksis relatert til spedbarnsvern.
- Familienettverks rolle med hensyn til spedbarnsvern.
- Rollen som andre sosiale nettverk har til spedbarnsvern.
- Vurdering av måten amming/spedbarnsvern har foregått.
- Fremtidsplaner i forbindelse med spedbarnsvern.

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

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 yngste barn? (hvis han/henne er med mor)

Finn ut: Hva slags fødsel, 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 (famielens) 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


*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
- spedbarnsnæring
- Hva er dine personlige erfaringer?


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?

Innføring av amming

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.


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 fullamlingen, når og hvorfor andre type væsker og mat vil bli introdusert. Spør hvilke type fastføde/væsker. Undersøk grunner til hennes praksis og kulturelle syn.


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.

Bruker ditt barn smøkk? Når, hvor lenge og hvorfor?

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

Mødrene syn på optimal spedbarnsernæring

Hva er dine oppfatninger til optimal spedbarnsernæring? og barrierer til denne praksisen?

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

Hva slags type informasjon om amming/spedbarnernæring 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 helsestasjonen?

*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 spedbarnerkost og barns/barne helse? Hva slags ernæringrelaterte råd har du fått?
Hvem gir deg råd om amming?

Hvordan opplever du måten helsesøster snakker til deg om spedbarnerkost 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 spedbarnermnæring/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 spedbarnernæring? 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 oppfølgings intervju etter 6 måneder og 18 måneder.
Appendix 6:  

Manual for tolk i  
InnBaKost-prosjektet  

FAFO 2012  

FAFO  
Favo 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.
Heftet inneholder:

1.0 Undersøkelsens bakgrunn og hensikt.......................................................................................... 86
   1.1 Ammepraksis blant mødre med somalisk og irakisk innvandringsbakgrunn ................ 86
   1.2 Din rolle i prosjektet........................................................................................................ 86
   1.3 Personvern...................................................................................................................... 86
2.0 Hvem skal intervjues?.................................................................................................................. 87
3.0 Hvordan være en god tolk under intervjuet?................................................................. 87
   3.1 Kvalitetskontroll............................................................................................................. 88
4.0 Oppbygging av tillit hos informanten ................................................................................ 88
   4.1 Generelle retningslinjer.................................................................................................. 89
   4.2 Holdningsspørsmål......................................................................................................... 89
   4.3 Høflighet og diskresjon ................................................................................................. 89
5.0 Forklar hensikten med prosjektet hvis informanten spør................................................... 89
   5.1 Profesjonell adferd ......................................................................................................... 90
1.0 Undersøkelsens bakgrunn og hensikt

1.1 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.


1.2 Din rolle i prosjektet
Innsatsen til folk vil være avgjørende for kvaliteten av datamaterialet. Nøyaktighet av oversetting av intervjuguide og folk 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.

1.3 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.
2.0 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 fokuset på enkelte næringsstoffer eller ikke vært representativt 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 barnemåt 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/tillstand som krever at barnet går på et spesielt kosthold. Informantene har blitt rekruttert på forhånd.

3.0 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 (forståelse 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.
3.1 Kvalitetskontroll
Under intervjuet er det viktig at spørsmålene som vi stiller blir riktig oversatt og formulert til intervjue, 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.

4.0 Oppbygging 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 intervjuene skal kunne overbevise intervjueventene om hvem som står bak undersøkelsen vil intervjuene 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 intervjueventene til å svare på en bestemt måte.

Dersom du får følelsen av at intervjueventet ikke gir helt sannferdige svar, kan du forsøke å på en vennlig eller spøklefull måte å peke på motsigelser i den informasjonen som du får. Dette må gjøres med varsomhet.
4.1 Generelle retningslinjer
1: Ikke bli aggressiv. Gi ikke intervjueobjektet 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.

4.2 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 uttrykk for hva du selv mener.

4.3 Høflighet og diskresjon

5.0 Forklar hensikten med prosjektet hvis informanten spør
For å skape tillit hos intervjueobjektene vil du i mange tilfeller måtte forklare nøyde om hva som er hensikten med undersøkelsen. Når du forklarer bør du huske følgende:

- 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 intervjueobjektet, fordi resultatene kan brukes til utarbeiding av tiltak for å forebygge kostholdsrelaterte helseproblemer blant spedbarn med innvandringsbakgrunn.
5.1 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.


**Appendix 7:**

<table>
<thead>
<tr>
<th>Fictious name</th>
<th>Duration of exclusive breastfeeding</th>
<th>Discontinuation of breastfeeding</th>
<th>Introduction of milk formula</th>
<th>Introduction of complementary food</th>
<th>Introduction of liquids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evin</td>
<td>4 months</td>
<td>From start</td>
<td>4 months</td>
<td>Water from start</td>
<td></td>
</tr>
<tr>
<td>Elmira</td>
<td>From start</td>
<td></td>
<td>5 months and 3 weeks</td>
<td>Water from start</td>
<td></td>
</tr>
<tr>
<td>Ronya</td>
<td>1 month</td>
<td></td>
<td>4 months</td>
<td>Water and sugar water from start</td>
<td></td>
</tr>
<tr>
<td>Asmira</td>
<td>3 months</td>
<td>From start</td>
<td>4 months</td>
<td>Water from start</td>
<td></td>
</tr>
<tr>
<td>Freshta</td>
<td>1 week</td>
<td>3 months</td>
<td>3 months</td>
<td>Water, one week</td>
<td></td>
</tr>
<tr>
<td>Dilare</td>
<td>5 months</td>
<td>2 months</td>
<td>40 days</td>
<td>Sugar water from start</td>
<td></td>
</tr>
<tr>
<td>Rihan</td>
<td>4 months</td>
<td></td>
<td>4 months</td>
<td>Sugar water from start</td>
<td></td>
</tr>
<tr>
<td>Sayran</td>
<td>6 months</td>
<td>From start</td>
<td>6 months</td>
<td>Sugar water from start</td>
<td></td>
</tr>
<tr>
<td>Jasin</td>
<td>40 days</td>
<td>From start</td>
<td>4 months</td>
<td>Sugar water 3 months</td>
<td></td>
</tr>
<tr>
<td>Belen</td>
<td>2 months</td>
<td>2 months</td>
<td>6 months</td>
<td>Water 6 months</td>
<td></td>
</tr>
<tr>
<td>Aylin</td>
<td>2 months</td>
<td>Stopped for 2 weeks only, when the infant was 2 months old, but still breastfeeding</td>
<td>2 months for 2 weeks</td>
<td>Water 4 months</td>
<td></td>
</tr>
<tr>
<td>Hana</td>
<td>4 months</td>
<td></td>
<td>3 months and 3 weeks</td>
<td>Water 4 months</td>
<td></td>
</tr>
<tr>
<td>Shayan</td>
<td>4 months</td>
<td></td>
<td>4 months</td>
<td>Water from 4 months</td>
<td></td>
</tr>
<tr>
<td>Aisha</td>
<td>5 months</td>
<td></td>
<td>5 months</td>
<td>Water 5 months</td>
<td></td>
</tr>
</tbody>
</table>