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Master thesis

**Bourdieu's Cultural Capital in Relation
to Food Choices: A qualitative
study among participants at a
Healthy Life Centre**

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Abstract in English

Aim: The aim of the study was to explore how incorporated cultural capital affect food choice among participants at a Healthy Life Centre, and explore the possibility to apply cultural capital theory to future public health promotion practice.

Method: A qualitative inquiry was conducted among participants at a Healthy Life Centre southeast in Norway. Data was collected by six in-depth interview, with a total of five men and one woman. A theory-driven thematic analysis was performed to look for similarities and differences across the data.

Findings and conclusion: Summarised, the findings of this study showed how cooking skills and health and nutritional knowledge (as constructs of incorporated cultural capital) affect food choices. Further, there was thought to be a relationship between the participants childhood experiences and their current food choices and overall lifestyle. These findings may contribute to explain the development and maintenance of differences in dietary intake. This in turn can explain the observed obesity gradient which is of importance when accounting for the social inequality in health.

Implications: Findings from this study cannot be generalized, but it may contribute to a better understanding of what affect food choice among participants at a Healthy Life Centre, which in turn may have implications for future public health promotion practice.

Key words: Healthy Life Centre, food choice, social inequality, behaviour, cultural capital theory, public health promotion practice.

Norsk sammendrag:

Formål: Målet med studien var å undersøke hvordan innkorporert kulturell kapital påvirker matvalg blant deltakerne på 'Frisklivsentralen', og utforske muligheten for å anvende kulturell kapital teori i fremtidig helsefremmende og forebyggende praksis.

Metode: En kvalitativ undersøkelse ble gjennomført blant deltakerne på en 'Frisklivsentral' sørøst i Norge. Data ble samlet inn ved seks dybdeintervju, med totalt fem menn og en kvinne. En teori-drevet tematisk analyse ble utført for å se etter likheter og forskjeller mellom dataene.

Resultater og konklusjon: Oppsummert kan disse funnene i denne studien viste hvordan matlagingsferdigheter og helse og ernæringsmessig kunnskap (som elementer av innlemmet kulturell kapital) påvirker matvalg. Videre ble det antatt å være en sammenheng mellom deltakerne barndomserfaringer og deres nåværende mat valg og generell livsstil. Disse funnene kan bidra til å forklare utvikling og vedlikehold av forskjeller i kosthold noe som igjen kan forklare den observerte fedme gradienten, som er av betydning for sosial ulikhet i helse.

Nøkkelord: Frisklivsentral, matvalg, sosial ulikhet, adferd, kulturell kapital teori, praktisk helsefremmende og forebyggende praksis.

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“It is not good for your health to write a Masters in Public Health!”

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Introduction

Globally, poor dietary intake is a major risk factor for morbidity and mortality (Martikainen, Brunner & Marmot, 2003). Of which people with low socioeconomic status (SES) are more likely to suffer from poorer health and have shorter life expectancy than their better-off counterparts (Thurston, 2014; Krokstad et al, 2013; Stringhini et al, 2010; Norwegian Ministry of Health and Social Affairs [SHD], 2006; Darmon & Drewnowski, 2008; Mackenbach, Stirbu, Roskam, Schaap, Menvielle, Leinsalu and Kunst, 2008; Dahl, 2002).

In Norway, as in many other countries, the correlation between people's socioeconomic position and their state of health is notable and firmly established (SHD, 2006). In the UK, The Black Report was one of the first documents to comprehensively document inequalities in health and its connection to social (occupational) class. Social inequalities have also been observed repeatedly in Norway, despite that the fact that the vast majority of the population are wealthy, well educated, and live comfortable and secure lives (Dahl, 2002; SHD, 2006, Dahl, Bergsli and van der Wel, 2014).

It has been suggested that the gradient in health outcome can, to a certain degree, be explained by the fact that compared to high SES groups; people in lower SES groups tend to engage more in unhealthy behaviours, such as unhealthy food choices (Skuland, 2015; Darmon & Drewnowski, 2008; Lallukka, Laaksonen, Rahkonen, Roos & Lahelma, 2007; Giskes, Turrell, Van Lenthe, Brug & Mackenbach, 2005; Johansson, Thelle, Solvoll, Bjørneboe & Drevon, 1999). Thus, there is arguably, also a case of social inequalities in health behaviour, such as healthy eating, as many of the diseases that underlie the social gradient in health are strongly diet related (Holmboe-Ottesen, Wandel & Mosdøl, 2004).

Eating behaviour is therefore one of many important elements for studies of how inequalities in health have developed, and are maintained.

When searching the literature about food choice (see appendix 1) and low socioeconomic status it became evident by the researcher that in spite of plentiful descriptive evidence in the field of public health on this subject, rather little understanding has been developed accounting for the socio-cultural processes that link the unequal distribution of *capital* to the social gradient in health (Abel, 2007). And although the relation between cultural capital and health (Abel, 2008; Abel, 2007), health behaviours and healthy lifestyle (Venstraa, 2000; Williams, 1995) is a subject of growing interest, the concept has not been used much in studies regarding socioeconomic inequalities in health behaviours, such as food choice (Kamphuis, Jansen, Mackenbach & van Lenthe, 2015; Khawaja & Mowafi, 2006).

In addition, my research is, as far as I know, the only qualitative research on this particular subject in Norway. And contrast to most of former studies, I focus on incorporated cultural capital. This form of capital consist of health-related values, operational skills, behavioural norms and knowledge. Because this form of capital is almost entirely invisible, it is therefore increasinly interesting to explore.

1. Literature review

The literature review will refer to previous research in the field of public health.

There are 5 main categories which will be presented, regarding (i) socioeconomic inequality in OW&B (ii) determinants of diet regarding OW&B (iii) lifestyle in connection to diet (iv) Bourdieu on lifestyle and (v) dietary change.

1.2 Socioeconomic inequality in OW&B in Europe, Norway and Stange

According to American Psychological Association (APA) (n.d) is often seen as the social standing or class of an individual or a group. It is often decided by measuring combination of education, income and occupation. Moreover, studies of socioeconomic (SES) status often show differences in access to resources, as well as issues related to privilege, power and control.

To put it briefly: OW&B is the biological result of positive energy balance due to an increased intake of energy-dense foods high in fat (World Health Organization [WHO], 2016). Although there has been increases in the prevalence of overweight/obesity in all SES groups over the past two decades, research from Europe has shown that socioeconomically disadvantaged groups have a higher prevalence of OW&B than their more advantaged counterparts (Giskes, Avendaño, Brug and Kunst, 2009; McLaren, 2007). This is also the case in the Nordic region. This is interesting as it points to the fact that the social gradient in obesity is present and persistent in the Nordic countries despite relative affluence, equity and socially egalitarian ideas (Magnuson et al, 2014)

In Norway the absolute difference in prevalence of overweight and obesity (OW&B) between low and high educational groups has increased (Magnuson et al, 2014; Krokstad et al, 2013; Ulset, Undheim & Malterud, 2007). The latest data from Norwegian Institute of Public Health

(2013b) reveal that 25% of Norwegian men reports being obese/overweight. In the case of Stange municipality, 30% of men reports being overweight/obese indicating that obesity is a bigger problem in Stange than for Norway as a whole. Roskam & Kunst (2007) state that overweight is more and more consistently related to education attainment than occupational class and income, which also is the case in Norway. Again, according to the Public Health Profile for Stange presented by the Norwegian Institute of Public Health (2013b) 83% of the Norwegian population has obtained higher levels of education, (e.g upper secondary school) whereas 80% of the inhabitants in Stange reports the same. This is interesting, because as the level of education often correlates with income level, compared to Norway as a whole, the inhabitants in Stange report the smallest gap in income between occupations (Stange, n.d). This narrow gap in income might be the result of Hedmark county (where Stange is situated) enduring a proud history as a worker's society, especially in agriculture. This may indicate that obtaining higher education may not have been an important factor as it has been easier to obtain work without it (Stange commune, n.d). This creates an interest to further elaborate on. The Nordkost 3 study, the third national dietary survey carried out among Norwegian adults, demonstrated that there are some social inequalities in food intake, of which the informants with higher levels of education consumed healthier diets compared to participants with lower levels of education (Directorate of Health, 2012). These findings is in accordance with several studies, reviewed by Giske et al, 2009, demonstrating that socioeconomically disadvantaged groups have a general pattern of dietary intakes and dietary behaviours that are (generally) less consistent with dietary recommendations for the prevention of weight gain and chronic disease.

1.3 The determinants of diet in relation to OW&B

Cost is often reported by socioeconomically disadvantaged groups to be a significant barrier to increasing their fruit and vegetable consumption (Cummins and Macintyre, 2007; Bolton-Smith, Brown and Tunstall-Pedoe, 1991). Energy-dense diets have been shown to be more affordable, indicating that intake of these foods are more often consumed by people in lower SES-groups (Monsivais, Darmon, Vieux & Drewnowski, 2007; Drewnowski, Monsivais, Maillot and Darmon, 2007; Drewnowski, 2004).

Findings from Fismen, Samdal & Torsheim (2012) and Kickbusch (2001) show that education influence food choice by facilitating or restricting reading and understanding of nutritional information, adherence with nutritional recommendations, as well as influencing values connected to healthy eating. These findings are consistent with those of Abel & Frohlich (2012) who found that well-educated people are better trained and more prone to follow, understand, and make use of the myriad of health, and especially nutritional, information communicated.

Giske et al (2009) found that unhealthy behaviours, such as poor dietary intake, are thought not to be the result of completely voluntary choices. To the contrary it is influenced by structures of the daily context and it is therefore interesting to consider the determinants of health. The interconnections between the various factors that influence health accumulate into a multifactorial illustration, provided by Dahlgren and Whitehead, as cited from Institute of Medicine (US) Committee on Assuring the Health of the Public in the 21st Century (2002).

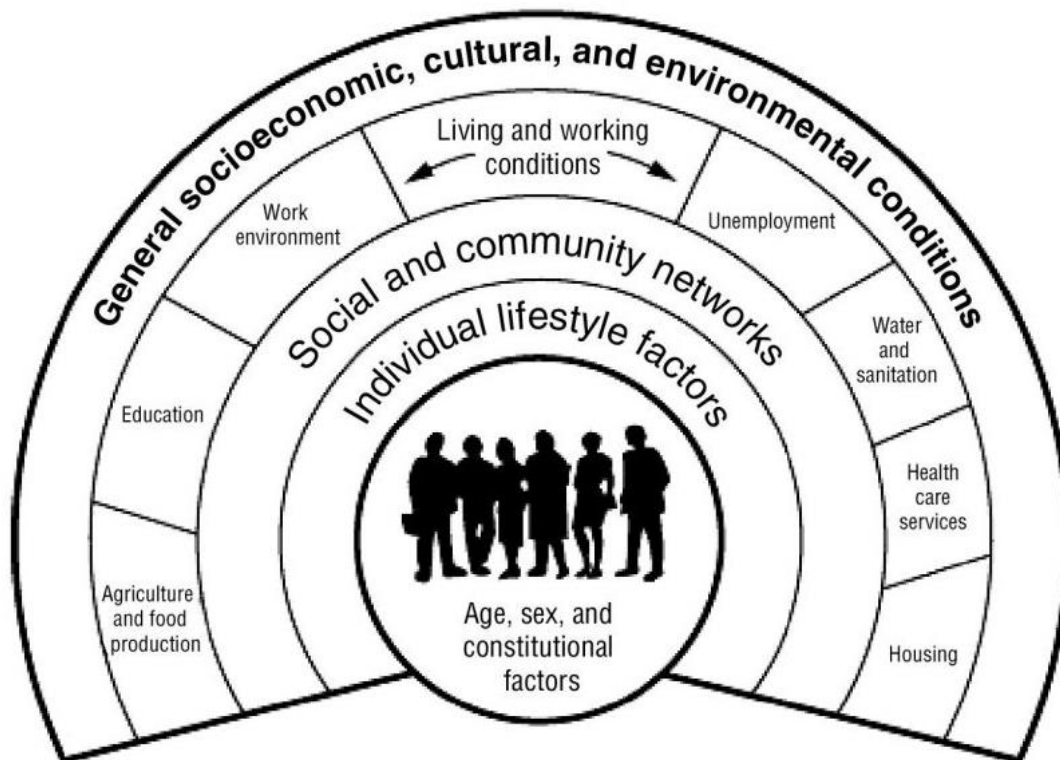


Figure 1. The Dahlgren-Whitehead model. The Dahlgren-Whitehead model shows a multifactorial illustration of what influences a person’s health. Also called the determinants of health. From Institute of Medicine (US) Committee on Assuring the Health of the Public in the 21st Century. Retrieved from <https://www.nap.edu/read/10548/chapter/11>. Copyright 2003 by the National Academy of Sciences.

This model can also shed light on ‘determinants of diet’ as this model shows that there is a complex mix of determinants, interacting at both the societal and individual level, influencing the conditions in which people live their lives. This may in turn affect their possibilities to establish habits that prevent the development of lifestyle-diseases, such as obesity, by shaping what, when, where and how much people eat (Friel, Hattersley, Ford & O’Rourke, 2015; Kanter, Walls, Tak, Roberts and Waage, 2015; Friel et al, 2013; Norwegian Ministry of Health and Care Services [HOD], 2011)

However, the decision to eat, and to eat particular foods, varies for different individuals and situations (Mela, 2001). Moreover, these individual differences in what to eat are developed through life due to differing food experiences and attitudes – as there are many internal and

external cues, not just biological cues such as hunger, which trigger the instant desire to eat or orient eating in the direction of certain foods. Health behaviour, such as food choice, have characteristics that make it of special interest due to the fact that it involves *more* than income and material wealth or the lack of ability to purchase goods and services that promote good health, and prevent overweight and obesity (Pampel, Krueger & Denney, 2010).

1.4 Lifestyle and it's influence on diet

As written by Thurston (2014), in the public health field, lifestyle has been conceptualized, operationalized and defined in two contrasting ways. On one side is the individualistic 'lifestyle model of disease'. The premise of this model is that diseases are the result of unhealthy clusters of behaviours and in order to gain health back it requires behaviour change. Moreover, definitions based on this model tend to view individual behaviours or habits as intentionally chosen by the individual. This is also the view reflected in many public health policies worldwide, including Norway.

There has, nonetheless, as described in Thurston (2014), been continuous critique of this model based upon three interrelated issues. The most fundamental of these relates to the causal mechanisms implied in this model. Because, as most diseases are caused by a web of interrelated internal and external factors reducing causality to a lifestyle or a particular behavioural aspect of lifestyle oversimplifies this rather complex phenomena (Vallgård, 2011). Besides, this model also offer little by way of understanding how lifestyles actually are developed and maintained, and critics argue that 'choice' is much more complex than implied by this individualistic approach to lifestyle.

Consequently, drawing on these criticisms an alternative perspective a model called the 'collective model' emerged. This model is to the contrary informed by a sociological understanding of human action, focusing on the interplay between social circumstances and

behaviours thus moving beyond individual risk factors (Thurston, 2014). Cockerham, Rütten and Abel (1997, p. 321) define health lifestyles as ‘collective patterns of health-related behaviour based on the choices from options available to people according to their life chance’. By defining lifestyle in terms of these ‘collective patternn’ the focus shifts away from individuals toward groups, based on wider social divisions – such as social class.

Besides, following this ‘collective’ notion Abel, Cockerham and Neimann (2000, p. 63) propose the following definition: ‘health lifestyles comprise interacting patters of health-related behaviours, orientations and resources adapted by groups of individuals in response to their social, cultural and economic environment’’. In agreement with Thurston (2014) this definition provides a more adequate starting point for understanding how (un)healthy lifestyles are developed and maintained, as well as providing insight into why they are so difficult to change.

1.5 Bourdieu on health- and lifestyle behaviours

From a sociological perspective the meaning of cultural factors go beyond health relevant consumer choices for goods and services, or explicit health behaviours. Kamphuis et al (2015) suggest it depend on one’s sociocultural resources, such as knowledge, skills, values and norms. Which in turn, by means of socialisation process and dispositions, shape individuals to become alike within each social class, and generation (Singh-Manoux & Marmot, 2005) and as such lays the foundation of one’s lifestyle.

Health has for long been understood as something given by nature only to be restored or repaired in the case of impairment or loss (Abel, 2007). However, one could also argue that, similar to wealth health is something not merely “given by nature” - it is actively produced and maintained at all stages of life and in all dimensions of society.

Pierre Bourdieu describes, as cited in Kamphuis et al (2015, p. 2), how health- and lifestyle behaviours may consequently be subject to class distinction through their ‘taste’ for numerous lifestyle attributes, such as culinary tastes which are developed through cultural capital, “a non-material resource that accumulates throughout the life course”.

In spite the fact that taste also is linked to economic capital, it mostly relates to cultural capital as taste remains stable also when people’s income increase over time, and as a result of that reflect certain cultural norms and values (Kamphuis et al, 2015; Blasius & Friedrichs, 2008). Moreover, as described in Abel et al (2000), Bourdieu argues that lifestyle choices are not only constrained but also shaped by life chances, and although individuals choose their lifestyle, they do not so voluntarily - as habitus lead them towards certain choices and that these choices again tend to reflect class position as people in the same social class share the same habitus. Besides, it has been suggested that class culture may influence food habits, and these habits in turn collectively help reproduce class culture (Abel et al, 2000).

1.6 Dietary change

Historically, the public health approach to dietary change refers to the explicit intention to shift unhealthy dietary behaviours in to a more ‘desirable’ direction in order to prevent future illness (Thurston, 2014; Nestle et al, 1998). However, as stated by Nestle et al (1998) although the assumption that knowledge shapes behaviour seem self-evident, research suggest that providing information about risk, such as developing overweight or diabetes, does not have much effect on peoples’ food behaviour. Unless it overcomes counteracting psychosocial and other behavioural barriers. For example, changing from butter to margarine as a way of reducing dietary fat, or eating fruit and vegetables to increase dietary fibres is seemingly simple. However, singular dietary behaviour change implies numerous accompanying decisions (Nestle et al, 1998). Furthermore, if dietary change were simple, then dissemination of information would automatically lead to behaviour change. However, as

research show - while the number of people trying to change aspects of their behaviours, such as changing their diet, is high, the proportion achieving sustainable change is low (Thurston, 2014). They persist despite abundant efforts to enlighten the public with knowledge about lifestyle choices and the necessity for changing attitudes and habits to improve health and well-being (Dahl et al, 2014; Dahl, 2002; Dahl & Elstad, 2001).

Because, although knowledge about health-behaviour links is a fundamental factor in an informed choice concerning a healthy lifestyle, knowledge is just one of several cognitive correlates of health behaviours (Abraham, Conner, Jones & O'Connor, 2008). Pampel, Krueger and Denny (2010) carried out an extensive literature review exploring why low-SES groups more often engage in unhealthy behaviours. They found that, besides financial constraints, SES can affect the incentives for healthy behaviour as low SES groups may feel they have less reason than high-SES groups to abstain from the short-term pleasures of unhealthy behaviour, for long-term gain in longevity. Arguments related to stress, limited health benefits, class distinctions and knowledge of risk each emphasise how SES form motives for healthy behaviour. Moreover, SES can also affect the methods to reach health goals. This review also found that although all SES groups may have similar desires for healthy behaviours, those in low SES groups have greater difficulty in realizing their goals. This is underpinned by prior studies such as Mirowsky and Ross (2003) which noted that the reduced lifetime earnings and wealth of low-SES groups give them less reason to invest in future longevity, and more reason to focus on the present in making decisions about health behaviours.

Moreover, research into nutritional knowledge and knowledge of health recommendations, also known as health literacy, show that lower socioeconomic groups tend to have lower levels of both knowledge and awareness of recommendations than their more-advantaged counterpart (Beydon and Wang. 2008; Kickbucsh, 2001). As a consequence, low-SES groups

may feel fatalistic about their ability to act in ways that prolong their lives and therefore, indulging in enjoyable but unhealthy behaviours, may make sense given shorter life expectancy and restricted payoff from healthier behaviours (Pampel et al, 2010; Wardle & Steptoe, 2003).

As seen throughout this paragraph, how people behave is a significant determinant of health. Thus, understanding how people develop patterns of behaviour as well as understanding behavioural influences is, therefore, a central endeavour of public health (Thurston, 2014). Moreover, eating behaviours (such as food choice) are of special interest as it is acquired over a lifetime and therefore; to change them requires changes in habits that must be continued permanently – long beyond any short-term period of intervention (Nestle et al, 1998).

2. Rationale for topic

Still today, social inequality remains a key issue in public health and public health promotion especially (Abel, 2007). Empirical evidence on the role of material and non-material resources are well accounted for by scholars such as Marmot (2005) and Marmot & Wilkinson (2000). When examining social conditions relevant to the unequal distribution of health and illness, social epidemiology has mostly focused upon either material conditions, such as income, or on social and psycho-social determinants, such as education (Abel, 2007). However, most often missing in public health research are cultural factors that link these resources together with social structure and health. As health promotion focuses upon the development and maintenance of health in everyday life, by people themselves - their cultural factors become of utter most importance for outlining practical interventions (Abel, 2007). For example, health relevant behaviours are closely connected with broader value systems and behavioural norms, among others, which are adopted according to the social determinants perpetuated by Dahlgren and Whitehead which in turn is socially learned throughout the life course (Abel, 2007). In sum, a wide range of differences exist between those who do and do not engage in health behaviours, such as healthy eating. However, most work on food choice behaviour have focused on the physiological and psychological determinants - with less attention given to the cultural, historical, social and demographic factors (Nestle et al, 1998). Thus, following the suggestion of Nestle et al (1998), understanding behavioural influences within the context of psychosocial influences is crucial for the development of dietary recommendations, nutrition programs and educational messages that will help people in constructing healthy diets and promote dietary change.

2.1 Overarching aim and research question

The overarching aim of this study is to better understand the ways in which incorporated cultural capital influences food choice, and explore the possibility to apply Cultural capital Theory to public health promotion practice.

Based on the purpose of this study as well as the literature gap on the subject my main research question is:

“How is food choice influenced by incorporated cultural capital?”

3. Theoretical framework

The French sociologist Pierre Bourdieu and his concepts of capital and habitus can be used as a framework for trying to understanding how routine practices of individuals are affected by the internal and external structure of their social world, and how these practices, in turn, play a part in the maintenance of that structure (Jenkins, 2002). Furthermore, as written in Abel (2007), one can try to answer the question as to how the unequal distribution of cultural resources contribute to the persisting social inequality in population health. These cultural resources comprise values, norms and behavioural patterns. Of special interest are those non-material resources which can be accumulated, invested and transformed for the sake of health gains.

As this theory consist of several aspects and definitions of both capital and cultural capital, a brief summary and its connection to each other and to my research question, is outlined below.

3.1 Economic, Social and Cultural Capital

In the 1980s, as given account for in Abel (2007), Bourdieu proposed a theory that focused on the interplay between material and non-material capital as the centre of an extensive analysis for social inequality, stratification and unequal distribution of power. His work demonstrated that the economy of a society go beyond the scope of the so-called economic marked of that society, and in consequence cannot be completely understood only in terms of economic capital alone. Moreover, his work illustrated that other forms of capital also are critical for understanding the complex processes of social differentiation in modern societies, namely social and cultural. However, as both economic and social capital are key factors for social

distinction and social inequality the focus in this thesis will be on cultural capital, and incorporated cultural capital especially. The rationale as to why is two-folded.

Firstly, when compared to economic or social capital, cultural capital has so far been given rather little attention when describing the production and re-production of health inequalities, such as dietary differences on the background of peoples food choices.

Secondly, with regards to the context of my study, following the findings in Chan, Birkelund, Aas and Wiborgs (2010) study ‘Social Status in Norway’: if status distinctions are less obvious in populations favoring egalitarian values, is it possible that where ‘objective’ economic differences are small, people will try to separate themselves through ‘subjective’, non-economic means, such as through aspects of cultural capital, resulting in even more proclaimed status distinction.

3.2 Cultural capital: An introduction

The present paragraph provides an introduction to Pierre Bourdieu’s cultural capital theory. Following Abel (2007), this introduction of cultural capital is selective and focused upon aspects relevant to issues in health promotion, and the hope is to demonstrate the importance of cultural capital to a critical understanding of the production of health.

According to Bourdieu, as given account for in Abel (2007), theory of cultural capital has its own particular logic that may be clearest in its contrast to the logic of economic capital..

Cultural capital itself refers to such resources which are related to one’s value systems and this specific type of capital becomes effective and finds its expression in personal dispositions and habits, also known as incorporated capital. It can also be found in the form of educational titles that grant an individual a certain social prestige and power, known as institutionalized cultural capital. Or in the form of knowledge stored in material form such as in books, machines etc, known as objectivized cultural capital. When linked to current public health

issues, such as how food choice leads to dietary differences and its connection to social inequality in health, specific examples for cultural capital would be: educational status (institutionalized), having health guidebooks or cooking books readily accessible (objectivized) or in the form of people's social and technical skills, perceptions, values and behaviors, which in sum shape people's health lifestyle preference (incorporated).

3.4 Incorporated cultural capital: An introduction.

With regard to incorporated cultural capital, a gap exists between Bourdieu's abstract ideas and the operationalisation into visible constructs of incorporated cultural capital as the measures that came forth from the literature review performed by Kamphuis et al (2015) were wide ranging. Therefore, the main underlying concepts of skills, knowledge, and values were selected.

Incorporated cultural capital does, according to Bourdieu, comprise of skills and knowledge of everyday practice that can be acquired by "culture" (Abel, 2007). Closest to what Bourdieu means here, by the French term "culture", is a fairly broad understanding of education. This include all forms of learning, not only acquiring knowledge, but also learning how to behave and how to make sense of the world. Seen in relation to incorporated cultural capital can health literacy be understood as consisting of values and norms which affects people's perception of health and illness. Consequently, these perceptions, skills and knowledge be understood as cultural resources virtually stored inside the individual. Furthermore, as these resources are obtained through a lifelong psycho-social process the respective perceptions and behaviors are applied and practiced in all social interactions, in consequence becoming daily routines. Besides, by being incorporated inside the body in this specific form, it becomes almost entirely invisible and the necessary learning process cannot be delegated (Abel, 2007).

In other words, investment in incorporated cultural capital, such as health literacy and cooking skills, has to be made by the same person who wants to use the resulting capital. This indicates that the options and means for accumulating incorporated cultural capital are limited. Moreover it means that the main source necessary to obtain this state of capital is both personal “time” and “affection”. As cited in Abel (2007) Bourdieu concludes that measure of “time of education” have to include all stages and forms of lifelong learning – including family education and peer group socialization; not just years of schooling. What is also meant by “affection” is that acquisition of incorporated cultural capital depends not only on external conditions but also a profound interest in the investment in and personal benefits. Furthermore, I followed Abel (2008) by appreciating values as reflecting incorporated cultural capital. Values are, as cited in Kamphuis et al (2015, p. 15) “typically long lasting dispositions of the mind”, which guide what individuals assess as to be important in their lives. Besides, values are not only individual characteristics but also cultural patterns of social class. And it is by Cockerham (2005) said to have a major influence on lifestyle and peoples’ consumption patterns.

3.5 The three states of cultural capital and their interaction with each other

According to Bourdieu, as described in Abel (2007), cultural capital has its own specific logic and he distinguished between three general states of capital which are briefly outlined below.

Bourdieu states that indicators depicted above are cultural factors as they carry a particular meaning based on systems of social values and norms, but at the same time can be understood as capital factors under the condition that they are useful elements of a society’s broader system of social distinction. For example: Objectivized cultural capital which comprise of books and technical tools. These can be seen as material forms and representation of the knowledge, and meaning, developed and obtained over time in a given society and particular

sub-culture. The meaning and utility value of this state of cultural capital however depends upon the incorporated cultural capital of the owner / user.

Institutionalized cultural capital is more easily understood as educational degrees. as it entitle particular forms of cognitive abilities, or practical skills, and competence that functions as a formal mode of social recognition. Which again is linked to the actor and consequently increases the social status of the ‘carrier’ of that competence (Abel, 2007).

The objectivized and institutionalized forms of cultural capital are the most visible and recognizable, but to the contrary we find incorporated cultural capital which is Bourdieu’s third classification of cultural capital.

This paper will focus the attention on incorporated cultural capital as although this specific type of cultural capital is much less visible than the other forms of capital, it plays a very important role in the exchanges and utilization of objectivized and institutionalized cultural capital. For example: objects of cultural capital, such as books or tools can only be useful on the condition that an actor’s incorporated cultural capital is adequate for understanding both the facts and knowledge that are provided in such books, and sufficient for using the tools. Likewise, institutionalized cultural capital can usually only be obtained in the basis of adequate incorporated capital (Abel, 2007).

3.6 Habitus

The notion of habitus is regarded as a particularly key Bourdieuan concept, which has been applied to the social world in order to perceive the intended meaning of individual and group socialization processes (Glithero, 2014). Wacquant (2008, p 267) writes that habitus is used to signify “the system of durable and transposable dispositions through which we perceive, judge and act in the world”. All through life, individuals are exposed to external restrictions,

social conditions and circumstances that affect our outlook and behaviours within society (Wacquant, 2008). Thus, exposure to different circumstances, so-called schemas, will create different habituses for individuals and groups (Sugden & Tomlison, 2006). Sugden and Tomlison (2006) define schemas as distinct patterns or dispositions of social behaviour. Moreover, individuals who are subjected to similar experiences and conditions share these dispositions, suggesting why individuals from certain groupings (e.g nationality, SES / class, gender) will often feel affiliated with and 'at home' with those from similar backgrounds (Wacquant, 2008). Due to constantly changing exposure to social conditions, Wacquant (2008) proposed that a schema is easily influenced because they inscribe into the body by the evolving influence of the social environment. However, these are restricted by a set 'standards' from previous experiences, as habitus is suggested to be both continuous and intermittent as it is affected by past experiences, but also by present stimuli, that may be modified by the acquisition of new dispositions (Wacquant, 2008). Such as class culture may influence food habits, and these habits in turn collectively help reproduce class culture (Abel et al, 2000).

In sum, the logic of incorporated cultural capital and habitus rests on these specific features: Incorporated cultural capital is tied to the body, it needs personal time to be acquired and incorporated, and acquisition and implementation need affection. And as habitus is constructed by earlier life experiences, perceptions of reality and experiences from childhood and education (Wilken, 2008) I will therefore turn to my informants childhood and explore what, if so, that has meant for their food choices today.

4. Methodology

The research question in this thesis is "How is food choice influenced by incorporated cultural capital".

In this chapter I will describe choice of method and research design, give a description of the sample, preparation of instrument and the practical implementation. Further, the data analysis procedure will be described and ethical considerations will be addressed, followed by a methods discussion.

This project holds a constructivist worldview. According to Bryman (2012), researchers who hold this worldview seek to examine the processes by which the social world is constructed, thus consider the ways in which social reality is an ongoing achievement of social actors rather than something external to them that constrains them completely. Besides, constructivist think that individuals seek understanding of the world in which they live and work. This worldview can be compared with the notion of cultural capital and habitus this thesis uses as a backdrop for understanding peoples food choices.

Moreover, researchers that hold this worldview, such as the researcher of this study, is inclined to reflect and address how their role in the study, and their personal background, culture and experience hold potential for shaping their assumptions and interpretations (Creswell, 2014).

4.1 Basis for the choice of approach

When seeking to understand if incorporated cultural capital influences food choice a qualitative approach was viewed as the most appropriate approach. This is because the answers can be used in the exploration of meanings of a social phenomenon as experienced

by the individual itself, in their natural context (Patton, 2015). Using qualitative methods to understand the background of food choice among HLC participants, entails an attempt at understanding the meaning behind food and eating in peoples' everyday lives. Such as taking in to account the social, and possible cultural context, in which people think about, buy, prepare and eat food. Thus, we can increase our understanding of human characteristics such as experiences, perceptions, thoughts, expectations, motives and attitude.

Using a qualitative method emphasises the need to view events and the social world through the eyes of the participants by talking directly to people, and seeing them behave and act within their context, thus providing information with regards to the participants lived experience (Creswell, 2014; Dallon, 2012). Furthermore, as the data collection is characterised by selectivity and closeness to the participants it is useful to perform semi-structured qualitative interviews. This is characterized by allowing the researcher some control over the line of questioning by asking open-ended questions, intended to elicit views and opinions from the interview subjects (Creswell, 2014). Thus, questions aimed at revealing people's incorporated cultural capital and the value and explanation the individuals ascribe, especially in relation to food choice behaviour is suitable for a qualitative interview.

4.2 Basis for the choice of design

The decision to use phenomenology as a design centred around that in qualitative inquiry, phenomenology is a term that points to an interest in understanding a social phenomenon from the participants' own experience, and describing the world as experienced by them (Brinkmann & Kvale, 2015; Reeves, Albert, Kuper & Hodges, 2008). As this research required an understanding of food choice, it entails an attempt at understanding the meaning behind food and eating in peoples' everyday lives, this design was considered suitable.

4.3 Strengths and weaknesses of the approach and design.

As Brinkmann & Kvale (2005) writes, qualitative research interview investigates human existence in detail and gives access to subjective experiences, in consequence allowing researchers to describe detailed aspects of people's life worlds. The advantages with qualitative research it that is emphasises the need to view events and the social world through the eyes of the participants by talking directly to people, and seeing them behave and act within their context, thus providing information with regards to the participants lived experience (Creswell, 2014; Dallon, 2012).

The biggest disadvantage with qualitative research is that it is time-consuming, and was therefore thought to hinder participant joining the study. This in turn has a negative impact on the projects reliability. Qualitative studies also tend to have problems with generalizability. By collecting such a vast amount of nuanced, detailed, data it may prove challenging to analyse the content in the best way possible since it provides indirect information, filtrated through the views of interviewees (Creswell, 2014). Moreover, this approach may not be problem-free as questions of this nature are very subjective, maybe making the respondents inclined to answer less truthfully than if they answered the same questions in a quantitative questionnaire, which is more anonymous. In addition, by making the inquirer involved in a persistent and intensive experience with participants, it affects both interviewees and informants. As a consequence, another important consideration to account for in qualitative research, is the researchers role. Furthermore, when using a theoretical lens, such as Bourdieu's theory of capital, it shapes the types of questions asked and informs how data are collected and analysed as therefore it may interfere with the researchers ability to look through the 'objective lens' when interpreting the findings.

All these abovementioned issues will be discussed further down this paragraph.

4.4 Sampling and sampling strategy

As the study aimed at gaining knowledge about food choice among people in low SES groups, it was deemed necessary to limit the sample to participants from a local Healthy Life Centre (HLC). This was on the background that an evaluation of two HLC in Norway showed that this municipal public health initiative, also known as a 'low-threshold service', aimed at people who has developed, or in risk of developing, lifestyle diseases, recruits people with low levels of education (Anderberg, 2014; Bjurholt, 2014; Norwegian Directorate of Health, 2013a). Moreover, a part of their training is to gain knowledge about how to read, understand and make use of nutritional information, thus the participants had nutritional knowledge.

Participants were recruited by means of purposive sampling. Bryman (2012) describes this method of sampling as selecting sites and participants with direct reference to the research question. Moreover, a typical case sampling were carried out as the researcher sampled a case because it exemplifies the dimension of interest. The site was also chosen because it is situated in the researchers native municipality. It was thought that it would be easier for the researcher to establish contact with the 'gatekeeper' and thus be more approachable to the participants, which in turn would give them a sense of security towards joining the project.

4.5 Recruitment

Initial contact to present the project was made with the Healthy Life Coordinator (HLC-coordinator) at HLC in Hedmark county in the fall of 2015. Through an additional meeting the project was identified as suitable and recruitment strategies were discussed.

Informant recruitment started as soon as the researcher got approval from Norwegian Centre for Research Data (NSD) (See appendix 2). This was in March 2016. After guidance from NSD, initial contact with the informants was established between the HCL-coordinator and the informants, because the HLC was subject to duty of confidentiality. The gatekeeper was given a 'parcel' consisting of the information sheet and letter of consent together with a 'ready-stamped' envelope, to hand out to the participants at the HLC. The thought behind this was that participants might find it easier, and free of charge, to participate in the study. The informant then sent the letter of consent in return together with a phone number so that the researcher could establish personal contact and set a date for the interview with those participants who expressed an interest in the study.

It was very difficult to recruit informants for this study and as a consequence it was deemed necessary that the 'gatekeeper' reached out to some of the HLC participants which she thought would be interested, but needed a 'nudge'. What is meant by this is that she spoke directly to the participants about the research, instead of only handing over the paperwork. Two more were recruited through this approach. An additional HLC centre was also contacted in an attempt to recruit participants to the study, however, they never answered my enquiry.

4.6 Data collection

4.6.1 Qualitative interview guide

Prior to the interviews, a semi-structured interview guide was developed (see appendix 3).

Broad questions on the participants demographics (e.g age, education and occupation), everyday life (e.g, friends and family and leisure time activities) were asked initially to ‘break the ice’, but also used as means to gain information about their SES. An additional question about what aspect of their health they wanted to improve since they were participants at a Healthy Life Centre were asked to gain knowledge about how they perceive their current health to be. Questions on childhood memories regarding food and food practice were asked as a means to make the informants think about the background for their current food choices. Further questions were then asked about food habits and eating practices nowadays - in the household, and outside the home. Thoughts and experiences about participants current food-practices, including grocery shopping and cooking were also asked. Other influences underlying their food choices such as perception of healthy / unhealthy diet and potential wished to change it and possible advantages and disadvantages with this, were also asked. In sum, the questions in this interview-guide covers a very broad scope as it touched on all forms of capital: economic, social and cultural.

However, emphasis is on incorporated cultural capital as this state of cultural capital is thought to affect the other forms and states of capital. Kamphuis *et al's* (2015) review of existing measures of incorporated cultural capital was therefore also used as main input for the development of this semi-structured interview guide to food choice relevant to cultural capital. The features of incorporated cultural capital that came forth from their literature review were wide ranging, however, I selected the main underlying themes of *knowledge and skills* as the constructs that shape one’s incorporated cultural capital. For *food related skills*

three types of abilities was chosen: cooking skills, grocery shopping skills and skills to find and process information about nutrients and food preparation.

Cooking skills regarded statements about cooking / preparing a meal and the use of recipes.

Grocery shopping skills regarded statements about how the participants usually go about grocery shopping. *Food information skills* regarded statements about the labels of food products and the usage of this information in the decision making of what foods to buy.

Nutritional knowledge regarded statements about self-assessed knowledge about nutrition and whether they make use of that when they choose foods.

4.6.2 Qualitative interviewing

During the interviews the researcher used this this piece of work to keep focus and make sure every topic was covered. The researcher also tried to work the questions in a conversational flow so the interviewee had a chance to elaborate further on every question. An advantage with semi-structured interviews is that questions or themes not thought about in the beginning can be discovered, in consequence potentially enhancing the study (Denscombe, 2014; Kvale & Brinkman, 2009).

To get a feel of how the guide worked the researcher performed two pilot-interviews, from which the researcher reflected on with my supervisor and made changes to both the ordering of the topic guide questions, and the wording.

6 semi-structured interviews were carried out. They lasted from 42 minutes to 101 minutes, of which five of them took place in the informants home and one at a meeting-room at a local library. These interviews has served as my main source of data.

A tape-recorder was used during the interviews. This gave me more detailed data, and it was less disruptive for the informants. At the same time I could focus on details and context around the conversation, like body language. I transcribed the interviews verbatim as soon as I could, which was important in order to have the interview and the situation clear in mind.

4.7 Ethics

When performing a social research project where personal data was collected, it falls under the Personal Data Act, thus there was a need to apply for permission from Norsk Samfunnsvitenskapelig Datatjeneste (NSD) (Thaagaard, 2009). Such approval was applied for in this study. Moreover, when performing a social research project, ethical considerations need to be considered and managed throughout the project.

The topic of food choice may appear sensitive, especially when the interviewer in this case is a public health nutritionist. It was voluntary to participate in this study. A written consent form (see appendix 4) stating the purpose of the study, and what impact their involvement in the study have, was collected at the beginning of the study. It also said that they can at any given time withdraw from the study without having to explain why (Thaagaard, 2009). The data collected was kept confidential as it was only the researcher that had access to personal data and phone-numbers. Fictional names were given to the informants in order to keep them confidential.

4.8 Credibility, transferability, dependability and conformability

Credibility in qualitative research involves establishing that the results are believable from the perspective of the participants (Patton, 2015). The informants in this study consisted of both men and women in different age groups, with different educational level and occupations, thus providing a broad range of accounts and views. As not all participants were equally articulate it made it more difficult to extract information from the interviewees. Therefore as a way to ensure credibility the researcher asked the informants if they wanted a summary of their interview in order to check for accuracy before writing the findings chapter.

Unfortunately, all informants turn down this offer.

Dependability in this study is not easily judged as it is not feasible, for instance, to check the quality of research and its findings by replicating the research, as its virtually impossible to replicate a social setting (Denscombe, 2014). The participants at the HLC are participants for 12 weeks only. Furthermore, time inevitably changes things and the likelihood of assembling equivalent people in comparable settings in a social environment that has not changed, is highly unlikely. Moreover, the researcher tends to be intimate with the data collection and analysis in such a way that the possibility of some other researcher being able to produce identical data, and reach the same conclusions, is equally unlikely. However, by using theories such as Cultural Capital Theory it makes it possible for the researcher to understand, and to translate to others the processes that happen under the visible surface and thus develop knowledge of underlying principles (Reeves et al, 2008). Just as Bourdieu intended his theory of capital to be applied to explore different contexts, this study might be able to transfer the theory about how capital influences diet in Norway to think about diet in other national context. And as such can conformability be reached.

Transferability refers to which extent the results can be transferred to other contexts or setting. When working with the analysis process, but also with regards to research in general, researchers should operate in an open and honest matter about what they are doing. This also involves accounting for your preconceptions, in consequence your 'scientific integrity'. This means presenting and explaining how your worldview and prior knowledge about the subject in question shape, and in turn influence our preconceptions, as well as our interpretation of findings (Brinkmann & Kvale, 2015; Denscombe, 2014; Creswell, 2014). The researcher position in this process has mainly build on curiosity and interest for the subject as although the researcher have no previous, formal work-experience in the field, she have a profound interest for Public Health, especially Public Health Nutrition, as she studied Public Health (Nutrition) both at bachelors- and masters level. Besides, she earned a degree in culinary when attending upper secondary school. This has shaped her preconceptions such as the way she view foodstuffs both in terms of nutritional content and how it influence us biologically, but also socially such as what 'role' food plays in peoples life and how they 'value' it. Furthermore, after being introduced to sociology, and especially the works of Pierre Bourdieu's and his 'theory of capitals', she was immediately interested in exploring this notion in Norway as we pride ourselves by living in an egalitarian society – somewhat opposite to the system of which Bourdieu's theory was intended for.

5. Analysis

The aim with this qualitative interview research is to gain an understanding of if food choice may be influenced by incorporated cultural capital.

This analysis was influenced by the spirit of social interpretivist and hermeneutics.

Hermeneutics is a term, when applied in social sciences, concerned with the theory and interpretations of meaningful human action (Bryman, 2012). This also involves Max Weber concept of “Verstehen”, which the emphasis is on empathetic understanding, as researchers generally, and also in this study, attempts to view things from that person’s point of view in order to understand their view of the world (Kvale & Brinkmann, 2015; Bryman, 2012).

5.1 Thematic analysis

The method of analysis in this thesis is a qualitative thematic analysis, and is described by Clarke and Braun (2016) as a method for identifying and interpreting patterns of meaning within the data. Moreover, this method is widely applied in qualitative research as it provides a flexible and useful research tool with the possibility to provide rich, detailed and complex accounts of data. Besides, it can offer a more convenient form of analysis, especially for those who find themselves early in a qualitative research career (Clarke & Braun, 2016).

Thematic analysis includes a number of decisions that needs to be considered and discussed in more depth. One of the decisions is at which level the themes are to be identified, at a semantic or a latent level. For this analysis the latent level was chosen as it goes beyond the semantic level and as a consequence identify or examine the underlying ideas of the data.

Identifying themes on a latent level requires what Clark and Braun (2016) call interpretative work. This means that during the coding procedure, the researcher “read between the lines” and labels the codes based on the researcher interpretation of the data, as well as for the data

collection in its entirety. What is here meant by “reading between the lines” is that as social reality has a meaning for human beings and for that reason human action is meaningful. That is, it has meaning for them and they act on the basis of meanings they ascribe to their acts and to the acts of others (Bryman, 2012). The job of the social scientist is therefore to gain access to people’s ‘common-sense thinking’ and in consequence interpret their actions and their social world from their point of view. Moreover, as the social scientist will almost undoubtedly be aiming to place the interpretations that have been obtained into a social scientific frame, there is a double interpretation going on: the researcher provides an interpretation of others’ interpretations (Bryman, 2012). In addition, there is a third level of interpretation because the researcher’s interpretation have to be further interpreted in terms of the concepts, theories and literature of that field of study – which in this case was the sociological Cultural Capital Theory.

The choice between inductive and theoretical analysis maps onto how and why you are coding the data as it can either be theory-driven or data-driven. In the former, the text is sorted in relation to categories which is pre-determined from existing theories, whilst the data-driven is based on the text and identifies components which form the basis for developing categories (Malterud, 2013). The analysis in this thesis is theory-driven.

According to Clark & Braun (2016) ‘theoretical’ thematic analysis tend to be driven by the researcher’s theoretical or analytic interest in the area, and as a result of that it is more explicitly analyst-driven. Although this form of thematic analysis tends to provide less a rich description of the data overall, it was deemed appropriate as it instead it gave a more a detailed analysis of some aspect of the data.

5.2 Phases of thematic analysis

The initial steps of analysing starts when the researcher begins to look for patterns of meaning and potential interesting issues while transcribing and reading through the raw data (Clark and Braun, 2016) As the researcher in this study collected and transcribed the data herself, assumptions about what codes that might develop emerged early on. Nevertheless, it was important to have repeated engagement with the data, as looking for codes without being familiar with the data may lead to making analytic leaps too soon, without the benefit of evidence to back them up, or miss the less obvious meanings that emerge through repeated engagement with the data (Terry, 2016). Hence, familiarization helps to engage with the data without the need to begin coding or worry about the shape of potential themes (Terry, 2016). While reading through the transcripts notes were taken about the ideas which began to form about the overall shape of the data. Then each transcript was revisited and comments under each question were added in order to provide some cohesion in the early phase of the analytic process. Afterwards, statements that appeared interesting and relevant was broken down to initial codes that were supposed to reflect the main substance of the content (Clarke & Braun, 2016). The next step was to go through the themes in relation to the codes and the data extracts associated with them, and exploring whether they ‘work’ in relation to the whole data set. From there an ongoing analysis to refine the data extracts that best demonstrate the key aspects of each theme was carried out (Terry, 2016). The task of defining and naming is about making clear what is distinct about the themes and how they relate to one another and criterion for themes in this study was responses concerning cooking skills, health- and nutritional literacy.

An example of the coding procedure is attached as appendix 5.

6. Findings

6.1 Participants characteristics

In order to maintain my informants confidentiality the names presented are fictional. Their household composition, occupation and health status are indicated. In addition, the informants in this study were all participants in a course at the HLC where they had access to nutrition counselling provided by health personnel.

Ola is in his late fifties and lives in Stange, where he also grew up. He is currently unemployed but worked as an unskilled chef before he became ill and had to have a lung-transplant. He now also suffers from obesity. He has no children and lives alone.

Eivind is in his mid-thirties originally from Rælingen but lives in Stange. He works as a teacher at a local secondary school. He suffers from celiac-disease. He is married and has three children.

Rolf is in his mid-fifties and lives in Stange, where he also grew up. A few years ago he was diagnosed with diabetes, which led to him becoming unemployed from his work as a taxi-driver. He has no children and lives alone.

Turid is in her seventies and lives in Stange, where she also grew up. She is now retired, but worked as a nurse, and later as a homeopath. After some years in retirement she started showing symptoms of Parkinsons disease. She lives with her husband.

Geir is in his mid-thirties and lives in Stange, where he also grew up. He currently works as a meat cutter and is a trained chef. He suffers from obesity. He has no children and lives alone

Arve is in his mid-forties and lives in Stange, where he was born. However due to different circumstances he moved around a lot during his childhood. He currently works as a chimney sweeper. He suffers from obesity. He has no biological children and has lived alone for quite some time, but because of family matters he now lives with his parents, sister and her three kids, in addition to a foster child whom he is responsible for.

6.2 Findings

As this analysis was theory-driven the key descriptive theme involved (as incorporated cultural capital comprise all skills and knowledge of everyday practice) *incorporated learning* of which *cooking skills and health- and nutritional literacy* worked as sub-themes. Insight to skills and literacy, it was felt by the researcher, would give insight to food choices.

The explanatory themes connecting the descriptive themes to each other involved *levels, origin and impact* as the study's findings showed that there was different levels of informants' cooking skills, perception and knowledge about healthy eating which seems to correlated with the origin of the knowledge base, which in turn seems to have an impact on their current food choices.

6.2.1 Cooking skills

As incorporated cultural capital has to be personally acquired and the investment has to be made by the same person who wants to use the resulting capital - cooking skills can be helpful to think of as an aspect of incorporated cultural capital. From what my informants told me

there was considerable variations in knowledge about cooking, its application, and relevance to food choice.

Findings suggested that cooking skills reflected implicit knowledge about cooking, which was not recognised by my informants as something they had been explicitly taught. Instead they explained that the way in which they felt they had been *taught* something about cooking, food and diet was by getting ‘hands-on’ experience in the kitchen, as the following quote from Eivind illustrates: “We were allowed to get a chance in the kitchen. I think that is an important aspect of it. To have a go. Whether it was with grandparents or with mum and dad”. Similarly, when Turid described how she ‘learned how to cook’ she did not mention either mechanical or practical techniques: “I was taught by my mum. But like she never *said* anything. I just helped her cook”. However, to the contrary, Rolf explained he had not been taught *anything* about cooking, food and diet at home, that that this has influences his confidence and ability to cook now. He explained that “the little that I’ve been taught, I guess I’ve been taught in home-economics”.

Interviewer: Okai. Do you enjoy cooking, or?

“No, that’s not my forte”.

Interviewer: Okay. Can you tell me why that is?

“Well, it kind of just. It never became any of it because when I lived at home I was served [dinner]. Sure, it happens occasionally that I cook here [at home]. A pizza, or chicken, or something like that. But it’s not. I’m not a kitchen whiz. That I’m not. (laughter)”.

The informants described using a range of different cooking skills as they went about preparing and cooking food. The informants talked about how they went about cooking a meal, opinions about cooking and their cooking abilities, they referred to, or made apparent,

various 'cooking skills'. The informants reported using few mechanical skills when they cook a meal as they described the most common way of preparing a meal was to do it in a haphazard way, which meant they did not use any measurement utensils. Overall, none of the informants reported following recipes; unless they were cooking a dish they had never cooked before such as this quote from Turid illustrates: "[one need to use a recipe] to cook new meals that you are unsure of. Of course, if you are going to make a cold meal or something, and you must make mousse and gratin, then you must use a recipe". Interestingly, Arve reported that "I usually use my wildest imagination when cooking, but when I use dry-soup mixes, then I follow the recipe on the back", suggesting that there might be differences between people's perception about the level of difficulty when preparing a meal. But also suggest differences in which dishes people consider necessary following a recipe, indicating that there are differences in people's confidence in cooking.

Findings also illustrate that cooking skills can be seen as complex, and include more than merely practical, technical ability. Such as the perceptual understandings of the properties of foods in terms of taste, colour and texture. Turid revealed an ability to judge the optimum moment at which to remove scallops (during the process of frying them) in order to eat them as this quote illustrates "When I cook scallops, I cook them until golden brown. [and] I don't use a timer when doing that". Ola's words on the other hand revealed that he uses perceptual skills when preparing pork belly as he judges the pork belly to have reached the ideal temperature when the pork rind has 'popped'. Turid also spoke about 'using leftovers' or in other words, designing meals or 'dishes' around available ingredients. 'I set aside the broth after I've cooked a pork loin, because then I have a nice broth to use as a base for a sauce later'.

To choose foods appropriate for the available resources and/or the occasion and/or the preferences or requirements of those for whom they were ‘cooking’ for was also referred to.

Geir spoke of cooking favourite foods for relatives coming over for dinner as this quote illustrates: “I served two kinds of sausage. With mashed potatoes and French fries. (laughter). To meet both the kids, and grown-ups, wishes.” Eivinds’ words on the other hand showed he had to take into account the different tastes and preferences of his children, himself and his wife as well as the guests: “I think [we served] either salmon or homemade lasagne. With salad. I always decide what to serve in agreement with my wife. We think a bit practical when deciding what to serve [for dinner]. Like what will be enough food. And in this case we knew that the kids would eat it. So we didn’t cook anything fancy. But we’ve made a bit more fancy fish soups and other things when we’ve had neighbours over for dinner”.

These findings suggest that exposure and involvement in cooking during childhood, and thus the acquisition of and repetitive use of these cooking skills became, for some of my informants a ‘intuitive frame of reference’ for cooking, but also for choosing foods.

In sum, the abovementioned findings indicate that having cooking skills is crucial for food choice. Moreover, without knowing how to cook, nor enjoying it, it can be difficult to make homemade, unprocessed foods.

People’s health and nutritional literacy can also be considered as one of the many factors influencing, and consequently determining, food choice. Which is what this next theme is about.

6.2.2 Health literacy

Values and norms which affects people's perception and illness seem in this study to also affect people's nutritional literacy, and in turn their food choices.

Rolf who is a diabetic and overweight explained how he perceives his current health status to be, in relation with the actions he has taken to improve his health.

“Yes. I've had a bit more focus on diet. At least I think I have. But these [blood sugar] values differs too much. But at least it is important – I've discovered that [my] levels drop considerably when I've been to the gym. And last night, I had a friend over who also has diabetes. And he had been to Thailand. And he said it was so hot there that it regulated his blood sugar levels. So he didn't have to take his pills because he sweated that much. So apparently, there more you sweat, all the more [your blood sugar] levels drop”. (...)

To the contrary, when Eivind explained his experience with having to deal with his celiac-disease and what actions he has taken in order to improve his health he talked about how the only way for him to get better, and to deal with the disease long term, was to seek help from a specialist clinic in order to undergo extensive health check-ups and follow strict dietary regimes. Although he found it to be quite comprehensive in the beginning, when he discovered the change it made in his life, it gave him such a comfort which again gave him profound motivation to keep on changing his diet and learn more about food and nutrition.

When my informants were to describe what they considered to be healthy / unhealthy Eivind, who grew up in a home where consciousness around food was especially evident, described healthy food with emphasis on animal welfare, environmental issues and sustainability as well as the biological benefits generated by eating healthy such as stable blood sugar and stable energy. And when he explained what *unhealthy* food is he said: “I think of unbalanced [diet],

empty calories. A lot of calories either in the shape of pure sugar, candy or just plain flour pancakes with jam on, which give you a quick release of energy, but doesn't 'give you' anything over time. And food with a lot of starch. Going back to that part with childhood and food. I remember we could be served sausage or just a ton of macaroni with nothing but ketchup. That's not healthy food for me". To the contrary, when Rolf was asked about what *unhealthy* food was for him, he said:

"I guess it's fatty foods such as French fries and a lot of dressing and bacon. Fast food if you like. Convenience food. That's probably. That is unhealthy. But on the other hand, if you buy chicken at a snack bar it should be OK, I suppose".

These abovementioned perceptions and behaviours are then, in turn, applied and practiced in all social interactions and as such they become daily routines – which arguably also can affect people's food choices. Which was evident for Arve, who said this: "I'm not a fanatic when it comes to food. Because it is something with the fact that what you usually buy, that is what you buy". And when daily routines become such a incorporated part of us it can become very difficult to change them, or create new ones without great effort. This was the case for Arve who said:

"I can say that during the first couple of weeks I started this Healthy Life Centre-thingy, I tried to eat healthy. But then all of the sudden it was Easter and then everything went astray. But that is how it is. I spoke to that physiotherapist [at the HLC] and she said 'it's red-letter days, so you have to take in to account that you go astray. It's nothing you can get away from".

In other words, certain lifestyles, although they may be relevant for health, are practiced habitually with no other intention towards any particular outcome beyond making ends meet.

And as such it can be viewed as a persons' health literacy as it consist of their values and norms concereng health.

6.2.3 Nutritional literacy

Informants in this study were participants at a Healthy Life Centre. A fundamental part of their training was to learn about the Norwegian dietary guidelines and as a consequence explain how 'nutritional information', such as the importance of eating more vegetables was part of how my participants described a healthy diet, such as these quotes from Arve and Rolf, (who have not been interested in food or diets before after joining the HLC, nor gaining hands-on experience in the kitchen in their childhood), illustrates: "[healthy food] It's pretty much everything. Almost. (laughter). If one is to think like that. But from what I used to eat to [before], to what I eat today [it] is healthier because it is more 'green stuffs' [vegetables] in what I eat now" (Arve) and "Vegetables [are healthy]. And red fish. So I've learned" (Rolf).

One of the ways to successfully accomplishing dietary changes is to learn how to read, understand and in turn make use of the information given on nutrition labels.

Eivind, the secondary school teacher, had many opinions reading the viability of labels of content on food. Indicating that he learns about the contents of food through a process of doing, and he as such invested both time and 'affection' in obtaining skills and knowledge and in turn utilize them as e assesses it to be beneficial for his health.

"As it can be difficult to read [the label] [because] it is not written in enough languages, and especially that it may be hidden underneath the packing, or that it's written in fine print, we use an app to scan them [the groceries] to look for gluten and milk-content. And we are very conscious about what it says, in what order it is in. If there is starch, wheat-starch, whether it's gluten-free or not, I react so strongly to

wheat that we have to look it up. But gradually we don't look up those food items we know from 'the inside out'.

To the contrary, people with less formal education may be less disposed to read the table of content and also less likely to understand and make use of the information the nutritional labels give. As Rolf, a former taxi driver suffering from diabetes, said:

“Well, yeah, I've started with that [reading the labels] lately because of [my] diabetes. But (pause) then I don't know what I should eat if one shall (laughter) avoid it [sugar]. But I've omitted butter [from my diet] because it is dangerous. Then it's better to use mayonnaise, full fat mayonnaise, because it's real fat being excreted. Light mayonnaise is much more dangerous than real mayonnaise. That is what I've been taught. Then I use mayonnaise instead of butter as the base [on a slice of bread].

Interviewer: I see. Where do you collect this information from?

“Well, I've been meeting with one of those dietitians, in connection with [my] diabetes”

Thus, findings indicate that although the nutritional information given by the HLC-nutritionist is based on the Norwegian Health Directorates' guidelines, which aims to be universal and easily understood, there seemed to be a gap between how the informants perceived and acted on scientific knowledge provided by a professional.

It is therefore interesting that among some of my informants was an emergence of a 'healthy eating' morality: “the should syndrome”. In other words a gap between “what I should do” and “what I really do”. Ola expressed that although he knows how he can increase his intake of fruit and vegetables by chopping it in to bit-size pieces and have it standing on the table, he seldom does it. And although Arve explained he knows it is unhealthy to eat foods with a high content of fat he also said “there are many people who think that all this saturated fat and stuff

[is bad for you]. But then I say, ‘sometimes I want to know that I will die from something nice’”. These findings indicate that people may understand the scientific advice related to healthy eating, however they may be unwilling, or unable, to follow through. Rolf also knows that he should eat fruit and vegetables “but not too many apples though, because she [the dietitian] told me that there was this one guy who had changed his diet and he had started eating only apples. And he developed diabetes. Because it’s sugar in apples you know”, indicating that Rolfs reason for not eating apples is due to an anecdote put forward by the dietitian. However, it was meant by the dietitian to serve as a extremity of dietary change.

Food and cooking skills is both a material mechanism for how we interact with one another in society, and an indicator for social distinction - both in what is eaten and it’s quality.

Among some of my informants, distinctions were made between themselves as quite ‘good’ (aware and conscious) eaters, and other who they perceived as ‘bad’ eaters, eating junk food, in addition to being less aware and conscious about their food choices and the affect it has on health, as this quote from Turid illustrated:

“We’re following in the footsteps of America. We’ve done it for a while now, and it’s getting even worse. I saw this other guy I in Hamar yesterday. He was huge. His jumper was to short and his pants hung below his waistline and his belly just dangled. And it was showing. It was just so unappetizing. I feel sorry for them when they end up looking like that. Think about it. And don’t try to tell me that they eat proper food. They eat too much and just foods that fill you up, but with no other value that to produce [fat].

At the same time Eivind mention he is worried about the development of A and B-teams in cooking, and in consequence support an emerging division in cooking skills and confidence.

His argument suggest that with a lack of cooking skills people are left with little choice but to 'accept' ready-prepared meals and other fast-foods.

"I'm worried were developing A and B-teams in cooking"

Interviewer: "What is the thought behind that?"

"With A and B-teams I'm think that some just end up 'in the same old rut' and eat a lot of pre-cooked foods maybe. And in the last minute buy a readymade pizza or make use of some fast-food restaurants. Or that [they] aren't conscious about [their intake of] vegetables and just increase a portion of that - as a good start. Eh. And we can experience attending birthday parties, or other places, where they don't just get a small amount of candy, but they get a huge bag [to take home] in addition to that. Or [that they] drink a kind of squash which we, not that I'm, not that we are fanatic, but I think is sad, and a pity, that so few think about it. And I disapprove of those who. Like, we are members of a few organizations in relation to my disease and we have friends who are, if not fanatic - it's just a completely different world where everything is wrong. That you can't ever eat anything that contains sugar. Everything is so alternative. Either it's raw food or low-carb you know. There are so many options, so I think it's become so complicated that some people backs out. It's become a bit 'black and white' when it comes to food and I think that is a bit scary."

The findings shown throughout these paragraphs lead to the belief that incorporated cultural capital do affect food choice. And that this in turn becomes a part of peoples habitus as, arguably, those who have grown up around food loving parents, learning to appreciate food and a healthy diet early on, may have made some of my informants think in ways that have guided them towards making healthy food choices, and maintain a healthy lifestyle later in their lives – which also is the case the other way around. Moreover, the findings in these paragraphs suggest that there are differences in both how people perceive the connection between food and health outcome, and how people view those who have these different view, which in turn may motivate or demotivate people to learn more about food and nutrition.

7. Discussion

In the discussion part, the findings will be discussed up against previous literature in the fields of both public health and sociology, as well as the key concepts cultural capital.

The discussion will be divided in three paragraphs, one concerning incorporated cultural capital for the informants experiences and attitudes toward cooking and food choice, and one concerning the cultural capital for the (re)-production of social inequality in health.

7.1 Incorporated cultural capital for the informants experiences and attitudes toward cooking and food choice

7.1.2 Cooking skills

The importance of experiences with cooking during childhood became evident by informants highlighting how family members and especially their parents brought different experiences and attitudes towards food and cooking. These findings corresponds with previous research (Fismen et al, 2012; Bugge, 2005) emphasizing how the family is often described as a link

between the individual and society, by means of imparting the prevailing values, norms, considerations and habits which in turn prepare the child to take part in society.

In this study, those of my informants who had little or no experiences with cooking during their childhood had lessons in home economic during primary and lower secondary education. These findings are in accordance with the overall aim of the Norwegian Government who, in order to ensure that all children in Norway have the optimum childhood, of which learning about cooking, health and nutrition is seen as a vital component, introduced home economics as a compulsory subject in school. Nevertheless, it does not necessarily mean that the ‘take-home message’ from being exposed and taught anything about cooking, health and nutrition in school make a huge difference in some of the informants current eating choices.

The findings of this study also support the findings of Abel (2008) which indicate that for people when operating within a given, and secure, economic frame of options, cultural resources come into play. Because, whereas the range of choices for health-relevant consumer goods depend on financial means, cultural capital becomes of particular importance for using those financial resources for specific healthy choices, such as purchasing healthy food.

7.1.3 Health literacy

WHO has defined health literacy as being more than merely being able to read pamphlets and understand the health information. It also means having “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information which promote and maintain good health” (WHO, 1998, p. 10). Health promotion measures, such as learning how to read, understand and make use of nutritional labels, have therefore been suggested to improve health literacy in the population (Abel, 2007). In order to achieve this there has been deemed necessary, by all Nordic Regions, to improve access to traditional (for example, brochures and posters) and more interactive technological sources (such as the Internet) of health information such as ‘The Key Hole’ (The Nordic Council of

Ministers, n.d) However, as my findings suggest, although given advice from the HLC-coordinator in the sense of “expert advice” to be followed, there is an exceptional gap between my informants health – and nutritional literacy. The findings in this study, therefore corroborate with Abel (2008) who propose that nutritional behaviour may be referred to as an example where peoples cultural resources come in to play. He suggest that values attached to health, knowledge about health effects of certain food products, and norms guide health behaviours are all cultural resources that structure people’s preferences and choices, including food choice.

7.1.4 ‘Taste’

Although making healthy food choice in many instances can depend on health literacy and cooking skills, this study showed that ‘taste’ can be of importance.

In spite the fact that taste also is linked to economic capital, it mostly relates to cultural capital. As taste remains stable also when people’s income increase over time, and as a result of that reflect certain cultural norms and values (Kamphuis et al, 2015; Blasius & Friedrichs, 2008). This seems to be accurate for this study as well, due to the different interpretations about healthy eating put forward by the informants. This is in compliance with Bisogni, Jastran, Seligson & Thopsen (2012) stating that peoples interpretations about this topic is simply not a set of belief which can be judged as correct or incorrect according to the ways scientist discuss healthy eating. To the contrary, as showed through this thesis, people hold complex multifaceted feelings about this topic that may be connected to other parts of their lives, and more importantly based on personal knowledge gained through their life experiences. Indicating that their personal knowledge may outweigh experts’ view and recommendations that does not match their own.

Besides, 'taste' is according to Bourdieu, as given account for in Jenkins (2002) and Heikkilään & Rahkonen (2011) a system of classificatory schemes developed as part of the habitus which works as a kind of social orientation, guiding people towards the particular social position that fits their characteristics and in turn towards the activities and goods, in this case food choices, that fit those in that position. The findings in this study corroborate with Warde (1997) as it is through the practical experience and emotional significance of cooking and eating together that creates peoples' identities and tastes for food.

However, as accounted for by Bourdieu (1984) in his book *Distinction*, the association between cultural practices and social origins is mediated through formal education, meaning that people learn to consume culture - but this 'education' is distinguished by social class.

The findings in the study was therefore unexpected as, mentioned earlier in the literature review, Norway is often portrayed as a country characterized by both economic and social equality (Bugge & Almås, 2006). Thus, it may be less legitimate to discuss differences, such as the saying – 'there is no arguing about taste' (Bugge & Almås, 2006, p. 221).

However, in a number of ways this study shows how food tastes indeed have an important function in how people classify themselves and others, as well as how they legitimize their own tastes. Independent of where my informants placed themselves in the social hierarchy, there were some tastes of which was regarded as 'good' and others as 'bad'. Interestingly, despite the fact that Norwegian society is characterized by smaller class differences than many of the Western societies (Bugge & Almås, 2006; Dahl, 2002) my informants food discourse show that there are differences which can be linked to Bourdieu's work on how food contributes to producing, reproducing and negotiating class identities and cultures. The additional analysis of my informants food discourse may indicate that the variations in how some of my informants express themselves through food, some so subtle they are barely noticeable. One example of this is small, and seemingly insignificant details such as the use of

ketchup. Moreover, from some of my informants descriptions it is clear that ‘those who drink a different kind of squash’ are examples of ideological ‘others’ – in other words people they do not want to be associated with. With that said, there is no doubt this choice is just one of many examples of how foods can tell much about the informants class affinity and social mobility (Bugge & Almås, 2006)

7.2 Cultural capital for the (re)-production of social inequality in health

As cited in Abel and Frohlich (2012) Bourdieu discussed the relationships between the states of cultural capital in terms of conversion, accumulation and transmission. In addition, Abel and Frohlich (2012) adds a fourth principle of interaction which they call “conditionality”. All four forms are important for the purposes of my argument.

Practical examples, accordingly with those of Abel & Frohlich (2012) which may serve to illustrate the importance of these four principles of interaction for the (re-)production of social inequality in health are: *conditionality* occurs, for instance, when cultural capital, in the form of knowledge with regard to health and health determinants becomes a necessity for spending one’s economic capital in a health promoting way. Such as purchasing a food-label-scanning app on his phone, like Eivind does. The conditionality relationship also account for the fact that some resources can lose their potential health benefits and instead turn into questionable assets from a health perspective, e.g. when income is spent eating out at the local pub every day. It has also been argued by such as Abel and Frohlich (2012) that spending money on health courses, cooking books or other health education measures means converting parts of one’s economic capital into health knowledge, that is to say, health-relevant cultural capital. However, as the course at the HLC is free of charge, the focus on monetary means for obtaining this specific type of capital diminish. Instead the focus shift back to be sociological reasoning that health-relevant knowledge and skills is accumulated over time in individuals through personal and collective investments such as cognitive learning, social exchange and support. All often a part of an individual’s lifelong socialization, also known as *habitus*.

Finally, transmission of health-relevant cultural capital takes place in, arguably the most important social network - families, when they bestow their children with environments conducive to the acquisition of health literacy and health promoting learning experiences such as cooking. As seen in the findings of this study, family, where parents were the most

influential, stood out as the 'prime mover' for some of the informants to start cooking. Findings of Robertson, Lang, Trichopoulou, de Zeeuw, Jensen and Garilow, as cited in Caraher and Lang (1999) suggest that being brought up in a home where there is no knowledge of cooking skills, or where there is as a lack of opportunity to experiment with diet in more healthy directions, are locked into a less healthy way of life.

The study confirms the decisive meaning, and interaction, of the three forms of capital, and especially cultural capital. It also leads us to acknowledge the role of the individuals who beyond simply owning or consuming such resources, obtain and use, in some active way, health-relevant capital (Abel and Frolich, 2012) as the active acquisition, development and usage of such capital is part of both individual and collective agency. Therefore, in order for cultural capital to become health promoting, individuals have to actively use them. For instance, in accordance with Pample et al (2010): knowledge is applied by individuals in order for the two other forms of capital to function actively, such as making decisions about what ones eat, which in turn lead to the different 'kinds' of health. The findings in this study are corroborative as there is a considerable gap between the informants understanding, interest in and commitment towards changing their food choices as a means to loose weight. Thus, in the shaping and reproduction of social inequalities these abovementioned 'actions' are related to each other through capital-interaction which facilitates status-specific habitus and lifestyles, which have been seen in this study as well. The findings in this study also corroborates with Abel and Frolich (2012) who suggested that inequality goes beyond just the unequal distribution of cultural capital, as there is also considerable social inequality in the chances and potential for people to have the different forms of cultural capital which consistently support and complement each other with the end result being a health advantage, such as weight loss. Moreover, these findings of this study are in accordance with Friel et al (2015) who indicate that focusing on direct action to help people eat more healthily misses the

heart of the problem, which is the underlying unequal distribution of factors that support the opportunity to eat a healthy. So unless this is addressed, inequities in healthy eating will persist and possibly increase.

8. Conclusion

The findings in this thesis are in agreement with Wardle's (1997) findings which suggest that, in the social sciences, the relationship of cooking, diet, health, taste and culture is immensely complex and circular. Moreover, just as there are cash differences between the rich and poor, so are there arguably divisions in skill and knowledge. As given account for in Charaher & Lang (1999), Shapiro argues that cooking skills and health, and nutritional knowledge frame the way people consume food the same way as the availability of foods determine the type and range of cooking to be applied.

Moreover, the current study found limitations for giving people nutritional knowledge and an understanding of the impact of food on their bodies when there is so much that has happened earlier in their childhood, e.g. of laying the foundations for norms and values tied up to those issues. It is therefore, in order to close the gap in the obesity gradient, as a central part for closing the overall gap in health inequality, suggested that future health promotion practices should give more attention to issues of social inequality and cultural capital for health at the early stages of intervention planning. And moreover, in agreement with Abel (2007), future health literacy interventions should start with a critical assessment of the (not) available incorporated cultural capital in those specific population groups they wish to work with. Besides, from the perspective of cultural capital theory, such interventions are not only basic investments in people's general cultural capital only for the sake of better health outcomes, but also for increasing chances for social participation and agency (Abel, 2007).

Moreover, the findings in this study start to point to the fact that in public health there is a need to pay attention to the context people are eating, their attitudes towards food and their 'frame of reference'. And to have a more reflective practice as these findings suggest that people may project an image associated with certain foods. And besides, rather than focusing on individual behaviour change, although they are successful, interventions that target social networks have by Kim et al (2015) been suggested to possibly enhance adaptation and efficacy of interventions and thereby improve population health. As the findings in this study suggest that people affiliate with those of the same acquaintances.

9. Limitations

To summarise the limitations of this study it is important to highlight some of the conundrums faced by the researcher. First and foremost, on the basis of not knowing enough about the sample before requirement and thus not ensure that only participants with lower levels of education were chosen, and that the recruitment was carried out by the HLC-coordinator, there is difficult to say if the sample is biased or not. Moreover, there are chances that the HLC-coordinator 'nudged' certain participants to join as she learnt that only four out of forty-six volunteered to join the study. Thus make sure the researcher had an adequate sample to interview. In addition, as an inexperienced interviewer, what could possibly have affected the findings of this study the most was the leading questions the researcher felt obligated to ask due to a lack of response, or in some cases excessive response, in the interviews. And not at least due to lack of concise and structured answers it became disproportionate difficult to analyse the findings. Besides, the findings in this study only portray, what is felt by the researcher, a fragment of all the answers put forward by the informants as there was so much to investigate and elaborate further on.

As the study focus on how incorporated cultural capital may influence food choice, (which in turn may explain the social inequalities in health) one does not get to know what actually affects these different factors other than through their own opinion.

Another potential weakness of this study is regarding translation from Norwegian to English, especially concerning quotations as some of the Norwegian words and proverbs are particularly difficult to translate in to English without it losing its essence. The researcher has been careful and taken this in to consideration while translating, however one cannot be sure that the meanings, as a whole, becomes the same in both languages.

10. Further research

The findings from this study leaves some questions that can be further investigated.

As this study reveals what affect food choice among adult participants at a Health Life Centre it would be interesting to see what affect food choice among every 'Tom, Dick and Harry' and explore if there are any differences and similarities. Moreover, as this study was done in one single HLC in rural Norway, it could be an idea to carry out the same type of study in other urban HLC in Norway to see if there are any similarities or differences between the participants. Moreover, this study could be an interesting overview for the HLC-coordinator to look at, in order to make them more aware of what actually affect food choice. Hence cultural capital theory possible applicability in public health promotion practice may be strengthen.

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Appendix 1 – Literature search

Search engines used: Oria and Google Scholar.

Words and combinations being used to search for relevant literature is:

Food choice + low socio-economic status
Food choice + culture
Food choice + cultural capital
Food + eating + social practice
Social determinants + cultural capital
Inequality + cultural capital + health



MELDESKJEMA

Meldeskjema (versjon 1.4) for forsknings- og studentprosjekt som medfører meldeplikt eller konsesjonsplikt (jf. personopplysningsloven og helseregisterloven med forskrifter).

1. Intro		
Samles det inn direkte personidentifiserende opplysninger?	Ja ● Nei ○	En person vil være direkte identifiserbar via navn, personnummer, eller andre personentydige kjennetegn. Les mer om hva personopplysninger . NB! Selv om opplysningene skal anonymiseres i oppgave/rapport, må det krysses av dersom det skal innhentes/registreres personidentifiserende opplysninger i forbindelse med prosjektet.
Hvis ja, hvilke?	<input checked="" type="checkbox"/> Navn <input type="checkbox"/> 11-sifret fødselsnummer <input type="checkbox"/> Adresse <input type="checkbox"/> E-post <input type="checkbox"/> Telefonnummer <input type="checkbox"/> Annet	
Annet, spesifiser hvilke		
Skal direkte personidentifiserende opplysninger kobles til datamaterialet (koblingsnøkkel)?	Ja ● Nei ○	Merk at meldeplikten utløses selv om du ikke får tilgang til koblingsnøkkel, slik fremgangsmåten ofte er når man benytter en databehandler
Samles det inn bakgrunnsopplysninger som kan identifisere enkeltpersoner (indirekte personidentifiserende opplysninger)?	Ja ● Nei ○	En person vil være indirekte identifiserbar dersom det er mulig å identifisere vedkommende gjennom bakgrunnsopplysninger som for eksempel bostedskommune eller arbeidsplass/skole kombinert med opplysninger som alder, kjønn, yrke, diagnose, etc. NB! For at stemme skal regnes som personidentifiserende, må denne bli registrert i kombinasjon med andre opplysninger, slik at personer kan gjenkjennes.
Hvis ja, hvilke	Navn, inntekt, bostuasjon, yrke	
Skal det registreres personopplysninger (direkte/indirekte/via IP-/epost adresse, etc) ved hjelp av nettbaserte	Ja ○ Nei ●	Les mer om nettbaserte spørreskjema .

spørreskjema?		
Blir det registrert personopplysninger på digitale bilde- eller videoopptak?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	Bilde/videoopptak av ansikter vil regnes som personidentifiserende.
Søkes det vurdering fra REK om hvorvidt prosjektet er omfattet av helseforskningsloven?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	NB! Dersom REK (Regional Komité for medisinsk og helsefaglig forskningsetikk) har vurdert prosjektet som helseforskning, er det ikke nødvendig å sende inn meldeskjema til personvernombudet (NB! Gjelder ikke prosjekter som skal benytte data fra pseudonyme helseregistre). Dersom tilbakemelding fra REK ikke foreligger, anbefaler vi at du avventer videre utfylling til svar fra REK foreligger.
2. Prosjekttittel		
Prosjekttittel	Kulturell kapital og matvalg / Cultural capital and food choice	Oppgi prosjektets tittel. NB! Dette kan ikke være «Masteroppgave» eller liknende, navnet må beskrive prosjektets innhold.
3. Behandlingsansvarlig institusjon		
Institusjon	Høgskolen i Hedmark	Velg den institusjonen du er tilknyttet. Alle nivå må oppgis. Ved studentprosjekt er det studentens tilknytning som er avgjørende. Dersom institusjonen ikke finnes på listen, har den ikke avtale med NSD som personvernombud. Vennligst ta kontakt med institusjonen.
Avdeling/Fakultet	Avdeling for folkehelsefag	
Institutt	Institutt for idrett og aktiv livsstil	
4. Daglig ansvarlig (forsker, veileder, stipendiat)		

Fornavn

Katie

Før opp navnet på den som har det daglige ansvaret for prosjektet. Veileder er vanligvis daglig ansvarlig

Etternavn	Powell	ved studentprosjekt. Veileder og student må være tilknyttet samme institusjon. Dersom studenten har ekstern veileder, kanbiveileder eller fagansvarlig ved studiestedet stå som daglig ansvarlig. Arbeidssted må være tilknyttet behandlingsansvarlig institusjon, f.eks. underavdeling, institutt etc. NB! Det er viktig at du oppgir en e-postadresse som brukes aktivt. Vennligst gi oss beskjed dersom den endres.
Stilling	Veileder	
Telefon	+447962210419	
Mobil	k.powell@sheffield.ac.uk	
E-post	k.powell@sheffield.ac.uk	
Alternativ e-post		
Arbeidssted	SHARR Sheffield University	
Adresse (arb.)	Street	
Postnr./sted (arb.sted)	P14 Sheffield	
Sted (arb.sted)	Sheffield	
5. Student (master, bachelor)		
Studentprosjekt	Ja <input checked="" type="radio"/> Nei <input type="radio"/>	Dersom det er flere studenter som samarbeider om et prosjekt, skal det velges en kontaktperson som føres opp her. Øvrige studenter kan føres opp under pkt 10.
Fornavn	Kaia Anette	
Etternavn	Fagerheim	
Telefon	95768846	
Mobil		
E-post	kafwork@hotmail.com	
Alternativ e-post	fkaia@hotmail.com	
Privatadresse	Midtvegen 14	
Postnr./sted (privatadr.)	2312 Ottestad	
Sted (arb.sted)	Ottestad	
Type oppgave	<input checked="" type="radio"/> Masteroppgave <input type="radio"/> Bacheloroppgave <input type="radio"/> Semesteroppgave <input type="radio"/> Annet	

6. Formålet med prosjektet		
Formål	<p>Formål: Undersøke om besittelse av 'kulturell kapital' kan være det manglende mellomledet i forståelsen av sammenhengen mellom sosioøkonomisk status og matvalg. Utforske om 'inkorporert kulturell kapital' kan være en medvirkende faktor når man tar mat valg.</p> <p>Forskningsprøsmål: "Hvordan er kulturell kapital oversatt til visse mat valg"</p>	Redegjør kort for prosjektets formål, problemstilling, forskningsspørsmål e.l.
7. Hvilke personer skal det innhentes personopplysninger om (utvalg)?		
Kryss av for utvalg	<input type="checkbox"/> Barnehagebarn <input type="checkbox"/> Skoleelever <input type="checkbox"/> Pasienter <input checked="" type="checkbox"/> Brukere/klienter/kunder <input type="checkbox"/> Ansatte <input type="checkbox"/> Barnevernsbarn <input type="checkbox"/> Lærere <input type="checkbox"/> Helsepersonell <input type="checkbox"/> Asyløkere <input type="checkbox"/> Andre	
Beskriv utvalg/deltakere	Brukere av Frisklivsentral i Stange kommune	Med utvalg menes dem som deltar i undersøkelsen eller dem det innhentes opplysninger om.

Rekruttering/trekking	Utvalget blir rekrutert gjennom Frisklivsentralen. Fortrinnsvis deltakere ved et 'Bra Mat-kurs', men om dette ikke lar seg gjøre vil andre brukere av Frisklivsentralen bli rekrutert.	Beskriv hvordan utvalget trekkes eller rekrutteres og oppgi hvem som foretar den. Et utvalg kan trekkes fra registre som f.eks. Folkeregisteret, SSB-registre, pasientregistre, eller det kan rekrutteres gjennom f.eks. en bedrift, skole, idrettsmiljø eller eget nettverk.
Førstegangskontakt	Førstegangskontakt ble opprettet med frisklivskoordinatoren, som videre skal hjelpe til med å rekrutere utvalget ved å dele ut informasjonsskriv ved individuell rådgivning.	Beskriv hvordan kontakt med utvalget blir opprettet og av hvem. Les mer om dette på temasidene .
Alder på utvalget	<input type="checkbox"/> Barn (0-15 år) <input type="checkbox"/> Ungdom (16-17 år) <input checked="" type="checkbox"/> Voksne (over 18 år)	Les om forskning som involverer barn på våre nettsider.
Omtrentlig antall personer som inngår i utvalget	15	

Samles det inn sensitive personopplysninger?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	Les mer om sensitive opplysninger .
Hvis ja, hvilke?	<input type="checkbox"/> Rasemessig eller etnisk bakgrunn, eller politisk, filosofisk eller religiøs oppfatning <input type="checkbox"/> At en person har vært mistenkt, siktet, tiltalt eller dømt for en straffbar handling <input type="checkbox"/> Helseforhold <input type="checkbox"/> Seksuelle forhold <input type="checkbox"/> Medlemskap i fagforeninger	
Inkluderes det myndige personer med redusert eller manglende samtykkekompetanse?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	Les mer om pasienter, brukere og personer med redusert eller manglende samtykkekompetanse .
Samles det inn personopplysninger om personer som selv ikke deltar (tredjepersoner)?	Ja <input checked="" type="radio"/> Nei <input type="radio"/>	Med opplysninger om tredjeperson menes opplysninger som kan spores tilbake til personer som ikke inngår i utvalget. Eksempler på tredjeperson er kollega, elev, klient, familiemedlem.
Hvem er tredjeperson og hvilke opplysninger registreres?	Familiemedlemmer, kollegaer, eksternt nettverk	
Registreres det sensitive opplysninger om tredjeperson?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	
8. Metode for innsamling av personopplysninger		
Kryss av for hvilke datainnsamlingsmetoder og datakilder som vil benyttes	<input checked="" type="checkbox"/> Papirbasert spørreskjema <input type="checkbox"/> Elektronisk spørreskjema <input checked="" type="checkbox"/> Personlig intervju <input type="checkbox"/> Gruppeintervju <input type="checkbox"/> Observasjon <input type="checkbox"/> Deltakende observasjon <input type="checkbox"/> Blogg/sosiale medier/internett <input type="checkbox"/> Psykologiske/pedagogiske tester <input type="checkbox"/> Medisinske undersøkelser/tester <input type="checkbox"/> Journaldata	<p>Personopplysninger kan innhentes direkte fra den registrerte f.eks. gjennom spørreskjema, intervju, tester, og/eller ulike journaler (f.eks. elevmapper, NAV, PPT, sykehus) og/eller registre (f.eks. Statistisk sentralbyrå, sentrale helseregistre).</p> <p>NB! Dersom personopplysninger innhentes fra forskjellige personer (utvalg) og med forskjellige metoder, må dette spesifiseres i kommentar-boksen. Husk også å legge ved relevante vedlegg til alle utvalgs-gruppene og metodene som skal benyttes.</p> <p>Les mer om registerstudier her.</p> <p>Dersom du skal anvende</p>

		registerdata, må variabelleste lastes opp under pkt. 15
	<input type="checkbox"/> Registerdata	
	<input type="checkbox"/> Annen innsamlingsmetode	
Tilleggsopplysninger	Det vil bli utdelt et kort spørreskjema for å svare på grunnleggende bakgrunnsinformasjon før intervjuet blir gjennomført for å danne et bilde av utvalget som vil bli brukt i analysen	

9. Informasjon og samtykke

Oppgi hvordan utvalget/deltakerne informeres	<input checked="" type="checkbox"/> Skriftlig <input checked="" type="checkbox"/> Muntlig <input type="checkbox"/> Informeres ikke	<p>Dersom utvalget ikke skal informeres om behandlingen av personopplysninger må det begrunnes.</p> <p>Les mer her.</p> <p>Vennligst send inn mal for skriftlig eller muntlig informasjon til deltakerne sammen med meldeskjema.</p> <p>Last ned en veiledende mal her.</p> <p>NB! Vedlegg lastes opp til sist i meldeskjemaet, se punkt 15 Vedlegg.</p>
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Samtykker utvalget til deltakelse?	<input checked="" type="radio"/> Ja <input type="radio"/> Nei <input type="radio"/> Flere utvalg, ikke samtykke fra alle	<p>For at et samtykke til deltakelse i forskning skal være gyldig, må det være frivillig, uttrykkelig og informert.</p> <p>Samtykke kan gis skriftlig, muntlig eller gjennom en aktiv handling. For eksempel vil et besvart spørreskjema være å regne som et aktivt samtykke.</p> <p>Dersom det ikke skal innhentes samtykke, må det begrunnes.</p>
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Bli tredjepersoner informert?	<input type="checkbox"/> Skriftlig <input type="checkbox"/> Muntlig <input checked="" type="checkbox"/> Informeres ikke	
Informeres ikke, begrunn	Det er ikke relevant for selve undersøkelsen, da kun student og veileder skal ha innsyn til informasjonen	
10. Informasjonssikkerhet		
Hvordan oppbevares navnelisten/ koblingsnøkkelen og hvem har tilgang til den?	Privat datamaskin med passord.	
Oppbevares direkte personidentifiserbare opplysninger på andre måter?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	
Spesifiser		NB! Som hovedregel bør ikke direkte personidentifiserende opplysninger registreres sammen med det øvrige datamaterialet.
Hvordan registreres og oppbevares personopplysningene?	<input type="checkbox"/> På server i virksomhetens nettverk <input type="checkbox"/> Fysisk isolert PC tilhørende virksomheten (dvs. ingen tilknytning til andre datamaskiner eller nettverk, interne eller eksterne) <input type="checkbox"/> Datamaskin i nettverkssystem tilknyttet Internett tilhørende virksomheten <input type="checkbox"/> Privat datamaskin <input type="checkbox"/> Videoopptak/fotografi <input checked="" type="checkbox"/> Lydopptak <input type="checkbox"/> Notater/papir <input checked="" type="checkbox"/> Mobile lagringsenheter (bærbar datamaskin, minnepenn, minnekort, cd, ekstern harddisk, mobiltelefon) <input type="checkbox"/> Annen registreringsmetode	Merk av for hvilke hjelpemidler som benyttes for registrering og analyse av opplysninger. Sett flere kryss dersom opplysningene registreres på flere måter. Med «virksomhet» menes her behandlingsansvarlig institusjon. NB! Som hovedregel bør data som inneholder personopplysninger lagres på behandlingsansvarlig sin forskningsserver.
Annen registreringsmetode beskriv		Lagring på andre medier - som privat pc, mobiltelefon, minnepinne, server på annet arbeidssted - er mindre sikkert, og må derfor begrunnes. Slik lagring må avklares med behandlingsansvarlig institusjon, og personopplysningene bør krypteres.

Hvordan er datamaterialet beskyttet mot at uvedkommende får innsyn?	Privat datamaskin og lydopptaker med brukernavn og passord.	Er f.eks. datamaskintilgangen beskyttet med brukernavn og passord, står datamaskinen i et låsbart rom, og hvordan sikres bærbare enheter, utskrifter og opptak?
Samles opplysningene inn/behandles av en databehandler?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	Dersom det benyttes eksterne til helt eller delvis å behandle personopplysninger, f.eks. Questback, transkriberingsassistent eller tolk, er dette å betrakte som en databehandler. Slike oppdrag må kontraktsreguleres.
Hvis ja, hvilken		
Overføres personopplysninger ved hjelp av e-post/Internett?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	F.eks. ved overføring av data til samarbeidspartner, databehandler mm.
Hvis ja, beskriv?		Dersom personopplysninger skal sendes via internett, bør de krypteres tilstrekkelig. Vi anbefaler for ikke lagring av personopplysninger på nettskytjenester. Dersom nettskytjeneste benyttes, skal det inngås skriftlig databehandleravtale med leverandøren av tjenesten.
Skal andre personer enn daglig ansvarlig/student ha tilgang til datamaterialet med personopplysninger?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	
Hvis ja, hvem (oppgi navn og arbeidssted)?		
Utleveres/deles personopplysninger med andre institusjoner eller land?	<input checked="" type="radio"/> Nei <input type="radio"/> Andre institusjoner <input type="radio"/> Institusjoner i andre land	F.eks. ved nasjonale samarbeidsprosjekter der personopplysninger utveksles eller ved internasjonale samarbeidsprosjekter der personopplysninger utveksles.
11. Vurdering/godkjenning fra andre instanser		
Søkes det om dispensasjon fra taushetsplikten for å få tilgang til data?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	For å få tilgang til taushetsbelagte opplysninger fra f.eks. NAV, PPT, sykehus, må det søkes om

Hvis ja, hvilke		dispensasjon fra taushetsplikten. Dispensasjon søkes vanligvis fra aktuelt departement.
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Søkes det godkjenning fra andre instanser?	Ja <input type="radio"/> Nei <input checked="" type="radio"/>	F.eks. søke registreier om tilgang til data, en ledelse om tilgang til forskning i virksomhet, skole.
Hvis ja, hvilken		

12. Periode for behandling av personopplysninger

Prosjektstart	01.10.2015	Prosjektstart Vennligst oppgi tidspunktet for når kontakt med utvalget skal gjøres/datainnsamlingen starter. Prosjektslutt: Vennligst oppgi tidspunktet for når datamaterialet enten skal anonymiseres/slettes, eller arkiveres i påvente av oppfølgingsstudier eller annet.
Planlagt dato for prosjektslutt	01.10.2016	
Skal personopplysninger publiseres (direkte eller indirekte)?	<input type="checkbox"/> Ja, direkte (navn e.l.) <input checked="" type="checkbox"/> Ja, indirekte (bakgrunnsopplysninger) <input type="checkbox"/> Nei, publiseres anonymt	NB! Dersom personopplysninger skal publiseres, må det vanligvis innhentes eksplisitt samtykke til dette fra den enkelte, og deltakere bør gis anledning til å lese gjennom og godkjenne sitater.
Hva skal skje med datamaterialet ved prosjektslutt?	<input checked="" type="checkbox"/> Datamaterialet anonymiseres <input type="checkbox"/> Datamaterialet oppbevares med personidentifikasjon	NB! Her menes datamaterialet, ikke publikasjon. Selv om data publiseres med personidentifikasjon skal som regel øvrig data anonymiseres. Med anonymisering menes at datamaterialet bearbeides slik at det ikke lenger er mulig å føre opplysningene tilbake til enkeltpersoner. Les mer om anonymisering .

13. Finansiering

Hvordan finansieres prosjektet?	Ingen finansiering	
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14. Tilleggsopplysninger

Tilleggsopplysninger		
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Appendix 3 - Informed consent

Forskningsprosjekt: Kulturell kapital og matvalg. Kaia Fagerheim, Høgskolen i Hedmark

Informasjonsskriv

Du har blitt invitert til å delta i et forskningsprosjekt og før du bestemmer deg om hvorvidt du vil delta eller ikke, vil det være nyttig for deg å få informasjon om hva dette prosjektet går ut på, og hva du vil bli spurt om å gjøre om du velger å delta i prosjektet. Du er velkommen til å kontakte forskeren hvis noe er uklart eller om du ønsker mer informasjon.

Hva går forskningsprosjektet ut på?

Formålet med forskningsprosjektet er å få mer kunnskap om erfaringer og opplevelser vedrørende matpraksis hos deltakere på en Frisklivssentral, og utforske hvordan 'innlemmet kulturell kapital' kan være en medvirkende faktor i forholdet mellom sosioøkonomisk status, livsstilssykdom og matpraksis.

Hvem utfører forskningsprosjektet?

Forskningsprosjektet vil bli utført av Kaia Fagerheim, Masterstuden ved Høgskolen i Hedmark, avd Elverum, som danner grunnlaget for masteroppgaven. Doktor Katie Powell vil være veileder på dette prosjektet.

Hvorfor har du bli valgt?

Du har blitt spurt om å delta i et intervju fordi du er deltaker på et kurs hos Frisklivscentralen, hvor formålet er å forbedre helsen.

Hva vil skje om jeg deltar?

Forskeren kontakte deg for å finne en tid som er beleilig for deg for å gjennomføre intervjuet i ditt hjem.

Intervjuet vil vare omkring 45-60 minutter. Om du samtykker vil forskeren ønske å ta opp intervjuet på lydbånd. Lyddopptaket vil bli oppbevart på en egen, passord-beskyttet, datamaskin som kun forskeren vil ha tilgang til.

Data vil bli anonymisert og slettet ved forskningsprosjektets slutt, som er forventet å være 31. oktober 2016.

Må jeg delta?

Å delta i dette forskningsprosjektet er frivillig. Om du velger å ikke delta vil ikke dette påvirke ditt arbeid på noen måte. Om du velger å delta vil du bli bedt om å skrive under på et samtykkeskjema som bekrefter at du har lest og forstått hva prosjektet går ut på. Om du velger å delta er det viktig å påpeke at du kan trekke deg når som helst, uten å oppgi forklaring.

Hva er fordelene og ulempene ved å deltakelse?

Du vil få muligheten til å dele og diskutere dine egne erfaringer og fremme dine synspunkter omkring temaet. Vi ser ingen ulemper i å ta del i intervjuet.

Vil min deltakelse bli holdt konfidensielt?

Å delta i dette intervjuet er anonymt, og ingen navn eller detaljer som kan brukes til å identifiserer deg vil noen gang bli brukt i skriftlige eller muntlige rapporter.

Hva vil resultatene blir brukt til?

Det er forventet at resultatene vil bli brukt til å forbedre kunnskapen og forståelsen om (hvorvidt) kulturell kapital (kan være) som en betydningsfull faktor for matvalg. Resultatene vil bli presentert som en del av masteroppgaven. Oppsummering av resultatene vil bli gjort tilgjengelig for deltakerne.

Hva om noen går galt?

Om du ønsker å rette en klage mot eller har andre bekymringer omkring hvordan du har blitt imøtekommet eller behandlet under studien, vær snill å kontakt Doktor Katie Powell, førsteamanuensis ved Public Health, Section of Public Health, School of Related Research, University of Sheffield, Regent Court, Sheffield, S1 4DA, 0114 2226120.

Hvem tar jeg kontakt med om jeg ønsker mer informasjon?

Dersom du ønsker å delta i undersøkelsene eller om du ønsker mer informasjon om studien kan du kontakte, Kaia Fagerheim, Master student i Folkehelsevitenskap, avdeling for Folkehelsefag, Høgskolen i Hedmark, Hamarveien 112, 2411 Elverum.
Telefon: 95 76 88 46 eller kafwork@hotmail.com

Samtykke til deltakelse i studien

Om du ønsker å delta i undersøkelsen sender du svarslippen i retur innen 13.april

Klipp av her og legg denne lappen i den ferdig frankerte konvolutten

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta

Mitt telefonnummer du kan nå meg på er: _____

(Signert av prosjektdeltaker, dato)

Appendix 4 – Interview guide

Questions with which to start the conversation:	Ask why! Continue with the following questions:
<i>Introduce yourself</i>	
Personal details	<ul style="list-style-type: none"> - Age? - Where are you born and raised? - Can you tell me about your family and friends - What is your education? - What kind of job/occupation have you had/do you hold now? - Who do you live with? - You are a participant at a Healthy Life Centre where the purpose is to improve health, what part of your help do you want to improve?
Can you say a little bit about food and meals from your childhood?	<ul style="list-style-type: none"> - Who cooked meals? - Can you explain the mealtime? - What kinds of food did you eat? (Homemade, fastfood, readymeals, local produce, healthy) - What did your parents teach you about food and diets?
<i>Food practice</i>	
- How has your food habits changed throughout your life?	Can you recall any incidents which lead to change? (P)
Tell me about your food habits and practice nowadays?	<ul style="list-style-type: none"> - Who is responsible for buying foods and cooking in your household? (OP) - What kinds of foods do you usually buy? - What sort of things are important when deciding what foods to buy? (BN) - Do you read the labels on what you buy? (OP)
What are your thoughts on, and experiences, with cooking?	<ul style="list-style-type: none"> - Is cooking something you enjoy? (P) - How did you learn to cook? (OP) - What is important for you when you decide what to cook? (P) - How do you go about when you cook a meal? (OP) Do you use a recipe, measure ingredients carefully, use of different tools? (OP)
Can you tell me about food and eating in your household?	<ul style="list-style-type: none"> - Who usually prepares dinner? (OP) - Who do you usually eat with? (BN) - Do family members / housemates eat together or by

	themselves usually? Has this always been the case? (BN)
Can you tell me about last time you went out for something to eat?	<ul style="list-style-type: none"> - Where did you go? With whom? - Why did you go there? - Is it a place you/and or your friends go to on a regular basis? - What did you eat? Is that typical for you to eat that?
Can you tell me about last time you had someone over for a dinner?	<ul style="list-style-type: none"> -Who visited? What did you serve? - How did you decide what to serve?
Can you tell me about last time you visited someone for dinner?	<ul style="list-style-type: none"> - Who did you visit? - What were you served? - Is it typical for that person to cook that for you?
<i>Food (habits) and diet</i>	
If I say food, what do you think about?	- What does food mean to you? (P)
What, or who, inspires you and motivates you to cook and eat the way you do?	TV-chefs, cook, cookbooks, people in your life?) (BN)
<ul style="list-style-type: none"> - What does “healthy” food mean to you? - What does “unhealthy” food mean you? 	<ul style="list-style-type: none"> - <i>What</i> will you describe as healthy? (P) - <i>What</i> will you describe as unhealthy? (P)
How would you describe <i>your</i> diet?	- Varied/limited/interesting/healthy? (P)

<p>Is there anything you would like to change about your diet?</p>	<ul style="list-style-type: none"> - What would you like to change about your diet? (P) Have you ever tried that? (OP) How did you try and how did you experience that? (P) - What do you see as advantage(s) of changing your diet? (P) - What do you see as disadvantage(s) of changing your diet? (P)
<p><i>Closing remarks</i></p>	<p>Is there anything you want to add about your experiences of food and eating?</p>

Appendix 5 - Thematic analysis codes

Data extract	Summarized data extract	Code	Theme
Eivind: “We were allowed to get a change in the kitchen. I think that is an important aspect of it. To have a go. Whether it was with grandparents or with mum and dad”.	Was important to gain hands-on experience. Be allowed to try.	Hand-on experience	Cooking skills
Rolf: “I guess it’s fatty foods such as French fries and a lot of dressing and bacon. Fast food if you like. Convenience food. That’s probably. That is unhealthy. But on the other hand, if you buy chicken at a snack bar it should be OK, I suppose”.	Perception of what unhealthy foods is and isn’t.	Contradiction in terms	Nutritional literacy

