Original Article

Ethnicity and children's diets: the practices and perceptions of mothers in two minority ethnic groups in Denmark

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Abstract

This study explores concerns and dilemmas connected with diet, health and child-feeding in families with ethnic minority background. The aim is to contribute to better targeting of dietary advice to ethnic minority parents in Denmark. Four focus group interviews were carried out with mothers of children between 4 months and 2 and a half years who were descendants of Turkish or Pakistani immigrants. The focus groups investigated: (1) everyday feeding practices; (2) values and concerns behind food choice; (3) social and cultural norms influencing feeding and eating practices; (4) experienced dilemmas in dietary change; and (5) sources of nutritional advice. Public health authorities in Denmark tend to link diet-related health problems among ethnic minority populations with their ethnic identity, dichotomising ethnic and Danish dietary habits. This may overlook values and concerns other than those related to ethnicity that are sometimes more important in determining food habits. The present study found that child-feeding practices were shaped by two main aims: (1) securing and improving child health; and (2) ensuring multi-cultural eating competence in children. The results confirm that ethnic distinctions do matter in the concerns and dilemmas mothers experience when feeding their children, but they also challenge the health authorities' reliance on dichotomies in promoting health among immigrant families. The participants' ethnic self-identification through food practices did not refer primarily to the birthplaces of their parents. Rather, it was context dependent and directed simultaneously towards majority and minority culture.

Keywords: ethnic minorities, parental concerns, feeding practices, health promotion, focus groups, cultural competency.

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Introduction

In Western countries, the incidence of overweight, dental caries, diabetes and cardiovascular disease is higher in some ethnic minority populations than in the majority population (Kirchengast & Schober 2006; Skeie *et al.* 2006; Kunst *et al.* 2011). Some researchers and public health organisations have pointed to cultural and ethnic identities – in the shape of specific sets of value orientation and practices, allegedly characterising such identities – as the main

contributors to these health problems (Banwell *et al.* 2011). It is widely acknowledged that health profiles of different ethnic minority populations in western societies tend to diverge as the result of, for instance, genetic inheritance, migration history, socioeconomic position and cultural background (Kunst *et al.* 2011). Explanations for health differences are also sought in the manner in which minority groups adapt, or fail to adapt, to ethnic-majority lifestyle. In this vein, studies refer to accelerated dietary 'acculturation', i.e. the assimilation of unhealthy 'western' eating patterns by

some ethnic immigrant groups (Satia-Abouta *et al.* 2002; Gilbert & Khokhar 2008). Conversely, it is recognised that original, unhealthy dietary preferences may continue after migration (Sarwar 2002; Gordon-Larsen *et al.* 2003; Mellin-Olsen & Wandel 2005; Akresh 2007). Such explanations imply either the ‘disruption’ of what was originally a healthy eating pattern when the individual is confronted by western, unhealthy alternatives or the opposite – the persistence of unhealthy cultural traditions involving the use of large amounts of fat and sugar which sometimes follow the migrant into the ‘new country’. Belief in the existence, and importance, of such ethnic differences in food cultures continues to guide health promotion strategies in Western societies. It leads to a focus on ethnic minorities from non-Western societies, and to the recommendation that individuals in immigrant population groups should adopt dietary strategies which work either to maintain or to abandon certain ‘traditional’ eating habits (Ayala *et al.* 2008; Johansen *et al.* 2009; Evans *et al.* 2011).

In Denmark, there is relatively limited systematic understanding of the food choices and eating practices of immigrants and the descendants of migrants (Holmberg *et al.* 2009). Some studies of school children – specifically, their intake of fruit and vegetables and sugar – have found significant differences between children with a Danish background and children with a non-Western immigrant or immigrant-descendent background (Osler & Hansen 1993; Jensen & Holstein 2010). The diets of pre-school children with an ethnic minority background remain largely unexplored. Nor is much known about the perceptions and concerns of parents where the food intake of young children is concerned.

Paradoxically, in Danish health promotion, the communication of dietary recommendations to parents of infants and young children has been powerfully influenced by the authorities’ belief in the importance of ethnicity in the food practices of migrant groups.

In 2002, the Danish Veterinary and Food Administration published a report which aimed to help health visitors ‘pose relevant and meaningful questions when meeting people from these cultures’ (The Danish Veterinary and Food Administration 2002: 8). The report contains descriptions of ‘breast feeding and complementary feeding practices’, ‘family meals’ and ‘food products’ that are characteristic of each of the 10 largest non-Western countries of emigration to Denmark. The descriptions are based on empirical data from the non-Western countries, because – as the report notes – no reliable data exist on the eating practices of ethnic minorities resident in Denmark. Further, various religious belief systems with a bearing on food and eating, and a range of ‘non-western’ conceptualisations of health and illness in relation to food and eating, are described in the report. A theoretical model of dietary change among immigrants is also set out in the report.

The report repeatedly cautions the reader about the representativeness of its own descriptions and data, but still, it gives the impression that diet-related health problems among non-Western migrant groups are linked to their ethnic minority identity, which is assumed to be important for them in their everyday life. By presenting immigrant and refugee food in terms of geographical distinctions, and by providing generalised models for dietary change in ethnic minorities, the report paints a dichotomised picture of

Key message

- Health promotion by public authorities is often based on dichotomised and essentialist representations of the food cultures of non-Western ethnic minority groups.
- Using qualitative data, this study argues that dietary advice to ethnic minorities risks failure if it rests upon such representations.
- The ethnic minority identity of participants in the study appeared to be of limited importance in food and meal practices, including health practices, and was mediated by many other non-ethnic concerns.
- Future dietary interventions should take into account the parental wish to support children in the shaping of multi-cultural identity.

Danish vs. non-Western ethnic identity and thus promotes essentialist concepts of food culture.

While respect for cultural and religious differences is clearly imperative in any kind of public intervention, there is reason to question the usefulness of basing public health promotion on such dichotomised representations of the food of ethnic minority groups. It has been suggested that when immigrant health behaviour is explained in terms of 'acculturation' processes, cultural factors are promoted 'as the focus of intervention at the expense of drawing attention to the structural constraints within which individuals operate' (Viruell-Fuentes 2007: 1525). This focus may lead to victim-blaming, as it reflects an essentialist view of culture as something tied to the individual through heritage, rather than seeing culture as continuously shaped in social and structural contexts.

Sociological studies show that even if collectively shared systems of symbolic meaning are important in food choice and eating patterns (Bourdieu 1984; Germov & Williams 2000), the meanings of food are also shaped by the contexts in which it is obtained, prepared, served and eaten (Warde 2005). Rather than anticipating ethnic identity to be generally central to food choice among immigrant groups, it is important to investigate whether, and in what specific contexts, ethnic identity becomes tied to food choice. Further, in order to better target initiatives promoting dietary change, it is important to investigate how cultural and ethnic identity influence the individual's motivations and experience of problems around dietary change.

The present study investigates the attributed importance of ethnicity in dietary concerns, and in practices relating to diet change, in the context of everyday life. The study focuses on families with young children with an ethnic minority background from either Pakistan or Turkey, as these are some of the largest ethnic, non-Western minority groups in Denmark.

Materials and methods

According to Bloor *et al.* (2001), the focus group interview is a fruitful method of mapping out and

exploring the perspectives and practices connected with a topic of common concern in a relatively homogeneous population. Focus group interviews are also ideally suited to the investigation and exploration of social norms and values pertaining to a specific issue through first-hand observation of group interactions. For these reasons, the present project used the focus group method with the aim of exploring parents' concerns about their young children's eating practices, including those linked to social norms and values.

Sample

The criteria for inclusion in the study were: at least one parent in the household should be a descendant of either Turkish or Pakistani immigrants to Denmark; the youngest child should be either 4–7 months old (younger) or 1 and a half to 2 and a half years old (older). Participants could have one or more children. With these criteria, four groups were defined using different permutations of parental ethnic background and age of the child. Only mothers were recruited, since pilot interviews suggested that they have the main responsibility, in the home, for choosing, preparing and giving food to children. In order to avoid methodological problems that arise when an interpreter is employed (Temple 2002), only mothers who were able to participate in interviews using Danish as their main language were recruited.

A broad range of recruitment methods were adopted, including: contacting respondents via internet websites and chat forums, distributing letters to parents through day-care institutions, face-to-face recruitment during social events in neighbourhoods with high numbers of immigrant citizens and snowballing through personal networks. Recruitment through these methods proved difficult, and therefore a few mothers were contacted through health professionals.

In accordance with Danish legislation, an institutional review board approval was not needed for this study. Data about food and eating practices is not defined as sensitive data and no experiments on humans or human biological material were carried out (Danish Data Protection Agency 2013; Danish Health Research Ethics Committee 2013).

Data collection

Interviews were structured according to an interview guide with four main thematic sections. They were introduced through a short presentation familiarising respondents with the study, the moderator and the assistant. In addition, participants were provided with guidance on being a focus group participant. The purpose of the first thematic section was to bring out every day dietary practices and encourage participants to discuss values related to these practices. In all groups, participants were asked to talk about the food their youngest child had been offered the day before the interview, and to explain the rationale of the choice to offer that food. The rationales obtained were recorded in written notes. Then participants were invited to discuss the importance of each rationale in turn, and to sort them into two categories: 'important' and 'less important'.

The second thematic section investigated dilemmas, values and concerns connected with specific food products and dishes. The guide for this section differed from one group to another, according to the ages of the children. Mothers of children 4–7 months were presented with 14 food products and asked to discuss each of them while allocating them to one of two groups of food they 'would give' or 'would not give' their youngest child. The products were selected to stimulate discussions of the following issues: nutritional health, price, the child's taste preferences, ethics, safety, convenience and parental food aversions. Mothers of children aged 1 and a half to 2 and a half years were instead presented with an exercise designed to introduce dilemmas relating to values and practices in the choice of family food. The women were asked to write down what they had eaten for breakfast, lunch and dinner the previous day, and the previous Saturday. Each dish or food product was noted and recorded, and participants then ranked each item according to what they thought to be most suitable for breakfast, lunch or dinner.

The third section was designed to unearth the social norms involved in parental concerns. Each group was confronted with a fictional dilemma and asked to give practical advice to friends whose one-year-old child

refused to eat anything but sweet foods; it was added that the health visitor had suggested that the child's intake of sugar needed lowering. In a final section, the mothers were asked about sources of information about food for their young children; they were asked to evaluate these sources. Following debriefing, participants were asked to fill in a short questionnaire about their background.

Throughout the study, ethical guidelines laid down by the British Sociological Association were strictly observed (British Sociological Association 2002).

All interviews were moderated by the first author, video- and audio-recorded.

The interviews lasted for 2 h. Participants were provided with a light meal. As a token of appreciation, they received a gift certificate for a grocery chain worth 300 DKK.

Data analysis

All interviews were transcribed verbatim and imported into the software program Atlas.ti. The reliability of data was controlled by comparing the transcript with the videotaped interviews.

The coding of qualitative data almost always involves both inductive and deductive procedures (Strauss & Corbin 1998). In keeping with the explorative nature of the study, an inductively inspired coding procedure was applied which supported data-derived (as opposed to theory-derived) perspectives on the analysis, but which also focused particularly on themes in the research question. Codes were generated, for instance, expressing the concerns of participants – concerns, that is, including 'health', 'socialization', 'conflicts', 'pickiness' 'practicalities' and 'sugar', which also sometimes referred to ethnic distinctions between Danish, Turkish and Pakistani food. A second round of coding applied a more deductive approach based on the emerging research interest. Here, special attention was devoted to the importance and use of ethnic distinctions in reports of participants' concerns. To test the validity of the analysis, a matrix was created which provided an overview of the occurrence of different

codes within the four groups and provided exemplification through quotations from participants. Group-to-group validation was carried out, using an approach suggested by Morgan (1997). In this, the centrality of concerns and experienced dilemmas was estimated by looking at the intensity of discussion and engagement which these issues raised within groups, and the frequency with which they occurred across groups.

Referring to this matrix, the first author generated a list of themes linked to the concerns and dilemmas. On the basis of this list, examples from the data set were presented to the other authors and further discussed with peer researchers. Finally, the presented analysis was agreed on.

Throughout the presentation, the use of notions such as Danish, Turkish, etc., reflect participants' own use of these terms. When text is omitted from a quotation because of irrelevance this is marked by (. . .). Explanatory text is marked by [. . .].

Results

Participants

In all, 20 mothers were recruited for four focus group interviews to be carried out during December 2009 and January 2010. Of these, 16 actually attended the interviews. Two groups consisted of four mothers, one group of five mothers and in one group, three mothers participated. The ages of participants ranged between 25 and 35 years. Nine of the mothers had more than one child living at home. One participant was a single parent, and two lived in households with extended family – i.e. with their husbands' parents and siblings. Seven participants were on maternity leave at the time of being interviewed, four were unemployed, 10 were employed and one was enrolled in a programme of education. Only five participants had received middle range or high level education. Most participants were descendants of immigrants to Denmark. Some were married to another descendant and some to an immigrant. Two participants were immigrants themselves and married to descendants. All participants in the groups with 4–7-month-old children were in sole charge of daily childcare; five of the older

children attended public or private day care outside the home.

Mothers' concerns

The presentation of results is structured around two major concerns which emerged in the interviews: (1) the securing and improvement of family health; and (2) the development of multi-cultural eating competences. The results are presented so that they focus on the ways in which ideas and categories of ethnicity enter into the women's descriptions of these two principal concerns and the practices they engage in to deal with them.

Securing family health

In all groups, mothers expressed a general desire to promote the health and well-being of their children by ensuring an adequate intake of energy and vitamins, and of fruit and vegetables. Many of the women were also concerned with their own or their husband's health and well-being, and engaged in attempts to lose weight or lower cholesterol levels. Efforts to improve the healthiness of a diet tended to be framed in terms of lowering the intake of sugar and fats and increasing dietary variation, especially through the consumption of more vegetables and fruit. Participants referred to this idea of healthy eating as common-sense knowledge and did not see it as particularly Danish. Some would explain that health was more important than the ethnic character or identity of the food served:

She's got to have something healthy. That is my first priority. It doesn't matter if it is Turkish, Arabic or Danish. She has to have some vegetables. She has to have fruit and dark bread and things like that. Then I feel good.

Many of the concerns about the healthiness of the children's diet described did not involve ethnic distinctions. These included the pickiness of children, their refusal to eat vegetables or other healthy foods and their preference for sweet or fatty foods. There were also concerns about the lack of parental control over, or energy to maintain rules and principles regarding, the child's food intake.

Ethnic dichotomies in descriptions of healthy eating practices

However, some dietary concerns did refer to ethnic food traditions that were perceived to be either damaging or conducive to good health. Thus, participants referred to Danish, Turkish and Pakistani food when reflecting on their strategies to make healthy improvements in the diets of their children or families:

We [Turks] eat a lot more vegetables and dough and things like that. I think they should have some vegetables, too, like peas and beans – what's Turkish – eggplant and things like that. I think they should have that.

This picture of healthy Turkish food traditions was presented as a contrast with the unhealthy influence of Danish society both on the women's choices of food for the family and, especially, on children's preferences.

P1: Just like Danish families, we have turned to fast food: hamburgers, and fish fingers and fish cake.

P2: Right, when you don't feel like cooking.

P1: Yes, when the fridge is empty or you are busy. Or the kids choose it (...) I think children dislike water-based dishes (...) and our Turkish food is very fluid (...) stews and things like that. Once they get older they prefer Danish food, or food like kebabs and other fast food things. But I insist that we have stew once or twice a week.

In this exchange, 'Danish food' is distinguished from 'fast food' and 'kebabs'. At the same time, however, it is associated with food types preferred by children and youths – foods that are less healthy than the vegetable-rich Turkish stews and soups.

On the other hand, Danish food was also associated with healthiness. Rye bread, in particular, was referred to as an element of Danish cuisine which it was important for children to learn to eat. Time spent in day-care institutions was for this reason ascribed an important role in the food socialisation of a child.

If you have choosy children who do not want to taste anything, I think it is good that they enter a nursery (...). They acquire a regular routine. Also regarding rye bread and drinking milk from a cup. I am really happy about that.

Rye bread, which is the traditional bread type for open sandwiches in a typical Danish lunch, was generally valued for its qualities of healthiness, tastiness and practicability. Some mothers described it as something they could not live without and 'the best part of Denmark'. Other women, however, reported that rye bread had slipped out of their own diet, because nurseries provided lunch for their child, and so they no longer needed to give it to the child themselves. The conceptual link between rye bread and health was also discernible in some participants' expression of regret that their husbands would not eat it:

P1: My husband will not eat healthy food like rye bread. And if you use less oil it does not taste as good, and he does not like that. Fortunately he is skinny, so he does not gain weight, but I do. So we always have discussions about that. If the food is tasteless he does not want to eat it, he says.

P2: My husband isn't like that. Then he would be out of here. When I'm short of time, I make rye bread sandwiches with spread, and my husband agrees to that (...). So this is nice, I think. You ought to work more on that. It will benefit you.

As has been shown in other studies (Mellin-Olsen & Wandel 2005, Kjøllesdal *et al.* 2011; Jensen & Halkier 2011), traditional styles of food preparation and eating in immigrant groups have been altered in response to concerns about health issues, especially by younger generations. These findings were supported in the data of the present study.

Health-related alterations of this sort meant that some foods lost their original identity. Tea seemed to be a drink appreciated by many of the Turkish descendants, but participants had also made efforts to alter their consumption of it for the sake of health. In this process, it seemed to lose some of its Turkishness:

I don't take sugar in my tea or coffee at all, and neither does my husband. And then the children do not either (...). Other Turks say it's strange not to add sugar, but, I mean, people with diabetes don't.

Some participants drew on ethnic categories when describing their efforts to secure healthy food intake in their youngest children. Advice from older relatives, or relatives living in Pakistan, or Turkey, based

on traditional Pakistani or Turkish practices were contrasted with advice from Danish doctors or health visitors. Among members of the focus groups, it was common practice to appeal to the advice given by the Danish health authorities as a means to get through to grandparents with health messages:

I have also had that discussion with my mother in law: 'Why did you give him that, and why did you not give him eggs?' Well, they are not advisable before eight months. 'But my other daughter gave it to her children when they were four months'. But I will not give it to him [the son being discussed] before he is eight months, that is for sure! You can get into these discussions. I tell them that I follow the advice of the doctor in Denmark.

In this way, categories of Danish, Turkish and Pakistani food and eating were applied in participants' expressions of concern about the healthiness of both their children's diet and the diet of the family in general. The various ethnic features served to signify the healthiness *as well as* the unhealthiness of different dishes and cooking styles. In addition, ethnic identification of the foods sometimes served to underline an attachment to, or (sometimes) a distance from, the participant's ethnic minority background. While noting the participants' use of ethnic food characterisations in talking about healthy eating, it should be made clear that concerns were also constituted by non-ethnic features, such as children's general pickiness, their preference for 'fast food' and the participant's own need to save time and energy on food preparation by using readily prepared dishes involving, for example, rye bread and fast food.

In Table 1, concerns about healthier eating relating to ethnic food distinctions are summarised.

Developing multi-cultural competences in children

When reflecting on their everyday eating practice, some participants directly opposed a dichotomised distinction between Danish food, on the one hand, and Turkish or Pakistani food, on the other:

Table 1. Application of ethnic distinctions: concerns about healthier eating

Concerns about healthy eating	Application of ethnic distinctions
More vegetables in child's diet	Danish food equated with unhealthy fast food – low in vegetables Danish food equated with healthy food – high in fresh vegetables Turkish dishes considered healthy: soups, stews and salads
Less sugar in child's diet	Turkish tea is taken with sugar
Less fat in family meals	Original Pakistani dishes are high-fat Danish food preparation involves little fat due to more boiling Fast food is part of Danish eating habits Gravy is part of Danish food
More rye bread	Rye bread = Danish food
Adherence to nutritional recommendations	Danish recommendations on children's diets contrasted with beliefs and practices associated with Turkey or Pakistan.

I am concerned that they can eat what is being served. Not whether it is Pakistani or Danish. It doesn't even cross my mind when I cook for them whether it is Danish or Pakistani food I am cooking at that moment. It is just . . . well eventually it has become so mixed up. We have taken up Danish food. Or, what is Danish food anyway?

Although women readily deployed the labels 'Danish food' and 'our food' or 'Pakistani/Turkish food', they would explain that they did not use these categories in the context of everyday life. Still, it seemed clear that the categories did serve to influence mothers' eating and feeding strategies in various ways. An important aim among focus group participants was enabling children to eat in accordance with the dietary practices of both the ethnic minority to which they belonged and the Danish majority population. Several drivers of this concern could be identified.

A central driver behind the dietary strategies was the consideration that, at some point in life, children were going to be involved in, and need to cope with, different types of cultural setting and with people with different ways of eating. Some mothers were aware of what they regarded as a specific need for the children to taste Pakistani or Turkish foods from an

early point in time, since the food given during the period of complementary feeding was fundamentally Danish in its taste style:

I find it really important that my children are able to eat both types (. . .). As soon as they started to eat solid food, I cooked that puree. For the first two months we followed exclusively the Danish recipe that we received from the health visitor. But after that I simply began to add a little bit of the taste from my own stew, so that they may get used to that. I just spent one month in Pakistan, and it was just great to watch how my children had no problem eating the Pakistani food. As long, as it was not too hot.

The importance of early exposure to Pakistani/Turkish food was underlined by stories of mothers who experienced problems with their children's social participation:

When he visits my mother or family, only Pakistani food is served, and that is a big problem for my older children, because the food is hot and there is nothing they can eat.

The use of specific spices and the hotness of Pakistani food were often referred to as the central challenge in accustoming children to this cuisine. Participants with Pakistani background referred to Danish food as food with very little spice as 'plain' or 'easy' food. With regard to Turkish food, mothers referred more to the texture, and to the liquidity as a main characteristic. They reported serving the child different types of soup from an early point in their lives, but in contrast with mothers with Pakistani background, they expressed reluctance to introduce some of the central ingredients, such as tomato puree, garlic, onions or mint, precisely because of the intensity of their taste.

Practical concerns were another important driver of the participants' adoption of strategies to influence children's preferences. As expressed in the following excerpt, mothers wanted their children to eat Pakistani/Turkish food to reduce their own workload:

My child is not in a nursery. I keep him at home because, currently, I'm a homemaker. I cook different types of food, because with the first two children, I have observed how they disliked Pakistani food after they entered nursery and kindergarten. They think it is too hot. They prefer Danish food,

rye bread and fast food, which they may carry around. So that is why I try, with my little one, to accustom him to Pakistani food, because otherwise cooking is twice the workload for me. My husband does not like Danish food. He wants his food really hot. I can eat both types myself.

In some participants, like the woman above, the wish to accustom children to Pakistani food derived from the husband's dislike of Danish food. While for the woman cited above, the cooking of Pakistani food was an unquestionable part of everyday meal practice, many other participants stated that they did not cook Pakistani or Turkish food very often because that would be too time consuming. Often, the serving of Pakistani or Turkish food had the status of a 'treat' – something other than ordinary family food:

P1: I only cook it a couple of times a week (. . .). It is when I have the time for it, because I think it takes longer. But like she said, I think it is important that children are served all types of food: what I grew up eating and what is common in society in which they live. It is important that they learn that food can be many things, and that they are able to go to places and be presented with unknown stuff, and then think 'Well that is food' – not 'yak' or some such thing.

P2: I agree.

For this mother, serving Pakistani food clearly is important partly because it allows her children to retain an awareness of the ethnic group to which they belong. At the same time, it is clear that in the daily eating practices of the family, ethnic minority identity is only one concern among others, including time management and the need to prepare children for broad social participation.

Throughout the interviews, participants made many remarks indicating that strong ethnic food preferences were problematic for practical, social and integrative reasons.

In the interviews, the notion that a preference for Pakistani, or for Turkish, food is linked to place of birth and depends on how closely connected people are to their country of emigration was often encountered. However, some women objected to this:

My husband [who emigrated to Denmark from Pakistan] is really not so fond of Pakistani food, but my daughter [who was born and raised in Denmark] really likes it.

Table 2. Application of ethnic distinctions: concerns relating to the development of multi-cultural eating practices

Concerns relating to the development of multi-cultural eating practices	Application of ethnic distinctions
Enabling participation in social contexts involving ethnic minority networks	Pakistani food is spicy and more difficult to learn to eat Turkish food is liquid Complementary food is Danish in its taste
Enabling integration into Danish institutional setting	Rye bread is the typical basis of Danish lunch and a core element in institutional life in Denmark.
Limit time and energy used for food preparation	Pakistani food takes more time to prepare than Danish and many other cuisines Serving only one meal requires all members to like a variety of international dishes Serving only one meal requires child to learn to eat Turkish/Pakistani food as husband does Serving only one meal means altering between Danish and Pakistani/Turkish food preferences in the family
Enabling general social participation	In general considered problematic/inconvenient to have preferences for only one cuisine
Mother's desire to cook other things than Pakistani/Turkish food	Participants often stress their preference for many kinds of food and their regret if only Pakistani/Turkish food is tolerated by husband

In sum, the downsizing of Pakistani and Turkish food in daily life in favour of other types of food was presented in various ways: sometimes as an element in adjustment to Danish cultural traditions which was necessary, or advisable, to avoid stigmatisation of the child; sometimes as a process that depended on people's individual preferences; and sometimes as a consequence of practical needs revolving around time and energy management in everyday life. Some participants also wished to separate their cooking and eating practices from their ethnic minority background for health or for other reasons:

Sometimes I get really tired of Pakistani food, because it is served to us everywhere. So, I am really pleased that we have a nice canteen at work, with a great variety to choose from. So I eat there a lot. I wish we could eat like that more often at home, because it is not always that you feel like Pakistani food. It takes one or one-and-a-half hours to prepare it. It's such a long time.

Immigrants may feel more comfortable with the food patterns they encounter outside their own ethnic minority culture and feel 'pressure' to eat Pakistani or Turkish food in the social networks within ethnic minority groupings.

The main concerns, and the use of ethnic distinctions in the development of multi-cultural eating competences, are summed up in Table 2.

Discussion

This study pointed to various ways in which ethnic distinctions help to shape parents' everyday feeding concerns. In parallel with the use of dichotomised representations among public nutrition authorities, the study found that mothers readily made use of distinctions between Danish and Pakistani or Turkish food when expressing concerns and describing practices relating to their children's food and eating.

The study showed that securing their children's health was a main concern among participants. Ethnic food distinctions are linked to perceptions of health in a complex and ambivalent set of connotations. Food types perceived as unhealthy may indeed sometimes be referred to as part of Danish lifestyle and tradition, but the concept of 'Danish food' was also used as an equivalent of healthy food. 'Turkish' beliefs and practices may connote either lack of knowledge of dietary health or a healthy lifestyle. Here, there is a contrast with 'Danish' practices. The same 'Pakistani' dish may be conceived in more or less healthy variants.

Contrary to what is assumed in the information material provided by Danish authorities' to the health visitors (The Danish Veterinary and Food Administration 2002), this study appears to show that

the desire, or need, to confirm one's ethnic minority identity is of limited importance in food and meal practices among parents with ethnic minority background. The shaping of the cultural identity of their children was certainly important to many mothers, but the identity referred to was never monocultural. Strategies of dietary upbringing were directed at teaching children both to become part of Danish society (in terms of day-care institutions and school life) and to be able to participate in activities at which Pakistani or Turkish food is served. In addition, the study indicated that multi-cultural, rather than double-cultural, identification of food formed part of the participants' everyday conceptualisations and practices. In reality, the food eaten was regarded as a blend of several ethnic traditions which have been adopted into modern lifestyle in Denmark.

Some models of dietary change recognise that self-identity can be manifested in the use of food distinctions (Koçtürk-Runefors 1991; Jonsson *et al.* 2002). However, it appeared that most of the participants in this study were not in a process either of 'becoming' Danes or of 'holding on' to a threatened ethnic minority identity. Rather, they appeared to integrate and ascribe importance to Danish and Pakistani or Turkish cuisines in different contexts. For instance, to many mothers in this study, the most important purpose of teaching children to eat Pakistani or Turkish dishes was not to retain a Pakistani or Turkish cultural identity in future generations, but to avoid the need to cook several courses for each meal, or to prevent their children from feeling excluded from shared meals. Likewise, the Danish character of, for example, rye bread was an important quality when mothers referred to concerns with children's integration, but in other contexts the choice of rye bread was tied to qualities such as its healthiness, its child-friendliness, its quick and easy preparation. Thus, concerns revolving around the children's health and multi-cultural upbringing were linked to ethnicity through a number of concerns of non-ethnic character. These included the desirability of a harmonious, conflict-free family meal, the general upbringing of children and the need to cope with limited time and energy for cooking and feeding.

Baumann (2000) distinguishes between the *demotic* and the *dominant* discourse on immigrants in England. Within the dominant discourse, an equation is made in which essentialist categories of 'culture' and 'ethnos' are linked to biological and cultural heritage. Within this discourse, immigrant cultural identity and practices are assumed to be directly related to ethnic background. Baumann's concept of demotic discourse describes the competences ethnic minorities possess to break down this equation. Following Baumann's analysis, concerns and practices relating to children's food can be seen to express dual discursive competences among study participants. On the one side, mothers employ, and support, the dominant discourse on immigrant food when they apply dichotomised distinctions between Danish food and non-Danish food. On the other side, they express a conscious awareness of, and scepticism about, the dominant discourse by stressing non-ethnic concerns and values in their everyday food practices, and by sometimes actively questioning the usefulness of ethnic dichotomies in food descriptions.

To date, studies which have investigated changes in dietary practice among immigrants and the descendants of immigrants have tended to build on dominant-discourse representations of ethnic identity and the culture of immigrant populations. This generalisation applies to dietary studies deploying the concept of acculturation, as discussed earlier, to explain the deterioration in the healthiness of food (Gordon-Larsen *et al.* 2003; Ayala *et al.* 2008; Gilbert & Khokhar 2008; Dave *et al.* 2009). It also includes qualitative investigations of the meaning structures involved in dietary change processes. In Jonsson *et al.* (2002), the meaning attributed to 'feeding the family' among Somali first-generation immigrant women in Sweden is investigated. The study shows that the formation of a cultural identity which enabled the women to both 'remain' Somali and 'become' Swedes was central to their food practices. Everyday food choice was described as a balance between 'striving to maintain cultural eating habits' and seeking to 'adjust to pressures from the host country'. In her frequently cited model of dietary change, Koçtürk-Runefors (1991) also frames immi-

grants' practices as ethnically authentic eating patterns determined by geographical origin, albeit in the new country invaded by the new food and eating culture. In contrast with these studies and analytical models, the present study underlines the notion that food practices are not linked to ethnicity in a pre-defined, determinist relation defined by geographical and biological ties. Rather, the link is defined, and may be redefined, contextually and strategically in ways connected with everyday life concerns and more general values.

A small number of studies have investigated the kinds of rationale for changes in food habits among ethnic minorities from a parental perspective. Studies by Jonsson *et al.* (2002) and Mellin-Olsen & Wandel (2005) of first-generation immigrants to Sweden and Norway showed that children's food preferences were a major factor influencing the inclusion of more Norwegian or Swedish food in the family diet. In both studies, however, the process of change is presented as the result of child-induced pressure on mothers. By contrast, the present study sees the mothers of second-generation immigrants taking an active role in introducing Danish food to their children. In their study on middle class parents in Sweden, Anving & Sellerberg (2010) suggest that the focus on socialisation towards diversity in food acceptance is linked to social class. The present study does not challenge this view, but it does broaden our understanding of the use of food, and meals, as socialising strategies. Like the middle class parents investigated by Anving and Sellerberg, the parents in the present study were aiming to prepare their children for lives which will be lived in a world requiring openness to diverse social and cultural norms. However, in contrast with the Swedish study, the present study suggests that the experience of such requirements is linked not just to class, but also to ethnic minority position – and, regardless of class, to the desire to help one's children integrate with the majority culture. As others have recently noted (Gilbert & Khokhar 2008), the increasingly multi-cultural character of European consumers emphasises the need to investigate the changes experienced by both ethnic majority and minority populations. The present study serves this need.

Implications for dietary advice

This study found that distinctions between 'Danish food' and various kinds of 'non-Danish' food can serve as a basis for communication between, for example, dietary health advisors and parents. However, there is a case for questioning whether health promotion strategies should continue to build on dichotomies that separate the national majority from ethnic minority cultures. A health promotion strategy which reproduces dichotomies, instead of contributing to their resolution, will not only fail to properly understand the complexity of values and concerns in the lives of the families in question, but miss an opportunity to influence processes of change already taking place.

This point should not be mistaken for an argument that cultural and ethnic identity is not important to immigrant descendants. To secure children's eating competences within *both* the minority and majority culture was a central concern of the participants in the present study. It follows that any public health promotion strategy which could be perceived, by immigrants and their descendants, as critical of minority food culture – e.g. because it represents ethnic foods as unhealthy, or the ethnic culture as one that is informed by irrational or pre-modern food beliefs – risks being opposed. The obverse of this is that, in planning dietary advice, it is advisable to recognise the existence of dual discursive competences among ethnic minorities. Such recognition allows us to see how immigrants and their descendants may both break with the dominant discourse on ethnicity while at the same time applying it actively in certain contexts.

Finally, dietary health promotion deploying ethnic dichotomies that do not properly capture the self-identities and health perceptions of immigrant parents may damage public confidence in the recommendations made. Instead, health authorities should support parents, from the beginning of the period of complementary feeding, to establish diets for their children which, in harmony with the parents' own requirements, are both healthy and conducive to the formation of multi-cultural identity.

Limitations of study

One important limitation of the present study was that several mothers declined to participate. Recruitment proved difficult, as it took place during spring 2008 when a much-discussed media campaign, initiated by The Danish Folk Party, sought to prohibit veils in public professions. Some mothers declined to participate in the study, arguing that the investigation might be used to stigmatise them in the Danish society by further underlining their differences from Danes. There is a possibility, therefore, that the study population was biased towards participants who feel well-integrated in society at large. A bias is also likely to have been introduced by the fact that only mothers who spoke Danish rather fluently were recruited, which probably influenced the share of Danish-born participants to be larger than the share of immigrant mothers.

As the study design was explorative and qualitative, the results should not be taken as an assessment of the general extent to which concerns about dietary change, or about ethnic and cultural identification of food, are important to ethnic minority populations in Denmark. On the other hand, the recruitment process used in the study resulted in a relatively large variation in household composition, in the participants' age, education and employment status, and in the daily childcare and feeding practices. This variation may be taken to support the validity of the analysis beyond the focus groups. Ideally, this extended validity will be investigated in a future representative study. Further, it should be noted that in this study, the recruitment criteria were based on a definition of ethnic identity referring to parental birthplace. A more constructionist definition involving, for example, a participant's self-defined ethnicity would have accorded better with the concept of ethnicity used in the article, and it ought to be considered in future studies.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

Contributions

AN worked out the detailed design of the study, had the main responsibility for collecting the data, analysing the results and writing the manuscript. AK participated in the design of the study, contributed to the data analysis and has continuously commented on the writing of the manuscript. LH supervised the design and execution the study and data collection. She also participated in data analysis and in writing of the manuscript.

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