Infant feeding practices of Somali mothers residing in Norway

A qualitative study

Camilla Nguyen

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Department of Nutrition, Faculty of Medicine

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Infant feeding practices of Somali mothers residing in Norway

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by

Camilla Nguyen

Supervisors:
Margareta Wandel, Professor
Marina M. de Paoli, Researcher

Department of Nutrition, Faculty of Medicine

UNIVERSITY OF OSLO

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Camilla Nguyen
ABSTRACT

BACKGROUND
Breastfeeding provides the optimal food for the healthy growth and development of infants. Norwegian recommendations for infant feeding consist of advice on exclusive breastfeeding for six months and timely introduction of complementary foods. Previous national surveys, have shown that the diet among Norwegian six months old infants, was generally in line with the recommendations for infant feeding. However, there is still limited knowledge about the diet and infant feeding practices among Norwegian-born infants with immigrant parents, since this group was not included in these national surveys. The group of Norwegian-born infants with immigrant parents have grown in the recent years. It is thereby important to increase knowledge on nutrition and infant feeding practices among this group. Earlier nutrition studies have shown that infant from certain immigrant groups, were more prone to various nutritional deficiencies compared to ethnic Norwegian children.

Other studies reported that immigrant mothers rarely receive cultural sensitive advices from their health care providers. An increase of knowledge on the infant feeding practices among immigrant groups may be beneficial, and perhaps a step towards targeting and improving the potential nutrition problems that may exist. This might also improve the nutrition information provided to immigrant parents.

METHOD
The InnBaKost- project aims at generating valuable information on early feeding practices of Somali immigrant mothers, their perceptions to infant feeding and experiences to these practices, as well the way the mothers experience nutrition communication for their children at the health clinics. This thesis is based on the findings from the first part of the qualitative sub study of InnBaKost. In-depth interviews were conducted with 15 Somali mothers with young infants in Oslo and Akershus municipality. An interpreter assisted in some of the interviews. The inclusion criteria were mothers of Somali origin, with infants who were born in Norway, aged around 6 (±2) months.

FINDINGS
In the present study, none of the Somali mothers breastfed exclusively for six months. Most mothers intended to breastfeed for one year. But four mothers had stopped breastfeeding at the time of the interview. Despite having a positive attitude towards breastfeeding, difficulties with breastfeeding and not knowing how to overcome them, influenced mothers’ choice to introduce complementary foods from early on, or to stop breastfeeding completely. There seemed to be a limited support from the health clinics regarding how to overcome breastfeeding problems, this might have further influenced some mothers to stop breastfeeding or to introduce complementary foods.
The mothers had diverse views on their health clinic, although most were pleased with the overall service provided, but stated that the information on infant feeding was lacking. Limited infant feeding advice and information given by health care providers, can in turn make a mother uncertain about how to feed her infant. The limited information given by the health clinic on exclusive breastfeeding and the timely introduction of complementary foods, may also have influenced the early introduction of others liquids foods. The choice of not breastfeeding in public, or not giving expressed breast milk when the infant was being taken care of by others, might have further influenced the mothers’ duration of exclusive breastfeeding.

Insufficient breast milk production or that the infant refused to be breastfeed was the most common problems that were mentioned. An interesting finding was the common advice to feed the infants formula milk among Somalis. The encouragement for formula feeding from family/relatives may further have motivated to the early cessation of exclusive breastfeeding.

Complementary foods, in form of formula milk and water, were usually introduced to the infant at the age of three months. Porridge, mashed vegetables and fruits were the most common solid foods that were introduced to the infant around four months of age.

**CONCLUSION**

Information about breastfeeding, exclusive breastfeeding and the timely introduction of complementary foods was not commonly informed between the health clinic and Somali mothers. Many of the mothers had experienced difficulties with breastfeeding, the findings seem to suggest that these mothers had not received the necessary support from the health clinic to overcome these challenges. It is important for the health clinic to follow up on mothers that are having difficulties with breastfeeding. Furthermore, it is also important for the health clinic to pay attention to mothers who are experiencing the pressure of formula feeding from their Somali network. Appropriate breastfeeding support and information about infant feeding, needs to be further communicated to mothers.
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Clarification of terms

**Exclusive breastfeeding:** the infant has only received breast milk (including milk expressed or from a wet nurse), in addition to syrups drops (vitamins, minerals, medicines, cod liver oil [Tran]).

**Predominant breastfeeding:** the infant have received breast milk (including milk expressed or from a wet nurse) as the predominant source of nourishment, in addition to certain liquids (water and water-based drinks, fruit juice), ritual fluids or syrups drops (vitamins, minerals, medicines).

**Complementary feeding:** the infant has received other foods (e.g. solid foods) and fluids, in addition to breast milk at any given time. This also refers to infants that have introduced to complementary foods earlier than six months.

**Solid foods:** any solid substance (as opposed to liquid) that is used as a source of nourishment

**Formula feeding:** the infant has received formula milk

**Milk expression:** the expression of milk via pump

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

**Multiparous:** a woman who has given birth two or more times

**Norwegian-born to immigrant parents:** a person who is born in Norway with two parents who are born abroad

The terms ‘few’, ‘some’, ‘half’ and ‘majority’ will be used in the findings chapter, in order to describe the number of mothers.

**Few:** one to three

**Some:** four to six

**Half:** seven to eight

**Majority:** over nine
Abbreviations

WHO: The World Health Organization

SSB: Statistics Norway

REK: The Regional Committees for Medical and Health Research Ethics

InnBaKost: The “Nutrition and health among immigrant infants and children”- project

BFHI: The Baby-Friendly Hospital Initiative
1 INTRODUCTION

Early childhood is considered to be the most important developmental stage in a human life (Irwin, Siddiqi & Hertzman, 2007). Adequate nutrition during this time is of great importance to the infant's health and wellbeing. Nutritional status in early life may have an impact on the risk of obesity and chronic diseases later in life (Jenum, et al., 2013). Furthermore, dietary habits established early in life tend to track into adulthood (Turnbull, Lanigan & Singhal, 2007).

Breastfeeding provides the optimal food for the healthy growth and development of infants (World Health Organization, 2008). Colostrum, the “first milk”, is a nutrient-rich fluid that a mother produces for the first few days after birth (Xanthou, Bines & Walker, 1995). The protective and health benefits of colostrum have been documented well (Uruakpa, Ismond & Akobund, 2002; Xanthou, Bines & Walker, 1995). Breastfeeding carries the double role of providing adequate nutrition and ensuring healthy infant development, it also creates attachment between mother and infant (Irwin et al., 2007). Breastfeeding is a form of nutrition with no socioeconomic boundaries (Premani, Kurji & Mithani, 2011) and provides the same nutritional content for infants all around the world.

Norwegian recommendations for infant feeding consist of advice on exclusive breastfeeding for six months and timely and adequate introduction of complementary foods (Norwegian Directorate for Health, 2001). These recommendations are based on international recommendations as well as available data on the diet of Norwegian infants and children (Norwegian Directorate for Health, 2001). National nutrition surveys with representative samples of 6, 12 and 24 months old children have been carried out in Norway, the ‘Spedkost’ surveys from 1998-99 and 2006-07 (Lande, Johansson, Frost-Andersen & Trygg, 2003; Øverby, Kristiansen & Frost Andersen, 2008) and the ‘Småbarnskost’ survey from 1999 and 2007 (Kristiansen, Frost-Andersen & Lande, 2009). Results from the Spedkost survey in 2006-07, concluded that the diet among six months old infants was generally in line with the recommendations for infant feeding (Øverby et al., 2008). Infants and children whose mothers were born outside Scandinavia (Lande et al., 2003; Øverby et al., 2008) were not included in these surveys, so the results do not apply to this group.
There is limited knowledge about diet and infant feeding practices among Norwegian-born infants with immigrant parents, even though this group has grown in recent years (Statistics Norway, 2012). Earlier studies on nutrition among infants of immigrant parents have shown that iron deficiency was more prevalent among various groups of infants of immigrant parents compared to ethnic Norwegian infants (Madar, 1997; Wandel et al., 1996). Vitamin D deficiency was reported to be more prevalent among infants with parents from Pakistan, Turkey and Somalia (Madar, Stene & Meyer, 2009). One study demonstrated earlier introduction of formula milk or cow’s milk among infants with parents from Turkey compared to ethnic Norwegian infants (Wandel, Fagerli, Olsen, Borch-Iohnsen & Ek, 1996). Another study showed no differences in breastfeeding duration between infants with parents from Pakistan and Norway (Arskey, 1996).

Findings from a Norwegian study showed that immigrant mothers face certain challenges in adapting to a new food culture, and that the advice given by health care providers was rarely culturally sensitive (Garnweidner, Terragni, Pettersen & Mosdøl, 2012). There has been an increased recognition that effective health communication should be culture sensitive (Schiavo, 2007). A study by Steinman et al. (2010) suggests that health providers may benefit from gaining a better understanding of a family’s social and cultural context. Furthermore, cultural bias or failure to recognize how culture and life situations affect health can result in inadequate care given by health care providers (Steinman et al., 2010; Walker & Jaranson, 1999).

According to Robinson and Vandevusse (2011), understanding how and why vulnerable population groups make healthcare choices that are not beneficial for them, is important in the attempt to reduce health disparities. The authors further underlined the need for narrative studies and other qualitative approaches to describe immigrant mothers’ life experiences, and how this influence their infant feeding choices. Knowledge on their perspectives will inform health care providers and encourage cultural awareness (Robinson & Vandevusse, 2011). When it comes to breastfeeding, Choudhry and Wallace (2011), emphasize the importance of acknowledging how infant feeding practices are embedded in the context of ethnic and cultural beliefs.

Several Norwegian studies have shown that health care providers have limited knowledge on the food culture of their clients, how this culture influence the interpretation of the advices
given, and the way these advices are practised (Fagerli, Lien & Wandel, 2005; Mellin-Olsen & Wandel, 2005; Wandel et al., 2007).

Increased knowledge of dietary habits in different immigrant groups may be beneficial and perhaps a step towards targeting and improving other nutrition problems that may exist among immigrant groups.

**The InnBaKost-project**

The “Nutrition and health among immigrant infants and children”- project funded by the Research Council of Norway (NFR), is conducted by Fafo in collaboration with the Nutrition Department at University of Oslo and the University college of Oslo and Akershus. This project will be referred to as the InnBaKost-project throughout this thesis. The InnBaKost-project targets immigrant mothers from Somalia and Iraq and their young children. These two groups were chosen, since they are the two non-Western immigrants groups with the highest number of births in Norway (SSB, 2012). The project consists of a qualitative and a quantitative sub study and will follow the infants from six months to two years of age. The first part of the qualitative findings will provide valuable information on early feeding practices and the way immigrant mothers experience nutrition communication for their children at the health clinics. This study is part of the qualitative sub study, and will focus on Somali mothers and their six months old infants.
2 BACKGROUND

2.1 Somali culture

2.1.1 Gender roles in Somalia

The gender roles in Somali culture have been described by Abdullahi (2001) as follows: men and women in Somalia have traditionally been assigned to different roles in their family. In rural Somalia, women were assigned to take care of the home, including childcare and milking the goats and sheep. On the other hand, the men were responsible for taking care of the outside business, such as milking the camels and going to meetings of the community.

Bryden and Steiner (1998) also described the tasks of Somali women related to their reproductive roles and looking after the extended family of their husbands. In Somali culture, women tend to marry young and cherish the ability to have a large family, since children are seen as gifts from God (Hill, Hunt & Hyrkäs, 2012). Marriage in the Somali culture is an empowering stage for both men and women, many young women view this as a way to escape the domineering control of their parents and a chance to manage their own households (Abdullahi, 2001). However, it has been argued that due to the war, the women have become more active in different forms of entrepreneurship and are now often regarded as the 'the stronger gender' (Nes, Skoug & Strømstad, 2005).

2.1.2 Somali cuisine

The Somali cuisine is influenced by the Swahili coastal people of east Africa, Indian and Arabian people with minor influences from Europe, such as spaghetti dishes from Italy and various desserts such as British puddings (Abdullahi, 2001).

The main ingredients of the Somali cuisine are cereal-based products (rice, spaghetti, sorghum, corn), beans, fresh vegetables and fruits, a broad variety of spices, and fresh meat products like mutton, beef, camel meat, fish and chicken (Abdullahi, 2001). Somalis do not usually eat bird meat with the exception of chicken, while fish is only consumed in the coastal area (Nes et al., 2005). Meat from pork, horses or donkeys are forbidden (Abdullahi, 2001). Meat is only consumed if the animal has been slaughtered according to Muslim practice (halal) (Abdullahi, 2001). Camel milk has traditionally been and still remains an important source of nutrition among nomadic families (Ehlers & Witzke, 1992).
Rice, wheat and tea are among the most common products that are imported to Somalia. Somalis usually drink spiced tea with a great amount of added sugar (Nes et al., 2005).

2.1.3 Infant feeding practice in Somalia

Little is known about infant feeding practices in Somalia. Previous nutrition surveys show a long duration of breast feeding, an absence of formula feeding and a delayed introduction of solid foods (Ibrahim, Person, Omar & Wall, 1992). A study of rural areas in Somalia showed that most mothers practised prolonged breastfeeding, and breastfed for one to two years (Ibrahim et al., 1992).

In focus groups conducted with Somali mothers in the United Kingdom, the mothers mentioned that they would usually breastfeed exclusively for six months in Somalia (Ingram et al., 2008). Earlier studies, have reported that Somali mothers would usually stay at home during the first 40 days of an infant's life, the so called U mol Bah, this tradition is for mothers to focus on breastfeeding their infants (Pak-Gorstein, Haq & Graham, 2009; Steinman et al., 2010). The mother usually receives help and support from her family and friends at this time (Pak-Gorstein et al., 2009).

A study in Somalia found that cow's milk was often introduced to infants in Somalia from the day they were born and onwards (Ibrahim et al., 1992). Additionally, sugar, oil and water were also introduced during early infancy. Steinmann et al. (2010) also described the common practice of giving cow's milk as supplement to the breast milk among Somali mothers who had immigrated to Seattle. Cereals, beans, meats, vegetables and fruits are often introduced as complementary foods after the children reached the age of 12 months (Ibrahim et al. 1992).
2.2 Immigrants in Norway

SSB (2013a) describes an immigrant as a person born abroad to two foreign-born parents, who at some point have immigrated to Norway. Norwegian-born to immigrant parents, is a person who is born in Norway with two parents who are born abroad (SSB, 2013a).

Immigrants accounted for 13.1% of the Norwegian population per 01.01.2012 (SSB, 2013b). The greatest growth has been in Oslo, where 23.0% of the population consists of immigrants (SSB, 2012). Findings from the Norwegian Living Conditions Survey (Blom & Henriksen, 2008) in Norway showed that immigrants have significantly lower levels of education, income and employment rate than ethnic Norwegians.

Norwegian-born with immigrant parents accounted for 16.0% of all children born in Norway in 2011 (SSB, 2012). The proportion of newborns in immigrant groups is higher than ethnic Norwegians as immigrant women tend to have more children than Norwegian women. In 2011, infants with Somali parents made up the largest group of Norwegian-born to non-Western immigrant parents, with 928 infants, followed by Iraqi parents with 693 infants (SSB, 2012).

2.2.1 Somali immigrants in Norway

Somali immigrants represent a relatively new immigrant group in Norway; a large number of them have arrived as refugees or through family reunion (Henriksen, 2007). There are 29,395 Somalis living in Norway, this makes Somalis the sixth largest immigrant group in Norway (SSB, 2012). The Somali population in Norway is quite young with 30% of all Somalis being under the age of 20 (Henriksen 2007). A Somali woman will have 3.7 children on an average, whereas a Norwegian woman will have 1.8 children (Østby, 2013).

Henriksen (2007) reported limited information regarding education backgrounds of Somalis, the data available showed that few Somalis have higher education. The collapse of the public school system in Somalia in 1991 is probably a reason for many newly arrived Somalis to have low education (Henriksen, 2007). Somalis are the non-Western immigrant group with the lowest employment rate of 30.6% in Norway (Olsen, 2012). Henriksen (2007) suggests that the low employment must be seen in the context of the fact that many Somalis have relatively short residence time in Norway.
2.3 Breastfeeding

2.3.1 Factors influencing breastfeeding
The duration of breastfeeding and exclusive breast feeding are generally reported to be associated with maternal age, maternal smoking, marital status, parental educational level, social status and infant birth weight (Lande et al., 2003; Ludvigsson & Ludvigsson, 2005; Michæelsen et al., 1994; Kristiansen, Lande, Øverby & Frost Andersen, 2010). The mother’s self-efficacy, that is defined as; her confidence in her ability to breastfeed, has also been associated with the duration of breastfeeding (Meedya, Fahy & Kable, 2010; Noel-Weiss, Bassett & Cragg, 2006).

According to Rogers and Golding (1997) education level seems to be of great importance for breastfeeding; where the higher educated mothers that belonged to a higher social class, were more likely to breastfeed. White & Dahlgren (2009) stated that breastfeeding duration have a tendency to decline with decreased social status. Breastfeeding duration has also been associated with insufficient milk supply, number of children, maternal work situation, infant health problems as well as health service-related factor (Ludvigsson & Ludvigsson, 2005; Thulier & Mercer, 2009). There is some evidence suggesting that mothers’ failure to establish breastfeeding might be due to delay in breast feeding initiation, lack of professional support, conflicting advice from health professionals and the presence of artificial milk (Rogers & Golding, 1997).

Swanson and Power (2005) suggested that a woman’s decision to breast- or formula feed may be open to social and cultural influences, but the influence of culture or ethnicity on breastfeeding has received little focus (Choudhry & Wallace, 2011; Griffith, Tate & Dezateux, 2005). Kelly et al. (2006) indicates that differences in breastfeeding practice may exist between ethnic groups, but little is known about the factors that contribute to these differences. They showed that Indian, Pakistani, Caribbean, and African mothers in the UK were more likely to initiate and continue breastfeeding compared to ethnic UK mothers. It was further suggested that initiation and continuation of the breastfeeding is determined by various personal, social, cultural and environmental factors (Kelly, Watt & Nazroo, 2006).
2.3.2 Acculturation of breastfeeding habits

The concept of acculturation reflects the degree to which people from one culture adapt to or accommodate their behaviours, thoughts and perceptions of the norms of new second culture (Rassin et al. 1993). In addition, country of birth, the use of native language, maintenance of traditional customs, and length of time in the new country (Rassin et al. 1994) can also influence the degree of acculturation.

The processes of acculturation might also affect breastfeeding behaviour (Riordin & Gill-Hopple, 2001). It is suggested that immigrant women’s ethnic and cultural beliefs might change after immigration as a way to adapt to a new geographic area. This may also include culture where infant feeding practices may be very different (Kannan, Carruth & Skinner, 1999). Kelly et al. (2006) imply that acculturating to a host country usually have a negative impact on immigrant mother’s breastfeeding practices, particularly if the mother comes from a country where the breastfeeding prevalence is higher than in Western countries. There has been a recognition that acculturation affects breastfeeding negatively, even if the immigrant mothers come from countries where breastfeeding is common (Rassin et al. 1993), their practice may deteriorate dramatically upon arrival to a new host country (Bonuck, Freeman, Trombley, 2005). A study from the United States suggested that every additional year spent in the US was associated with a four per cent decrease in the odds of breastfeeding (Gibson-Davis & Brooks-Gunn, 2006). Low acculturation levels are said to have a protective effect on breastfeeding habits, when a mother is living in a country where breastfeeding is not common (Choudhry & Wallace, 2012). The United Kingdom Infant Feeding Survey showed that every additional five year spent in the United Kingdom was associated with a five per cent decrease in the probability of breastfeeding for at least four months among immigrant mothers (Hawkins et al, 2008).

2.3.3 National and international recommendations for infant feeding

Exclusive breastfeeding is defined as feeding the infant only breast milk without any additional food or drink (WHO, 2008), where only the addition of vitamins, minerals, and medicine is allowed. The WHO describes complementary foods as any fluid or food other than breast milk (WHO, 2008). Thus substitutes such as cow’s milk and formula milk are regarded as complementary foods (Fewtrell et al. 2007). The term complementary feeding is reserved to describe appropriate feeding of complementary foods in breastfed infants six
months of age or beyond (WHO, 2008). The WHO recommendation for breastfeeding applies to all countries and populations regardless of economic status or developmental level (Hörnell, Lagström, Lande & Thorsdottir, 2013).

Up to 2001, the WHO recommended that infants should be exclusively breastfed for four to six months before the introduction of complementary foods (Fewtrell et al. 2007). In 2001, after conducting a systematic review and expert consultation, this advice was changed. The WHO now recommends mothers to exclusively breastfeed their infant for the first six months of life, with continued breastfeeding along with appropriate complementary food up to two years of age or beyond (WHO, 2008). The systematic review commissioned by the WHO compared infant and maternal outcomes for exclusive breastfeeding for three to four months versus six months (Fewtrell et al. 2007). The review pointed out a number of benefits with exclusive breastfeeding of infants for six months. These included a lower risk of gastrointestinal infection, more rapid maternal weight loss after birth (Kramer & Kakuma, 2012).

In 2010, the Nordic Council of Ministers carried out a systematic literature review as part of the fifth revision of the Nordic Nutrition Recommendations (NNR). The authors concluded that the recommendation from the NNR in 2004 about exclusive breastfeeding for six months and continued partial breastfeeding thereafter can stand unchanged (Hörnell et al., 2013). The optimal duration of exclusive breastfeeding has, according to Fewtrell et al. (2007), often equated with the optimal age for introduction of solid foods. The authors stated that there is still no data available; to form evidence based recommendations for the introduction of solids in formula-fed infants (Fewtrell et al., 2007).

In Norway, it is also recommended that infants should if possible, be exclusively breastfed for the first six months of life (Norwegian Directorate of Health, 2001); but can receive daily supplements of vitamin D [tran] from the age of four weeks. Solid foods should be introduced gradually from the age of six months, breastfeeding should be continued. The Norwegian Directorate of Health mentions that some infants may need solid foods before the age of six months, but the introduction should not take place earlier than at four months of age. Infants, who are not breastfed, should receive formula milk instead of cow’s milk for the first 10 to 12
months; a gradual introduction to complementary foods can happen when the infant reaches the age between four to six months (Norwegian Directorate of Health, 2001).

The reasons for why some infants might need complementary foods before reaching six months are inadequate weight gain, difficulties with breastfeeding, the infant seems hungry even after frequent breastfeeding, or if the infant shows interest to other foods (Norwegian Directorate of Health, 2001).

2.3.4 Breastfeeding in Norway

The prevalence and duration of breastfeeding varies considerably worldwide (Rogers & Golding, 1997). In some countries in Scandinavia, the prevalence is very high, while it is quite low in other industrialized countries (Zetterstrøm, 1999). In Norway, the increase in breastfeeding prevalence in the period from 1970 to 1983 has been more distinct compared to other European countries (Endresen & Helsing, 1995). In the early 1970s, however, only 20-30% of the mothers were still breastfeeding three months after birth, and at six months only 10% breastfed (Helsing & Kjærnes, 1985). The period from 1973 and onwards marked a raise in breastfeeding prevalence and duration in Norway. In 1982 the prevalence of breastfeeding at three months had increased to approximately 70%, and at six months the prevalence was estimated to be around 48% (Endresen & Helsing, 1995).

The increase in breastfeeding prevalence in the 1970s was most common among more educated and professional women (Endresen & Helsing, 1995; Liestøl, Rosenberg & Malløe, 1988). An increased number of women started working outside their homes and the women’s educational levels had risen over the past decades (Endresen & Helsing, 1995). Mother to-mother support groups were established all over Norway since 1968, providing useful information to mothers and health workers (Endresen & Helsing, 1995). Among the political agendas of the feminist movement in the early 1970s was improvement of the conditions for breastfeeding mothers (Endresen & Helsing, 1995). Further, structural changes such as a longer maternity leave and less aggressive formula milk advertisement may have influenced mothers’ breastfeeding patterns in the period from 1973 to 1991 (Helsing & Kjærnes, 1985).

In Norway, nine to twelve months paid maternity leave gives mothers the opportunity to breastfeed during their infant’s first year of life (Kristiansen et al., 2010). The parental benefit
guarantees all mothers paid leave from their work after childbirth, this period is either 47 weeks (100% of their salary) or 57 weeks at 80% benefit (NAV, 2013).

The breastfeeding prevalence in Norway still remains relatively high. The Spedkost survey from 2006-07 (Øverby et al., 2008) showed that 95% of the infants were breastfed during the first month, 85% at four months and 80% at six months. The proportion of exclusively breastfed infants was 82% at one month, 46% at four months and 9% at six months (Øverby et al., 2008). Eleven percent of the infants were introduced to solid foods before reaching the age of four months. Insufficient breast milk production was reported as the main reason why some mothers had stopped breastfeeding before the infants reached six months. Other important reasons reported were that the infant did not want breast milk and there were sucking problems (Øverby et al., 2008).

2.3.5 Breastfeeding promotion

Mothers in Norway are often supervised and trained by health care providers on pregnancy, childbirth and breastfeeding (Helsing & Kjærnes, 1985; Norwegian directorate of Health, 2010). In this way, health workers can become a potential support for breastfeeding and infant feeding practices. The roles of health care providers are to protect, promote, facilitate and support good breastfeeding establishment among postnatal women, as well as assisting mothers who may experience problems with breastfeeding (Rogers & Golding, 1997; WHO & UNICEF, 1989).

In 1989, WHO and UNICEF jointly published a ten step plan to successful breastfeeding suggesting the best practice for hospitals in protecting, promoting and supporting breast feeding (WHO & UNICEF, 1989). This was a way to enable hospital staff to start making policies and decisions on ways to increase breast feeding (Rogers & Golding, 1997). The Baby-Friendly Hospital Initiative (BFHI) was launched by WHO and UNICEF in 1991 (WHO, 2009). This was a worldwide effort in improving the role of maternity services to protect, promote and enable mothers to breastfeed their infants for an optimal start of life. BFHI follows the ten steps to successful breastfeeding previously outlined by WHO and UNICEF in 1989.

In the mid 90s, Norway decided followed up on the BFHI with the Mother-child- friendly initiative, currently, over 90% of all Norwegian infants are born in a Mother-child- friendly
hospital (Norwegian Competence Centre for Breastfeeding, 2012). Each hospital must fulfil the ten requirements from WHO/UNICEF’s ten steps to successful breastfeeding in order to be approved as a Mother-child- friendly hospital in Norway (Norwegian Competence Centre for Breastfeeding, 2012).

The Norwegian Competence Centre for Breastfeeding [Nasjonalt kompetansesenter for amming] has also expanded WHO and UNICEF’s BFHI through breastfeeding skilled health clinics [ammekyndig helsestasjon] (Norwegian Directorate of Health, 2010). This was a follow up to Norway’s efforts to promote breastfeeding, improve health and prevent disease among infants. This was also an effort to reduce social inequalities in breastfeeding with a universal measure, through strengthening the availability and quality of services for all (Norwegian Directorate of Health, 2010). To this day, there are 53 certified breastfeeding skilled health clinics in Norway (Norwegian National Competence Centre for breastfeeding, 2012). The breastfeeding skilled health clinic must fulfil a quality standard consisting of a six step plan based on the Mother-child- friendly hospital and WHO/UNICEF’s ten steps to successful breastfeeding.

This quality standard is to ensure that breastfeeding guidance from the health clinics is based on updated knowledge. This is also to make sure that all pregnant women and mothers with young infants receive the same consistent breastfeeding guidance, from the health care providers (Norwegian Competence Centre for Breastfeeding, 2012). The six guide lines from the quality standard states that the health clinic should:

1. Should have a written breastfeeding procedure that is routinely communicated to all health care professionals at the clinic.
2. Provide training so that the health care staff would be able to follow this procedure.
3. Help convey information to pregnant women about the benefits of breastfeeding and how they can manage breastfeeding.
4. Contribute to the establishment of an initiative group between antenatal care, maternity / neonatal and health clinics. The health clinic should inform about Ammehjelpen.
5. Guide mothers in breastfeeding techniques and how to continue breastfeeding
6. Ensure that mothers receive the support they need to be able to exclusively breastfeed for the first six months. After the introduction of solid foods, the health clinic should
advice mothers to continue breastfeeding throughout the first year or beyond based on the wish from the mother and infant.

2.4 Qualitative approach

The InnBaKost-project has chosen a qualitative approach for this sub study, which is often used in "description and analysis of traits, characteristics or qualities of a phenomenon" (Malterud, 2003, p 26). Qualitative research often focuses on "understanding a social phenomenon from the participants' own perspectives and describes the world as it is experienced by the informants" (Kvale and Brinkmann, 2012, p. 45). InnBaKost aims, among other things, at exploring Somali women’s own perceptions of infant feeding, as well the way mothers experience the meeting with the health clinic. The analytical method will be based on some of the principles of Grounded Theory (Dahlgren, Emmelin & Winkvist, 2007). This involves a systematic approach to the analysis of qualitative data with the aim of discovery and theory development (Dahlgren et al., 2007), though the aim of this thesis was not to develop a new theory. Grounded theory is also suitable in investigations of topics with little prior research. Infant feeding beliefs and practices among the Somali women living in Norway are regarded as such a topic.
2.5 Definitions

Further in this thesis, the term exclusive breastfeeding, predominant breastfeeding and complementary feeding will be defined as follows:

**Exclusive breastfeeding**: will follow the definition by WHO, with the addition to cod liver oil [tran].

**Predominant breastfeeding**: the infant have received breast milk (including milk expressed or from a wet nurse) as the predominant source of nourishment, in addition to certain liquids (water and water-based drinks, fruit juice), ritual fluids or syrups drops (vitamins, minerals, medicines).

**Complementary feeding**: the infant has received other foods and fluids, in addition to breast milk at any given time. This also refers to infants that have introduced to complementary foods earlier than six months. The master student notes that her definition differs from the WHO’s definition of *complementary feeding*, where the definition is reserved for infants from six months and beyond (WHO, 2008). A recent study has questioned the current definitions used in breastfeeding research (Noel-Weiss, Boersma & Kujawa-Myles, 2012). A recent report by the European Food Safety Authority (EFSA) (2009) had also used the term ‘complementary foods’, to describe foods/fluids that are given to the infant (together with breast milk or breast milk substitute) before six months.
3 THE STUDY OBJECTIVES

The main objective of this study is:

To generate knowledge about infant feeding practices of Somali mothers living in Norway

The sub objectives are:

1. To describe Somali mothers’ infant feeding practices.
2. To explore factors that influence mothers' infant feeding choices and practices, such as how they breastfeed and its duration, choice and time of complementary foods
3. To explore how mothers experience and deal with the food practice in Somalia and the one in Norway with regards to how they feed their infants.
4. To explore mothers' experiences with the health clinic and specifically with regards to advice given on infant feeding practices.
5. To explore the potential conflict between advice given by the mothers’ Somali network/social network and the advice given at the health clinic

4 METHODOLOGY

4.1 Study design

The data collection was carried out in Oslo and Akershus municipality from October 2012 to March 2013. Data was collected by in-depth interviews with 15 Somali mothers with the help of a semi structured interview guide as proposed by Kvale and Brinkmann (2012). The first four interviews were conducted by one of the project leaders with the presence of the master student of this thesis. The master student performed the remaining interviews with the supervision of the project leader during two of the interviews. The master student had also received training in conducting interviews and analysis method from the project leader prior to this.
The interviews were either conducted in the participants’ home, at Fafo or in cafés. The participants chose the place and time of the interviews. Each interview lasted from 45 minutes to 1.5 hour. An audio recorder was used during all of the interviews. Field notes on impressions and reflections of each interview were made by the master student to supplement the audio recordings. An incentive for participating in the study (150 NOK gift card) was given to each participant at the end of the interview.

The interviews were held in the preferred language of the participants (Norwegian or Somali). A Somali interpreter assisted in interviews where participants did not speak Norwegian fluently, and the conversation was interpreted simultaneously. Two female Somali interpreters were recruited to the InnBaKost project prior to the interviews. Both of them have had previous experience working as an interpreter. The interpreters were born in Somalia, had Somali as their native language, and they spoke Norwegian fluently. An interpreter manual (appendix 5) was given to the interpreter before the interviews, this served as a supplement to their task of interpreting. Some of the themes from the manual were: information about the InnBaKost project, the role of a good interpreter and general guidelines on professional behaviour, courtesy and discretion during the interviews.

**4.1.1 Ethical considerations**

The InnBaKost project was approved by the Regional Committees for Medical and Health Research Ethics (REK). An informed consent form was carefully explained to the participants (Appendix 1) before the interviews, and signatures from all participants were collected. The written consent was either in Norwegian or Somali. The participants were told that participation in the study was voluntary and that they could withdraw at any time. Both the interviewer and interpreter signed a confidentiality agreement prior to the interviews. Confidentiality and the anonymity of the participants were obtained by using fictive names under presentation of the results. The study was carried out in accordance to the Helsinki declaration.
4.1.2 Recruitment and participants

The recruitment of participants took place in different municipalities in Oslo and Akershus, where a high number of women with Somali background were living. Participants were recruited both through purposive and snowball sampling. The inclusion criteria were Somali women who were born outside Norway with infants at six months of age, born in Norway. Due to difficulties in the recruitment, the inclusion criteria were then extended to Somali mothers with 6 (±2) months old infants born in Norway. The criteria for including mothers with infants younger than six months, were that the mothers had stopped practising exclusive breastfeeding. All participants who fulfilled the inclusion criteria and consented to part of the study were included.

A multi-recruitment strategy has been recommended for hard to reach immigrant groups (Hussain-Gambles, Leese, Atkin, Mason, & Tovey, 2004). This strategy has been followed for recruitment in this study, and included visits to local health clinics and other relevant recruitment places. Recruitment was initially planned and carried out in the waiting room at the health clinics that were part of InnBaKost (Grorud, Grønland, Grünerløkka, Romsås and Østensjø). Three participants were recruited through the health clinics. Due to difficulties in obtaining enough participants from these health clinics, other recruitment places were explored.

These included activity centres and cafés organized by the Red Cross (n= 2). In addition, the snow-ball method (Dahlgren et al., 2007) for recruitment was used through the help of interpreters and participating mothers in the project. Six participants were recruited through this method.

Finally, recruitment was made through getting access to the information from the National Population Registry [Folkeregisteret], about Somali women who had given birth between February and July 2012. The women from the list were contacted by one of the Somali interpreters, who informed them about the study and asked them to participate. Four women were recruited in this way.
4.2 Data collection

Grounded Theory provides a systematic way of transforming the collected data into a more abstract form of information. Dahlgren et al. (2007) writes that this technique, involves a number of distinctive steps: (1) data collection; (2) documentation (e.g. organizing of interview transcripts); (3) open coding; (4) selective coding; (5) theoretical coding; (6) integration of the findings with an existing theory.

The master student followed five of these steps during the data collection and analysis: in-depth interviews/step one, transcription/step two, open coding/step three, selective coding/step four and theoretical coding/step five. They will be described below (4.2.3-4.3.2). The sixth step was not followed as it was considered too advanced for a master thesis.

4.2.1 Pilot interview

A pilot interview was conducted by the project leader in October 2012 prior to the data collection. This was to test and evaluate the interview guide; and give the master student hands on experience with the interview process. The pilot interview was done with a young Somali mother.

4.2.2 Interview guide

The interview guide was developed in English and Norwegian. The interview guide focused on the target group's infant feeding practices and perceptions, as well as the mother’s experiences with the health care system. One of the Somali interpreters was asked to translate the Norwegian interview guide to Somali. The other Somali interpreter was giving the task of comparing the two versions, to make sure that the Norwegian and Somali interview guide were consistent with each other. This was to ensure that the interpreters had understood the meaning and the way the questions of the interview guide were formulated. The Norwegian interview guide was the one that was used during the in-depth interviews.

The main themes were: breastfeeding practices, exclusive breastfeeding, transition to solid foods, complementary foods, services at the health clinic and advice given on infant feeding (appendix 3). Questions were worded in a neutral way to avoid response bias. New emerging
themes from the previous interviews were added to the interview guide (e.g. breastfeeding in public, pressure of formula feeding from the Somali network etc.).

4.2.3 In-depth interviews

Before each interview it was made clear to all the participants that the interviewer had no affiliation with the Norwegian Health Service [Helsevesenet]. The interviewer asked the participants for permission to audio record the conversation. Oral and written information about the topic of the study, including the anonymity, voluntary participation was explained to the participants. The participants were also informed that they would receive a gift card as thanks for their participation.

A semi-structured interview guide can help create a better flow during the conversations (Kvale, 2001), as the interviewer becomes less dependent on the order of the questions than when using a questionnaire. The interview guide was primarily used as a checklist during the interviews; the participants had the chance to discuss subjects that were not included in the questions. All of the questions were open-ended so the participants could express themselves freely. Follow-up questions were asked for confirmation or clarification of some of the responses. Questions or topics that the participant wanted to elaborate on were addressed at the end of the interview. One of the Somali interpreters was used in six of the interviews, the remaining interviews (n=6) were conducted in Norwegian.

According to Kvale and Brinkmann (2012), there are no fixed rules when it comes to the number of interviews. The number of interviews in regular qualitative research is often around 15 ±10 (Kvale & Brinkmann, 2012). The aim was to continue with interviewing until reaching a saturation of information from the participants. This means that no new information was obtained by conducting another interview.
4.3 Data analysis

4.3.1 Transcription

All interviews were audio recorded, transcribed, analyzed and supported by field notes. The transcribed interviews make up the data material in this study.

The files from the audio recordings were first transferred over to a computer; the interviews were then transcribed verbatim in Norwegian into a word document.

The previous interview was usually transcribed before conducting the next one. In that way insight gained from the transcribed interview could be used to refine or elaborate new questions for the subsequent interviews. It took approximately eight to twelve hours to transcribe each interview. The mothers’ names were anonymised by giving them code names during the transcription. The mothers’ code names were highlighted in bold letters to separate between what the interviewer and the mothers was saying.

4.3.2 Coding and analysis

The data collection and analyses were performed consecutively to ensure to which extent the collected data addressed the objectives. The finished transcripts and field notes were reviewed to get an overview of the mother’s narratives.

Coding plays an important role in Grounded Theory (Kvale & Brinkmann, 2012). Open coding refers to the ‘analysis, investigation, comparison, conceptualization and categorization of data’ (Kvale & Brinkmann, 2012, p. 209). The codes in a Grounded Theory approach are part of a qualitative analysis where the researcher is investigating the relationships between different codes, and the context and the consequences of different behaviours (Dahlgren et al., 2007).
The transcripts were organised with the help of the software programme OpenCode version 3.6.2.0. (Dahlgren et al., 2007). The master student first went through the transcripts, the data were then coded openly line-by-line. An example of the coding process is illustrated below.

“No, sometimes he (my child) would suck on (the breast) and then it (my milk supply) would be empty, there is no more milk coming out. It was so exhausting and painful, I tried all time (to breastfeed)…”

The example above illustrates a translated quote that is part of an interview transcript, with a Somali mother. The master student created the codes; ‘breastfeeding’, ‘insufficient milk’, ‘exhausting’, ‘pain’ and ‘frustration’ for that quote.

The codes “breastfeeding” and “insufficient milk” are purely descriptive codes. The code ‘exhausting’ is an adjective, used to describe that the mother felt it was difficult to continue breastfeeding (due to insufficient breast milk production). The code ‘pain’, describes the mother’s experience with breastfeeding. The remaining code ‘frustration’, was created after ‘reading’ between the lines’, as this statement seemed to express the mother’s sense of frustration over her failed attempt to manage the breastfeeding.

The generated codes helped to characterise and to label important information (e.g. ‘insufficient milk’, ‘formula pressure’, ‘breastfeeding in public’) from each transcript. The next step, was the selection and elimination of codes; the codes that seemed important were first identified. The relevant codes with similar meanings, were then selected out from each transcript and grouped into broader categories. An example was the creation of the category ‘breastfeeding barriers’, the codes such as ‘pain’, ‘exhausting’ and ‘insufficient milk’ were then grouped into this category. A number of categories (e.g. breastfeeding duration, breastfeeding motivations) were then created. The next step was the theoretical coding, where the master student tried to find connections between the codes and between categories. An example, was the relation between the category ‘breastfeeding barriers’ and the category ‘introduction of complementary foods’.

All the transcripts were re-read after grouping the codes and creation of categories. This was to make sure that no important information was overlooked. A matrix was also created to help identify and describe the common infant feeding practices among Somali mothers. The master student re-read the interview transcripts to make sure that the summaries in the matrix were correct.
The findings are presented in text and supported by quotes. These quotes are translated from Norwegian to English. The master student tried to make sure that the meaning of the translated quotes was still in line with the original Norwegian quotes. The translated quotes were also assessed by one the project leader in InnBaKost. Some of the quotes contain a small explanation in parentheses, to make it easier for the reader to understand what topic the mother was talking about. The mothers are all given fictive names in the presentation of the quotes. The master student has defined the term ‘few’ as one to three, ‘some’ as four to six, ‘half’ as seven to eight, ‘the majority’ as over nine. These terms will be used to describe the number of mothers.
5 FINDINGS

5.1 Characteristics of participants

Background information of each mother was collected before the start of each interview. This provided information on mother’s age, occupation, marital status, number of children, age of the last born infant and educational level (Table 1.)

Table 1. Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Informant (fictive name)</th>
<th>Age of the mother (years)</th>
<th>Years of residence in Norway</th>
<th>Education</th>
<th>Occupation</th>
<th>Marital status</th>
<th>Number of children</th>
<th>Age of the infant (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idil</td>
<td>25</td>
<td>17</td>
<td>Secondary</td>
<td>Employed</td>
<td>Married</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Hibo</td>
<td>25</td>
<td>15</td>
<td>Tertiary</td>
<td>Student</td>
<td>Cohabiting</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Leylo</td>
<td>33</td>
<td>19</td>
<td>Tertiary</td>
<td>Student</td>
<td>Married</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Ayanna</td>
<td>25</td>
<td>11</td>
<td>Secondary</td>
<td>Employed</td>
<td>Married</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Timiro</td>
<td>35</td>
<td>21</td>
<td>Tertiary</td>
<td>Employed</td>
<td>Married</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Sharifa</td>
<td>21</td>
<td>20</td>
<td>Secondary</td>
<td>Student</td>
<td>Cohabiting</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Hani</td>
<td>35</td>
<td>11</td>
<td>Primary</td>
<td>Housewife</td>
<td>Married</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Kaafiyo</td>
<td>33</td>
<td>11</td>
<td>Primary</td>
<td>Housewife</td>
<td>Single</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Taliso</td>
<td>23</td>
<td>22</td>
<td>Tertiary</td>
<td>Student</td>
<td>Married</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Caaliyah</td>
<td>28</td>
<td>16</td>
<td>Tertiary</td>
<td>Employed</td>
<td>Married</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Nadifa</td>
<td>24</td>
<td>10</td>
<td>Secondary</td>
<td>Housewife</td>
<td>Married</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Ikraan</td>
<td>23</td>
<td>3</td>
<td>Primary</td>
<td>Housewife</td>
<td>Married</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Muriyo</td>
<td>25</td>
<td>4</td>
<td>Primary</td>
<td>Housewife</td>
<td>Married</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Yurub</td>
<td>29</td>
<td>15</td>
<td>Tertiary</td>
<td>Student</td>
<td>Married</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Turiba</td>
<td>24</td>
<td>7</td>
<td>Primary</td>
<td>Employed</td>
<td>Married</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

There were 15 Somali mothers who participated in the study. The mothers had infants from five to eight months of age. All, but two of the mothers were born in Somalia. These two mothers were born in Kuwait and Zambia and had parents from Somalia. The age of the mothers ranged between 21 to 35 years old, with 27 as the average age. The majority were married with the exception of three, where two were cohabiting with the father and one was a single mother.

The majority of the mothers were multiparous and almost all have only experienced child birth in Norway. Only two mothers experienced child birth both in Somalia and Norway. Six of the mothers required an interpreter during the in-depth interviews. All of the participants
lived in municipalities of Oslo and Akershus. The education level of the mothers varied, four of the mothers had only completed primary education in Somalia. Nine participants spoke were fluent in Norwegian. All of the participants were on maternity leave at the time of the interviews. Before the last pregnancy, five were employed, five were students, and five were housewives.

5.2 Breastfeeding practices

5.2.1 Initiation of breastfeeding at the hospital

Half of the mothers reported that there was little milk in the beginning, and that the initiation of breastfeeding therefore was delayed. Other reasons for a delay in breastfeeding were complications after birth and that the infant did not want to suck on the breast. One mother suggested that this was due to the anaesthetic she had received when giving birth. Two of the infants had been given formula milk by the hospital staff as these mothers’ breast milk production was delayed. One mother said that her infant received sugar water from the hospital staff, during a check-up by the doctor. The majority of the mothers did not give formula milk since they wanted to breastfeed the infant. Some decided to express the breast milk and feed it through a cup, since the infant had difficulties sucking on to breast.

All mothers had given the first milk, colostrum, but only a few had also been informed about the benefits of it. The information about breastfeeding at the hospital seemed to vary, as around half of the mothers had been informed about breastfeeding while others had not. Most of the multiparous mothers felt that they received little information about breastfeeding compared to their previous births. These mothers suggested that this was because the nurses might have perceived them as experienced mothers, who already were knowledgeable about breastfeeding.

“They gave me a lot of information with my firstborn, but when you are a second or third time mother, there is less information compared to before... Since they think you have enough experience...”
(Nadifa, age 24, five month old infant)

The majority of the mothers were satisfied with the care provided at the hospital, with the exception of a few, who wished that they had been given more support from the hospital staff.

“(I was having trouble with breastfeeding) I asked for help even though I am an experienced mother. I asked if they could help me, but there was never time.” (Timiro, age 35, five month old infant)
Another mother was dissatisfied with the care she had received at the hospital. This mother felt pressured to breastfeed and complained about the attitudes of the health care providers. This mother described her experience as follows:

“...I felt it was mostly from healthcare providers, the ones at the hospital is the most extreme, I do not know if they are aware of it. And everyone I have talked to have the same feeling (the pressure of breastfeeding). They are really, I think it is not what they say, but I think it is the way that they are, it is like you have to be able to breastfeed, it is this pressure with breastfeeding, that it is best for the child. It's like no other alternative, it is sort of like that ... When they came into the room after the birth, I had trouble with them. Because when they arrived they had seen my name, they knew I was a Somali so when they came into the room it was ‘YOU HAVE TO BREASTFEED!’, I remember them screaming, and then I remember thinking to myself what the hell, are they deaf?, and sometimes I would think, OK let us just say that I do not speak Norwegian, it does not help to scream. Then I remember that I said to them, ‘I HAVE BREASTFED’ and suddenly they came to me and said ‘Oh, you speak Norwegian?’ it was like ‘Oh!’ they were so surprised.”

(Hibo, age 25, seven month old infant)

A few of the mothers who expressed dissatisfaction, pointed to important factors for breastfeeding; that there is enough time for counselling and that the mothers perceive the information as a help for them, and not as a pressure or discriminating behaviour.

5.2.2 Breastfeeding duration

The majority of the mothers were still breastfeeding at the time of the interview, and intended to breastfeed for an average of one year, with responses ranging from six months to two years (table.2). Four mothers had stopped breastfeeding, of these, two stopped breastfeeding when their infant were three months old, while the other two stopped when their infant were between four and five months old. None of the mothers practised exclusive breastfeeding for six months. The longest reported duration of exclusive breastfeeding was five months (n=1). Half of the mothers practised exclusive breastfeeding for around three months, and a few exclusively breastfeed for longer, and the rest practised exclusive breastfeeding for less than three months. Two mothers only breastfed their infant at the hospital (around 3 days). There were two who had not exclusively breastfed their infant at all, although one of these mothers gave breast milk alone after she came home from the hospital till the infant reached four and a half months. But it was not considered as exclusive breastfeeding, as the infant had already received formula milk and sugar water at the hospital.
Table 2. The duration of exclusive breastfeeding and planned breastfeeding duration

<table>
<thead>
<tr>
<th>Informant</th>
<th>Duration of exclusive breastfeeding</th>
<th>Planned breastfeeding duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idil, age 25, 5 month old infant</td>
<td>3 months</td>
<td>1 year</td>
</tr>
<tr>
<td>Hibo, age 25, 7 month old infant</td>
<td>Have not exclusively breastfed gave breastmilk (alone) 3 days to 4.5 months</td>
<td>Stopped breastfeeding at 5 months</td>
</tr>
<tr>
<td>Leylo, age 33, 8 month old infant</td>
<td>Have not exclusively breastfed (formula milk at the hospital)</td>
<td>Stopped breastfeeding at 4 months</td>
</tr>
<tr>
<td>Fartuun, age 25, 8 month old infant</td>
<td>3 months</td>
<td>1.5 year</td>
</tr>
<tr>
<td>Timiro, age 35, 5 month old infant</td>
<td>3 months</td>
<td>1 year</td>
</tr>
<tr>
<td>Ayan, age 21, 6 month old infant</td>
<td>3 months</td>
<td>1 year</td>
</tr>
<tr>
<td>Hani, age 35, 5 month old infant</td>
<td>3 months</td>
<td>2 years</td>
</tr>
<tr>
<td>Kaafiyo, age 33, 5 month old infant</td>
<td>3 months</td>
<td>2 years</td>
</tr>
<tr>
<td>Taliso, age 23, 5 month old infant</td>
<td>4 months</td>
<td>1 year</td>
</tr>
<tr>
<td>Qani, age 28, 6 month old infant</td>
<td>2 months</td>
<td>1 year</td>
</tr>
<tr>
<td>Nadifa, age 24, 5 month old infant</td>
<td>3 days (at the hospital)</td>
<td>Stopped breastfeeding at 3 months</td>
</tr>
<tr>
<td>Ikraan, age 23, 6 month old infant</td>
<td>5 months</td>
<td>2 years</td>
</tr>
<tr>
<td>Muriyo, age 25, 7 month old infant</td>
<td>3 months</td>
<td>Stopped breastfeeding at 3 months</td>
</tr>
<tr>
<td>Yurub, age 29, 5 month old infant</td>
<td>4 months</td>
<td>1 year</td>
</tr>
<tr>
<td>Turiba, age 24, 5 month old infant</td>
<td>3 days (at the hospital)</td>
<td>6 months</td>
</tr>
</tbody>
</table>
5.2.3 Breastfeeding motivations

When the mothers were asked about their views on breastfeeding, the majority mentioned that breastfeeding seem like a natural thing to do. These mothers viewed breastfeeding as common practice, which is why they had not considered the option of not breastfeeding. Some of the mothers mentioned that they wanted to continue breastfeeding, since they did not have any difficulties and believed that they could manage breastfeeding. Some wanted to breastfeed due to their own belief and knowledge; that breastfeeding is beneficial for the infant’s immune system and for the infant’s health later in life.

“It is in a way the most important milk that the baby can get, it strengthens their immune system and protect against so many things.” (Ikraan, age 23, five month old infant)

“I’ve read about it (breastfeeding) myself and I have always been determined that I should breastfeed my children until they are one year old, or as long as possible and they still show interest in it.” (Caaliyah, age 28, six month old infant)

Some of the mothers had also received support from their partner to continue breastfeeding. One mother mentioned that her husband was very supportive and encouraged her to breastfeed. This mother also stated that breastfeeding help create a special bond between her and her infant.

“I would absolutely recommend a mother to breastfeed because it provides closeness to the child, between you and your child. This is a connection between you and your child, linking you very much to your child, at least that is what I have experienced…He (my husband) is very happy that I am breastfeeding, he thinks it is great and has advised me to breastfeed… and thinks it is important, that it is the best for the child…” (Taliso, age 23, five month old infant)

A few of the mothers wanted to practice prolonged breastfeeding, as they mentioned that the Quran recommends mothers to breastfeed for two years.

“... We are Muslims. Our culture and religion say that we have to breastfeed for two years ... Honestly, it is very tough, but our Quran says that it protects against a number of diseases once the child grow older.” (Ayanna, age 25, eight month old infant)

Some mothers had also heard about the recommendation from the Quran, but these mothers did to intend to follow this recommendation. A few of the mothers mentioned the common infant feeding practice in Somalia, where mothers would usually breastfeed for two years. Three of these mothers intended to breastfeed their infant for two years, two of them also
mentioned that their own mother had breastfed them for two years. These mothers were also advised by their own mother (living in Somalia) to continue breastfeeding for as long as possible.

“She (my mother living in Somalia) said that if I manage (breastfeeding), that I should try to breastfeed for at least two years.” (Ikraan, age 23, six month old infant)

“My siblings and I were breastfed for two years (back in Somalia).”
(Kaafiyo, age 33, five month old infant)

“It is my mom that has actually taught me everything that I know (about taking care of children)... and she still gives me advice constantly (even with my youngest child) on what to give... that I should breastfeed as much as possible...” (Hani, age 35, five month old infant)

Thus many of the mothers mentioned several motivating factors for practising prolonged breastfeeding, such as their own belief about the benefits of breastfeeding, their Islamic religion, and support from their partner. Encouragement from their own mothers who were living Somalia, motivated a few of these mothers to continue breastfeeding, as illustrated in the quotes above.

5.2.4 Breastfeeding barriers
Various barriers to breastfeeding were mentioned by the mothers during the interviews. Insufficient breast milk production was the most frequently mentioned barrier. These mothers mentioned that their infant seemed unsatisfied after being breastfeed. They saw this as a sign that they were not producing enough breastmilk. The second most frequently stated barrier was the infant’s refusal to breastfeeding.

“Yes, when he (my child) got home (from the hospital), I breastfed him but it was not enough for him, he screamed and cried like he wanted more, so I used to give him (formula milk).”
(Leylo, age 33, multiparous, eight month old infant)

“But she (my child) did not want to (be breastfed, she refused to.”
(Muriyo, age 25, multiparous, five month old infant)

Insufficient breast milk production or that the infant refused to be breastfeed, were also the main reasons why four of the mothers had stopped breastfeeding, at the time of the interview. Two of these mothers had been advised by the health clinic, to drink more fluids, to help increase their breast milk production, while another mother, had also received this advice from her own mother. But none of them felt that this advice was helpful, and chose to stop
breastfeeding completely. These mothers expressed that having enough milk was important if a mother wanted to continue breastfeeding. Three of these mothers mentioned that the breast milk production differ between mothers, where some mothers are able to produce enough breast milk, while others cannot.

“It is different some (mothers) have a lot of milk and some not so much…there is nothing else you can do.” (Turiba, age 24, multiparous, five month old infant)

Some of the less frequently stated barriers were: breastfeeding in public; work or school related commitments; the lack of time; discomforts or pain with breastfeeding; not giving expressed breast milk when someone else is taking care of the infant.

The mothers had different practices when it came to feeding their infant in public. A few preferred to give formula milk or express the breast milk beforehand.

“Yes, it happens that sometimes, when I am out that I mix (formula milk) to avoid stripping.” (Timiro, 35 years, five month old infant)

“No... no, not in public... it is best if I know that I am going out beforehand, so I can express milk in advance or I will take a little formula in addition, so the child can get that when we are out. It is not like that I take it (the breasts) out...I think people would think it is weird if a person who is covered...suddenly start to (take out the breasts)...” (Idil, age 25, five months old infant)

A few planned their schedule in advance, to avoid breastfeeding when they were out.

“... I plan ahead, so I would breastfeed before I go out, and I would not be gone for more than two hours / two to three hours, because I know that she (my child) has to be breastfed after that time.” (Yurub, 29 years, five month old infant)

Returning to work or studies influenced a few of the mothers' intention to stop breastfeeding. These mothers felt that it would be difficult to continue breastfeeding, as illustrated below.

“But I do not know if I can manage it, milk engorgement at work and stuff I cannot bear it.” (Timiro, 35 years, five month old infant)

“I think (I will) at least try to maintain it (breastfeeding) until she is one year old at least. Yes, because that is when I start school again, so it would be difficult to breastfeed...” (Taliso, 23 years, five month old infant)

A few of the mothers referred to the issue of time constraint, this made it difficult for them to breastfeed due to their hectic schedule.

“I have three children, I am stressed, I do not have time to give breast milk ... I have to give formula since I have a lot of things to do...” (Turiba, age 24, five month old infant)
Two of these mothers had given birth both in Somalia and Norway. These mothers mentioned that they received much more support and help from their family and network in Somalia. This enabled them to continue breastfeeding. One mother articulated her experience as follows:

“There is some difference in the length of breastfeeding with the two who were born outside Norway and the two who were born in Norway. Especially because with the ones born in Somalia, I had much more time and was available to breastfeed. I also received much more help from others with chores and could focus merely on my children... Here it is very much the time constraint, where we try to be on time with one thing and another and it has been overwhelming.”  
(Kaafiyo, age 33, five month old infant)

One further mentioned barrier, was that breastfeeding was troublesome at times. One mother stated that her infant had to be around her most of the time, this made it difficult for her to leave her infant under the care of others. This mother further expressed that continuation of breastfeeding requires commitment at the expense of her social life. Another mother felt discomfort with having milk in her breasts.

“She (my child) gets everything she needs in the breastmilk...but since I breastfeed exclusively which is why I have not introduced her to the bottle at all. So it is very hard for me to leave her, like if I am going out, just to go out for a walk and not just sit (at home) ... be able to go out on my own...It was much easier with my first child, since I gave him formula so I could just say ‘OK, I going out now’ and my husband could take care of him, because he could just blend it (formula) together and give him the milk. So he (first born) was not fully dependent on me as she is. Since I have to be with her 24 hours a day because I am breastfeeding.” (Taliso, age 23, five month old infant)

“To be honest, if I had stopped breastfeeding, I would actually be inclined, because I do not like walking around with milk in my breasts... I really do want to breastfeed because it is best for her...But of course, if I had the opportunity to avoid it and in a way not have that on my conscience.”  
(Idil, age 25, five month old infant)

The multiparous mothers that experienced problems with breastfeeding, seemed determined to stop breastfeeding and introduce formula milk early on. These were often mothers that had encountered previous problems with breastfeeding their other children. A few mothers mentioned that their breastfeeding duration had been very different for their children. One of the reasons for why a mother would stop breastfeeding early on, would be when they got pregnant again.
5.2.5 Perceptions of exclusive breastfeeding

The perception of exclusive breastfeeding varied among the mother. Some said that they breastfed exclusively, but it became evident through their responses, that the infant had been introduced to small portions of porridge, fruits, vegetables, formula milk or water.

“I exclusively breastfeed him (my child), but sometimes when we are out and I'm on the bus, or I do not have the opportunity to breastfeed him, because of my clothes, so I would usually give him a little bit of formula.” (Hani, age 35, five month old infant)

“Yes I give her (my child) some porridge, but I still exclusively breastfeed since she does not eat that much porridge.” (Yurub, age 29, five months old infant)

“No, like I said earlier, I still exclusively breastfeed, but I give her, I have started to give her small like two to three teaspoons of porridge, like a little bit, just to familiarize her to a different taste. It has been good, since she is very fond of food.” (Taliso, age 23, five month old infant)

The findings suggest that mothers have not been fully informed about exclusive breastfeeding. Some mothers perceived exclusive breastfeeding as giving breast milk to every meal. They believed that small amounts of formula milk or taste portions of solid foods could be given, since this did not comprise an entire meal. A few of the mothers said that they had been advised by their health clinic to begin with small taste portions at four months. This might have potentially misled mothers to believe that even when giving small taste portions of various foods, that they were exclusively breastfeeding.

5.3 Predominant breastfeeding and the introduction of complementary foods

The start of predominant breastfeeding varied, with responses ranging from “since birth” to five months. The majority of the mothers began to practise predominant breastfeeding, with addition of formula milk or water, when the infant was three months old (Table 2). Some of the mothers felt the need to give formula milk as their infant kept crying or seemed unsatisfied after being breastfed. One of these mothers was also concerned about her infant’s insufficient weight gain. A few of the mothers introduced water to their infant at three months or earlier, because they thought the infant needed other liquids in addition to the breast milk. One mother recalled the time when she first introduced water when the infant was three months old. She was of the opinion that breastfeeding does not quench the thirst.
“I thought that maybe he (my child) got thirsty by just giving breast milk.” (Ayanna, age 25, eight month old infant)

A few of the mothers only gave formula milk during times where it was considered to be more practical, such as when they were in public or when someone else was taking care of the infant. The majority of the mothers with the exception of three feed their infant formula milk at the time of the interview. These three mothers said that they had not given formula milk, since they felt that breast milk was the best nutrition for the infant. They also emphasized that they had enough milk to feed the infant. These mothers had infants between five to eight months. Two of them have only given water beside breast milk. The remaining mother had recently introduced small taste portions of porridge; which was an advice from the health clinic. A few mothers said that they had been advised by the health clinic to introduce solid food when the infant was four months old.

“Yes she (my child) only drank formula when she was four months old, and when I felt that she needed something else so I would introduce food or porridge at least, and when I asked the health clinic, they said that I could begin introducing it at four months and recommended that in a way.” (Muriyo, age 25, seven month old infant)

Solid foods, in the form of small taste portions of porridge and/or mashed vegetables and fruits, were usually introduced when the infant was four months old. A few mothers felt that the infant was ready to consume solid foods, and to accustomize the infant to other food flavours.

“I also feel that that my child has been ready for it (to start eating solid foods), when he (my son) can sit properly and it seems like he is somehow scratching his gums and want something.” (Hani, age 35, five month old infant)

“She (my child) is very curious and loves to try different flavours so I tend to give her some different types (of vegetables... thoroughly mashed of course, and just let her try it and she loves it so I think that it is going to be just fine when she starts to get food fulltime.” (Taliso, age 23, five month old infant)

“I think it is good to exclusively breastfeed but I also believe that one should perhaps introduce some different things food samples a little earlier so that, like with my son I began to introduce to him a little bit when he was 4 months, but just a little taste. And it took a long time before he liked the food.” (Sharifa, age 21, six month old infant)
One mother did not consider breast milk as sufficient ‘food’ when the infant grew older (from four months and beyond).

“And now when she (my child) reached five months... She (my child) began; actually she just hung on my breast all the time. And then I began introducing (other foods) and now she gets it (porridge) around both morning and evening. In addition to the teeth... Yes, one can get caries. So when the child has reached this age (five months) I do not consider it (breast milk) as food it is just cuddling.”

(Timiro, age 35, five month old infant)

As illustrated in the quotes above, there were various reasons why mothers decided to introduce solid foods, a few wanted to accustomize the infant to other foods, while a few had been informed that they can introduce solid foods from the health clinic. One mother was also worried that breast milk was enough to satisfy the infant.

5.4 Attitudes to commercially prepared infant foods

The majority of the mothers stated that they did not feed their infant commercially prepared infant foods, as they questioned the content and freshness of the products. They intended to prepare homemade infant foods and give to the infant, since they believed it was better than the commercially prepared infant foods. Some of these mothers’ responses are illustrated as follows:

“No ... no, I don’t like it, no I don’t know how long it has been there. If my child was to eat something, then I think it should be made right there and then, fresh (freshly prepared.).”

(Idil, age 25, five month old infant)

“I only buy the porridge (from the store), but I make the dinner dishes, yogurts and fruit purées myself. I have no interest in buying (commercially prepared infant foods) because I do not think it neither smells nor tastes good and I think why should I bother giving my children this?. So I usually prepare the food for my children, like every third day with slightly different ingredients, which I store in the fridge. When they finish it after three days then I would make another batch.”

(Caaliyah, age 28, six month old infant)

“There is certainly a big difference between the food that you make at home and food that has been commercially prepared, that has been sitting there (on the shelf in the stores) for a while and that has been added a large amount of preservatives and stuff. Homemade food is in a way you notice is fresh and good somehow. So yes there are many (Somali mothers) who makes it themselves.”

(Muriyo, age 25, seven month old infant)
A few of the mothers gave commercially prepared infant foods, one mother dismissed her own belief that home prepared infant foods were better than commercially prepared infant foods. These mothers felt that their infant preferred the infant foods purchased from the store.

“I prepared the food, potato and stuff to him, but he did not like it, so we usually buy the food that he likes.” (Leylo, age 33, eight month old infant)

“I think it is something that they put in those glasses that make them taste better I do not know because he... Yes, I give him ‘Hipp’ and ‘Småfolk’, he only like the food from those glasses. I have tried to prepare vegetables but he did not want it. Actually, I prefer to prepare it myself, because I do not completely trust what is in there glasses. At first, I began introducing the food from the glasses because it was so much easier instead of making a lot of food and he would only eat a teaspoon of it. So I just tried to give him the food from those glasses at the beginning, later when I made home cooked food but he did not want to eat it.” (Sharifa, age 21, mother of six month old infant)

As illustrated above, the infant’s preference to commercially prepared infant foods influenced a few mothers to give this instead of preparing the food themselves. This was despite the fact that one of these mothers perceived the home prepared foods to be better for the infant.

5.5 Infant feeding practices in Somalia

A few of the mothers mentioned that it was common to introduce cow’s milk and sugar water at an early age in Somalia. Some said that infants were usually given sugar water from birth or within the first few months of the infant’s life. One mother mentioned that this practise came from the common belief in Somalia, that the infant needed energy from the glucose. It was also common to add sugar to the cow’s milk. Cow’s milk was often introduced early on, depending on the mother’s breast milk production.

Another mother said that she had given sugar water to her two eldest children, but chose not to introduce this to her two youngest who were born in Norway. The reason why she had not given sugar water to the two last born, was because she generally tried to avoid feeding her children with foods rich in sugar. She thought that sugar had a different effect on children’s health.

“In Somalia, it is not that dangerous how much sugar they (the children) consume, it is usually not a big deal because of the climate, while here it seems crucial to your health, how much sugar you consume and the amount of sweets that you eat. So, that is why I think that it is very important to adapt to the country you live in and see what is good and bad for their health”…“It is hot in Somali, so you sweat it (the sugar) all out right away.” (Muriyo, age 25, seven month old infant)
As articulated in the quote above, this mother stated, that she now pays more attention to her children’s sugar consumption. Due to the cold climate in Norway, she felt it was important to watch the children’s sugar consumption, since it might be harmful to their health.

A few mothers mentioned that infant foods introduced in Norway, were a little different compared to the foods introduced in Somalia. These mothers mentioned that more options and variety exist in Norway; where infant foods are labelled and made for specific age groups. Some also felt that the food in Somalia was fresher, compared to the large availability of processed food here in Norway.

“In my home country (Somalia) when the infants are around six months of age, they usually get to taste the typical foods that the family or household are eating. So they are introduced to a rich start (of a variety of foods).” (Ikraan, age 23, six month old infant)

“In Somalia, I have introduced food (around four to five months) and it is common (to introduce food around that age) there as well, but there is not like this... It is not so much specified like here, with specifications related to months and stuff. I followed it and thought that it is good nutrition in a way, that they get full from the food I give and have been much more aware of it or followed it more, compared to what I gave to the others (children) where it was more like the child was close to the breast all the time.” (Kaafiyo, age 33, five month old infant)

A few of the mothers said that in Somalia, the infant usually eats the food that the family is having, such as various pasta dishes, different stews and chicken. Some mothers further mentioned the time of introduction of these solid foods varied depending on each mother’s breast milk production.

5.6 Information regarding infant feeding

It became clear from the interviews that mothers combined the advice/information from different sources, such as books, the internet, the health clinic, doctors, friends and family with their intuition and knowledge. One mother said:

“…You get so much (information/comments from relatives), and it's not necessary that you should take everything that you hear, you have to pick what (advices) you think is best somehow. But I think in that the public health nurse is trained here, and know how it is with children, so I would rather put what (the advice) she says first. I also have to see everything (information/advice) that is said about it (infant feeding) and if it fits what she (the nurse) said. If it does not then I would just put that (the advices) aside.” (Caaliyah, age 28, six month old infant)

All of the multiparous mothers combined their previous infant feeding experiences together with advice they received from the health clinic and the Somali network into their current feeding practice. These mothers seemed confident with their own infant feeding practices. This was probably due to the experience that they acquired with their previous children.
“I am an experienced mother in a way, so I trust myself very much. But when it comes to the health clinic I usually take the advices that suits me the most...There is something that is suitable for them but I kind of have my background and culture and follow a lot of that too. And when it comes to family I tend to ask things from those who have had children here for a long time... I take it (this information) and use my common sense when I choose things.” (Kaafiyo, age 33, multiparous, five month old infant)

The primiparous mothers on the other hand, seemed to value the information and advice received from the health clinic more compared to the multiparous mothers. Most of the mothers who did not speak Norwegian fluently (n=6), valued advices from health care providers the most, in addition to advices from their own mothers, none of these mothers used the internet as an information source. These mothers trusted the advice from doctors and other health care providers, because they believed that the doctors/nurses were the ones with knowledge on infant nutrition.

“I listen to the doctor the most, because they have a lot of knowledge about this field here, especially in this country... I usually listen to advice from doctors.” (Muriyo, age 25, seven month old infant)

One of these mothers also mentioned the advice and support she received from her public health nurse when she experienced difficulties with breastfeeding.

“She (my nurse) is a wonderful lady, who even helped me when I had an (breasts) infection...She gave me a balm (to ease the pain), she was the one who helped me... I am very pleased with her...” (Hani, age 35, five month old infant)

The mothers, who had brought up children both in Somalia and Norway, felt that they had received much more information and support from their family and acquaintances in Somalia. In Norway, the advice and information given were merely from the health care providers. The majority of the mothers that arrived in Norway as children, preferred to find information about infant nutrition themselves, either in books or searching the internet or through friends, and occasionally advices from the health clinic and doctors.

“I read and I go on Google” (Sharifa, age 21, six months old infant)

“...I kind of follow my own advice (my intuition), my own thing..., because she (my mother) knows that we read so much. Our parents at that time embraced it all, what I shall call it– old wives tales. But here, we can mostly find out what is we should give to children and what they should eat and what they should, in a way what you should give her and him of that...” (Idil, age 25, five month old infant)

“Yes there is a difference because my mom has not brought up children in Norway... She lived in Somalia not here. She does not know what good nutrition is.” (Turiba, age 24, five month old infant)

As illustrated above, a few mothers preferred to find information on their own since they viewed advices from their parents as ‘outdated’, or that they were not suited to the situation in Norway. These mothers felt that advices on infant feeding from their parents were not
relevant, since these advices were only based on their parent’s own assumptions rather than scientific proof.

5.6.1 Mothers perception of feeding advice and service from the health clinics

Infant feeding advice

According to the Somali mothers narratives, the amount of information provided at the health clinic varied. The majority were pleased with the overall service provided by the public health nurses. But topics such as infant nutrition seem less prioritized at the health clinic according to the mothers. Judging from the mothers’ responses, the emphasis on breastfeeding seemed to differ between the health clinics. A few of the multiparous mothers thought the information and advice they had received was limited, compared to the information they received from the health clinic with their first born. Some mentioned that they have received brochures and a booklet from the health clinic. A few said that they did not receive any advice on breastfeeding from the health clinic or from the hospital. Some mothers expressed the wish of more personal advices on the types of nutritious foods they could introduce to their infant.

One mother said:

“So if there was something useful (advice) I would take it with me, but the question “Is there anything?” (useful information) I currently I have not seen anything (any useful information). I thought when it comes to porridge and stuff, it would be better if they had informed me about the different porridges and what they contain.” (Idil, age 25, five month old infant)

Some of the mothers also stated that they had not received any specific recommendations regarding the benefits of breastfeeding, exclusive breastfeeding. Two of mothers that had stopped breastfeeding, mentioned that they had only received the advice of drinking more fluids when they were have problems with breastfeeding. Half of the mothers in the study said that they had not received information on the timely introduction of complementary foods from the health clinic. A few felt they had to seek advice from the health clinic on their own initiative. The rest felt that they did not need information or advice from the health clinic, since they perceived themselves as experienced mothers.

“I know this kind of information (infant nutrition), it is fine.” (Nadifa, age 24, five months old infant)

“It is primarily the health clinic, but since my oldest child is nine years old and I have experience from previous pregnancies, so I feel I have most things under control, and they (the health clinic) also
tend to say ‘you do not need much assistance, you already have lots of experience with the other children’”. (Hani, age 35, five month old infant)

Based on the mothers’ responses, the advices regarding the appropriate introduction to complementary foods seem to vary, ranging from four to six months.

“They have not said anything specific with my youngest. With the other children they said from four months of age (complementary food)”...“I have been told to not give water or any supplements since breast milk is both thirst-quenching and in a way replaces the water and other types of milk that’s what I’ve been told.”” (Hani, age 35, five month old infant)

A few of the mothers were encouraged to breastfeed exclusively for the first six months, before the introduction of complementary foods. However, only a few had received information on the timely introduction of water and other complementary foods. The advices for timely introduction of water seem to differ between health clinics, from two to six months.

“I asked (the health clinic) when I can start giving water, and they said you can start giving water when the child is two or two and a half months.” (Ayanna, age 25, eight month old infant)

The majority of the mothers gave formula milk from early on (from three months or earlier). Most mothers of these mothers felt that the public health nurse had a passive approach to this topic, where the public health nurse did not pay attention to the reason why they had introduced formula milk. However, a few mothers had received comments on this practice from their health clinics. These mothers said that the public health nurse were against this, and advised the mother to continue breastfeeding. The way the public health nurses acted on this issue could make mothers feel insulted.

“At first, they (the health clinic) asked me if I was still breastfeeding. I said no, so one of them (the public health nurse) said ‘OK why you are not breastfeeding?’ she said ‘Why?’ (she questioned me). I said because I did not have enough milk. I felt a little insulted ... She did not believe me and said ‘You think that your breast will not get saggy (because you do not breastfeed)’...” (Leylo, age 33, eight month old infant)

Service at the health clinic

As earlier mentioned, the majority of the mother was pleased with the overall service provided at the health clinic. However, some of the mothers felt the atmosphere at the health clinic was stressful, and that the public health nurses did not give enough attention to the mothers’ needs. The focus was, according to some mothers, merely on measuring the height, weight and following the growth development of the infant.
“I just go there for the weighting...It is very important to write down, that I have weighed yes... It is somehow more important than seeing me (and asking me about how I am doing) ...”
(Timiro, age 25, five month old infant)

“...Honestly, it is a little stressful since there are so many mothers there. I do not know, but I think they have many appointments with so many clients...Mothers are there for a very short time. It is really like, you go to the front desk to notify them that you have arrived, you weigh the baby, (measure the) height and then the midwife comes in (to talk to you), it is a very short process”
(Taliso, age 23, five month old infant)

A few of the mothers described contrasting experiences of the service at the health clinics.

“I feel that I have gotten a very good welcome at the health clinic.”
(Muriyo, age 25, seven month old infant)

One of the multiparous mothers felt that the service had deteriorated over the years, where she was not given the same attention and care as she did with her other children.

“No it was a completely different world back then” (Timiro, age 35, multiparous, 5 months old infant)

One mother felt that she was treated differently compared to other ethnic Norwegian mothers who were coming to the health clinic.

“... When you come in with a child I feel, I probably should not have felt this. I feel that when Norwegian mothers come with their toddlers they (the public health nurses) are like ‘Oh they are so cute oh’...When I get there with my son, ”Yet another child she drags with her”. There is a living room, they sit down with them (Norwegian mothers), and talk a bit and play a bit with the child and are really nice and maybe after five or ten minutes ‘OK, shall we go in and start weighing and stuff’. But when I arrive, it is straight away, ‘Hey, let’s weigh!’ and then it is straight into the room. It only takes five to ten minutes” (Idil, age 25, five month old infant)

Most mothers said that they were generally satisfied with their health clinic, even though some also pointed out that the atmosphere to be stressful and that they did not get enough information on infant feeding. Insulting episodes and differences in treatment, compared to Norwegian mothers, were also reported.

5.6.2 Mothers’ perceptions of conflicting advices between the health clinic and their Somali network

The majority of the mothers reported that advices would sometimes differ between health care providers, and their family and relatives. The mothers perceived especially conflicting advices regarding the time for introduction of water and the introduction of formula milk. This made some of the mothers confused and insecure about how to feed their infant. A few were advised by their Somali network to begin with water when the infant was around three months
old or earlier on, while they had been told by the health clinic, that water is not necessary if the infant is breastfed.

“... She (my mother) said that I should start giving him water when he was three months old and the health clinic told me not to do it...” (Sharifa, age 21, six month old infant)

“I did not give (my child) water, and I got criticized by Somalis, my family and relatives (for that) who said ‘He is a human being, he gets thirsty (as well he needs water)’ and that (breast)milk is not quenching... And the health clinic said ‘No he (my child) does not need water’.” (Hibo, age 25, 7month old infant)

A few of the mothers were also encouraged to give sugar water, which is a common practice in Somalia according to some mothers. A few were encouraged to give sweetened beverages, such as soda and juice. But they did not follow these advices, as they felt the advices did not apply here in Norway.

It seems like the advice to give formula milk is commonly given to Somali mothers. Around half of the mothers reported that they were encouraged from their family members or relatives to introduce formula milk early (at three months or earlier on). These mothers meant that this advice was conflicting with the advice they received from the health clinic. This also differed with their intention to breastfeed their infant without the need of formula feeding. Some of these mothers felt this was a form of obligation due to their Somali network’s persistent request.

“I have received advice from several relatives who has said that I should give formula milk as early as possible, even when I was still in the hospital. For the first few months, people were like ‘No you should give it (formula milk) to him. Just disregard what the doctor is saying and ‘sneak’ it (formula) in’...” (Ikraan, age 23, six month old infant)

“My mom yeah, yeah, yeah, when it came to breastfeeding, she was really like I should breastfeed, BUT I should also give some formula as well. So that is where we collided a bit ... I was totally against formula. I was like ‘But why should I give formula when I have so much milk?’... Many mothers give formula because they might get the pressure from their network or maybe aunts. Recently, a couple of weeks ago I met ... a friend of my sister... that hides (from her parents ,that she only breastfeeds) and tell her parents that she gives formula but she does not really do it. She (usually) gives only breast milk, but she has to give formula when she is with her mother... But then she said to me ‘I am breastfeeding and I want to breastfeed exclusively BUT I am told that I must give formula’.” (Taliso, age 23, multiparous, five month old infant)

One mother stopped breastfeeding when her infant was around four and a half months old. This mother decided to give formula milk instead of breast milk. She had been encouraged by her family to give formula milk early on. Another mother followed her own mother’s advice
in giving formula milk at night. She felt it was important for her infant to get the right ‘amount’ of formula milk; this was to make sure that her infant received enough food before bedtime.

“She sleeps a lot at night, so I would like her to have the ‘dosage’ she should have.”

(Caa liyah, age 29, six month old infant)

When asked about the reason for the encouragement of formula feeding, a few of the mothers expressed that Somalis usually prefer chubby infants.

“... I think I'm very influenced by my culture, and I received a clear message from everyone around me that breast milk was not enough. This is a belief all Somalis have, that breast milk is not enough. They do not think children can get satiated from it, they do not believe that breast milk... that children can grow from it... I was really bullied because of my breast size. Yes they are so small that everyone went like this: ‘Oh my god there ain’t no milk there’ and I just thought and I remember just thinking 'how rude!'” (Hibo, age 25, seven month old infant)

According some of the mothers, Somalis usually praise the mother for doing a good job if they see that the infant is round and chubby. However, family members and acquaintances also seemed to be quick in voicing their opinions when they saw an infant that do not fit the ‘ideal’ standard that they had set out. The best way to achieve this was through feeding the infant with formula milk.

“...Yes, I know that they (Somalis) think that breast milk does not contain enough ... the composition of fat and all that stuff is not enough. That is why the children should get formula, to put on weight.” (Timoro, age 35, five month old infant)

One mother also discussed the potential reason for the encouragement of formula feeding. She suggested that it was easier for mothers know the exact amount of milk that had been given.

"... You see the bottle and you see that there are 200 milliliters and you see...when it is empty, that is when you (mothers) are satisfied. But when you are breastfeeding you do not really know how much your child have had. You do not really have numbers to rely on...”

(Taliso, age 23, multiparous, five month old infant)

However, some mothers were able to overcome the pressure from their Somali network, and follow their own knowledge and beliefs. This group consisted of multiparous mothers. Most of the multiparous mothers expressed regrets in introducing formula milk to their previous children. They were thereby determined not to follow the advice for formula feeding with their youngest infant. These mothers expressed that they have learned from their former experiences, and became more confident in their infant feeding practice.
“I had enough milk at that time also, I did not need to give formula, but because my mom said ‘You just give a small amount, give it to him’ and I thought ‘Yeah yeah you know what is best, so I will do it’. But with this child I was determined that no, she does not have a need for it (formula milk) at all”. (Talisol, age 23, multiparous, five month old infant)

“This thing with the bottle, there were two different worlds I remember. In Norway the only truth was the breast is it not? Among the Somalis the baby should be chubby, so it made me very confused back then. So that’s why I chose to read and find the information on my own. This helped me eliminate all that nonsense”. (Timiro, age 35, multiparous, five month old infant)

Only one of the multiparous mothers had persistently stood by her own decision of not giving formula milk to any of her children. One of the primiparous mothers also resisted this type of encouragement, since she received advice from her mother who was living in Somalia, to continue breastfeeding and not give formula milk. A few mothers stated that they have not felt obligated to give formula milk by their Somali network. One mother said:

“My child is like ‘Mashallah’ who easily puts on weight, but if people see that they (the infant) is a bit thin, they are like ‘Well what are you doing?(it is not right)’, ‘You have to give more milk (formula milk)...’” (Yurub, age 29, five month old infant)

This mother suggested that she might have gotten advice to formula feed if her infant was ‘smaller’ in size. According to the mother, it was easier to avoid getting the encouragement for formula feeding from Somalis, if the infant already looked round and chubby.
6 METHODOLOGY DISCUSSION

6.1 Data collection

Pilot interview
Conducting pilot interviews prior to the data collection might enhance the quality of the interview guide and the interview situation. One of the project leaders conducted one pilot interview where the master student was present. This gave the master student the opportunity to learn from the observation. No major changes were done with the interview guide. It might have been beneficial to conduct more pilot interviews, to make sure that the interview guide captured all of the study objectives. However, due to problems with recruitment, only one pilot interview was carried out before the data collection.

Pre-knowledge
Malterud (2003) describes pre-knowledge as follows; the experiences, hypothesis, research perspective, or the projects theoretical framework that researchers bring with them before the start of a project. The researcher’s pre-knowledge can affect the data collection and interpretation of the data material; this can both strengthen and weaken the study findings (Malterud, 2003). It is thereby important to be aware of one's own pre-knowledge.

Being a student in Public Nutrition may restrict the master student’s way of interpreting the data material due to the potential pre-knowledge or narrow views to this topic. The master student did not make any hypothesis before the data collection. There is little prior research on this topic; hence it felt more natural to approach the data collection without neither a theoretical framework nor some hypothesis. The master student does not have any children of her own or any relation to the Somali community prior to the study. This can potentially have both negative and positive impact on the data collection. For instance, the master student might not follow up on certain topics as thoroughly as an interviewer, who has experience with breastfeeding and childbirth. One the other hand, having little pre-knowledge regarding the topic of the study might be positive for the data collection, since it can contribute to a more open approach when conducting the interviews with the mothers.
The use of in-depth interviews

The in-depth interview is described as “an active knowledge-bearing process where the interviewer and informant create the knowledge together” (Kvale & Brinkmann, 2012, p.37). The openness and calmness around an interview situation can create a good basis to explore the informants’ experiences and opinions of the topic (Malterud, 2003). In the present study we made a point of creating an open and friendly atmosphere. The mothers were usually not interrupted if they began to talk about topics in the later part of the interview guide or topics that were not directly related to the study objectives; this was to create a natural flow in the conversation. The interviewer also tried to guide the conversation back to the topics of the interview guide in a natural manner. Malterud (2003) states that it is important not to follow the interview guide too strictly, especially if the aim is to explore a topic with little prior research.

The quality of the interviews might have varied as the master student became more acquainted in conducting the interviews, and was less dependent on the interview guide during the progress of the data collection. The master student also became more aware of asking follow up questions to topics that were relevant to the study objectives after having gained more experience with interviewing.

Challenges with the use of interpreters

Six of the in-depth interviews were conducted with the help of a Somali interpreter. According to Wallin & Allström (2006), discussions of the challenges with the use of interpreter in cross-cultural studies, have been scarcely documented.

The role of the interpreter was addressed prior to the interviews. The written manual that the interpreter was asked to read, explained the interpreter’s role in the study and how a good interpreter should behave during an interview situation (appendix 5). The interpreter was asked to translate the conversations as precisely as possible. The interpreter also had former experience in interpreting. She translated the conversation consecutively, where only one person spoke at a time, as opposed to a simultaneous style, where the interpreter translates and speaks at the same time as the participant or interviewer (Wallin & Allström, 2006).

Baker et.al (1991) writes that a consecutive interpreting style is less distracting for the
respondent, whereas a simultaneous style can expose the interpreter to more stress and fatigue, which can increase the chance of error.

Using an interpreter may involve certain challenges (Wallin & Allstrøm, 2006). The interpreter may for instance, interpret the mothers responses based on their own preconceived understanding of the topic. This may result in the potential loss of important information. A way to avoid this, is to have another Somali interpreter compare the recordings with the transcripts, this is to make sure that the translations are correct. But that was not possible due to the limited resources and time frame of this study.

Differences in culture, region, ethnicity, gender and age may also influence the way the mother relates to the interviewer and interpreter. Baker et al. (1991) recommends using an interpreter with a similar characteristic in terms of gender, age, and ethnicity as the study sample. The interpreter employed in the InnBaKost- project; who assisted in some of the interviews, was a young Somali woman, who was a mother herself. Given that the interpreter shared a similar cultural background, and was similar age as the participants, might have enhanced the quality of the interviews. The mothers may have perceived the interpreter as more reliable compared to an interpreter with a different cultural background than themselves.

It has been argued that the interpreter’s presence should not be prominent during the interviews (Wallin & Ahlstrøm, 2006). Techniques such as how two parties sit in relation to each other could be used to minimize the impact of the interpreter’s presence (Wallin & Ahlstrøm, 2006). In the present study, the interpreter was usually placed in between the interviewer and mother, making sure that interviewer and the mother were still facing each other and were able to maintain eye contact.

Lastly, misinterpretations might have been a potential limitation. The master student could not be able to detect the misunderstandings that might have occurred between the interpreter and mother. Misinterpretations from the interpreter were also at times corrected by the mother themselves. The master student experienced that interpreter at times, could not interpret everything that the mother was saying. This happened during situations where the mother was talking for a long time; instead, the interpreter gave a summary of what the mother said rather
than interpreting the responses verbatim. The interpreter was later asked to take notes when
the mother was talking, to avoid the loss of relevant information.

**The use of audio recorder**

The use of audio recorder in the in-depth interviews enabled the interviewer to fully
concentrate on the conversation with the mothers. It also enabled re-listening of the interviews
after the data collection. Audio recorders are suitable when the data material is based on
conversations, but it only captures what is being said, in addition to pauses, hesitations or
laughter during the conversation (Kvale & Brinkmann, 2012). Nonverbal communication (e.g.
body language, facial expressions) cannot be audio recorded (Malterud, 2003). The use of an
audio recorder, made some mothers reluctant to participate before the interview. These
mothers may have expressed themselves less freely, as they knew that the conversation was
being recorded. The master student or interpreter had to carefully explain the anonymity and
confidentiality surrounding the in-depth interviews. None of the mothers refused that the
interview was to be recorded.

**Study sample**

Fifteen Somali mothers aged between 21 to 35 years were included in this thesis. It is
uncertain if a higher number of participants could have enhanced the findings. No new
information was uncovered with the last in-depth interviews, indicating a saturation of
information and participants. The mothers had different educational levels, occupation and
residence time in Norway; this might strengthen the study since it represents a variety in the
sample.

The recruitment of participants turned out to be a major challenge in this study, especially
with the original recruitment method (through health clinics). The fact that we were able to
recruit only a few (n=3) through the health clinics indicates that these were not the most
effective recruitment places. Mothers seemed more willing to participate when the master
student met them in person along with the interpreter.

In order to facilitate the participants participation, they could choose the date and place of the
interviews. Some mothers (n =5) decided to not show up for the interviews, and the
recruitment had to be continued.
6.2 Data analysis

Transcribing
All of the in-depth interviews were transcribed verbatim by the master student. Transcribing, coding and analyzing the interview transcripts, allowed the master student to gain extensive information from the data material, such as details and aspects that were not detected during the interviews.

Coding
The use of the programme OpenCode (Dahlgren et al., 2007) helped to systemize the data material. The creation of categories in the selective coding stage, made it easier to identify codes and other segments that were relevant to each category.

The master student’s pre-knowledge must be taken into account when discussing the process of open coding, selective coding and theoretical coding of the data material. As these three steps might be a subject to potential bias. Firstly, all the generated codes at the stage of open coding, were based on the master student’s own understanding and perception of the mothers’ responses/narratives. Secondly, the generated categories and codes that were later selected during the stage of selective coding; were based on the master student’s own opinion of codes/categories that seemed important and relevant. Lastly, the relationships between different segments during the stage of theoretical coding, was based on the important categories and codes that the master student felt was related to each other.

The master student’s limited experience with breastfeeding, childbirth and child rearing, might have made it difficult to identify potential connections between certain categories and codes. For example, other potential breastfeeding challenges that might exist, beside what the mother is saying. Findings were later discussed with senior researchers in the InnBaKost-project. This might have further enhanced the quality of the findings.
According to Dahlgren et al. (2007), the trustworthiness of qualitative studies can be assessed by considering the *dependability, confirmability, credibility* and *transferability*.

**Dependability**

The *dependability* emphasizes the need for the researcher to be aware of the changes that occur in the research process, and how these changes affected the research findings (Dahlgren et al., 2007).

As previously mentioned, one of the project leaders conducted the first few interviews while the master student conducted the remaining ones. All the mothers were aware of that the master student was a student in nutrition. It is important to address that this could have influenced some of the mothers’ responses, especially when it came to the types of foods and liquids that they said they had given to the infants. Some of the mothers might have felt that it was more important to respond ‘correctly’ to these questions, instead of what they truly practised/or believed.

The few mothers (n=3) who were recruited from the health clinics, might have been more hesitant in talking about their bad experiences with the health clinics, compared to mothers (n=12) who were recruited elsewhere. It is possible that these three mothers might have thought that their responses could be reported back to their health clinics. However, it was important to inform the mothers that the interviewer had no affiliation with the health clinic, and to also reassure that the participants’ anonymity will be respected. This could have made the mothers feel more at ease when talking about their negative or positive experience with the health clinic.

**Confirmability**

*Confirmability* refers to the degree to which the results could be confirmed by others (Dahlgren et al. 2007).

The master student re-read the interview transcripts several times to check or re-check if the findings correspond to the mothers’ narratives. The master student also searched for contradicting responses/ practices among the mother’s common infant feeding practices and their perceptions of infant feeding advice from the health clinics. This might strengthen the confimability of the findings.
**Credibility**

*Credibility* in qualitative research can be seen as the extent to which our findings truly reflect the perspectives of the participants in the study (Dahlgren et al. 2007).

In the present study, the question is whether the findings truly represent the mothers own experiences, knowledge or beliefs regarding the topic of infant feeding practices and their experiences with infant feeding advice from health care providers. The study’s credibility can be weakened through misunderstandings and misinterpretations between the interviewer and the mother during the interview (Kvale & Brinkmann, 2012).

The interviewer asked follow up questions (e.g. "Have I understood you right, when you say that ...?") for confirmation and correction of the responses. This was to make sure that there was a mutual understanding between the interviewer and mother on the information that was created.

Having mothers read through the interview transcripts can potentially enhance the study findings (Malterud, 2003). This might correct potential errors in the translation and transcription, but the time frame of this study did not permit this. Field notes on the impression and narratives of the interviews, as well as discussions with the interpreter after each the interview, helped verify some of the responses that seemed vague.

**Transferability**

How applicable the findings are to other study samples and settings, is referred to as *transferability* (Dahlgren et al. 2007). Qualitative research deals with few cases to study a phenomenon in-depth, meaning that samples are small and demographically non-representative. Qualitative researchers never try to obtain statistical generalization (Kvale & Brinkmann, 2012), rather than to contribute to knowledge and understanding of the phenomenon of interest. Demographic resemblance between the study sample and the general population is thereby not important (Dahlgren et al. 2007), instead, qualitative researchers aim to achieve analytical generalizations. Thus, each participant is selected to contribute to the descriptions that are being developed.

Mothers who fulfilled the inclusion criteria and voluntarily wanted to participate, was included in this study. It is unclear if these mothers had a special interest in the topic of infant
feeding. This must be taken into account when assessing the transferability of Somali mothers' infant feeding practices.

This study aimed at describing the context of the mothers’ narratives as clearly as possible. But due to the small study sample size, the findings can only describe the infant practice among Somali mothers living in the Akershus and Oslo municipality. It cannot provide a general description of the infant practices among Somali mothers living in Norway or in other countries and settings. However, similarities with earlier studies about Somali infant feeding practices other Somali immigrant mothers, might strengthen the transferability.

7 FINDINGS DISCUSSION

7.1 Breastfeeding duration
The majority of the mothers were still breastfeeding at the time of the interview, while four mothers had stopped breastfeeding. This suggests that breastfeeding is a common practice among Somali mothers. Findings from the present study showed that none of the Somali mothers practised exclusive breastfeeding for six months which is recommended in Norway. A review by Pak-Gorstein et al. (2009) implied that exclusive breastfeeding was not a common practice in Somalia, due to the common infant feeding practice of introducing prelacteal fluids (sugar water, goat milk, other livestock milk, and powdered milk). The Spedkost-survey in Norway reported that only nine per cent of the Norwegian mothers, exclusively breastfeed for the first six months (Øverby et al., 2008). This suggests that few Somali and Norwegian mothers exclusively breastfeed their infants for the first six months.

Four of mothers in this the present study had stopped breastfeeding at the time of the interview. Two of these mothers stopped breastfeeding at three months, while the remaining two stopped when their infant was four to five months old. Askestad and Øien (2012) conducted a qualitative study, where they explored the attitudes and experiences of breastfeeding among Norwegian mothers (n=14), with young infants (two to six months). That study reported that three of the Norwegian mothers had stopped breastfeeding, due to breastfeeding difficulties; two mothers stopped breastfeeding at two months, and one at three months (Askestad & Øien, 2012). These findings seem suggest that both Norwegian and Somali mothers experience difficulties with breastfeeding. The number of mothers that had
stopped breastfeeding in that study is similar to the number of mothers who stopped breastfeeding, in the present study. But some of the mothers who had stopped breastfeeding in the present study, breastfed a little longer compared to the three mothers from the study by Askestad and Øien (2012).

A study in the United Kingdom showed that some of the South Asian immigrant mothers tend to adjust their infant feeding practices, including breastfeeding duration according to the infant practice in the host country (Choudhry & Wallace, 2012). It is difficult to make a comparison of breastfeeding in Somalia and among Somalis in Norway, because of the limited available evidence on infant feeding practice in Somalia. An old study by Ibrahim et al. (1992) showed that mothers in Somalia breastfed for an average of 19.5 months. The common breastfeeding duration among mothers in Somalia might have changed since then. However, some of the mothers in the present study mentioned that the practice of prolonged breastfeeding (around two years) was still common in Somalia.

Kelly et al. (2006) suggest that “integration” into a host country where the duration of breastfeeding is low, may negatively affect the breastfeeding duration in immigrant groups. However, since the breastfeeding duration in Norway is quite high compared to other European countries (Øverby et al., 2008), integration into a Norwegian breastfeeding pattern can be expected to be less negative compared to integration into a country with low breastfeeding duration. The majority of the mothers in the present study intended to breastfeed for one year. Only a few mothers in the present study, plan to practise prolonged breastfeeding for up to two years. These mothers were among the ones who came to Norway as young adults (in their 20s) and did not speak Norwegian fluently. None of the mothers who came to Norway as children and spoke Norwegian planned to breastfeed for two years. A study from United Kingdom (Hawkins, 2008) demonstrated that immigrants who spoke the English were more likely to adopt British cultural practices, including the common infant feeding practices compared to immigrant mothers who were not fluent in English. Mothers, who planned to practise prolonged breastfeeding for two years, were among the ones who were acquainted with the infant feeding practices in Somalia, where they mentioned the long duration of breastfeeding in their home country. These mothers were also encouraged by their own mothers (living in Somalia) to continue breastfeeding. This may have motivated them to continue breastfeeding. Kelly et al. (2008) have pointed out that the “traditional” immigrant mothers are more likely to breastfeed. The data in the present study also suggest that the
mothers, who were more acquainted to the infant feeding practice in Somalia, wanted to follow the breastfeeding practice of their home country. As previously mentioned, a few of the mothers seemed to hold on to the breastfeeding practices in Somalia. This suggest that these mothers still perceived some of the infant feeding practices in their home country (e.g. long breastfeeding duration) as relevant, even when they are living in Norway.

A study conducted in Seattle, showed that Somali immigrant mothers had a shorter duration of breastfeeding compared to their breastfeeding duration in Somalia (Steinman, et al., 2010). Lifestyle changes and issues with time were further listed as the main reasons for the change in the Somali immigrant mothers’ breastfeeding practice. These findings were also similar to the responses from multiparous mothers in the present study, who had both given birth both in Somalia and Norway. This seem to imply that the breastfeeding duration tend to change when the mothers move to another country.

7.2 Breastfeeding motivations

The mothers’ motivation to practise prolonged breastfeeding seemed to be influenced by a number of factors. Among the common motivations were that it felt natural to start breastfeeding, they believed that they could manage to breastfeed and their own beliefs and knowledge about the benefits with breastfeeding. A few mothers also mentioned religion and the breastfeeding practice in Somalia.

The findings from the present study were consistent with some of the findings from a qualitative study conducted in the United States (Steinman et al., 2010). The researchers of that study found a number of factors influenced the breastfeeding habits of Somali immigrant mothers. They further found the Islamic religion influenced the Somali mothers who had a long duration of breastfeeding, where the Quran encouraged breastfeeding for two years (Steinman, et al., 2010). Only two of the mothers in the present study mentioned that their religion (Islam) influenced their choice to practise prolonged breastfeed. Some of the mothers had also heard about the advice from the Quran, but they felt that it was not relevant for them.

Previous research showed that a mother’s intention to breastfeed, her self-efficacy with regards to breastfeeding and social support to breastfeeding are factors that positively
influence mothers to continue breastfeeding in the first six months (Meedya, Fahy & Kable, 2010). The mothers in the present study felt that breastfeeding was a natural thing to do, which is why most of them mentioned that they did not need any specific help from their partner. According to Meedya et al. (2010), the attitude of the woman’s partner to breastfeeding is crucial to both the woman’s attitude and her breastfeeding practice. In the present study, only a few were encouraged by their partner to breastfeed; this might have motivated these mothers to continue breastfeeding. Some of the mothers who were still breastfeeding did not have any problems with insufficient breast milk production. The confidence of having enough breast milk might help mothers gain positive attitudes to breastfeeding, which might encourage them to continue breastfeeding.

7.3 Breastfeeding barriers and the early introduction of complementary foods

A major finding in this study, which was commonly mentioned by the mothers, was the practice of supplementing breast milk with formula milk and other complementary foods. The majority of the mothers practised predominant breastfeeding from three months. The most common reason for giving something in addition to breast milk was insufficient breast milk production or that the infant refused to be breastfed. These findings are in line with the breastfeeding barriers that have been reported in other earlier studies in other ethnic groups (Aryeetey & Goh, 2013; Olang, Heidarzadeh, Strandvik & Yngve, 2012). A few mothers chose not to breastfeed or give expressed milk during situations where they felt it was impractical, such as in public, or when someone else was taken care of the infant when the mother went out on her own. The few mothers who had brought up children both in Somalia and Norway mentioned the issue of time constraint. One mother said that she breastfeed for a shorter duration here in Norway compared to Somalia. The changing lifestyles seem to make breastfeeding more challenging, which was also mentioned by Steinman et al. (2010).

Another study conducted among 1000 Norwegian mothers, identified the mothers experiences of breastfeeding problems (Tufte, 2005). Eighty eight per cent of the mothers, reported that they had experienced problems with breastfeeding (to different degrees). This seems to suggest that breastfeeding problems are quite common both among Somali and Norwegian mothers.
According to Earle (2002), a mother’s desire to involve the infant’s father in the parenting and feeding practice, seems to motivate the introduction of formula milk. Formula feeding was seen as a way to re-establish the mothers’ identities as independent individuals, and to share the infant feeding responsibility with their partner (Earle, 2002). This does not seem to be the case for the mothers in this study, although some did feel that breastfeeding was tiresome at times, since it meant less freedom for the mothers to go out on their own.

In the present study, a few of the mothers practised predominant breastfeeding even before the infant reached three months. Some stopped breastfeeding completely (at three to five months). Through analysis of the interview transcripts, it became clear that the lack of breastfeeding support, lack of advice on infant feeding and knowledge of ways to overcome the breastfeeding problems, influenced the mothers to introduce complementary foods early on, or to stop breastfeeding. This despite the fact that some of the mothers knew that breastfeeding was good for the infant.

The four mothers who had stopped breastfeeding felt it was difficult to breastfeed with insufficient milk, or during situations where the infant did not want to be breastfed. Scott et al. (1997) writes that the condition of breast milk insufficiency, is often self-perceived by the mothers themselves, where a mother often base her perception of limited breast milk production, on observations that her infant is crying more frequently, or not sleeping enough. In the present study, the judgement of breast milk insufficiency was based on subjective opinions given by the mothers themselves. None of the mothers who were having trouble with their breast milk production, mentioned to have had this confirmed by their health clinic or doctor. Other reasons why mothers stopped breastfeeding, beside their own self-perceived breast milk supply or that the child refused to be breastfed were not probed enough in the interviews. Insufficient breast milk production is a common reason why mothers would stop breastfeeding (Ludvigsson & Ludvigsson, 2005; Tufte, 2005). Some mothers might perceive insufficient breast milk as ‘justified’ reason to stop breastfeeding, especially if they have heard about other mothers, stating similar breastfeeding problems. If mothers believe that insufficient breast milk is common, can in turn justify and confirm a mother’s choice to stop breastfeeding. According to Mahon-Daly & Andrews (2002) insufficient breast milk has become more of a cultural belief rather than a fact.
Meeduya et al. (2010) suggested that a mother is more likely to continue breastfeeding, if she believes that she could be able to manage breastfeeding. This might suggest that a negative attitude and a lack of confidence in breastfeeding, can make it difficult for mothers to continue breastfeeding. Having the feeling of not being able to breastfeed, might influence these mothers to develop a negative attitude to breastfeeding. In the present study, the ones who had stopped breastfeeding (at three to five months) were all multiparous. Most of them had previous problems with breastfeeding. Other studies have shown that the duration of breastfeeding of the second child is often related to previous breastfeeding experience (Nagy, Orvos, Pal & Loveland, 2001), where a mother would adjust the breastfeeding duration to her previous breastfeeding practice. Having negative associations to breastfeeding might have influenced the mothers’ attitude to breastfeeding. If a mother already have a bad experience with breastfeeding, might be easier for them to ‘give up’ when they face breastfeeding problems. It is thereby important to follow up on the mothers who are experiencing problems, in order prevent them from giving up breastfeeding completely.

Skilled breastfeeding support has shown to enhance breastfeeding duration (McInnes & Chambers 2008). The lack of information and explanation of the benefits of/how to overcome practical problems with exclusive breastfeeding from the health clinic, may have influenced the early introduction of fluids or other complementary foods among the mothers, and thereby affected their duration of exclusive breastfeeding. A study from Ghana showed that mothers did not practise exclusive breastfeeding because they believed that the infants would get thirsty if they were only breastfed (Fjeld, et al., 2008). These findings are consistent the present study, where a few mothers had introduced water early on (within the first three months) because of the same reason stated by Fjeld et al.(2008). A study from Zambia showed that the practice of exclusive breastfeeding was uncommon among mothers. The barriers found to this practice were the mother’s perception of insufficient milk and a lack of knowledge regarding exclusive breastfeeding (Aryeetey & Goh, 2013).

Half of the mothers in the present study said that they had received limited information on the infant feeding from the health clinic, such as the timely introduction of complementary foods. The lack of information provided by the health clinic might have contributed to the mothers’ choice of introducing complementary foods at an inappropriate time. An increased focus on the interaction between health care providers and mothers will perhaps help address the
mothers’ potential misperceptions of *exclusive breastfeeding*. It might be important to inform the mothers about the benefits of exclusive breastfeeding. This will perhaps assure that mothers know what the term exclusive breastfeeding truly involves.

7.4 Infant feeding practice in Somalia
A few of the mothers mentioned certain infant feeding practices in Somalia, such as introducing sugar water and cow’s milk within the first few months of an infant’s life. None of the mothers followed these traditions in Norway. A few mothers held on to the tradition of prolonged breastfeeding for two years, while they chose to dismiss the tradition of giving cow’s milk and sugar water. The mothers, who had experienced childbirth both in Somalia and Norway, highlighted the importance of adapting to the new country that one is living in. This might suggest that mothers would let go of the Somali infant feeding practices, which they believed did not “fit” into the common infant feeding practice in Norway. The reason why these mothers chose not to follow certain infant feeding practices from Somalia (e.g. sugar water and cow’s milk), might be that they perceive these practices as not good for the infant, and that it was not common in Norway. One mother also mentioned that the cold weather in Norway made it inappropriate for her to give her infant liquids/foods high in sugar. Not following some of the infant feeding practices from Somalia, might be seen as the mothers way of adapting into the infant feeding practices in Norway. The mothers might view the practice of prolonged breastfeeding as positive and common in Norway, which might be the reason why some wanted to continue breastfeeding. Although some of these women planned to breastfeed for two years, which might be less common in Norway.

All mothers did not follow the infant feeding practices of giving sugar water and cow’s milk, while only a few, intended to follow the practice of prolonged breastfeeding for two years. This might be because over half of the mothers in this study sample, immigrated to Norway as children or teenagers. These mothers were often the ones who had little knowledge about the infant feeding practice in Somalia.

7.5 Introduction of solid foods
The majority of the mothers introduced the first sample of solid food when the infant was about four months old. The time of introduction of solid foods and the type of solid foods prepared among Somali mothers seemed to be similar with Norwegian mothers in the Spedkost-survey (Øverby et al., 2008).
The majority of the mothers chose to give home-prepared infant foods; these mothers questioned the quality of the commercially prepared infant foods that can be bought from the stores. These findings are also consistent with the findings from Steinman et al. (2010) where many of the Somali immigrant mothers in Seattle, gave their infant home-prepared infant foods. The preference for home-prepared infant foods has also been seen among native mothers from Germany, Italy, Scotland, Spain and Sweden (Synnott, et al., 2007). Only a few of the Somali mothers gave their infant commercially prepared infant foods, because their infant preferred this type of food.

7.6 Perception of feeding advice from the health clinic

Some of the mothers combined the advice and information from different sources (books, internet, friends, family, and the health care providers) together with their own knowledge and intuition, into their practice. The majority of the multiparous mothers based their practice on what they believed was right and from their previous experiences as a mother. The multiparous mothers mentioned that the information and advice they received was limited, compared to the information they received at the health clinic (in Norway) with their first born. The public health nurses might have perceived some of the mothers as experienced, since the majority of this study sample was multiparous mothers. These findings highlight the importance for the health clinic to provide infant feeding advice also to multiparous mothers.

Half of the mothers stated that they had not received any specific advice about the benefits of breastfeeding, exclusive breastfeeding and the timely introduction of water and other complementary foods. Whether this is because the health clinic could not find the time to consult the mothers or it was due to language barriers was not investigated. It is important to note that how the mothers’ perceived advice and service from the health clinics might differ from the health clinics point of view. A study on mother’s experiences of breastfeeding support from midwives and the experiences from midwives in giving breastfeeding support; found differing experiences between the mothers and midwives (Bäckström, Ekström & Wahn, 2010). The study showed that mothers wanted more understanding and support from the midwives, in contrast to the midwives who felt that they encouraged and supported the mothers’ needs.

Some of the mothers wished that the public health nurses could be more active in provided information on infant feeding. Half of the mothers sought advice from the health clinic on
their own initiative. It was interesting to find that these mothers shared similar views to on the lack of information provided at the health clinics, as the majority belonged to different health clinics in the Oslo area. These mothers expressed the wish for more personal advices on infant feeding from the health clinics. This demonstrates a need to improve the breastfeeding education and support programs for Somali mothers and possibly for other immigrant mothers. An increased focus on breastfeeding practices at the health clinic could potentially have an impact on the Somali mother’s choice to breastfeed, as well as their breastfeeding duration.

It had been argued that the health care providers’ ability to listen and understand a mother’s individual need, is important since it can influence her chance to breastfeed (Ekström & Nissen, 2006). The Global Strategy on Infant and Young Child Feeding highlights that health care providers should have evidence-based knowledge and skills to give advice regarding breastfeeding (WHO & UNICEF, 2003).

Half of the mothers had received brochures and booklets from the health clinic. The ability to read and understand health related information seems to be a challenge for many (Søberg-Finbråten & Pettersen, 2012). Kumar and Viken (2012) stated that many immigrants perceived the information material written in Norwegian as not relevant to them. Information material may not be read due to difficulties with understanding of the language of the written information (Kumar & Viken, 2012). Written information material in Norwegian, might a challenge for mothers who do not speak Norwegian fluently, where valuable information about infant feeding might be overlooked. Having language barriers might restrict the mothers’ access to other relevant information sources (e.g. internet, books) beside the health clinic. It important to provide the mothers who do not Norwegian fluently, with adequate and relevant information, which they can understand, such as brochures in Somali, or having an interpreter during the counselling sessions at the health clinic.

Some of the mothers preferred to search for information on infant feeding by themselves. This may indicate that these mothers felt that they were not getting the information that they needed from the health clinic. A person would be more likely to listen to nutrition information if it was tailored to their specific needs than to standard generic written materials given by other health care providers (Campbell, et al., 1994). Some of the mothers in the present study felt that information from the health clinic was not relevant to them, and had thereby chosen
to seek information and advices elsewhere. The mothers that had experienced problems with breastfeeding, stated that they only received the advice of consuming more fluids to increase the breast milk production from the health clinic. These mothers felt this advice was not helpful and decided to introduce formula milk instead. The findings by Ekström and Nissen (2006) showed that mothers felt more confident to continue breastfeeding when they were given relevant information and received support from midwives and nurses.

In a Finnish study, more than 33% of the mothers reported that they had received absolutely no breastfeeding guidance from public health nurses, and over 50% noted that the encouragement by the nurses to breastfeed was minimal (Hedberg-Nyqvist & Kylberg, 2000). Health professionals’ lack of individual attention to mothers is a serious gap in health care (McInnes & Chambers, 2008). Poor interpersonal communication between health care providers and mothers and the low confidence that health care providers have in their skill level in nutrition care is likely to negatively influence the quality of care provided to the mothers (Nnyepi, Bond, Mullan, Uebersax & Weatherspoon, 2006). An empowerment approach among health care providers has shown to be an effective strategy, where the mothers were provided with information, expertise support and skills that they need to engage in the interaction with health care providers (Labonte, 1994).

Health care providers play a key role in providing support to breastfeeding mothers, they have a unique opportunity to interact with the mothers and thereby influence the mother’s infant feeding practices (High, Hopmann, LaGasse, & Linn, 1998). It is thereby important for public health nurses to keep encouraging mothers to breastfeed, but also making sure that the mothers do not feel like they are being pressured to breastfeed, which a few of the mothers in the present study had mentioned. McInnes and Chambers (2008) recently conducted a literature review on Western studies exploring the breastfeeding support by health care providers. The authors concluded that the breastfeeding support from health care providers was perceived as unfavourable, with emphasis on time pressure, conflicting advices, and a lack of breastfeeding guidance in addition to the promotion of unhelpful practices (McInnes & Chambers, 2008).
7.7 Conflicting advices

The mothers said that they sometimes received conflicting advices from the health clinic and their Somali network. They expressed that this increased the uncertainty of their own infant feeding practices.

Some were advised by their Somali network to begin with complementary foods early, and this conflicted with the advice given at the health clinic. It is important that health care providers are aware that mothers might be facing conflicting advices on their infant feeding practice. Field et al. (2008) stated that the family pressure may put the mother in a difficult situation. She will have to make decisions based on contradictory advice, from the health clinic giving her one kind of advice, and her family members giving her other advice. In this context, the promotion of breastfeeding must not only target the mother, but also her social network, including her partner, her mother and other family members (McInnes & Chambers 2008). Since the health clinic is in regular contact with the mothers, this unique opportunity should be used to address the issues and challenges that a mother might be facing. It is important to continue to strengthen mother's decision making power (Fjeld, et al., 2008) as conflicting advice can confirm a mother's own doubts in her ability to breastfeed, which might increase the chance for the mother to stop breastfeeding (McInnes & Chambers, 2008).

A commonly mentioned topic among the mothers, was the encouragement of formula feeding from her family and relatives. According to some of the mothers, the desire to have chubby infants was often mentioned by her family and relatives, and that formula feeding in combination with breastfeeding was the best way to achieve this. The findings from the present study are consistent with findings from focus groups with Somali mothers in Seattle (Steinman, et al., 2010). That study revealed a strong community and family pressure to supplement breast milk with formula milk to keep the infants “chubby” (Steinman, et al., 2010). Pak-Gorstein et al. also suggested that the preference for “chubby” infants among Somalis may stem from their cultural and past experiences with the fear of infant undernutrition (Pak-Gorstein, Haq & Graham, 2009). Although the wish for chubby infants was not the reason for why some of the mothers chose to give formula milk, a few of them felt it was rather an obligation to give formula milk because of their family members’ persistent encouragement. The majority of the multiparous mothers who had received this type of encouragement, expressed regrets in following this obligation with their first child. This was because they later realised that their breast milk alone would have been enough to
breastfed the infant, without the need of formula milk. This seems to suggest that mothers tend to learn and gain valuable experience with their first child, since this allows them to look back and re-evaluate the practices that they believed was “right” or “wrong”. Learning from their previous experiences might increase their confidence with infant feeding and make them more prepared, when or if they face future conflicting infant feeding advices, from different sources. These multiparous mothers seem to be less influenced from the advices given by their Somali network and health clinic, as they have become more determined to follow the infant feeding practice that they believe is right. Most of the multiparous mothers who had received these conflicting advices, have thereby chosen to seek information on infant feeding themselves, in books, the internet, friends or using their previous infant feeding experience as a “guide”.

These findings highlight the importance of paying attention to the primiparous mothers who might be encouraged by their Somalia network to practise formula feeding. The primiparous mothers might feel more unsecure compared to the multiparous mothers regarding the advice that they receive from the health and Somali network, as these mothers often lack experience with infant feeding. The primiparous mothers might place a higher trust on the advices that are given from their family/relatives.

8 Limitations of the study
This study provides information of infant feeding practice of Somali immigrant mothers in Norway, which is an understudied topic. Background information on each mother was also collected; this made it possible to identify the mothers’ common and differing opinions and infant feeding practices in relation to the mother’s age, residence time in Norway, education level and number of children.

However, the findings from this study faced limitations. The sample size (n=15) limits the transferability of findings to other Somali settings. The extension of the inclusion criteria resulted in a wider age gap (6±2 months) than originally planned. There were more Somali mothers who spoke Norwegianfluently than those who did not speak fluent Norwegian in this study sample, although this thesis tried to include a demographically diverse sample. It would have been better with a larger number of Somali mothers with a shorter residence time in Norway, to see if these mothers face the same problems with infant feeding as those found in
this study. But the master student felt that this study also managed to get a small insight into
the infant feeding practices of some of the “less” integrated mothers in this study sample. The
wide age span between the infants might serve as a limitation. The mothers who had children
over six months were interviewed retrospectively focusing on their infant feeding practice
when the infant was a new born to the time the infant reached six months. This might have
reduced the limitation of the wide age span among the infants. A triangulation of methods
such as discussions with key informants would have further strengthened the study findings.
9 CONCLUSION AND FUTURE IMPLICATIONS

This study explored Somali mothers’ infant feeding practices as well as their experience of advice given by the health clinic. The findings show that none of the mothers practised exclusive breastfeeding for six months. It is apparent that exclusive breastfeeding during the first six months of the infant’s life needs to be further encouraged among Somali mothers. Limited information regarding infant feeding from the health clinic, is suggested from these findings. Mother’s breastfeeding decisions, were influenced by her knowledge and belief of her own ability to breastfeed. Mothers, who felt that breastfeeding was difficult, discontinued breastfeeding early on. Difficulties with breastfeeding or the choice of not breastfeeding during situations where it was perceived as impractical (e.g. in public), influenced the early introduction of complementary foods. This highlights the importance of helping mothers to overcome their barriers to breastfeeding.

The ways to overcome breastfeeding barriers does not seem to be thoroughly dealt with at the health clinic. To make mothers breastfeed optimally, it is crucial that health care providers, can give mothers both adequate support and breastfeeding skills. For example, the public health nurse can help the mothers to develop positive attitudes to breastfeeding. An increased emphasis on individually tailored support might help mothers overcome their problems with breastfeeding. During counselling, the nurse can explain the benefits of breastfeeding to the mothers, making sure that the mother is aware that breastfeeding can be beneficial, for both the mother and infant. The nurses can also demonstrate the different breastfeeding techniques, to enhance the mothers’ knowledge and confidence in breastfeeding.

An interesting finding, was the encouragement of early formula feeding by the mothers Somali network, which was in conflict with advice given at the health clinic. This made some of the mothers confused and insecure on how to feed their infant. This might have served as a motivation for mothers to practise predominant breastfeeding early on. Health care providers should also assist mothers in overcoming the pressure of formula feeding, as well as being aware that some mothers might be experiencing this type of pressure from their social network. It is also important to target the mothers’ family members, as they were often the ones encouraging mothers to give formula milk. The health clinic could arrange group
counselling sessions for mothers and their family, to reassuring the mothers’ family that breast milk is enough to feed the infant.

This study is among one of the few that has focused on infant feeding practices, among Somali mothers in Norway. The findings can potentially benefit both Somali mothers and health care providers. Firstly, it can contribute valuable knowledge to the health clinic. This can inform the public health nurses about the mother’s individual needs to continue breastfeeding, and create more awareness to the topics of infant feeding, that deserves a higher focus at the clinic. The findings can further help improve the service, provided to Somali mothers at the health clinic; and perhaps enable the mothers to practice exclusive and prolonged breastfeeding in the future. These findings are based on the mothers’ point of view and experiences of the health clinic. It pivotal to further investigate the public health nurses views, on the advices that they provide to mothers on infant feeding.
References


Appendixes

Appendix 1: Invitation letter to participants and consent form

Appendix 2: Background information sheet

Appendix 3: Interview guide (Norwegian)

Appendix 4: Interview guide (English)

Appendix 5: Interpreter manual

Appendix 6: Overview table the mother’s infant feeding practice
Appendix 1: Invitation letter to participants and consent form
Forespørsel om å delta i InnBaKost-prosjektet

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

Dette er et spørsmål til deg om å delta i en forskningsstudie. Fafo skal gjennomføre en undersøkelse av kostholdet blant 6 måneder gamle spedbarn med innvandringsbakgrunn. Undersøkelsen gjennomføres i samarbeid med Universitet i Oslo, Høgskolen i Oslo og Akershus, Nasjonal kompetanseheten for minoritetshelse og Nasjonalt kompetansecenter 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 innvandringsbakgrunn fra Somalia og Irak. Barna vil bli fulgt opp når de er 1 og 2 år gamle. Kvinner som er født i Somalia og Irak, og som er innvandret til Norge, vil bli spurrt 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 familiensammensetning.
- Din opplevelse av møtet og nytteverdien av helsekontroller på helsestasjonen.

Studien innebærer ingen medisinske undersøkelser eller målinger.

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

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

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

**Kompensasjon**

**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 oppfølgingsstudien 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 deltakelse i studien

Jeg er villig til å delta i studien

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)
Appendix 2: Background information sheet
InnBaKost-prosjektet

Bakgrunnsinformasjon til intervju

Dato:
Intervjested:
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 3: Interview guide (Norwegian)
Intervjuguide

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

Tema og hovedspørsmål

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

Nedenfor er en liste over spørsmål. Hovedspørsmål og hovedmål for studien er å samle informasjon om syn, opplevelse, kunnskap og praksis i forbindelse med spedbarnsnæring 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/Iрак av deres mødre?

Hva slags mat fikk du som spedbarn?

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

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


For mødre som også har fødtt i deres hjemland: Har det vært noen forandringer siden du kom til Norge i forhold til deltagelse 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 fullammeningen, 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 fullammenen 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/spedbarnsvernæring kan være nyttig for deg?
Hvem mener du vil være den passende personen til å gi informasjon om amming?
Hva slags hjelp/støtte trenger du med hensyn til ditt barns kosthold?
Hvem mener du er den beste personen som kan gi deg råd om amming og hva slags mat du bør gi barnet ditt?

Tjenester på helsestasjon

Hva er din nåværende erfaring med helsestasjon?

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

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

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

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

Slutt spørsmål (Alt tatt i betraktnings spørsmål (sammendrag spørsmål / avsluttende spørsmål)

Har du noen spørsmål eller forklaring til noe vi ikke har nevnt om amming?

Har du noe mer du ønsker å tilføye?

Henvisning til et oppfølging intervju etter 6 måneder og 18 måneder
Appendix 4: Interview guide (English)
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: Interpreter manual
**Manual for tolk i InnBaKost-prosjektet**

Fafo 2012

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

**Forord**

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

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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 seks måneder gamle spedbarn med somalisk og irakisk innvandringsbakgrunn; InnBaKost. Undersøkelsen gjennomføres i samarbeid med Universitet i Oslo, Høgskolen i Oslo og Akershus, Nasjonal Kompetanseenhet for Minoritetshelse og Nasjonal Kompetansesenter for Amming.

Det finnes lite informasjon om ammepraksis og spedbarnernæring blant kvinner med innvandringsbakgrunn. Årsaken er at kvinner med innvandringsbakgrunn har vært ekskludert i de nasjonale amme- og spedbarnskost studier som til dags dato er utført. Tidligere studier som har sett på kosthold og ernæring blant barn med innvandringsbakgrunn har ofte kun fokusert på enkelte næringsstoffer og har heller ikke vært representativ 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 kunnskap om tradisjonell barnemat og barneoppdragelse blant innvandrerbefolkninger. Dette kan svekke rådgivningssituasjonen på helsestasjonen.

Hovedformålet med undersøkelsen er å øke kunnskapen om kostholdet blant sped- og småbarn med innvandringsbakgrunn. I tillegg ønsker vi å få et bedre grunnlag for å forebygge kostholdsrelaterte helseproblemer i denne gruppen. Helsepersonell vil også kunne dra nytte av denne type kunnskap i deres møte med mødre med innvandringsbakgrunn.

2.0 Din rolle i prosjektet

Tolkens innsats er viktig for å sikre kvaliteten av informasjon/data under datainnsamlingen. Derfor er det viktig å nøyaktig oversette hva forskeren spør om under intervjuet og hva informanten svarer. Tolken skal ikke komme med personlige synspunkter eller på noen måte vise hva hun/han synes om det informanten sier. Dette er viktig for å sikre datakvaliteten. Det er også viktig å huske at tolken har taushetsplikt til det som blir sagt under intervjuet.

2.1 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 informant om når og hvor intervjuegene skal foregå. Det vil til sammen utgjøre omtrent 15 intervjuer av enkeltpersoner.
1) Presenter deg selv for informanten, fortell at du er tolk. Påpeke at du er et mellomledd, og at samtalen er mellom intervjuer og informant.

2) Oversett direkte og nøyaktig, unngå å utelate informasjon. Vi ønsker å vite alt som informanten sier.

3) Unngå egne kommentarer og meninger.

4) Prøv å oversette fortløpende.

5) Vær oppmerksom på kroppsspråket ditt (vær nøytral i reaksjonen din, ikke gi uttrykk for om du er enig eller uenig med informanten.

2.2 Kvalitetskontroll

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

2.3 Personvern

InnBaKost er godkjent av de Regionale komiteer for medisinsk og helsefaglig forskningsetikk (REK). REK er en komité som undersøker om prosjekter er i samsvar med forskningsetikkloven og helseforskningsloven.

3.0 Hvem skal intervjues?

I denne studien vil møder som oppfyller inklusjonskriteriene bli rekruttert til intervju. Inklusjonskriteriene er mødre som er født i Somalia eller Irak og som har et barn som er 5-7 måneder gammelt. Barnet skal være friskt og ikke har en sykdom/tilstand som krever at barnet går på et spesielt kosthold.

4.0 Oppbygging av tillit hos informanten

I et dybdeintervju er det viktig at tolken forsøker/prøver å skape tillit hos dem som skal intervjues. For at intervjuene skal kunne overbevise intervjueobjektene om hvem som står bak undersøkelsen vil intervjuerne bli utstyrt med:

1) Et informasjonsbrev fra Fafo, og

   2) Et kort med telefonnummer og navn på en av de prosjektansvarlige ved Fafo

Det er viktig at tolken:

1) forklarer 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 informant til å svare på en bestemt måte.
4.1 Generelle retningslinjer

1: Ikke bli utålmodig. Gi informanten tid til å reflektere på sine svar. Prøv heller å ikke gi inntrykk av at du tror at de ikke forteller alt eller at de holder tilbake informasjon.

2: Hvis det er klare motsigelser i svarene som avgis bør du høflig gjøre oppmerksom på dette. Du kan unnskyde deg med at du ikke forstår, 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 tolk ikke på noen måte gir uttrykk for hva du selv mener.

4.3 Høflighet og diskresjon

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

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.

2: Du må virke overbevisende i intervju situasjonen. Dette innebærer at du må kjenne intervjuguiden så godt at du kan behandle det på en rolig og sikker måte. Det er lurt å ha noen penner i reserve, slik at du slipper å løne.
Appendix 6: Overview table the mother’s infant feeding practice
<table>
<thead>
<tr>
<th>Fictive name</th>
<th>Age of the infant (months)</th>
<th>Duration of exclusive breastfeeding</th>
<th>Duration of breastfeeding</th>
<th>Introduction of solid foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idil</td>
<td>5</td>
<td>3 months</td>
<td>Still breastfeeding</td>
<td>6 months (plan)</td>
</tr>
<tr>
<td>Hibo</td>
<td>7</td>
<td>Have not exclusively breastfed</td>
<td>5 months</td>
<td>5 months</td>
</tr>
<tr>
<td>Leylo</td>
<td>8</td>
<td>Have not exclusively breastfed</td>
<td>4 months</td>
<td>4 months</td>
</tr>
<tr>
<td>Ayanna</td>
<td>8</td>
<td>3 months</td>
<td>Still breastfeeding</td>
<td>6 months</td>
</tr>
<tr>
<td>Timiro</td>
<td>5</td>
<td>3 months</td>
<td>Still breastfeeding</td>
<td>4 months</td>
</tr>
<tr>
<td>Sharifa</td>
<td>6</td>
<td>3 months</td>
<td>Still breastfeeding</td>
<td>4 months</td>
</tr>
<tr>
<td>Hani</td>
<td>5</td>
<td>3 months</td>
<td>Still breastfeeding</td>
<td>5 months</td>
</tr>
<tr>
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<td>1 month</td>
<td>Still breastfeeding</td>
<td>4 months</td>
</tr>
<tr>
<td>Taliso</td>
<td>5</td>
<td>4 months</td>
<td>Still breastfeeding</td>
<td>6 months (plan)</td>
</tr>
<tr>
<td>Caaliyah</td>
<td>6</td>
<td>2 months</td>
<td>Still breastfeeding</td>
<td>4,5 months</td>
</tr>
<tr>
<td>Nadifa</td>
<td>5</td>
<td>Around 3 days</td>
<td>3 months</td>
<td>4 months</td>
</tr>
<tr>
<td>Ikraan</td>
<td>6</td>
<td>5 months</td>
<td>Still breastfeeding</td>
<td>5 months</td>
</tr>
<tr>
<td>Muriyo</td>
<td>7</td>
<td>3 months</td>
<td>3 months</td>
<td>5 months</td>
</tr>
<tr>
<td>Yurub</td>
<td>5</td>
<td>4 months</td>
<td>Still breastfeeding</td>
<td>4,5 months</td>
</tr>
<tr>
<td>Turiba</td>
<td>5</td>
<td>Around 3 days</td>
<td>Still breastfeeding</td>
<td>4 months</td>
</tr>
</tbody>
</table>