

CONSTRUCTING EVERYDAY NOTIONS OF HEALTHY EATING:
EXPLORING HOW PEOPLE OF THREE ETHNOCULTURAL BACKGROUNDS IN
CANADA ENGAGE WITH FOOD AND HEALTH STRUCTURES

by

SVETLANA RISTOVSKI-SLIJEPCEVIC

B.Sc., The University of Toronto, 2000
M.Sc., The University of British Columbia, 2003

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE STUDIES

(Human Nutrition)

THE UNIVERSITY OF BRITISH COLUMBIA
December 2007

© Svetlana Ristovski-Slijepcevic, 2007

ABSTRACT

Despite widespread health promotion and nutrition education efforts, gaps between official healthy eating messages and people's actual eating practices persist. There is increasing recognition that emphasizing individual responsibility for eating may have limited applicability in improving people's health. Many experts advocate that future research on healthy eating should involve exploration of how food practices are shaped by social structures (or determinants) and individual agency.

The purpose of this study was to explore the ways in which people *engage* with food structures to construct everyday notions of healthy eating. 'Food structures' draws on the concept of 'structure,' described by the social theorist Anthony Giddens, to refer to the range of food rules and resources people draw on. The research was conducted as part of a qualitative study on family food decision-making that included 144 participants from 13 African Nova Scotian, 10 European Nova Scotian, 12 Punjabi British Columbian and 11 European British Columbian families. These groups were chosen for their potential differences in perspectives based on place, ethnocultural background and histories of immigration to Canada.

Data collection consisted of individual interviews with three or more family members aged 13 and older, and, with each family, observation of a grocery shopping trip and a family meal. Analysis followed common qualitative procedures including coding, memoing and thematic analysis.

Together, the analyses support views that the gaps between official healthy eating messages and people's eating practices may not be closed by further education about how to eat. Drawing on the theoretical concepts of Anthony Giddens and Michael Foucault, the

findings suggest that one way to understand why people eat the way they do and how changes in eating habits occur is to think about the constant exposure to change through everyday, taken-for-granted practices. The findings also suggest that further healthy eating discourses may require more reflection with respect to the roles of nutrition educators and the social roles/autonomy of people in goals for health and well-being. Dietary goals for the population cannot be considered as isolated scientific objectives without taking into consideration how healthy eating discourses provide social standards beyond messages about healthy eating.

TABLE OF CONTENTS

ABSTRACT	ii
TABLE OF CONTENTS.....	iv
LIST OF TABLES	vii
LIST OF FIGURES.....	viii
CO-AUTHORSHIP STATEMENT.....	x
CHAPTER 1. HEALTHY EATING PERCEPTIONS AND PRACTICES.....	1
1.1 INTRODUCTION.....	1
1.2. LITERATURE REVIEW	7
1.2.1. <i>HOW DO WE DESCRIBE HEALTHY EATING?</i>	7
1.2.1.1. The Official Healthy Eating Guidelines	8
1.2.1.2. People’s Healthy Eating Interpretations: Recognizing ‘Lay’ Interpretations as Knowledge.....	10
1.2.1.3. Turning Perspectives into Practice: Do People Incorporate Healthy Eating Guidelines into Everyday Food Choice?.....	12
1.2.1.3.1. ‘Accessing’ Healthy Eating Information.....	12
1.2.1.3.2. ‘Understanding’ Healthy Eating Information.....	16
1.2.1.3.3. ‘Using’ Healthy Eating Information.....	18
1.2.2. <i>HOW IS HEALTHY EATING SHAPED?</i>	23
1.2.2.1. Determinants of Healthy Eating	25
1.2.2.1.1. Socio-demographic Determinants	27
1.2.2.1.2. Life-course Determinants.....	28
1.2.2.1.3. Socio-cultural Determinants	30
1.2.2.2. Examining Interactions between Determinants: Perspectives from Social Theory	34
1.2.3. <i>WHY DO WE CONCERN OURSELVES WITH HEALTHY EATING (in the ways that we do)?</i>	38
1.2.4. <i>LITERATURE REVIEW SUMMARY</i>	42
1.2.5. <i>EMERGING QUESTIONS, STUDY PURPOSE AND OBJECTIVES</i>	45
1.2.6. <i>NOTES</i>	51
1.2.7. <i>REFERENCES</i>	52
CHAPTER 2: CONSTRUCTING HEALTH AND PLACE THROUGH DECISIONS ABOUT FOOD IN THREE ETHNOCULTURAL GROUPS IN CANADA	69

2.1. INTRODUCTION.....	69
2.2. METHODS	72
2.3. RESULTS.....	74
2.3.1. <i>CONSTRUCTING MEANINGS FOR EATING WELL</i>	75
2.3.2. <i>CONSTRUCTING MEANINGS OF PLACE</i>	78
2.3.3. <i>CONSTRUCTING BOUNDARIES FOR COMMUNITY</i>	83
2.4. DISCUSSION	85
2.5. REFERENCES.....	90
CHAPTER 3: ENGAGING WITH HEALTHY EATING DISCOURSE(S): WAYS OF KNOWING	
ABOUT FOOD AND HEALTH IN THREE ETHNOCULTURAL GROUPS IN CANADA	94
3.1. INTRODUCTION.....	94
3.2. METHODS	99
3.3. RESULTS.....	101
3.3.1. <i>CULTURAL/TRADITIONAL HEALTHY EATING DISCOURSES: PROMOTING THE</i> <i>POSITIVE ASPECTS OF FOOD</i>	102
3.3.2. <i>MAINSTREAM HEALTHY EATING DISCOURSES: CONTROLLING THE EFFECTS</i> <i>OF FOOD AND NUTRIENTS</i>	108
3.3.3. <i>COMPLEMENTARY/ETHICAL HEALTHY EATING DISCOURSES: HEALTHY</i> <i>EATING IN THE LARGER FOOD SYSTEM</i>	113
3.4. DISCUSSION	116
3.5. REFERENCES.....	125
CHAPTER 4: INTERGENERATIONAL TRANSMISSION OF HEALTHY EATING KNOWLEDGE	
IN THREE ETHNOCULTURAL GROUPS IN CANADA	132
4.1. INTRODUCTION.....	132
4.1.1. <i>GOVERNMENTALITY AND ITS TECHNIQUES</i>	133
4.1.2. <i>DIETARY GOVERNMENTALITY WITHIN THE FAMILY</i>	133
4.2. METHODS	136
4.3. RESULTS.....	139
4.3.1. <i>TRANSMITTING HEALTHY EATING KNOWLEDGE IN FAMILIES WITH</i> <i>CONGRUENT GENERATIONAL KNOWLEDGES ABOUT FOOD AND HEALTH</i>	140
4.3.2. <i>TRANSMITTING HEALTHY EATING KNOWLEDGE IN FAMILIES WITH</i> <i>INCONGRUENT GENERATIONAL KNOWLEDGES ABOUT FOOD AND HEALTH</i>	147
4.4. DISCUSSION	154
4.5. NOTES	160
4.6. REFERENCES.....	161

CHAPTER 5. DISCUSSION AND CONCLUSIONS	166
5.1. DISCUSSION AND IMPLICATIONS	166
5.2. STRENGTHS, LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH.....	175
5.3. CONCLUSIONS.....	177
5.4. REFERENCES.....	179
APPENDICES	183
APPENDIX 1: CANADA’S FOOD GUIDE TO HEALTHY EATING, 1992 (HEALTH CANADA).....	183
APPENDIX 2: EATING WELL WITH CANADA’S FOOD GUIDE, 2007 (HEALTH CANADA).....	184
APPENDIX 3: THE FAMILY CONTEXT OF FOOD DECISION-MAKING IN DIVERSE ETHNOCULTURAL GROUPS	187
APPENDIX 4: METHODOLOGY	188
APPENDIX 5: UBC RESEARCH ETHICS BOARD'S CERTIFICATES OF APPROVAL	203
APPENDIX 6: RECRUITMENT POSTER	204
APPENDIX 7: SCREENING GUIDE.....	205
APPENDIX 8: CONSENT FORM FOR INTERVIEWS.....	206
APPENDIX 9: INTERVIEW GUIDE - ADULTS	212
APPENDIX 10: INTERVIEW GUIDE - TEENAGERS.....	214
APPENDIX 11: GROCERY STORE INTERVIEW GUIDE	216
APPENDIX 12: CONSENT FORM FOR MEAL OBSERVATION	217
APPENDIX 13: CODE LIST BY CATEGORY	223
APPENDIX 14: GUIDELINES FOR QUESTIONS AND WRITING FIELDNOTES.....	224
APPENDIX 15: INTRODUCING THE TWO MINORITY ETHNOCULTURAL GROUPS: PUNJABI BRITISH COLUMBIANS AND AFRICAN NOVA SCOTIANS.....	225
APPENDIX 16: PARTICIPANTS’ SUMMARY SHEET	228

LIST OF TABLES

Table 1: Ethical Food Choice Considerations.....	194
Table 2: Making Sense of Healthy Eating Discourses.....	196

LIST OF FIGURES

Figure 1.1: A conceptual model of the components in the food choice process.....	21
Figure 1.2: A life course model of a food choice trajectory.....	22
Figure 1.3: Framework of determinants of physical activity and eating behaviour at the level of the individual, and intervention strategies.....	24

PREFACE

This dissertation was prepared according to the manuscript-based thesis requirements described by the Faculty of Graduate Studies at the University of British Columbia.¹ The manuscript-based format is suitable for writing dissertations that have produced one or more manuscripts suitable for journal publication. Each of chapters 2 to 4, therefore, are individual manuscripts that have been or will be submitted for publication to peer-reviewed scientific journals. Barring the abstracts, they have complete manuscript-style sections including an introduction, methods, results, discussion/conclusions and references. An additional methods section for the study as a whole as well as other relevant study documents are appended in the Appendices section.

¹ University of British Columbia, Faculty of Graduate Studies. *Masters and Doctoral Thesis Preparation and Submission*. can be accessed at <http://www.grad.ubc.ca/students/thesis/index.asp>.

CO-AUTHORSHIP STATEMENT

Identification and design of the research project as a whole ('Family Food Decision-Making in Three Diverse Ethnocultural Groups in Canada') was done primarily by Dr. Gwen Chapman and Dr. Brenda Beagan. Within this research project, Svetlana Ristovski-Slijepcevic's interests were in the participants' 'healthy eating perceptions and practices.' She contributed to the research project by adding a group of questions to the interview guide that examined these interests.

Participant recruitment and data collection for the study as a whole was performed by Svetlana Ristovski-Slijepcevic, Andrea D'Sylva, Carolyn Gill/Candy and Lucki Kang/Barinderjeet Chane. Svetlana Ristovski-Slijepcevic recruited and collected data with one of the four groups of families that participated; coordinated/managed the files for all of the four groups; contributed significantly to the development of analytic strategies (e.g., development of coding schemes in general) and actual analyses (e.g., coding of 1.5 of the four groups).

Data analyses and interpretation of the 'healthy eating perceptions and practices' data in particular were performed by Svetlana Ristovski-Slijepcevic with continuous guidance from Dr. Gwen Chapman and Dr. Brenda Beagan.

Manuscripts were prepared by Svetlana Ristovski-Slijepcevic with continuous guidance from Dr. Gwen Chapman and Dr. Brenda Beagan.

CHAPTER 1. HEALTHY EATING PERCEPTIONS AND PRACTICES

1.1 INTRODUCTION

Diet-related chronic diseases, such as cardiovascular disease, diabetes, and cancer, continue to prevail in Canada as well as much of the world (WHO, 2004). Such conditions, associated with suboptimal nutrition, contribute to an increase in health care costs, and a decrease in economic productivity and quality of life. In contrast, good nutrition contributes to a healthier, more productive population, lower health care and social costs, and better quality of life. The role of healthy eating as a lifestyle change in reducing the incidence of diet-related chronic diseases is significant (Nutrition for Health, 1996).

Because of its role in health, messages promoting healthy eating have become widespread across various levels of society. Educational tools about healthy eating, such as Health Canada's Food Guide to Healthy Eating (Appendix 1), have become familiar references for healthy eating recommendations for many people in Canada.

However, a gap between healthy eating messages and people's actual eating practices persists. Using data from the Food Habits of Canadians Survey, Jacobs Starkey et al. (2001) compared food intake with food group recommendations from the Food Guide and found that only males aged 13-34 met the minimum recommended intake levels for all four food groups. Similarly, the British Columbia Nutrition Survey (2004) found that the majority of adult British Columbians did not meet the minimum Food Guide food group recommendations. Only 0.7-3.2% of women and 5.2-14.2% of men met the minimum suggested servings for all four food groups on a given day (British Columbia Nutrition Survey, 2004). Similar results were found in the U.S.A. where 1-3% of the youth and adult

population ate the recommended minimum servings of all 5 food groups from the USDA Food Pyramid on a given day (Dixon et al., 2001). These data, coupled with rising obesity rates in Canada (Statistics Canada, 2005), suggest a discrepancy between what is recommended by health and nutrition experts and what is consumed by the Canadian population.

The reasons for a gap between healthy eating recommendations and people's actual eating practices remain poorly understood, partly because of the complexity of factors that may be involved in food decision-making processes. However, several different approaches to addressing the gap have been used. These have included examinations of the effectiveness of communication messages about healthy eating as well as people's ability to act on messages provided.

For the general Canadian population, most of whom are aware of and can read the current healthy eating recommendations, one area of examination has been to enhance the ways healthy eating information is communicated to people (with the underlying assumption that if communication improves, practices will as well). The rationale here is that current messages may not be communicated well to the public leading people to find the recommendations unclear and/or ambiguous. In a review of Canada's Food Guide to Healthy Eating, Health Canada (2004a) provided some clues as to why there is a discrepancy between the messages promoted in the Food Guide and people's interpretations of these messages. The review concluded that the Food Guide needs to be clearer about issues such as its application (e.g., people are not clear about serving sizes), terminology (e.g., people do not understand terms such as whole grains, enriched products, more often, variety) and the messaging used (e.g., there is a discrepancy between serving sizes illustrated in the Food Guide and what people think constitutes a portion). In

addition, there seemed to be a need to modernize and update the Food Guide to reflect the present food market availability, as well as to improve its communication in the current environment (e.g., balancing the simplicity of the Food Guide with providing sufficient detail so that people can individualize the information for their needs) (Health Canada, 2004a). These changes have been incorporated into the recently released new Food Guide (now called Eating Well with Canada's Food Guide) (Appendix 2).

The effect of such subtle changes on decreasing the gap between healthy eating recommendations and practices of people, however, remains to be seen. Some commentators remain skeptical that the changes made to the Food Guide will be of much use to people. Despite criticism of the clarity of the messages themselves, the literature about people's interpretations of healthy eating (which will be fully discussed in the next section) has shown that a large majority of people, at least those of Caucasian-European background living in Western countries, are quite knowledgeable about healthy eating – perhaps even beyond the information provided in food guides and guidelines (Paquette, 2005). Although people do not specifically refer to nutritional guidelines, they often use concepts – such as food groups, eating in moderation, including a variety of foods, increasing fruits and vegetables - that are featured in such guidelines (Health Canada, 2004b; Keane & Willetts, 1996; Povey et al., 1998). The new Food Guide, therefore, may not meet the needs of these people because they already know the messages but may interpret and implement them differently.

A second critique raised by skeptics of the Food Guide changes addresses a different group – those who may need such information but are unable to access it. Healthy eating messages may not be received by vulnerable subgroups of people such as those with difficulty in reading (and, therefore, understanding) educational materials. According to

the International Adult Literacy and Skills Survey conducted in 2003, over 40% of adult Canadians fall into the two lowest levels of all four types of literacy (prose, document, numeracy and problem-solving) (Statistics Canada, 2003). These data have changed little from the 1994 International Adult and Literacy Survey in which over 22% of Canadians were limited in their ability to deal with much of the written material they would encounter in everyday life (e.g., reading a medicine label to determine the correct amount of medicine to give to a child) and a further 26% of Canadians were at level 2 where individuals could read but only material that is simple, clearly laid out, and presented in familiar contexts (Statistics Canada & HRDC, NLS, 1996). It is, therefore, questionable that the changes in the new Food Guide address the needs of either those Canadians who already have knowledge of such basic information or of those Canadians who may need help with accessing such information.

Another area for examination into the gap between healthy eating recommendations and practices has been people's ability to act on healthy eating messages. While people may be able to obtain and understand healthy eating messages they may be unable to enact them in their everyday lives. Examining this area – people's (in)ability to act on healthy eating messages – has proven to be a very complex endeavour requiring an interdisciplinary approach. Both the complexity and inter-relatedness of factors influencing food decisions, where knowledge of healthy eating may play a role of varying significance, are evident in efforts attempting to conceptualize food choice processes (Devine et al., 1998; Furst et al., 1996; Wetter et al., 2001). Within these processes, decisions about healthy eating may be influenced by material or practical concerns of individuals – knowledge, information, cost, time/ convenience, availability

and accessibility have been widely documented as enhancing or impeding people's efforts to make healthy food choices. More abstract/conceptual concerns – psychological, social or cultural – also play a significant role in people's decisions about healthy eating; healthy eating values may conflict with other values (e.g., socializing, identity as a teenager, a mother or of belonging to a community) in the food choice process.

Conflict between messages may arise during decisions about healthy eating as one set of healthy eating messages (e.g., official guidelines) may conflict with other another set of messages (e.g., healthy eating notions from cultural background) that people draw on. This examination is particularly relevant for people living in Western countries with a cultural background other than the dominant Western background, as their cultural beliefs about healthy eating may take precedence over health organizations' recommendations. Studies show that despite attaining a high level of dietary acculturation (Anderson & Lean, 1995), many people still hold on to certain traditional ways of cooking and eating (Axelson, 1986; Satia-Abouta et al., 2002). Due to the rooted nature of meanings food provides, certain food practices persist even when the lack of nutrition in those practices is recognized (Airhihenbuwa et al., 1996). In addition to the above-mentioned literacy issues, therefore, some people in Canada are faced with additional language and cultural barriers and may have difficulty relating to and learning from educational tools like the Food Guide.

Both health researchers and policy makers are beginning to recognize that educational tools about healthy eating, such as the Food Guide, may have limited applicability in improving people's health. Instead, recognition of how healthy eating practices are determined by a wide range of influences is of priority for future work in this

area (Raine, 2005). Health Canada's Office of Nutrition Policy and Promotion recently commissioned a series of review papers to identify the main knowledge gaps and research needs with regard to the promotion and support of healthy eating of Canadians (published as a supplementary issue in the Canadian Journal of Public Health in 2005). Overall, the papers suggest that future research focus on the determinants of healthy eating through an examination of: a) the interaction between *individual* and *environmental determinants*¹ that influence healthy eating, as well as b) *why* the interactions of individual and environmental determinants operate differently in diverse populations and life circumstances (Health Canada, 2001).

These two priorities – to examine interactions between individual and broader influences and why interactions operate differently in diverse populations and life circumstances – along with the need to understand healthy eating from the perspective of the everyday experience can be considered as the point of departure for the current study which sought *to explore healthy eating perceptions and practices within specific ethnocultural groups in Canada*. Having the study situated within the context of the family allowed for such analysis to deepen beyond the level of individuals' perceptions and practices about healthy eating and considered the negotiated nature of these between individuals and interpersonal and environmental influences within the context of everyday life.

The rest of chapter 1 continues with a review of the literature with regard to healthy eating. The review is concerned with summarizing not only knowledge about healthy eating from an applied nutrition perspective, but also putting this knowledge into an historical and social context of how and why societies concern themselves with health in

particular ways. It thus incorporates a range of approaches to examining healthy eating perspectives, hoping to broaden the scope of nutrition approaches by amalgamating this knowledge with perspectives from population health/health promotion, sociology of health and illness, and social theory. What follows this literature review is a brief summary of the review, a short discussion of remaining/emerging questions from the literature as well as a more detailed description of the purpose and objectives of the current study.

1.2. LITERATURE REVIEW

The literature review below provides an overview of research regarding healthy eating interpretations. Based on the underlying assumption that humans actively construct knowledge about the world through their interactions with the environment (Schwandt, 1994; Schwandt, 2001), it is shaped around the historically and socially relevant ways that we currently come to know about, understand and explain healthy eating. Three main questions constitute the review: 1. how do we concern ourselves with healthy eating (e.g., how do we define and characterize healthy eating), 2. what shapes our healthy eating perceptions and practices (e.g., how do we explain variability in healthy eating) and 3. why do we concern ourselves with healthy eating in the particular ways that we do? In organizing the review this way, it will gradually take a broader and broader focus on the issues of healthy eating perspectives and practices moving from a focus on the individual, through specific social determinants to a broad view of the societal context.

1.2.1. HOW DO WE DESCRIBE HEALTHY EATING?

Developments over the last couple of centuries in medical and nutrition-related fields have influenced how we define and characterize healthy eating. The evolution of

nutritional science over the past century, in particular, has raised the complexity of our understanding about food and nutrients and what it means to eat healthfully. When making decisions about food, people today are likely to be considering a variety of factors about the healthful and unhealthful elements in food - e.g., the amount of calories, the type and amount of fat, the type and amount of vitamins and minerals, the colour of food, its quality, portion size versus serving size, food group acceptability, age and gender appropriateness of consuming a particular food. To make this process easier for the Canadian population, Health Canada provides leadership in nutrition, summarizing complex scientific evidence about food, nutrition and health into official national guidelines. Below, the official healthy eating tools in Canada are summarized (recent and current). This is followed with a summary describing if and how people interpret these guidelines in their daily lives.

1.2.1.1. The Official Healthy Eating Guidelines

Health Canada is the federal regulatory body responsible for helping Canadians maintain and improve their health. As part of its many roles, Health Canada provides national leadership in nutrition:

Working collaboratively with federal partners, provinces and territories and a range of other stakeholders, the Department develops and implements evidence-based policy that defines healthy eating and promotes environments that support Canadians in making healthy food choices. Health Canada is also recognized as an authoritative source of nutrition information (Health Canada, 2004d).

The federal leadership in part has responded to larger social and scientific developments in the health field. The first *Food Guide*, for example, developed and introduced to the public during WWII (1942) under the name of *Official Food Rules*, reflected the social and nutritional concerns of the time – wartime food rationing and nutritional deficiencies. Since then, both the name of the *Food Guide* and the strategies used to encourage Canadians to eat healthfully have undergone revisions to respond to the changes in scientific knowledge and nutritional needs of the Canadian population (Health Canada, 2007). Some of the more recent changes have been the result of both scientific advances and health promotion developments (Bush, 2003).

Since the early 1990s, *Canada's Guidelines to Healthy Eating* (Health Canada, 2004c) and *Canada's Food Guide to Healthy Eating* (Appendix 1) formed the basis of the nationally recognized dietary messages and a wide range of nutrition initiatives across the country. The *Guidelines* were adapted from the scientific *Nutrition Recommendations* (Health Canada, 2004c) into consumer-friendly statements. The *Food Guide*, based on the *Guidelines*, gave consumers more detailed information on establishing a healthy eating pattern through the daily selection of food. These three tools have recently been replaced by Health Canada's new *Eating Well with Canada's Food Guide* released early in 2007 (Appendix 2). The current *Food Guide* is a more personalized attempt to educate the public about healthy eating; however, the original purpose of the *Food Guide* – to “*translate the science of nutrient requirements into a practical pattern of food choices, incorporating variety and flexibility*” (Health Canada, 2007) – along with the expectations that once people have the knowledge the *Food Guide* provides they will take action and eat better

(i.e., healthier) has remained. The following sections focus on describing whether this is in fact how people respond to healthy eating messages.

1.2.1.2. People's Healthy Eating Interpretations: Recognizing 'Lay' Interpretations as Knowledge

In the last few decades, research in the sociology of health and illness has questioned our society's placement of values in medicine with regard to health (McKinlay and McKinlay, 2005). Whereas much of the twentieth century has hailed scientific discoveries (e.g., germ theory) and medical interventions (e.g., vaccinations, drugs) as having the largest effect on the health of populations (e.g., through diminishing infectious diseases), social scientists argue that it is social changes in the environment (e.g., public health interventions for cleaner air, proper sewage disposal) that have been the most significant contributors to health through improvements in 1. sanitation, 2. housing and nutrition and 3. general rise in standard of living (Conrad, 2005). These limitations of medicine underline the need for a broader understanding of health and illness, "a perspective that focuses on the significance of social structure and change in disease causation and prevention" (Conrad, 2005:6).

Similarly, scholarly work on people's understandings of health and illness has also been undergoing a shift in recent decades. In the 1980s, this interest was addressed through differentiation between the concepts of people's health and illness 'beliefs' as opposed to experts' 'knowledge.' This hierarchical distinction has since been criticised so that many sociologists now refer to both as different kinds of knowledges rather than 'lay beliefs' and 'expert knowledge' (Bury, 2000; Popay et al., 1998). Part of this shift is also due to medical knowledge becoming part of the vocabulary in everyday life. People's

views of health and illness do not always conflict with medical views but instead often echo them in explanations of personal experience (Moscovici, 2001).

As well, rather than being viewed as passive recipients of medical knowledge, people are increasingly viewed as 'actors', creatively making sense of their health and illness by using cultural resources such as expert knowledge and media images in order to explain their own personal experience. The media addresses matters of health and illness daily, while at the same time people actively search for more health and illness information. Thus, 'lay' health and illness views contain expert information but are not limited to this as they also draw on other knowledge bases (Bury 1998). In this light, the traditional expert role of science and medicine has become challenged, where discontent with the disease-oriented medical perspectives has led to demands for more holistic and patient-centred orientations. These orientations find people's understandings and experiences of health and illness as a social phenomenon (Bury 2000), lived and experienced as members of a family, community and society (Blaxter 1990; Herzlich 1973).

In a similar manner, people's perceptions, understandings and interpretations of healthy eating have become increasingly important in research in part because there seems to be a gap between healthy eating recommendations and people's practices. Understanding people's knowledge is of utmost importance if this gap is to be properly addressed and diminished. Below is a summary of this literature.

1.2.1.3. Turning Perspectives into Practice: Do People Incorporate Healthy Eating Guidelines into Everyday Food Choice?

While people's interest in the relationship between food and health has waxed and waned over time, Canadians today are extremely attentive to new health and nutrition information (Ostry, 2006). A recent review of the literature about the Canadian population's perceptions of healthy eating² found that, while grain and milk products were not mentioned often, in general, people's perceptions of healthy eating seem to be heavily influenced by dietary guidance with considerations of fruit and vegetables, meat, limitations of fat and salt, variety and moderation. However, the review also found that people's perceptions of healthy eating include additional considerations not mentioned by dietary guidelines such as the importance of freshness, unprocessed and homemade foods and limiting sugar intake as well as interpretations of the concept of balance in ways that differ from the official concept (Paquette, 2005). What follows is a broader review of how people in Western countries incorporate healthy eating guidelines into their everyday decisions about food. Rather than focusing on perceptions only, the review broadens into interpretations about healthy eating that incorporate the aspects of 'accessing', 'understanding' and 'using'³ of healthy eating information. 'Accessing' focuses on findings about the sources of information people draw from to learn about healthy eating, 'understanding' focuses on the ways people come to understand healthy eating discourse, while 'using' focuses on the ways people incorporate their healthy eating knowledge in the everyday food context.

1.2.1.3.1. 'Accessing' Healthy Eating Information

An increasing number of sources of information are available where people can learn about health and nutrition topics. But the sources people actually use, as reported in

surveys, seem to vary. A study in the Netherlands found that primary care physicians, friends and neighbours, and family were reported as more frequently used sources than dietitians and the Food and Nutrition Education Bureau, even though dietitians and the Bureau followed by the physicians were perceived to have the highest expertise (Hiddink et al., 1997). In a U.S. study, however, respondents tended to use non-personal contact types of nutrition information sources such as books/magazines, newspaper and TV/radio more than physicians/nurses, nutritionists/dietitians and extension home economists (Medeiros et al., 1991). In another U.S. study, mass media and family/friends were more often used than health care professionals by men, except for those men diagnosed with high blood cholesterol. For these men, health care professionals were most often used. Interestingly, of the four categories of sources surveyed, only health care professionals and community sources were positively and significantly correlated with adoption of food behaviours to reduce dietary fat (Ankeny et al., 1991). For cancer patients in Ireland, the most frequently cited sources of nutrition information were hospital consultants, general practitioners, chemotherapy/radiotherapy staff, ward staff, and family/friends. The internet was reported as a source by less than 10% of patients (Mills & Davidson, 2002). A multi-site study in European Union member states found that the most frequently mentioned sources of information about healthy eating were TV/radio, newspaper, magazines, health professionals and food labels. There were slight differences regarding sources of healthy eating information between Spain and the rest of the European Union countries, as people in Spain used sources such as TV/radio, magazines, and newspapers less often than the rest of the countries (Holgado et al., 2000). In their large study, though, there was wide variability in sources on healthy eating information mentioned, even though health professionals and government agencies were reported as most trusted (Lappalainen et al.,

1998). As a whole, the most frequently mentioned sources were TV/radio, magazines and newspapers and health professionals, but Greek and French respondents reported using TV/radio and magazines and newspapers least frequently.

Because an increasing amount of health and nutrition information is available in the mass media, mass media tools have become the focus of some research. Some trends have been observed over time. Barr (1989) observed an increase in avoidance messages (such as messages to minimize or eliminate certain substances) in a Canadian women's magazine between 1928 and 1986. In Australia, Hill & Radimer (1996) found that there was much less emphasis about nutrition in younger women's magazines in comparison to magazines that targeted mature women. Lohmann & Kant (1998) found that nutrition messages in U.S. magazines do not seem to be influenced by changes in governmental nutrition recommendations. Their study was about the responsiveness of food advertising to the release of the Food Pyramid in both culinary and health-oriented magazines. They found that the 4 magazines they analyzed in 1991 (prior to the release) and 1994 (after the release) did not change their food advertisements to reflect the recommendations of the Food Pyramid. Similarly, Byrd-Bredbenner & Grasso (2000) found that even though U.S. prime time television advertisements in 1992 and 1998 often included health advertisements, the messages were frequently not in line with health recommendations. The foods most often advertised seemed to be those that are over-consumed by people (e.g., soft drinks) while almost no advertisements were about fruits, vegetables, or milk.

In addition to the sources discussed above, new sources of health and nutrition information seem to be emerging, one example being the internet (Goldberg, 2000; Van Woerkum, 2003) perhaps as a sign that people actively seek out information (Vaandrager & Koelen, 1997). According to some researchers, people are increasingly becoming

interested in new topics in nutrition such as genetically modified foods, food safety, vitamin supplements, and functional foods (Clayton, 2000; Miles & Frewer, 2001; Coulson, 2002). For example, although balanced diet, fruit and vegetables, and eating less fat were the most important food topics in Van Dillen et al.'s (2004) study, most respondents felt no more information about these topics was needed. Instead, desire for more information about food topics such as genetically modified foods and losing weight was expressed. Differences by gender, age, and socioeconomic status were observed. For example, people of higher SES perceived functional foods as more important, while those of lower SES perceived eating less fat as an important food topic. Therefore, some specific food topics seem to need tailoring for specific populations.

But having sources for nutrition information does not necessarily ensure that the knowledge obtained from these sources will be applied when making food choices. There is a fear that people are confused by or are rejecting the plethora of nutrition and health messages available today (Goldberg, 1992; Patterson et al., 2001). The problem is compounded by how messages are presented to people. Diverse groups take different approaches in presenting healthy eating information to people depending on their own perspectives and goals (e.g., food industry has different goals from government agencies). Similarly, not all sources are equally effective in delivering their messages. The media as an important source of nutrition and health information, in particular, has been associated with consumer confusion as well as skepticism of the nutrition research field (Goldberg, 1992).

Even so, there is not as much skepticism about nutrition information as some might expect. Patterson et al. (2001) found that people in the U.S. do care about nutrition and health information, as 91% of those surveyed thought that research on nutrition is going to

help them live longer. But, people also do not want to be told what to do (eat). In the same study, 43% respondents agreed that they are tired of hearing about what foods they should or should not eat and 71% agreed that the government should not tell people what to eat. In their study, skepticism was higher in men than women, the younger and older than the middle aged, and in those with lower SES, so that specific subpopulations appear to be more prone to disbelieve nutrition and health messages.

The literature, therefore, shows that people access healthy eating information through both formal (e.g., health professionals) and informal (e.g., family, media) sources which may not be completely in line with official guidelines. While some skepticism of nutritional messages does exist (in specific populations and in relation to whether people should be told what to eat), there is a general trust in these messages. The following section delves more deeply into how people understand healthy eating information.

1.2.1.3.2. 'Understanding' Healthy Eating Information

Research findings about people's interpretations about healthy eating come from mainly Caucasian participants. Nonetheless, they give a glimpse into the ways people come to understand healthy eating discourses. Studies indicate that people interpret healthy eating in both similar and different ways. In general, people are quite familiar with the basic assumptions of healthy eating and, although they may not specifically refer to nutritional guidelines as sources, they often use messages from such guidelines (Health Canada, 2003; Keane & Willetts, 1996; Paquette, 2005). But, beyond the general guidelines, people define healthy eating in a variety of ways (Chapman & Beagan, 2003; Falk et al., 2001; Keane & Willetts, 1996; Povey et al., 1998). In Chapman & Beagan's (2003) study with Canadian women who have and have not experienced breast cancer, for example, women expressed three different orientations to healthy eating: a 'traditional'

orientation that emphasized eating meat, potatoes and vegetables; a 'mainstream' orientation that emphasized increasing fruit and vegetable intake and decreasing fat intake; and an 'alternative' orientation that emphasized the role of toxic and cleansing effects of food and issues such as cancer and the immune system.

According to Falk et al.'s study (2001) in the US, participants' perceptions of healthy eating differed by themes and by complexity of definition. The range of individuals' perceptions of healthy eating varied in complexity such that a person could perceive healthy eating to have anywhere from one to several themes. The seven predominant themes that people focused on in their study were that healthy eating is: 1. balanced eating ('balance'), 2. eating low fat ('low fat'), 3. eating to control weight ('weight control'), 4. maintaining nutrient balance ('nutrient balance'), 5. eating natural/unprocessed foods ('natural'), 6. eating to prevent disease ('disease prevention'), and 7. eating to manage an existing disease ('disease management'). Five of the seven predominant themes had secondary themes; for example, the predominant theme 'weight control' had 'low fat' and 'balance' as secondary themes. All themes varied to an extent with respect to experiential and informational sources, classifications and strategies used in food choice.

A British study also found a diversity of healthy eating definitions in their participants' responses (Keane & Willets, 1996). While some spoke of healthy eating in very general terms ("eating the right sort of food at the right time"), others gave specific explanations with proportions of protein, grains, vegetables and carbohydrates that should be consumed. Balance in eating seemed to be a common theme for most people, but most participants found it difficult to explain what balance is.

Another European study, a survey of European member states, found that, despite between-country commonalities in terminology (e.g., balance and variety, lots of fruits and vegetables and eating low fat diet), there was considerable between-country variation in the extent of use of particular healthy eating definitions (Lappalainen et al., 1998). For example, fresh foods were mentioned by 56% of respondents in Italy and only 6% in Denmark. Similarly, 66% of Greek respondents mentioned fruits and vegetables, while only 17% of French respondents did the same.

Similarly, Povey et al. (1998) found that people interpret healthy and unhealthy eating in various ways. Some of the most commonly mentioned terms used to describe concepts of healthy eating were (in descending order of mentioning): 1. eating 'healthy' foods, 2. avoiding 'unhealthy' foods, 3. food containing fibre, 4. natural foods, 5. food containing vitamins, 6. a balanced diet, 7. fresh foods, 8. avoiding fried foods, 9. eating a variety of food, and 10. being careful about food. From this list, similarities can be deduced with Keane and Willets' study in which some participants give specific interpretations (e.g., food containing fibre) and others focus on broader themes (e.g., eating a balanced diet).

Therefore, while people seem to be knowledgeable about messages from official guidelines (seen through their use of such terminology), at the descriptive level the literature shows that healthy eating definitions and interpretations vary. There still is not a clear understanding as to the nature of this variability.

1.2.1.3.3. 'Using' Healthy Eating Information

A large part of the literature around 'using' healthy eating information has revolved around reporting statistics of poor compliance between people's eating practices and healthy eating guidelines (BC Nutrition Survey, 2004; Dixon et al., 2001; Jacobs Starkey

et al., 2001; Statistics Canada, 2005). Apart from this literature, empirical and theoretical explorations into *why* there is variability in interpretations and *how* people use healthy eating knowledge are scant.

In terms of *why* there is variability in healthy eating interpretations, explanations incorporate issues of both accessing and processing healthy eating information. Some have suggested that people's continued consumption of suboptimal diets may be associated with the broad nature of how the concept 'healthy eating' can be interpreted (Povey et al., 1998). Consumers may have a fragmented rather than a coherent picture of what a healthy diet is partly due to the evolving nature of the message. Nutrition recommendations undergo inevitable changes and increased complexity as new knowledge about healthy eating emerges. Others believe that the reason for poor healthy eating practices may be related to the nature of changes required of people. People find some changes easier to make than others. For example, people find it easier to choose lower fat milk over whole milk, but still also choose high-fat ice creams (Goldberg 1992).

Gedrich (2003) believes there are two types of factors that hinder dietary changes. The first type is the conflicts that exist in nutrition norms and food rules in different situations, and the coping strategies people develop to deal with these conflicts. Gedrich explains that in trying to amalgamate all the different factors that influence food choice, conflicts arise for people such as "the variance of different nutrition-related motives or values" and "the contradictions of food and nutrition related information provided by scientists, public health organizations and industry" (p. 236). As a result, people develop strategies for making food choices to help them cope with the conflicts. These coping strategies may be only temporary, but if they prove to work they can become stable. The second type of factors are the concurrent gains and losses that come with change. Gedrich

claims that there are gains and losses with every change people have to make (e.g., the gain of health and the loss of food taste), but where dietary change losses are immediately experienced health gains are often related to the far (e.g., longer life), uncertain (e.g., death may happen as a result of something unrelated to nutrition), and hardly perceivable (e.g., don't explicitly experience avoidance of a certain disease) future. A dietary change is further complicated in that even if gains are equal to losses, Gedrich believes that people will probably choose stability over change.

In terms of *how* people use healthy eating knowledge, a group of researchers from Cornell University has contributed to our understanding through their analysis of the food choice process. In this analysis, 'health and nutrition' are conceptualized as a value, dependant on a person's experiences over her or his life-course (Furst, Connors, Bisogni, et al., 1996; Devine et al., 1998; Furst, Connors, Bisogni et al., 2002). According to their food choice model (Furst, Connors, Bisogni, et al., 1996) (see Figure 1.1), food choice is a dynamic process determined by a unique relationship between the person's life-course, influences, and a personal food choice system. In the model, life-course experiences generate and shape a set of food choice influences such as a person's ideals, personal factors, resources, social and food contexts. Some of these influences are more salient to some people in particular food choice situations than others. The influences experienced over the life-course in turn lead to the development of personal food choice systems consisting of value negotiations and strategies for making food choices. 'Health and nutrition' enter the model as one of the most common value negotiations, defined as "the weighing and accommodation of values salient to a person in a particular situation" (Furst et al., 1996:257). The value of 'health and nutrition' is seen to compete with or be

negotiated by ‘sensory perceptions’, ‘monetary considerations’, ‘convenience’, ‘quality’, and ‘managing relationships’. As a result of these value negotiations over time, a person

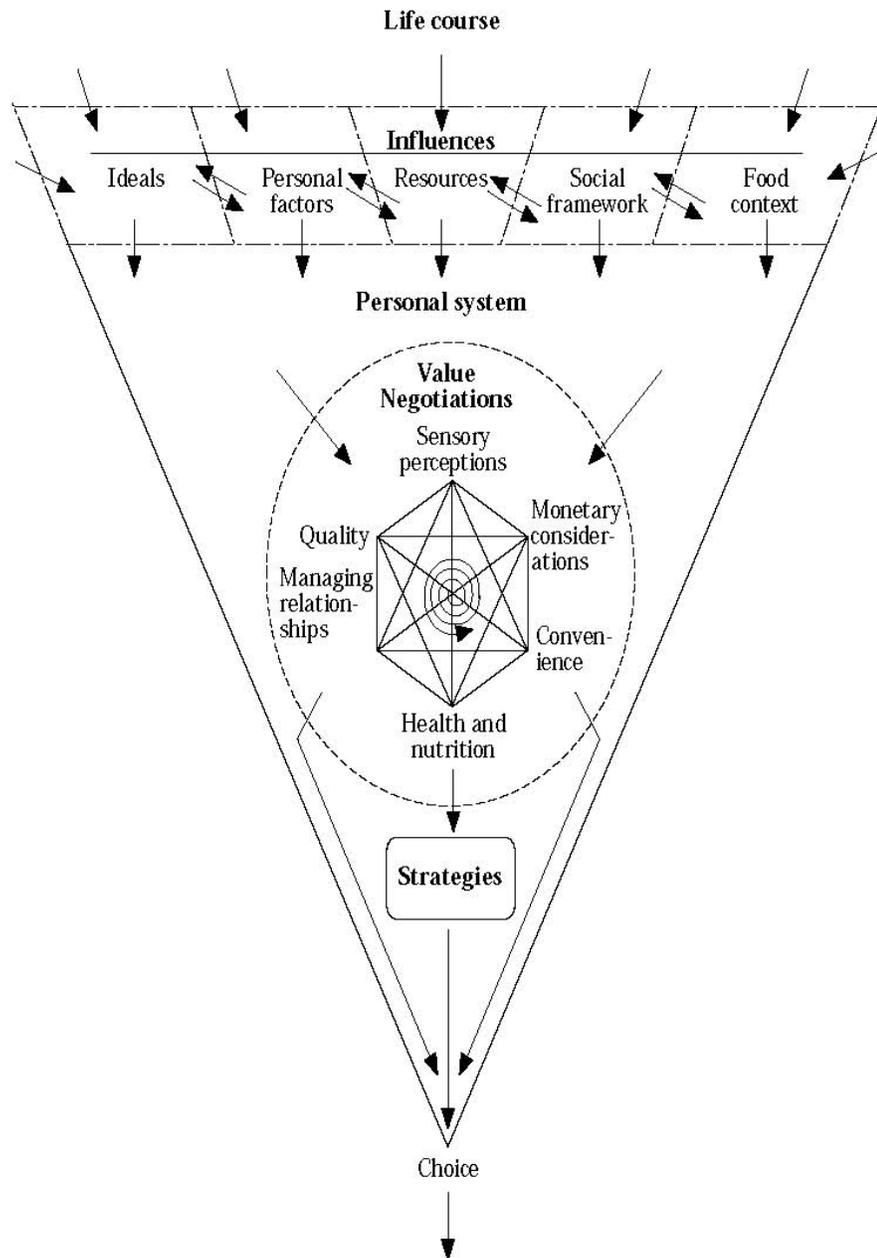


Figure 1.1: A conceptual model of the components in the food choice process (Furst et al., 1996).

develops habitual strategies or personal food systems to enact the food choice. Some of these involve i) categorizing foods and eating situations, ii) prioritizing conflicting values for specific eating situations, and iii) balancing prioritizations across personally defined time frames (Connors, Bisogni, Sobal & Devine, 2001). These personal food systems may be modified with new life-course experiences and changes in personal self images (Bisogni et al., 2002; Connors et al., 2001; Furst et al., 1996). As part of the same research, Devine et al. (1998) described a fruit and vegetable food choice trajectory influenced by life-course events and experiences such as food upbringing, roles, health, ethnic traditions, resources, location, and the food system (see Figure 1.2). They defined trajectory as a "person's persistent thoughts, feelings, strategies, and actions as she/he approached food choice" (Devine et al., 1998:363).

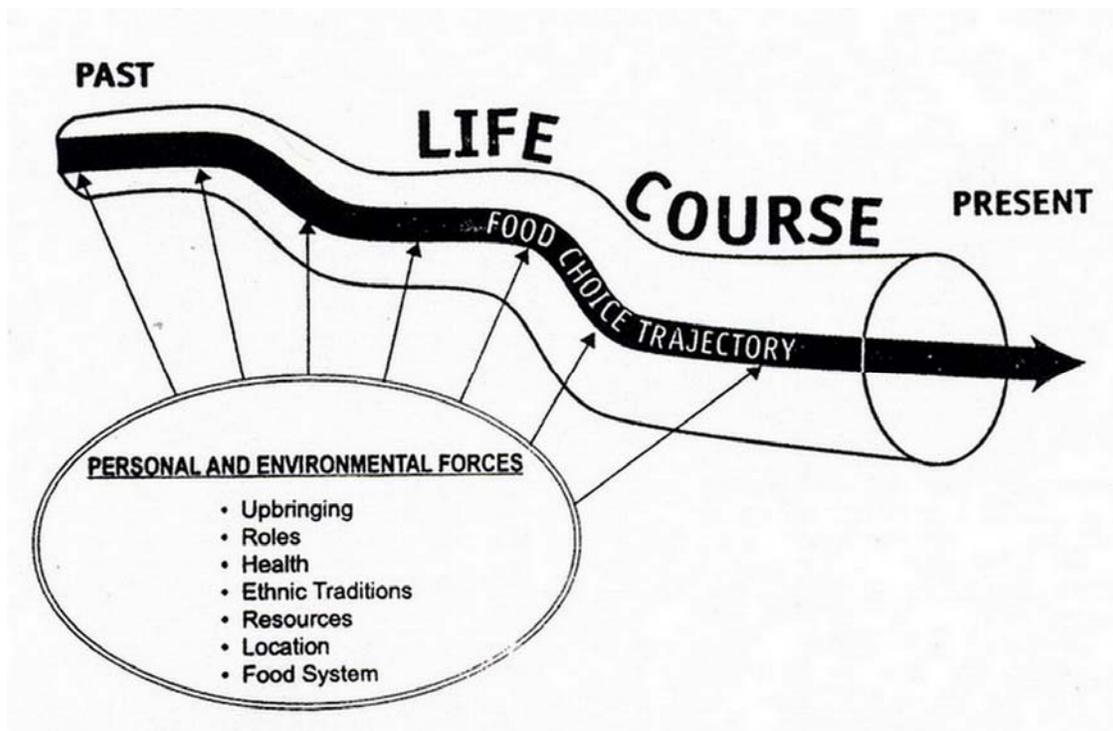


Figure 1.2: A life course model of a food choice trajectory (From Devine et al., 1998).

In the ‘using’ of healthy eating information literature, therefore, few attempts have been made to explore *why* there is variability in healthy eating interpretations and *how* people use healthy eating knowledge to make food choices in the everyday context but the existing literature does show that there are complex processes that would need to be addressed.

In summary of the first question – how do we define and characterize healthy eating – healthy eating is officially defined in terms of scientific knowledge about the relationship between food and health translated by official healthy eating guidelines into everyday messages about food choice. In the everyday context, however, people learn about healthy eating both from official as well as unofficial sources which they process and use in a variety of different ways. This literature has predominantly focused at the individual level with little consideration about the ways in which individuals’ food choices are shaped by influences surrounding them. The literature below, drawing predominantly from the health promotion and social theory fields, delves into this area.

1.2.2. HOW IS HEALTHY EATING SHAPED?

The above review of healthy eating interpretations provides an introduction into the complex ways that healthy eating is shaped. But, in practice, emphasis on what shapes healthy eating has been placed primarily at the level of individuals – their knowledge, attitudes and information-seeking patterns. While there has been a recognition that notions of healthy eating are the result of a dynamic process that is influenced by a complex integration of many biological, psychological, social and cultural factors, the primary focus in Canada has thus far been on how to change ‘lifestyle’ food behaviour (Wetter et al., 2001) (Figure 1.3) so that once people obtain these skills, they will be able to change their

eating behaviour and have better health.

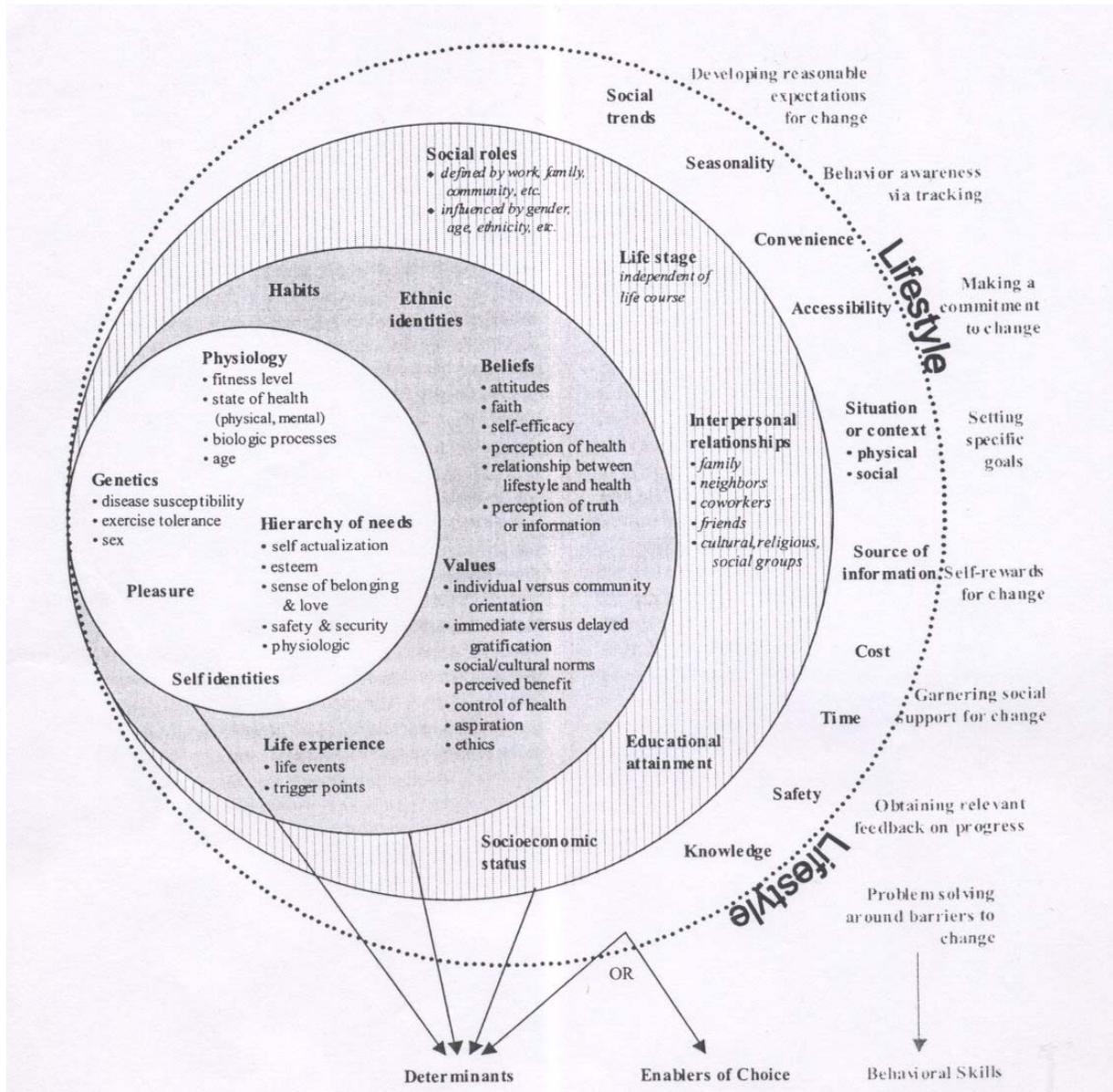


Figure 1.3: Framework of determinants of physical activity and eating behavior at the level of the individual, and intervention strategies (from Wetter et al., 2001).

The literature discussed below suggests that current work in the area of healthy eating perceptions and practices needs to extend its focus on the individual and consider other determinants that influence these. In the next section, approaches from health

promotion/population health that examine and characterize some determinants of health as well as healthy eating are discussed. In the section following that, approaches from social theory that suggest how to examine interactions between determinants are discussed.

1.2.2.1. Determinants of Healthy Eating

In contrast to this emphasis on eating behaviours as under individuals' control, health promotion/population health approaches have suggested other frameworks for understanding what shapes healthy eating. Much of this research, under the rubric of 'determinants of health', suggests that we need to broaden the focus on the individual - towards the social, economic and physical environment - to understand what influences health. The Public Health Agency of Canada (2003) describes 12 *determinants of health* that contribute to the health of Canadians: income and social status, social support networks, education and literacy, employment/working conditions, social environments, development, biology and genetic endowment, health services, gender and culture. Of these, *social determinants of health* are the economic and social conditions that influence the health of individuals, communities and jurisdictions. These conditions determine whether individuals stay healthy or become ill. More broadly, they also determine the extent to which a person possesses the physical, social and personal resources to identify physical environments, personal health practices and coping skills, healthy child and achieve personal aspirations, meet safety needs, and cope with the environment. They refer to the quantity and quality of a variety of resources that a society makes available to people. Such an emphasis on societal conditions contrasts with the traditional focus upon biomedical and behavioural risk factors (e.g., cholesterol, body weight, diet, physical activity, tobacco use). It thus directs attention to economic and social policies as means of

improving health (Raphael, 2004). Raphael (and colleagues) (2004) identified 11 *social determinants of health* that affect the health of Canadians: Aboriginal status, early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion and unemployment and employment security.

A similar line of thinking has only recently become part of the healthy eating discourse in Canada (Health Canada, 2002). Upon Health Canada's request, Raine (2005) recently provided an overview/synthesis of the current knowledge with regard to *determinants of healthy eating*. The determinants, discussed from a population health promotion framework, included: *Individual determinants* (physiological influences, food preferences, nutritional knowledge, perceptions of healthy eating, and psychological factors); *Collective determinants 1*: Environmental determinants of healthy eating as context for individual behaviour (interpersonal influences, physical environment, economic environment, social environment) and *Collective determinants 2*: Public policy creating supportive environments for healthy eating.

While useful as a starting point, Raine's review does not include a detailed discussion of some important determinants such as gender and socioeconomic status (SES) or how determinants of healthy eating operate at the everyday level. In addition, (and as Raine suggests herself for future research) determinants of healthy eating should not continue to be examined in isolation from each other, as health is determined by complex *interactions* between social, economic physical and individual determinants. A comprehensive approach to healthy eating needs to take into account that health and illness can be the result of some combination of physical and social circumstances of life in an area or personal characteristics of individuals living in that area (Syme and Berkman,

2005). Below, therefore, is a brief summary of the literature that has examined some of the determinants shaping healthy eating practices at the everyday level, including socio-demographic, life-course and socio-cultural determinants.

1.2.2.1.1. Socio-demographic Determinants

The more often studied factors that influence healthy eating are the group level factors, particularly those related to socio-demographic differences. For example, higher age (but with a decrease in the elderly), higher level of education, higher socioeconomic status, and female sex have been positively associated with both self-described healthy eating and with enacting behaviours closer to dietary guidelines suggested by health professionals (Charles & Kerr, 1988; Charles & Walters, 1998; Kearney, Kearney, Dunne & Gibney, 2000; Johansson et al., 1999; Martinez-Gonzalez et al., 2000; Martinez-Gonzalez et al., 1998; Povey et al., 1998; Roos, Lahelma, Virtanen, Prattala, & Pietinen, 1998). In addition, Power's review of income as a key determinant of healthy eating (2005) found suggestions for the existence of both an income threshold (beneath which income is the most important determinant of consumption) and a socio-economic gradient (suggestive of an interaction of income with other determinants such as education), perhaps above the income threshold. Below the income threshold, however, neither education nor nutrition knowledge and skills mitigate the effects of inadequate income on diet.

Socio-demographic factors often, however, work in varying combinations with each other and with other psychosocial and cultural factors (Axelson, 1986), making it difficult to distinguish how or to what extent each contributes. Turrell's (1998) study in Australia, for example, showed that socioeconomic variability in healthy food choice is partially explained by SES differences in liking or disliking foods. He showed that people

of different SES groups not only purchased but also liked/disliked different foods. The food choices of participants in the high income group were the most consistent with dietary recommendations and those participants reported liking a greater number of healthy foods. Participants in the welfare group, on the other hand, were less likely to purchase and disliked many of the healthy foods. Turrell suggested that these differences may be the result of a variety of factors including: reporting bias (e.g., higher SES groups know what the expectation is for them to say), differential exposure to healthy food (e.g., assuming that food likes increase with greater exposure and that lower SES groups have been less exposed to or have less access to healthy foods), and/or through subcultural differences in beliefs, values and meanings of the different groups.

Similarly, Coveney (2005) found that, concerning their children's eating habits, parents living in different social backgrounds (drawn from low- and high-income suburbs in Australia) draw on and use different forms of knowledge about food and health. Parents from the high-income suburb were more likely to talk about food and health using terminology consistent with contemporary nutritional and medical discourses. In contrast, parents from the low-income suburb were more likely to talk about food and health using terminology that related to their children's outward appearance and functional capacity. Coveney concluded that these differences highlight a relationship between social class and the different stocks of knowledge about food and health parents draw on. Taken together, then, these studies show that while SES is a determinant in healthy eating, it may be so through its interaction with other determinants such as (sub)cultural norms and values.

1.2.2.1.2. Life-course Determinants

Healthy eating perceptions and practices have also been shown to be dynamic processes that are shaped and modified by new life-course experiences (Devine et al.,

1998; Falk et al., 2001; Paisley et al., 2001). People apply the information they learn from experiences into their own definitions and ways of managing healthy eating. Approaches to healthy eating are diverse depending on both experiential and informational sources stemming from life-course experiences. From these sources, people classify both foods and eating situations as either healthy or unhealthy and employ strategies such as substituting, avoiding, comparing and limiting certain foods in order to create a set of rules and behaviour patterns for healthy eating (Falk et al., 2001). Research has shown that these beliefs and strategies about healthy eating are an important factor in the food choice process for people in both North America (Bisogni, Connors, Devine & Sobal, 2002; Devine, Connors, Bisogni & Sobal, 1998) and Europe (Kearney, Gibney, Livingstone, Robson, Kiely, et al., 2001; Lennernas, Fjellstrom, Becker, Giachetti, Schmitt, et al., 1997).

A number of stages in the life-course seem to act as turning points for healthy eating practices including the onset of adolescence (Cavadini et al., 1999; Story et al., 2002), cohabiting (Laitinen et al., 1997; Kemmer et al., 1998; Paisley et al., 2001) and chronic disease (Devine et al., 1998; Furst et al., 1996; Gregory, 2005). One particularly important life-course determinant that seems to have potent influences on healthy eating practices is becoming/being a parent. A number of studies have shown that having children is seen as an opportunity to try new fruits and vegetables and model healthy eating to their children (Charles & Kerr, 1988; Gillman et al., 2000; Koivisto, 1999; DeVault, 1991; Paisley et al., 2001). Devine et al. (1998) also showed that past life-course experiences influence people's current fruit and vegetable choices over time. They found that certain life-course transitions act as salient influences in constructing a fruit and vegetable trajectory for each person. Two of the more salient life-course transitions for their

participants were role changes and health events (Devine et al., 1998). Some of the life-course determinants that affect healthy eating were previously summarized in Figure 1.2.

1.2.2.1.3. Socio-cultural Determinants

An underlying theme for much of the literature on socio-demographic and life-course determinants is that there seem to also be broader determinants that influence how people interpret healthy eating. Culture is one such determinant. It is a guide for how members of a community ought to think, feel, and act; in other words, culture provides standards for ways of being or doing – or eating. For example, North American cultural standards for food choice are represented by Canada’s Food Guide to Healthy Eating (now Eating Well with Canada’s Food Guide) and the U.S.D.A. Food Pyramid. In contrast, South Asian cultural standards for food choice might be said to be represented by the hot-cold distinction of foods, while African cultural standards might incorporate ‘soul foods’ as part of cultural standards. Similarly, there are country-different interpretations about which foods constitute a part of healthy eating (Lappalainen et al., 1998).

As food choice is influenced by culture, culture is influenced by larger social processes occurring where people live. Discourses about societal patterns and changes in food are inextricably related to discourses about more general social patterns and changes. Sobal (2000), for example, described how social processes influence changes in food culture. Social processes such as globalization, modernization, urbanization, and migration shape changes in food culture that in turn lead to consumerization, commodification, delocalization, and acculturation.

Dietary acculturation as a result of immigration to a host country can be conceptualized as a process that involves the movement from traditional to ‘acculturated’ food choices and eating patterns. Because of Canada’s multicultural population and

immigration patterns, dietary acculturation as an influence on healthy eating represents a salient issue for public health. Dietary acculturation refers to the process of a minority group adopting the food choices and eating patterns of the host country. According to a model of dietary acculturation proposed by Satia-Abouta et al. (2002), an exposure to a host culture involves a number of changes in psychosocial factors and taste preferences, as well as in environmental factors, food procurement and preparation. These changes lead to new patterns of dietary intake.

But, the process of dietary acculturation is by no means a linear one as immigrants develop many strategies to incorporate traditional foods/ingredients/ways of cooking into new ways (Satia-Abouta et al., 2002). For example, a study of Glaswegian South Asian migrant women showed that in a span of 10 years after migration, the women's food choices had not changed much but had shifted more in line with mainstream dietary recommendations. Although not much change was seen in the eating patterns and food choices in general, the women had shifted to using recommended 'healthier' versions of food items such as margarine instead of butter and skimmed milk instead of whole milk (Anderson & Lean, 1995). Similarly, a study of South Asian people from Scotland showed that participants ate both British- and South Asian-style meals at varying times and that most parents and some young people were committed to South Asian cuisine (Wyke & Landman, 1997).

The process of acculturation becomes even more complex as variations in acculturation patterns exist between different cultures, often dependent on the norms and values of the cultures. In another publication from the study in Glasgow, for example, the authors showed that different ethnicities/cultures (in their case South Asians and Italians) acculturate with their diets in different ways. The different cultural values

between the two cultural groups with regard to, for example, body size, home-made foods and exercise, were a stronger factor in making food choices than income and racism experienced by each group (Williams et al., 1998). Similarly, Kassam-Khamis et al. (1995) showed that even though both groups live in London, differences in food choice (e.g., similar foods but different nutrient content used in preparation) exist between South Asians of the Punjab (Sikhs) and Gujerat (Hindus) origin.

These types of social processes lead to cultural changes that can be observed over time in healthy eating interpretations between generations of people. For example, Yuhua (2000) compared children's dietetic knowledge with that of their parents and grandparents in Beijing, China and found that each generation was associated with different dietetic knowledge. Grandparents used *traditionalist* discourse about dietetic knowledge including yin and yang, hot and cold foods explanations, wide range of foods, natural foods, foods to be eaten according to season as this influences child's growth, lots of vegetables, some meat. Parents, on the other hand, used *modernist* discourse about dietetic knowledge, their ideas being informed by schooling and familiarity with modern science, discourse around vegetables, vitamins and minerals. In contrast, children were associated with *consumerist* dietetic knowledge and were influenced by new and imported foods, were familiar with Western type fast-foods, and liked games in packaged foods and food that is "fun" (from fast food chains). She described these as age/lifestage differences in how generations described their dietetic knowledge; however the study also points to the influence of larger social effects such as changes in educational level between generations, increased scientific usage in explanations about nutrition (e.g., in parents' discourses compared to grandparents' traditional discourses), consumerization and globalization (e.g., the influence of Western culture in the children's discourses).

Broader social changes can thus be seen as influencing changes in food norms. In a qualitative Canadian study, for example, Paisley, Sheeshka & Daly (2001) observed the changing status of fruit and vegetables over the life-course of their study participants. While fruits and vegetables were considered to be foods of low status when participants were children, due to many social, cultural and economic factors, they came to be considered virtuous and associated with health during adulthood. The authors reasoned that couples' fruit and vegetable choices were based on attempts to construct couple food norms and practices as a different identity within a context of social changes.

These approaches to healthy eating, therefore, bring to the forefront the complexity involved in approaching, changing or maintaining healthy eating perceptions and practices. Healthy eating behaviour is seen as developing and changing over time not only as a result of new nutritional knowledge and information, but also as a result of broader life-course and societal changes. This kind of a focus emphasizes the need to explore factors beyond healthy lifestyle choices and health care, factors that shape health and affect society as a whole (Romanow, 2004). It also emphasizes the need to examine the complex *interactions* between the individual and social, economic and physical determinants. Thus far, however, there has been a paucity of attempts in health-related fields to describe how an examination of these interactions would proceed.

Therefore, in addition to socio-demographic and life-course determinants, this last section of determinants argues that healthy eating perceptions and practices are also the result of broader societal and/or cultural continuities and changes that become visible at the everyday level of individual and family practices.

1.2.2.2. Examining Interactions between Determinants: Perspectives from Social Theory

Perspectives from social theory can help provide clues as to how to examine interactions between individual- and collective-level determinants. Two such perspectives that have been particularly helpful in this study, Anthony Giddens' 'duality of structure' and Michel Foucault's 'governmentality' are introduced below as they relate to the 'structure-agency' debate. In attempt to avoid redundancy, they are introduced but not discussed fully here – they are covered in more depth in chapters 2, 3 and 4 as they apply to each of the manuscripts.

One of the central issues in sociology is the debate surrounding the influence of 'structure' and 'agency' on human thought and behaviour, a debate that resembles the question of 'social determinants' versus 'lifestyle' in the health-related fields. In the sociological context, '*agency*' refers to the capacity of individuals to act independently and their freedom to make their own choices. '*Structure*', on the other hand, refers to those factors, such as social class, religion, gender and ethnicity, which seem to limit or influence the opportunities that individuals have.

The debate is a question of social ontology (e.g., what is the social world made of?). Do social structures determine an individual's behaviour or can/does human agency give people the capacity to construct and reconstruct their worlds so that structure is the result and consequence of the actions and activities of interacting individuals? There are three possible theoretical positions in the response to this line of questioning – that: 1) agency rules, 2) structure rules, or 3) structure and agency influence each other (both exist **because** of each other) so that structure influences human behaviour and individuals are able to change the social structures they inhabit (Jary and Jary, 1995).

Anthony Giddens' *Theory of Structuration* (1984) provides a framework for considering the third theoretical position, arguing that our social practices (for example, our decisions around healthy eating) are the result of an *interaction* between 'structure' and 'agency,' a relationship he terms the 'duality of structure.' He defines *structure* as the rules and resources people draw upon in their practices. These rules and resources can range from simple and tangible ones to more complex ones that can enable or constrain people's practices. *Agency* refers to what people do or how they interact with structure. People are not seen as passively accepting whatever rules are around (although they may and sometimes do). Instead, they are seen as also interacting with and having the opportunity to make changes in systems. They can, therefore, produce new meanings/rules or reproduce meanings/ rules through the routinization of practices.

Examining the same agency-structure debate from a slightly different angle, the focus of Michel Foucault's career was to outline a history of "*the different ways in our culture that humans develop knowledge about themselves*" (Foucault, 1988:17-18). He saw these knowledges as 'truth games' with specific techniques for understanding where the world is being constituted of four different types of technologies: 1) *technologies of production* – permitting us to produce, transform and manipulate; 2) *technologies of sign systems* – permitting us to use signs, meanings and symbols; 3) *technologies of power* – determining the conduct of individuals and submitting them to certain forms of domination; and 4) *technologies of the self* – practices of the individuals on themselves (Foucault, 1988). In his own work, Foucault focused most of his efforts in theorizing about the latter two of the four types of technologies and these are the types of technologies which most concern this thesis, especially as they are linked by the concept of *governmentality* - the mechanism by which contemporary society is governed (Foucault,

1991). Together, they speak about how Foucault was also concerned about the interaction of agency² with structure. In particular, his interest revolved around the ways in which people's experiences are regulated by others (through technologies of power) and the ways that individuals regulate themselves (through technologies of the self) (Coveney, 1998; Coveney, 2000).

One of the prominent ways in which governmentality is actualized is through discourses. *Discourse* is commonly defined as a particular way of talking about and understanding the world or aspects of the world (Phillips and Jorgensen, 2002). Foucault saw discourse as a system of representation or a:

“a group of statements which provide a language for talking about ...a particular topic at a particular historical moment... Discourse, Foucault argues, constructs the topic. It defines and produces the objects of our knowledge. It governs the way that a topic can be meaningfully talked about and reasoned about” (Hall, 1997:44).

In its purest form (e.g., Laclau and Mouffe's approach in Phillips & Jorgensen, 2002), then, discourse constructs meaning for our social world. The meaning is always transforming through the interactions and/or struggles of one discourse with other discourses. The nature of discourse is given a historical perspective by Foucault so that common understandings about things mean something and are 'true' in a particular way only within a specific historical context (Coveney, 2000). In each period, discourse

² It is of importance to reiterate here that the term 'agent' – which is in some writings taken to represent the free-willed, unconstrained and autonomous individual –has, following the work of Giddens and Foucault, a slightly different meaning in this dissertation. While giving the individual varying degrees of agency in their writings, both Giddens and Foucault see the 'agent' or 'subject', respectively, not as free-willed, unconstrained and autonomous, but as continually in a relationship and dependent on his/her power relationship with 'structure' or the 'state'. Both believed in the possibility, however, that an individual can use their agency to effect change. The term 'agent' rather than 'subject' is used in this thesis for consistency with the 'duality of structure' framework.

produces forms of knowledge and practices of knowledge which differ from period to period, without having necessarily continuity between them. Hegemony occurs when one discourse dominates over others (Jorgensen and Phillips, 2002). What interested Foucault were the particular but changing rules and practices that produced meaningful statements and regulated discourse in different historical periods (Coveney, 2000).

It is of note to mention that both Giddens and Foucault owe their dialectical focus on these interactions to the work of Max Weber (Giddens perhaps more directly than Foucault). Weber's conceptualization of 'lifestyle,' in particular, is relevant for this study because it differs substantially from how it has come to be used in health-related fields in recent times (Cockerham, 1997; Cockerham, 2005; Frohlich et al., 2001). Frohlich et al. point out that "when lifestyle is currently discussed within the socio-medical discourse, there is a decided tendency for it to be used in reference to individual behavioral patterns that affect disease status" (Frohlich et al., 2001:783). In contrast, although Weber's work often reflected agency-oriented approach to social patterns, he did not view people's practices as uncoordinated or individualized and completely free of structure. Instead, he saw them as "regularities and uniformities repeated by numerous actors over time... in which people act in concert, not individually" (Cockerham, 2005:52-3) to represent collective forms of social behaviour where social institutions and widespread belief systems act as powerful forces in shaping the thoughts and behaviour of individuals (Cockerham, 2005). Weber, thus, saw people's practices as a result of choices influenced by chances (Cockerham, 1997).

In addressing the second question in the literature review – how is healthy eating shaped –, therefore, it is argued that research on healthy eating perceptions and practices has benefited recently and may benefit in the future from approaches used in health

promotion/population health and social theory. The former suggests that research on healthy eating perceptions and practices can build on knowledge about determinants of health through considerations of socio-demographic, life-course and socio-cultural determinants. The latter suggests opportunities for how to examine the relationships and/or interactions between people and various levels of determinants. At the centre of these approaches is the notion that lay perspectives about health and illness in the everyday are of invaluable significance, able to reflect both on their own practices as well as how they are embedded in contexts. These approaches, thus, see lay knowledge as a way of theorizing the structure-agency problem through the recursive relationships between people and the 'food structures' around them (Popay et al., 1998; Williams, 2003). As originally described by Giddens (1984), the concept of 'structure' refers to the rules and resources people draw on and use in food decision-making. The final question of the literature review turns to yet some even broader aspects that situate healthy eating perceptions and practices in societal and historical considerations.

1.2.3. WHY DO WE CONCERN OURSELVES WITH HEALTHY EATING (in the ways that we do)?

In this part of the literature review, the ways the above-mentioned concerns with healthy eating are shaped in contemporary society are understood as they reflect our more general, historically and socially influenced, understandings about health and modes of being. Our knowledge and perspectives about healthy eating, therefore, need to be seen in the backdrop of these broader developments.

To be concerned with health is by no means a concept novel to modern societies. Throughout time, societies have developed complex notions about explaining health and

illness, some of which have changed over time (e.g., as new knowledge was learned) and others have continued (e.g., as traditions). Some societies (many with longer histories than our current one) use different but none-the-less complex ways to conceptualize health and illness, often encompassing more integrated relationships between the individual and the environment (Airhihenbuwa, 1995; Jovchelovitch & Gervais, 1999). Current Western representations about knowledge have followed particular developments that led to specific ways of describing and explaining health and illness. These developments revolve around a theoretical focus described below relating to the emergence of modern (scientific) discourses that examine food and nutrients as a ‘risk’ and ‘individual responsibility.’

Within contemporary Western society, current social representations of health and illness are predominantly commonsense versions of scientific theories practiced at the level of everyday discourse (Moscovici, 2001). Over the last century, medical knowledge about health and illness has become accessible as information used by people in their daily lives, thus turning into common sense explanations. When medical metaphors and terminology become a part of people’s epistemology they form an important part of the resources in making sense of illness and health (Moscovici, 2001).

These types of representations about health and illness are said to be associated with the emergence of modernity in the 17th century that marked a clear change in explanations about the world from previous societies. Modernity worked then and still does under the conviction that human progress and social order depend on objective knowledge of the world which can be controlled, measured and predicted through scientific exploration and rational thinking (Lupton, 1999). The progression of scientific exploration and rational thinking have influenced the particular ways that people come to see the world and their contribution to it.

Buchanan (2006) uses Habermas' differentiation of instrumental and communicative rationality to argue that because of society's dependence on the scientific rationale, modes of socialization and social integration are changing. According to Habermas, *instrumental rationality* is a goal- and success-oriented rationality that focuses on efficiency and profit; *communicative rationality*, on the other hand, is a consent-oriented rationality that focuses on gaining mutual understanding and agreement about the validity/moral rightness of norms of behaviour. The latter is characteristic of the world of everyday human existence or a 'lifeworld' – "the implicit 'taken-for-granted' background of shared understandings, values, and routine ways of life in which one's social identity develops" (Buchanan, 2006:292), but as Buchanan describes, Habermas suggested that instrumental rationality is gradually displacing communicatively-oriented modes of socialization and social integration. Buchanan calls this an "inappropriate imposition of instrumental thinking on the sphere of lifeworld affairs" (Buchanan, 2006:292) through a process of rationalization where consensus becomes secondary to efficiency.

As a consequence, some theoreticians argue that we have come to live in a 'risk society' - a society that is organized on the basis of or in response to risks. It is a systematic way of dealing with the hazards and insecurities of life (Beck, 1992). Over the past few decades, 'risk' has become one of the key concepts of health-related research. Castel (1991) and others drawing on his work (Lupton, 1999; Petersen, 1996; Petersen, 1997) have commented on the shift in health discourse between an earlier focus on a more individual-based 'dangerousness' to the current focus on population-based 'risks'. The latter is calculated through systematic statistical correlations and probabilities based on populations rather than an observation of the individual(s).

In part, this shift in health discourse towards risk is related to important developments in statistics and surveillance of populations (Castel, 1991; Lupton, 1999), along with the statistical and epidemiological measures of twentieth century. Surveillance in health focuses on the normal (i.e., healthy) rather than diseased populations and uses sophisticated statistical screening and other measurements. This is done through an epidemiological risk rationality in which the calculation of risk for a targeted illness or disease in particular populations is undertaken by assessment of a range of abstract factors.

The concept of risk is an approach to health that focuses on the risk of health or illness as a consequence of the 'lifestyle' choices made by individuals (Lupton, 2005). In an ideal situation, for example, through this continuing monitoring of health, experts should potentially contribute to the creation of new knowledge on different kinds of health risks, and attempt to disseminate this knowledge to lay people. This new awareness should, then, have an impact on lay people such that they would change their behaviour and way of life because of those new findings. Even though such knowledges may and do become replaced by new ones, a model citizen should take the most recent health advice seriously and avoid currently known risks. The concept of 'risk', thus, is situated in a context with an underlying assumption that, enabled with awareness of a health hazard, individuals will act on it themselves (Lupton, 1999) both for the sake of their own health as well as the greater good of society (Lupton, 2005).

Many intellectuals, do, in fact argue that there exists social pressure for health in Western societies, one that turns the responsibility for the maintenance and improvement of health to the individual. Beck-Gernsheim (2000), for example, makes a case for the novel importance of health and (individual) responsibility as a characteristic of modern society. She argues that one of the ways in which life in the modern society differs from

that before industrialization is the way that health is of value. While life in pre-industrialized societies may have to a large extent depended on explanations based on religion (e.g., health and illness related to notions of sin, afterlife, salvation and eternity), today's society sees life largely as an individual task (e.g., health and illness related to one's ability to compete/be successful in the labour market and contribute to society).

Attending to our own health has, thus, become a moral norm. Health and responsibility are not individual but are social values, part of modern life's options and demands (Beck-Gernsheim, 2000). Risk discourse, along with its emphasis on lifestyle risks, serves as an agent of surveillance and control. Being that it works under the goal of health, it is difficult to challenge, even when it draws attention away from the structural influences on health and illness (Lupton, 2005).

The framework of healthful practices, i.e., eating healthy, can, therefore, be placed in these larger contexts of current values about health – risk and individual responsibility. In this way, healthy eating is understood through its associations with decreasing of risk/possibility of disease, while the responsibility is placed primarily at the level of the individual. This level of analysis will be of importance for examining whether the perceptions and practices of participants can be situated in a similar worldview.

1.2.4. LITERATURE REVIEW SUMMARY

The literature review above attempted not only to provide a summary of some of the current knowledge about healthy eating perceptions and practices, but also to situate these in perspectives about healthy eating that draw on broader social theories about human thought and behaviour. It was organized around three questions: 1. how do we

concern ourselves with healthy eating (e.g., how do we define, characterize and behave with respect to healthy eating), 2. what shapes our healthy eating perceptions and practices (e.g., how do we explain variability in healthy eating) and 3. why do we concern ourselves with healthy eating in the particular ways that we do?

In summarizing the literature around the first question - how do we concern ourselves with healthy eating – I described first the nature of the Canadian official dietary guidelines. These consist of several policy documents (some recently updated) including the Food Guide, healthy eating guidelines and nutrition recommendations developed, organized and maintained by Health Canada. Together, these documents provide leadership in nutrition by summarizing complex scientific evidence about food, nutrition and health into national guidelines that people should use in everyday decisions about food. However, this approach seems to be less than successful as research shows that few people eat according to the standards of these guidelines.

Turning then to the literature on people's healthy eating perceptions and practices, research has shown that people's sources of health and nutrition information are situated in the everyday life with sources including the media, health professionals, friends and family and, more recently, the internet. There is general trust in nutrition messages, although certain subpopulations (e.g., lower income, men) seem more prone to skepticism. In addition, rather than seeking more information about basic nutrition information, people seem to instead be increasingly interested in 'hot' or more current topics in nutrition. But even though people know the basic healthy eating messages, beyond these messages, they interpret healthy eating differently, focusing usually on nutrition issues of relevance to them.

The second part of the literature review – organized around the question of what shapes our healthy eating perceptions and practices – showed that in learning from other disciplines (e.g., health promotion/population health, social science research on health and illness, social theory) nutrition-related researchers, practitioners and policy makers have recently begun to see that placing responsibility for change in healthy eating primarily at the level of individuals may be limited in scope. Healthy eating perceptions and practices, like food choice in general, are shaped by a complex integration of biological, psychological, cultural and social factors. One of the major foci that these disciplines have started to consider are the social determinants of health directing attention to the social, economic and cultural conditions that influence health. This line of thinking suggests that we need to look broader than the individual to understand what influences healthy eating.

Important knowledge is emerging as to what kind of determinants influence healthy eating. These include socio-demographic determinants such as age, gender, SES; life-course determinants such as the onset of adolescence, cohabiting with someone, chronic disease and becoming a parent; as well as socio-cultural determinants such as cultural origin, and societal changes in discourses and norms. Unfortunately where further research lacks guidance is in tools to examine *how* these determinants interact to influence healthy eating perceptions and practices. Turning to social theory may be able to provide us suggestions as to how to approach these interactions. Two perspectives that deal with interactions between people's practices and social determinants – or agency and structure in social theory terms - were described briefly; these were Giddens' work on the duality of structure and Foucault's work on governmentality.

Seeing the current concerns surrounding healthy eating in a larger context, in the third and last question of the literature review – why do we concern ourselves with healthy

eating in the ways that we do – these concerns were situated in a larger context of social representations about knowledge as they reflect more general, historically and socially influenced, understandings about health and modes of conduct. Contemporary social representations of health and illness are said to reflect ways of thinking emerging in the 17th century that marked a clear change in explanations about the world from previous periods. These explanations represent human progress and social order as dependent on objective knowledge of the world which can be controlled, measured and predicted through scientific exploration and rational thinking and have influenced the particular ways that people come to see the world and their participation in it. Two major products of this way of thinking have entered people’s common sense explanations about health and illness (and we can argue healthy eating). One relates to the concepts of ‘risk’ and ‘individual responsibility’, together exemplifying the notion that it is our personal responsibility to be continuously working on decreasing our risks in life. The other relates to our moral and ethical conduct fulfilled through our decisions about food. Today, perhaps more than ever, moral and ethical responsibilities relate to making sure we choose healthy food. Both products ensure that people practice continuous surveillance of themselves and focus on the risk of health or illness both for the sake of their own health as well as the greater good of society.

1.2.5. EMERGING QUESTIONS, STUDY PURPOSE AND OBJECTIVES

From the literature review above, there are several major interrelated *questions that remain* to be answered by research on healthy eating perceptions and practices in the Canadian context. As an overarching theme for future research, it is becoming clear that healthy eating perceptions and practices are the result of complex integrations between

people and structural/determining influences, and that by focusing either solely on the individual or solely on the determinants does not provide a holistic depiction of those perceptions and practices. There is, therefore, a significant need for future research to provide a better understanding of *the interactions between individual and collective determinants* (Raine, 2005).

Within this area for research, little has been done, particularly in the Canadian context, to describe the interactions *sociologically and qualitatively as they occur in the everyday experience* where people either produce new or reproduce established food norms and cultures (Power, 2005). For example, there is lack of research that addresses the social dimensions of making decisions in the family – how factors such as the desire to belong to a community, expectations to be a good parent, constraints in making sure food choices are within the family’s budget, etc – affect the individual’s and family’s food practices. If we come from the perspective that health conceptualizations and behaviours are embedded and expressed in daily life, it will be important to study them, then, as part of a broader socio-cultural reality (Backett, 1992).

Furthermore, despite the immigration patterns in Canada - which include individuals who may not speak English, come from very different educational, religious and/or cultural backgrounds - the literature on healthy eating perceptions and practices has mainly drawn on Caucasian participants and Western/scientific perspectives about acquiring healthy eating knowledge. It has neglected to include *an examination of broader social and cultural influences* on healthy eating perceptions and practices, particularly *as they occur for different populations/groups* in everyday food decisions.

The current study attempted to begin addressing these questions for the Canadian context. The *purpose* was to explore the ways in which people of three different

ethnocultural backgrounds in two locations of Canada *engage* with food structures to construct everyday notions of healthy eating. The concept of ‘food structures’ draws on Giddens’ (1984) concept of ‘structure’ to refer to the range of food and health rules and resources people draw on and use in their daily lives. These include both tangible and abstract concepts and resources used in food decision-making such as considerations of cost, food availability and/or accessibility, preferences, official dietary guidelines, media sources and discourses, social and cultural beliefs/knowledge about health, illness, gender relations and proper ways of eating, and so on. The study’s *research objectives* were: 1) to examine how participants chose among and drew on sources of healthy eating information, how they defined healthy eating, and how they incorporated knowledge about healthy eating in their everyday food context, and 2) to explore how participants’ healthy eating perspectives and practices reflect opportunities for individual agency, constraint by socially constructed norms or discourses, and contemporary social representations of knowledge, health and illness. The *theoretical approach* of the study drew from Giddens’ and Foucault’s perspectives relating to the agency-structure debate to make sense of the ways in which participants interacted with food and healthy eating discourses in their decisions about food. Participants’ interactions were also examined in the context of broader social perspectives about why we concern ourselves with healthy eating in the particular ways that we do.

These research questions were addressed as part of a broader qualitative study of food decision-making in the family context (Appendix 3). The methodological aspects of the study as they fit into the larger study are described in Appendix 4, while the recruitment, data collection and analysis tools can be found in Appendices 5-14. The methodological aspects pertinent to the findings in chapters 2-4 are described in each of

those chapters. Briefly, the study included 144 participants from 13 African Nova Scotian (NS) and 10 European NS families in Halifax, and 12 Punjabi British Columbian (BC) and 11 European BC families in Vancouver. These groups were chosen for their potential differences in perspectives based on place, ethnocultural³ background and histories of immigration to Canada.

European NS and BC participants represent the dominant culture in the two cities. Halifax is a city with a population of over 380,000 (Statistics Canada, 2007) situated on the East coast of Canada. Vancouver, Canada's third largest city with a population of over 2.2 million (Statistics Canada, 2007), is situated on the West coast of the country. Both groups have similar ethnic origins including English, Scottish, Irish, French, German and Dutch backgrounds (Statistics Canada, 2005a; Statistics Canada, 2005b). Despite the similarity in ethnic origin, eating habits (consumption patterns) (Statistics Canada, 2006) and obesity rates (Statistics Canada, 2004; Statistics Canada, 2005) have shown to differ regionally between the two cities and provinces. These two groups of European heritage in both provinces could thus potentially provide important information about how healthy eating interpretations of the dominant culture may be influenced by the locations where people live.

The two minority groups, African NS and Punjabi BC, potentially provided both cultural differences as well as differing histories of immigration - recent immigration patterns of Punjabi Canadians in British Columbia and longer African Canadian presence in Nova Scotia. In addition, from a health-promotion perspective both groups deserve

³ I am aware of the much debated difficulty in labeling participants as belonging to a particular cultural, ethnic or ethnocultural group as this may contribute to a risk of inappropriately 'othering' or 'racializing' individuals. However, for the purpose of this dissertation, we use the terms 'African NS', 'European NS', 'Punjabi BC' and 'European BC' as heuristic terms to differentiate findings between groups of participants. An implicit understanding remains that the participants in these four groups are by no means a homogeneous group.

special attention as they belong to communities that have been shown to have higher than average risks for developing CVD and Type-2 diabetes (Abate & Chandalia, 2001; Health Protection Branch-Laboratory Centre for Disease Control, 1999; Sheth et al., 1999; Simmons et al., 1992; Sekikawa & Kuller, 2000). While some have proposed a link between immigrants' dietary acculturation upon arrival to North America and a decrease in the healthfulness of their food choices (Hyman et al., 2002; Satia-Abouta et al., 2002) - and therefore an increase their risk for chronic diet-related diseases – this proposal does not explain the risk in African NS who have not experienced recent immigration phases and/or dietary acculturation. A brief introduction to the immigration patterns and traditional foods of Punjabi BC and African NS is provided in Appendix 15. A summary table of participating families of all four groups (African NS, European NS, Punjabi BC and European BC) is provided in Appendix 16.

The purpose and research questions were addressed through three different topics discussed in chapter 2-4. Chapter 2 commences from the perspective that people's decisions about what foods to buy, prepare and consume are shaped by many influences and that while health considerations are regarded as increasingly salient influences in the Western world, ethical considerations may not be of equal importance to everyone. The chapter uses Giddens' framework around the duality of structure to examine the ways in which participants interacted with place- and group-specific rules and resources about food. In particular, this chapter examines how people's health considerations interact with ethical or cultural/traditional concerns within place-specific values and norms about food.

Chapter 3 aims to address the paucity of knowledge about how people make sense of healthy eating discourses. It is interested in the ways in which people pull together available discourses of healthy eating into meaningful 'ways of knowing' about healthy

eating. 'Ways of knowing' about healthy eating in this context refer to participants' discussions of experiences, interpretations, and reasoning used in learning and deciding what to believe and/or reject about healthy eating. Foucault's theorizations about 'technologies of the self' (Foucault, 1988b) are used to examine whether differing natures of engagement with discourses leads participants to undertake different healthy eating practices upon themselves.

Using Foucault's concept of governmentality (Foucault, 1991), chapter 4 examines dietary guidelines - considered to be of paramount importance for promotion and maintenance of health - as providing standards for people's conduct in the family by normalizing particular roles and behaviours as desirable. The chapter examines the extent to which family food practices and family members' roles are normalized by standards from Canadian dietary guidelines by exploring how notions of healthy eating are communicated and transmitted between family members of different generations.

In chapter 5, the findings from chapters 2-4 are woven together to compose an overall, coherent message for the thesis as a whole. The chapter also outlines some of the strengths and limitations of the study, and it provides some implications for practitioners and suggestions for future research in this area.

1.2.6. NOTES

¹In this project, *individual determinants* referred to knowledge, perceptions and beliefs about nutrition, healthy eating, food safety and quality whereas *environmental determinants* referred to the influence of social and economic factors such as culture, social norms, family structures and dynamics, work and family responsibilities, income, cost of and access to food, food marketing, changes in the food supply (including packaging, prepared and fast foods, food safety and quality).

²In this review, *perceptions of healthy eating* were defined as the public's (children, adolescents and adults) and health professionals' meanings, understandings, views, attitudes and beliefs about healthy eating, eating for health, and healthy foods. While the focus was on the Canadian population, due to lack of Canadian research and homogeneity in perceptions of healthy eating across countries, findings from other countries were also included.

³The 'access', 'process' and 'use' components for healthy eating interpretations reflect recent definitions of terms in the health literature. For example, in their work, Jim Frankish and Irv Rootman define health literacy as a person's ability to 'access', 'understand' and 'apply' information to improve their health and quality of life. Similarly, the US Department of Health and Human Services defines health literacy as the degree to which individuals have the capacity to 'obtain', 'process' and 'understand' basic health information and services needed to make appropriate health decisions.

1.2.7. REFERENCES

Abate, N., & Chandalia, M. (2001). Ethnicity and type 2 diabetes – Focus on Asian

Indians. *Journal of Diabetes and Its Complications*, 15, 320-327.

Airhihenbuwa, Collins O., Kumanyika, S. (1996). Cultural aspects of African American eating patterns. *Ethnicity & Health*, 1, 145-260.

Anderson, A.S., & Lean, M.E.J. (1995). Healthy changes? Observations on a decade of dietary change in a sample of Glaswegian South Asian migrant women. *Journal of Human Nutrition and Dietetics*, 8, 129-136.

Ankeny, K., Oakland, M.J., & Terry, R.D. (1991). Dietary fat: Sources of information used by men. *Journal of the American Dietetic Association*, 91, 1116-1117.

Axelson, M.L. (1986). The impact of culture on food-related behavior. *Annual Reviews of Nutrition*, 6, 345-363.

Backett, K. (1992). Taboos and excesses: Lay health moralities in middle class families. *Sociology of Health & Illness*, 14, 255-274.

Barr, S.I. (1989). Nutrition in food advertising – Content analysis of Canadian womens magazine, 1928-1986. *Journal of Nutrition Education*, 21, 64-72.

B.C. Ministry of Community, Aboriginal & Women's Services. (2001). Profile of immigrants in B.C. communities: Mainland/Southwest.

http://www.profiles.mcaaws.gov.bc.ca/Community_Profiles/profiles/Immigration%20Profiles/MainlandSouthwest%20DR.pdf, accessed November 22nd, 2004.

Beck, U. (1992). *Risk Society: Towards a New Modernity*. London: Sage Publications.

- Beck-Gernsheim, E. (2000). Health and responsibility. In B. Adam, U. Beck & J. Van Loon (Eds.), *The Risk Society and Beyond: Critical Issues for Social Theory*, (pp. 122-135). London: SAGE Publications Ltd.
- Beardsworth, A., & Keil, T. (1997). *Sociology on the Menu: An Invitation to the Study of Food and Society*. London: Routledge.
- Bisogni, C.A., Connors, M., Devine, C.M., & Sobal, J. (2002). Who we are and how we eat: A qualitative study of identities in food choice. *Journal of Nutrition Education and Behavior*, 34, 128-139.
- Bourdieu, P. (1984). *Distinction: A Social Critique of the Judgement of Taste*. Cambridge: Harvard University Press.
- Bourdieu, P. (1990). *The Logic of Practice*. Palo Alto: Stanford University Press.
- British Columbia Nutrition Survey. (2004). Report on food group use. BC Ministry of Health Services.
- Buchanan, D.R. (2006). A new ethic for health promotion: Reflections on a philosophy of health education for the 21st Century. *Health Education & Behavior*, 33, 290-304.
- Bush, M., & Kirkpatrick, S. (2003). Setting dietary guidance: The Canadian experience. *Journal of the American Dietetic Association*, 103, S22-S27.
- Byrd-Bredbenner, C., & Grasso, D. (2000). Health, medicine, and food messages in television commercials during 1992 and 1998. *Journal of School Health*, 70, 61-65.
- Castel, R. (1991). From dangerousness to risk. In G. Burchell, C. Gordon, & P. Miller. (Eds.), *The Foucault Effect: Studies in Governmentality*, (pp. 281-289). Chicago: Chicago University Press.
- Cavadini, C., Decarli, B., Dirren, H., Cauderay, M., Narring, F., & Michaud, P.-A. (1999). Assessment of Adolescent Food Habits in Switzerland. *Appetite*, 32, 97-106.

- Chapman, G.E., & Beagan, B. (2003). Women's orientations to nutrition, health, and disease. *Journal of Nutrition Education and Behavior*, 35, 135-141.
- Charles, N., & Kerr, M. (1988). *Women, Food and Families*. Manchester: Manchester University Press.
- Charles, N., & Walters, V. (1998). Age and gender in women's accounts of their health: Interviews with women in South Wales. *Sociology of Health & Illness*, 20, 331-350.
- Clayton, D.B. (2000). Improving public awareness of nutrition issues. *Nutrition*, 7/8, 637-639.
- Coff, C. (2006). *The Taste for Ethics: An Ethic of Food Consumption*. Dordrecht: Springer.
- Cockerham, W.C., Rutten, A., & Abel, T. (1997). Conceptualizing contemporary health lifestyles: Moving beyond Weber. *The Sociological Quarterly*, 38, 321-342.
- Cockerham, W.C. (2005). Health lifestyle theory and the convergence of agency and structure. *Journal of Health and Social Behavior*, 46, 51-67.
- Coffey, A., & Atkinson, P. (1996). *Making Sense of Qualitative Data: Complementary Research Strategies*. Thousand Oaks: Sage.
- Connors, M., Bisogni, C.A., Sobal, J., & Devine, C.M. (2001). Managing values in personal food systems. *Appetite*, 36, 189-200.
- Conrad, P. (2005). The social nature of disease. In P. Conrad (Ed.), *The Sociology of Health & Illness: Critical Perspectives*, 7th Edition, (pp. 5-6). New York: Worth Publishers.
- Coulson, N.S. (2002). Sources of food safety information: Whom do adolescents trust? *Appetite*, 38, 199-200.
- Coveney, J. (1998). The government and ethics of health promotion: The importance of Michel Foucault. *Health Education Research: Theory & Practice*, 13, 459-468.

- Coveney, J. (2000). *Food, Morals and Meaning: The Pleasure and Anxiety of Eating*. London: Routledge.
- Counihan, C., & Van Esterik, P. (1997). *Food and culture: A reader*. New York: Routledge.
- DeVault, M.L. (1991). *Feeding the Family: The Social Organization of Caring and Gendered Work*. Chicago: University of Chicago Press.
- Devine, C.M., Connors, M., Bisogni, C.A., & Sobal, J. (1998). Life-course influences on fruit and vegetable trajectories: Qualitative analysis of food choices. *Journal of Nutrition Education*, 30, 361-370.
- Dixon, L.B., Cronin, F.J., & Kebs-Smith, S.M. (2001). Let the pyramid guide your food choices: Capturing the total diet concept. *Journal of Nutrition*, 131, 461-472.
- Falk, L.W., Sobal, J., Bisogni, C.A., Connors, M., & Devine, C.M. (2001). Managing healthy eating: Definitions, classifications, and strategies. *Health Education & Behavior*, 28, 425-439.
- Foucault, M. (1980). In C. Gordon (Ed.), *Power/Knowledge and Selected Interviews and Other Writings 1972-1977*, (pp. 146-165). New York: Pantheon Books.
- Foucault, M. (1988a). The ethic of the care of the self as a practice of freedom. In Bernauer, J. & Rasmussen, D. (Eds.), *The Final Foucault*, (pp.1-20). Cambridge: MIT Press.
- Foucault, M. (1988b). Technologies of the self. In L. H. Martin, H. Gutman, & P.H. Hutton (Eds.), *Technologies of the Self: A Seminar with Michel Foucault*, (pp. 16-49). Amherst: University of Massachusetts Press.
- Foucault, M. (1990). *The History of Sexuality: The Use of Pleasure*. New York: Random House.

- Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault Effect: Studies in Governmentality with Two Lectures by and an Interview with Michel Foucault*, (pp.87-104). Chicago: University of Chicago Press.
- Frohlich, K.L., Corin, E., & Potvin, L. (2001). A theoretical proposal for the relationship between context and disease. *Sociology of Health & Illness*, 23, 776-797.
- Furst, T., Connors, M., Bisogni, C.A., Sobal, J., & Falk, L.W. (1996). Food choice: A conceptual model of the process. *Appetite*, 26, 247-266.
- Gedrich, K. (2003). Determinants of nutritional behaviour: A multitude of levers for successful intervention? *Appetite*, 41, 231-238.
- Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. Berkley: University of California Press.
- Gillman, M.W., Rifas-Shiman, S.L., Frazier, A.L., Rockett, H.R.H., Camargo, C.A., Field, A.E., Berkey, C.S., & Colditz, G.A. (2000). Family dinner and diet quality among older children and adolescents. *Archives of Family Medicine*, 9, 235-240.
- Glanz, K., Basil, M., Maibach, E., Goldberg, G., & Snyder, D. (1998). Why Americans eat what they do: Taste, nutrition, cost, convenience, and weight control concerns as influences on food consumption. *Journal of the American Dietetic Association*, 98, 1118-1126.
- Goldberg, J.P. (1992). Nutrition and health communication: The message and the media over half a century. *Nutrition Reviews*, 50, 71-77.
- Goldberg, J. (2000). Nutrition communication in the 21st century: What are the challenges and how can we meet them? *Nutrition*, 16, 644-646.

- Gregory, S. (2005). Living with chronic illness in the family setting. *Sociology of Health & Illness*, 27, 372-392.
- Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N.K. Denzin, & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research*, (pp. 105-117). Thousand Oaks: Sage Publications.
- Hall, S. (1997). The work of representation. In S. Hall (Ed.), *Representation: Cultural Representations and Signifying Practices*, (pp. 13-74). London: Sage.
- Health Canada. (2001). Promotion and support of healthy eating: An initial overview of knowledge gaps and research needs.
http://www.hc-sc.gc.ca/fn-an/alt_formats/hpfb-dgpsa/pdf/res-rech/pro_sup_healthy_eating-pro_mes_saine_alimentation_e.pdf, accessed on November 21, 2006.
- Health Canada. (2002). Nutrition for Health: An Agenda for Action
http://www.hc-sc.gc.ca/fn-an/nutrition/pol/nutrition_health_agenda-nutrition_virage_sante_e.html, accessed on June 29th, 2007.
- Health Canada. (2004a). Office of Nutrition Policy and Promotion. Review of Canada's Food Guide to Healthy Eating - Interpretation of Findings and Next Steps.
http://www.hc-sc.gc.ca/hpfb-dgpsa/onpp-bppn/review_interpret_findings_e.html, accessed October 14th, 2004.
- Health Canada. (2004b). Nutrition and Healthy Eating.
http://www.hc-sc.gc.ca/fn-an/nutrition/index_e.html, accessed January 31st, 2007.
- Health Canada. (2004c). Nutrition Policy Reports.
http://www.hc-sc.gc.ca/fn-an/nutrition/pol/action_healthy_eating-action_saine_alimentation-02_e.html, accessed February 1st, 2007.

Health Canada. (2007). Canada's Food Guide.

http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/order-commander/index_e.html,

accessed March 28th, 2007.

Health Protection Branch-Laboratory Centre for Disease Control. (1999). Diabetes in

Canada. Ottawa: Minister of Public Works and Government Services Canada.

Available at http://www.hc-sc.gc.ca/hpb/lcdc/publicat/diabet99/d04_e.html.

Accessed June 13, 2002.

Hiddink, G.J., Hautvast, G.A.J., van Woerkum, C.M.J., & Fieren, C.J. (1997). Consumers' expectations about nutrition guidance: The importance of primary care physicians.

American Journal of Clinical Nutrition, 65, 1974S-1979S.

Hill, J.M., & Radimer, K.L. (1996). Health and nutrition messages in food advertisements:

A comparative content analysis of young and mature Australian women's magazines. *Journal of Nutrition Education*, 28, 313-320.

Hindess, B. (1996). *Discourses of Power: From Hobbes to Foucault*. Oxford: Blackwell Publishers Ltd.

Holgado, B., Martinez-Gonzalez, M.A., De Irala-Estevéz, J., Gibney, M.J., Kearney, J., &

Martinez, J.A. (2000). Sources of information about diet and health in a Mediterranean country: Comparison with other European member states. *European Journal of Public Health*, 10, 185-191.

Holmes, D. & Gastaldo, D. (2002). Nursing as a means of governmentality. *Journal of Advanced Nursing*, 38, 557-565.

Hyman, I., Guruge, S., Makarchuk, M., Cameron, J., & Micevski, V. (2002) Promotion of healthy eating among new immigrant women in Ontario. *Canadian Journal of*

Dietetic Practice and Research, 63, 125-129.

- Jary, D. & Jary, J. (1995). *Collins Dictionary of Sociology*. Glasgow: Harper Collins.
- Jackson, J.J. (1981). Urban black Americans. In P.G. Kittler, & K.P. Sucher (Eds.), (1998). *Food and Culture in America: A Nutrition Handbook*, 2nd edition, (p.232). Belmont: West/Wadsworth.
- Jacobs Starkey, L., Johnson-Down, L., & Gray-Donald, K. (2001). Food habits of Canadians: Comparison of intakes in adults and adolescents to Canada's Food Guide to Healthy Eating. *Canadian Journal of Dietetic Practice and Research*, 62, 61-34.
- Johansson, L., Thelle, D.S., Solvoll, K., Bjorneboe, G-E.A., & Drevon, C.A. (1999). Healthy dietary habits in relation to social determinants and lifestyle factors. *British Journal of Nutrition*, 81, 211-220.
- Kassam-Khamis, T., Judd, P.A., Thomas, J.E., Sevak, L., Reddy, S., & Ganatra, S. (1995). Frequency of consumption and nutrient composition of composite dishes commonly consumed by South Asians originating from Gujerat and the Punjab. *Journal of Human Nutrition and Dietetics*, 8, 265-277.
- Kearney, M., Kearney, J.M., Dunne, A., & Gibney, M.J. (2000). Sociodemographic determinants of perceived influences on food choice in a nationally representative sample of Irish adults. *Public Health Nutrition*, 3, 219-226.
- Kearney, J.M., Gibney, M.J., Livingstone, B.E., Robson, P.J., Kiely, M., & Harrington, K. (2001). Attitudes towards and beliefs about nutrition and health among a random sample of adults in the Republic of Ireland and Northern Ireland. *Public Health Nutrition*, 4, 1117-1126.

- Kemmer, D., Anderson A.S., & Marshall, D.W. (1998). Living together and eating together: Changes in food choice and eating habits during the transition from single to married/cohabiting. *The Sociological Review*, *46*, 48-72.
- Kittler, P.G., & Sucher K.P. (1998). *Food and Culture in America: A Nutrition Handbook*, 2nd edition. Belmont: West/Wadsworth.
- Koivisto, H. (1999). Factors influencing children's food choice. *Annals of Medicine*, *31*, S26-S32.
- Lappalainen, R., Kearney, J., & Gibney, M. (1998). A PAN EU survey of consumer attitudes to food, nutrition, and health: An overview. *Food Quality and Preference*, *9*, 467-478.
- Laitinen, S., Hogstrom, P., & Rasanen, L. (1997). Similarity of food choices among young Finnish couples. *Journal of Human Nutrition and Dietetics*, *10*, 353-360.
- Lennernas, M., Fjellstrom, C., Becker, W., Giachetti, I., Schmitt, A., Remaut de Winter, A.M., & Kearney, M. (1997). Influences on food choice perceived to be important by nationally-representative samples of adults in the European Union. *European Journal of Clinical Nutrition*, *51*, S8-S15.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic Enquiry*. Beverly Hills: Sage Publications.
- Lohmann, J., & Kant, A.K. (1998). Effect of the Food Guide Pyramid on food advertising. *Journal of Nutrition Education*, *30*, 23-28.
- Lupton, D. (1996). *Food, the Body and the Self*. Thousand Oaks: Sage.
- Lupton, D. (1997). Foucault and the medicalization critique. In A. Peterson, & R. Bunton (Eds.), *Foucault, Health and Medicine*, (pp. 94-110). London: Routledge.
- Lupton, D. (1999). *Risk*. London: Routledge.

- Lupton, D. (2005). Risk as moral danger: The social and political functions of risk discourse in public health. In P. Conrad (Ed.), *The Sociology of Health & Illness: Critical Perspectives*, 7th edition, (pp. 422-429). New York: Worth Publishers.
- Marshall C, & Rossman, G.B. (1989). *Designing Qualitative Research*. Newbury Park: Sage Publications.
- Martinez-Gonzalez, M.A., Holgado, B., Gibney, M., Kearney, J., & Martinez, J.A. (2000). Definitions of healthy eating in Spain as compared to other European Member States. *European Journal of Epidemiology*, 16, 557-564.
- Martinez-Gonzalez, M.A., Lopez-Azpiazu, I., Kearney, J., Kearney, M., Gibney, M., & Martinez, J.A. (1998). Definition of healthy eating in the Spanish adult population: a national sample in a pan-European survey. *Public Health*, 112, 95-101.
- Maxwell, J.A. (1996). *Qualitative Research Design: An Interactive Approach*. Thousand Oaks: Sage Publications.
- McKinlay, J.B., & McKinlay, S.M. (2005). Medical measures and the decline of mortality. In P. Conrad (Ed.), *The Sociology of Health & Illness; Critical Perspectives*, 7th edition, (pp. 7-19). New York: Worth Publishers.
- Medeiros, L., Russell, W., & Shipp, R. (1991). Nutrition knowledge as influenced by source of nutrition information. *Nutrition Research*, 11, 979-988.
- Miles, M.B., & Huberman, A.M. (1994). *Qualitative Data Analysis: A Sourcebook of New Methods*. 2nd Edition. Beverley Hills: Sage Publications.
- Miles, S., & Frewer, L.J. (2001). Investigating specific concerns about different food hazards. *Food Quality and Preference*, 12, 47-61.
- Mills, M.E., & Davidson, R. (2002). Cancer patients' sources of information: Use and quality issues. *Psycho-Oncology*, 11, 371-378.

- Nettleton, S. (1997). Governing the risky self: How to become healthy, wealthy and wise. In A. Peterson & R. Bunton (Eds.), *Foucault, Health and Medicine*, (pp.207-222). London: Routledge.
- Nova Scotia archives & records management. (2004). <http://www.gov.ns.ca/nsarm/virtual/africanns/>, accessed November 22nd, 2004.
- Nutrition for health: An agenda for action. (1996). Joint steering committee responsible for development of a national nutrition plan for Canada.
- Ostry, A.S. (2006). *Nutrition Policy in Canada, 1870-1939*. Vancouver: UBC Press.
- Paisley, J., Sheeshka, J., & Daly, K. (2001). Qualitative investigation of the meanings of eating fruits and vegetables for adult couples. *Journal of Nutrition Education*, 33, 199-207.
- Paquette, M-C. (2005). Perceptions of healthy eating: State of knowledge and research gaps. *Canadian Journal of Public Health*, 96, S15-S19.
- Patterson, R.E., Satia, J.A., Kristal, A.R., Neuhouser, M.L., & Drewnowski, A. (2001). Is there consumer backlash against the diet and health message? *Journal of the American Dietetic Association*, 101, 37-41.
- Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods: 2nd edition*. Newbury Park: Sage Publications.
- Petersen, A. (1997). The new morality: Public health and personal conduct. In C. O'Farrell (Ed.), *Foucault: The Legacy*, (pp. 696-706). Brisbane: Queensland University of Technology.
- Petersen, A. R. (1996). Risk and the regulated self: The discourse of health promotion as politics of uncertainty. *Australian & New Zealand Journal of Statistics*, 32, 44-57.
- Petersen, A., & Bunton, R. (1997). *Foucault, Health and Medicine*. London: Routledge.

- Phillips, L., & Jorgensen, M.W. (2002). *Discourse Analysis as Theory and Method*.
London: SAGE Publication Ltd.
- Popay, J., Williams, G., Thomas, C., & Gatrell, A. (1998). Theorising inequalities in health: The place of lay knowledge. *Sociology of Health & Illness*, 20, 619-44.
- Povey, R., Conner, M., Sparks, P., James, R., & Shepherd, R. (1998). Interpretations of healthy and unhealthy eating, and implications for dietary change. *Health Education Research*, 13, 171-183.
- Power, E. (1999). An introduction to Pierre Bourdieu's key theoretical concepts. *Journal for the Study of Food and Society*, 3, 48-52.
- Power, E.M. (2005). Determinants of healthy eating among low income Canadians. *Canadian Journal of Public Health*, 96, S37-S42.
- Public Health Agency of Canada. (2003). What determines health?
<http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/determinants.html#personalhealth>, accessed March 30th, 2007.
- Raine, K.D. (2005). Determinants of healthy eating in Canada: An overview and synthesis. *Canadian Journal of Public Health*, 96, S8-S14.
- Raphael, D. (2004). Introduction to the social determinants of health. In D. Raphael (Ed.), *Social Determinants of Health: Canadian Perspectives*, (pp. 1-18). Toronto: Canadian Scholars' Press Inc.
- Romanow, R.J. (2004). Foreword. In D. Raphael (Ed.), *Social Determinants of Health: Canadian Perspectives* (pp. ix-x). Toronto: Canadian Scholars' Press Inc.

- Roos, E., Lahelma, E., Virtanen, M., Prattala, R., & Pietinen, P. Gender, socioeconomic status and family status and determinants of food behaviour. *Social Science & Medicine*, 46, 1519-1529.
- Rossman, G.B., & Rallis, S.F. (1998). *Learning in the Field: An Introduction to Qualitative Research*. Thousand Oaks: Sage Publications.
- Satia-Abouta, J., Patterson, R.E., Neuhouser, M.L., & Elder, J. (2002). Dietary acculturation: Applications to nutrition research and dietetics. *Journal of the American Dietetic Association*, 102, 1105-1118.
- Schwandt, T.A. (1994). Constructivist, interpretivist approaches to human inquiry. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research*, (pp. 118-137). Thousand Oaks: Sage Publications.
- Schwandt, T.A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructionism. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research: 2nd edition*, (pp. 189-213). Thousand Oaks: Sage Publications.
- Schwandt, T.A. (2001). *Dictionary Of Qualitative Inquiry: 2nd edition*. Thousand Oaks: Sage.
- Sekikawa, A., & Kuller, L.H. (2000). Striking variation in coronary heart disease mortality in the United States among black and white women aged 45-54 by state. *Journal of Women's Health and Gender-Based Medicine*, 9, 545-558.
- Sheth, T., Nair, C., Nargundkar, M., Anand, S., & Yusuf, S. (1999). Cardiovascular and cancer mortality among Canadians of European, South Asian and Chinese origin from 1979 to 1993; an analysis of 1.2 million deaths. *Canadian Medical Association Journal*, 161, 132-138.

- Simmons D, Williams DRR, & Powell MJ. (1992). Prevalence of diabetes in different regional and religious South Asian communities in Coventry. *Diabetic Medicine*, 9, 428-431.
- Smith, D. (1998). The discourse of scientific knowledge of nutrition and dietary change in the twentieth century. In A. Murcott (Ed.), *The Nation's Diet: The Social Science of Food Choice*, (pp. 311-331). London: Longman.
- Sobal, J. (2000). Social change and foodways.
<http://food.oregonstate.edu/ref/culture/sobal.html>, accessed May 20th, 2004.
- Statistics Canada & HRDC, NLS. (1996). Reading the Future: A Portrait of Literacy in Canada. In Public Health Agency of Canada (2003). *How Does Literacy Affect the Health of Canadians?*
<http://www.phac-aspc.gc.ca/ph-sp/phdd/literacy/literacy.html>, accessed September 1st, 2007.
- Statistics Canada. (2003). International Adult Literacy and Life Skills Survey. In Canadian Council on Learning Report. (2007). State of Learning in Canada: No Time for Complacency.
http://www.ccl-cca.ca/NR/ronlyres/5ECAA2E9-D5E4-43B9-94E4-84D6D31BC5BC/0/NewSOLR_Report.pdf, accessed September 1st, 2007.
- Statistics Canada. (2004). Adult obesity in Canada: Measured height and weight. Findings from the Canadian Community Health Survey. Catalogue no. 82-620-MWE2005001.
- Statistics Canada. (2005). Canadian Community Health Survey: Obesity among children and adults.

- <http://www.statcan.ca/Daily/English/050706/d050706a.htm>, accessed March 28th, 2007.
- Statistics Canada. (2005a). Population by selected ethnic origins, by census metropolitan areas (2001 Census). (Halifax)
- <http://www40.statcan.ca/101/cst01/demo27b.htm>, accessed August 28th, 2007
- Statistics Canada. (2005b). Population by selected ethnic origins, by census metropolitan areas (2001 Census). (Vancouver)
- <http://www40.statcan.ca/101/cst01/demo27x.htm>, accessed August 28th, 2007.
- Statistics Canada. (2006). Overview of Canadians' Eating Habits 2004. Findings from the Canadian Community Health Survey. Catalogue no. 82-620-MIE – No.2.
- Statistics Canada. (2007). Population of census metropolitan areas (2001 Census boundaries).
- <http://www40.statcan.ca/101/cst01/demo05a.htm>, accessed August 28th, 2007.
- Story, M., Neumark-Steiner, D., & French, S. (2002). Individual and environmental influences on adolescent eating behaviors. *Journal of the American Dietetic Association, March Supplement, 102*, S40-S51.
- Syme, S.L., & Berkman, L.F. (2005). Social class, susceptibility, and sickness. In P. Conrad (Ed.), *The Sociology of Health & Illness: Critical Perspectives*, 7th edition, (pp. 24-29). New York: Worth Publishers.
- Turner, B.S. (1997). From governmentality to risk: Some reflections on Foucault's contribution to medical sociology. In A. Petersen, & R. Bunton (Eds.), *Foucault, Health and medicine*, (pp. ix-xxi). London: Routledge.

- Turrell, G. (1998). Socioeconomic differences in food preference and their influence on healthy food purchasing choices. *Journal of Human Nutrition and Dietetics*, 11, 135-149.
- Vaandrager, H.W., & Koelen, M.A. (1997). Consumer involvement in nutritional issues: The role of information. *American Journal of Clinical Nutrition*, 65, 1980S-1984S.
- Van Dillen, S.M.E., Hiddink, G.J., Koelen, M.A., de Graaf, C., & van Woerkum, C.M.J. (2004). Perceived relevance and information needs regarding food topics and preferred information sources among Dutch adults: Results of a quantitative consumer study. *European Journal of Clinical Nutrition*, 58, 1306-1313.
- Van Woerkum, C.M.J. (2003). The internet and primary care physicians: Coping with different expectations. *American Journal of Clinical Nutrition*, 77, 1016S-1018S.
- Wetter, A.C., Goldberg, J.P., King, A.C., Sigman-Grant, M., Baer, R., et al. (2001). How and why do individuals make food and physical activity choices? *Nutrition Reviews*, 59, 11-S20.
- WHO – World Health Organization. (2004). Facts related to chronic diseases. <http://www.who.int/dietphysicalactivity/publications/facts/chronic/en/>, accessed August 24th, 2004.
- WHO/FAO – World Health Organization/Food and Agriculture Organization. (2003). WHO Technical Report Series 916: Diet, Nutrition and the Prevention of Chronic Diseases. http://www.who.int/hpr/NPH/docs/who_fao_expert_report.pdf, accessed April 3rd, 2007.
- Williams, G. (2003). The determinants of health: Structure, context and agency. *Sociology of Health & Illness*, 25, 131-54.

- Williams, M.V., Baker, D.W., Parker, R.M., & Nurss, J.R. (1998). Relationship of functional health literacy to patients' knowledge of their chronic disease: A study of patients with hypertension and diabetes. *Archives of Internal Medicine*, 158, 166-172.
- Williams, R., Bush, H., Lean, M., Anderson, A.S., & Bradby, H. (1998). Food choice and culture in a cosmopolitan city: South Asians, Italians and other Glaswegians. In A. Murcott (Ed.), *The Nations's Diet: The Social Science of Food Choice*, (pp. 267-284). New York: Addison Wesley Longman Ltd.
- Wyke, S., & Landman, J. (1997). Healthy eating? Diet and cuisine amongst Scottish South Asian people. *British Food Journal*, 99:27-34.
- Yuhua, G. (2000). Family relations: The generation gap at the table. In J. Jing (Ed.), *Feeding China's Little Emperors: Food, Children, and Social Change*, (pp. 94-113). Stanford: Stanford University Press.

CHAPTER 2: Constructing Health and Place through Decisions about Food in three ethnocultural groups in Canada⁴

2.1. INTRODUCTION

Health is both spatially and socially patterned (Shaw et al., 2001). Whereas the former focuses on physical geographic elements, the latter adds the engagement of human characteristics, perceptions and experiences to elements of space (Frohlich et al., 2001; Popay et al., 1998; Tunstall et al., 2004; Williams, 2003). In the Canadian context, how food practices are patterned spatially has received attention (Statistics Canada, 2006), but examinations of how such practices are socially patterned are scarce. Such examinations would prove significant to health research and may contribute to queries of why places with similar socio-economic characteristics can have populations with different health profiles (Phillimore, 1993).

Decisions about food are the result of a complex interaction of various influences (Connors et al., 2001; Furst et al., 1996). Ethical food considerations, either separately or as a component of health, have been in recent decades emerging as important food decision-making criteria in Western countries (Belasco, 1989; Belasco, 2005; Cunningham, 2001; Davies et al., 1995; Lockie et al., 2002). In addition to using common purchasing criteria such as quality of food and health, ethical food consumers also apply criteria arising from a variety of political, religious, environmental or social values (Harrison et al., 2005).

Despite previous stereotypes of ethical food consumers being a specific demographic slice of the population (e.g., ‘hippies’ or ‘yuppies’), recent studies

⁴ A version of this chapter has been submitted for publication. Ristovski-Slijepcevic, S., Chapman, G.E., & Beagan, B.L. Constructing Health and Place through Decisions about Food. *Health & Place*.

have shown that they actually comprise a wide range of consumers (Cunningham, 2001; Lockie et al., 2002). But, they are also more likely to be women and to have higher education, although age and income are not consistently associated with ethical consumption (Cunningham, 2001; Davies et al., 1995; Lockie, 2002).

Ethical food consumers may be part of a rising trend of ‘smart consumers’ – people who are well-informed and up-to-date with the latest information on health issues in the media (Wiles and Rosenberg, 2001) and aware of how larger social, health and ethical issues relate to the complexity of their own food decisions (Belasco, 2005; Brown & Zavestoski, 2004; Cunningham, 2001; Doel & Segrott, 2003; Wiles & Rosenberg, 2001).

While previous studies have described the characteristics of ethical food consumers, there is lack of knowledge about how emerging food practices fit into broader examinations of why some people prioritize certain food choices and others do not. One suggestion made for pursuing this type of research is to consider how individuals make sense of and act upon their environments which in turn influence their health (Popay et al., 1998).

Anthony Giddens’ Theory of Structuration (1984) provides a framework for tapping into such processes, arguing that our social practices (e.g., food practices) are the result of an interaction between ‘structure’ and ‘action,’ a relationship he terms the ‘*duality of structure.*’ *Structure* refers to the rules and resources people draw upon in their practices. Rules and resources range from simple and tangible ones such as the exchange of food for money to more complex and less tangible ones such as the meanings of food (psychological, cultural, social) that influence

our food practices. As such, structure can enable as well as constrain people's food practices. *Action*, or agency, refers to what people do, or how they interact with structure. Giddens does not see people as passively accepting whatever rules are around (although they may), but as interacting with and having the opportunity to make changes in social practices. People can produce new meanings or rules about food (e.g. constructing red meat – once considered central to healthy eating – as unhealthy) or reproduce meanings or rules about food choice through routinization (prepare turkey for Thanksgiving because it is culturally/traditionally meaningful). Giddens, thus, sees people as able to reflexively monitor their own practices through either *discursive consciousness* (explanations which people are able to put into words) or *practical consciousness* (routine practices done in order to 'go on' without having to always question why they are doing something).

In our food decision-making study with three ethnocultural groups in two Canadian cities, beyond common considerations such as food preferences, cost, and socio-demographic differences, participants presented varying degrees of ethical food concerns when making decisions about food. Drawing on the above-described notions of 'place' and 'duality of structure' we propose that the varying degrees of ethical food considerations need to be understood as part of the broader socially and culturally influenced ways in which participants interacted with surrounding food structures – food-related discourses and resources – to contribute to particular constructions of eating well, place and the boundaries of community.

2.2. METHODS

Research Design

The findings presented in this paper come from a qualitative study examining food decision-making in families. Qualitative methods were used as they are best suited for depicting the complex nature of humans through describing individuals' perceptions of experiences within their social contexts (Denzin & Lincoln, 2000; Lincoln & Guba, 1985). Participant families were recruited through community-based organizations, notices posted in public locations and snowball sampling. Ethical approval was obtained from Research Ethics Boards at both Dalhousie University in Halifax and the University of British Columbia in Vancouver. Data collection consisted of individual interviews with three or more family members, grocery shopping trip observations and family meal observations that were carried out in parallel ways in Halifax with families of African and European origin and in Vancouver with families of Punjabi and European origin. Both the individual interviews and grocery shopping trip observations were tape-recorded and transcribed verbatim, while fieldnotes were written for the grocery trip and family meal observations.

Analysis for this paper was based on the adult participants (18 years and older), including 26 African Nova Scotians (NS) (19 females and 7 males) and 20 European NS (13 females and 7 males) in Halifax, as well as 34 Punjabi British Columbians (BC) (22 females and 11 males) and 25 European BC (17 females and 8 males) in Vancouver. Our sample consists of a larger number of women than men in part because we recruited families where one woman aged 25-55 years was willing to be interviewed. In some households there was no male partner, in others

male partners did not volunteer to be interviewed (perhaps reflecting a gendered interest in food-related issues).

Communities/Groups in the Study

Halifax metropolitan area, with a population of over 380,000 (Statistics Canada 2001), is situated on the East coast of Canada. Vancouver metropolitan area, with a population of over 2.2 million (Statistics Canada 2001), is Canada's third largest city situated on the West coast of the country. The dominant ethnocultural group in both cities is people of European origin.

African NS communities are scattered throughout Nova Scotia, concentrated in several clusters around Halifax Regional Municipality. It is the largest visible minority community in Halifax, with roots in the area for over 400 years. With an estimated 13,000 people, 3.7% of the total population, it comprises just over half of the city's 7% total visible minority population (Racism, Violence and Health Project 2006).

The Indo-Canadian community in Vancouver is the second largest visible minority group, second only to the Chinese community (Statistics Canada 2001). The largest majority are Punjabi Sikhs, with an estimated population size of 90,000 comprising 4.5% of Vancouver's total population. The community has existed since the early 1900's, but the majority have immigrated to Canada in two waves in the 1960-70s and the late 1980s/early 1990s. Today, the Indo-Canadian community in Vancouver is well-dispersed and developed, offering considerable access to East-Indian products, including a large range of food-related ingredients, markets and restaurants. Even though it is a newer community compared to the African NS community in Halifax, it is much larger and more integrated within the city.

2.3. RESULTS

During the progress of our study it became apparent that ethical⁵ concerns played an important role in shaping the decisions around food for some participants. Ethically-concerned participants expressed preferences for local and organic produce, vegetarianism, disapproval of unethical treatment of animals and distrust of governmental healthy eating guidelines (particularly the involvement of meat and dairy industries in developing Canada's Food Guide). While we recognize potential challenges with collapsing such disparate issues, in this paper we consider all of these issues as 'ethical food concerns.'

Ethical food concerns were, however, disproportionately represented among the four different groups (as we differentiate participants by both place and ethnocultural membership) being voiced the most by European BC participants, considerably less by European NS, and the least by Punjabi BC and African NS. Most participants raising ethical concerns were women. Women's descriptions of ethical concerns were more elaborate and complex, especially those of European BC women. Socioeconomic distinctions were less obvious in Vancouver where such concerns also surfaced in interviews with participants who had lower levels of income and education. European NS and European BC participants were of similar income ranges, with about a third of families considered lower-income in each place, yet there was a clear pattern of the BC group being more likely to raise ethical concerns.

⁵ In this chapter, the term 'ethical', as is 'traditional', is taken up as heuristic. I do not mean to imply any value judgements about participants with or without 'ethical' considerations. Similarly, I do not mean to imply that the concepts described in contrast to ethical food choice considerations are 'unethical'.

Moving beyond gender and socioeconomic differences, it is our purpose in the following sections to examine ethical and other food considerations in the context of food practices that arise from and at the same time (re)produce differing constructions of: 1. healthy eating/eating well, 2. place, and 3. community.

Giddens' (1984) 'duality of structure' conceptualization suggests that in engaging in everyday food practices people constantly interact with local and extra-local food-related discourses and resources, structured by and restructuring meanings, 'rules,' and routines. Exploring food practices in Halifax and Vancouver, among two ethnocultural groups in each city, we examine how such practices construct differing places often in the same spaces, even as ethical and health-related food practices are themselves shaped by place.

2.3.1. CONSTRUCTING MEANINGS FOR EATING WELL

Health considerations played an important role in food decision-making for all groups. The relationships between health considerations and other factors in the food choice process, however, differed between groups. For those participants with ethical food concerns, these concerns seemed to complement already established health concerns. For example, purchasing salmon was seen as a food choice that needed to be both healthy *and* good-for-the-environment:

First of all, the farmed salmon affect the wild salmon and they could devastate the wild salmon culture, right? Secondly, the farmed salmon have lots of mites in them. They're filled with antibiotics and they have PCB's, they're not healthy (European BC Woman, 51).

Developments in both health and ethical fields were part of participants' food considerations over a long period of time. For some, the process began early during childhood, observing the food changes their parents were making from the 'very traditional kind of standard North American way of eating in the early 60's' to 'all of a sudden my mom started reading Adelle Davis... baking whole wheat bread instead of white bread' (European BC Woman, 43). Even though health and ethical concerns may have developed separately over time, participants were merging findings from and making connections between the two discourses:

Partly it's the health stuff. It's, you know, the more and more research coming out about, you know, the negatives associated with eating, you know, a high meat, high fat diet, and... Just the whole environmental movement... people are just becoming more conscious of how the whole, you know, everything's connected (European BC Woman, 47).

As a result of the interrelatedness, eating well for these participants had become 'a cultural value' (European BC Woman, 55) unique to people in Vancouver signifying food practices that needed to be both health and ethically informed: 'eating food to nurture your spirit as well as your body... being connected to where [food] comes from... to the land that it grew in' (European BC Woman, 52).

In contrast to the connections between health and ethics, participants from the other three groups voiced values that linked food practices to family, tradition and culture. Reflecting on food eaten during childhood that provided comfort and meaning, and that was perhaps modified to be healthier now, was a more prominent discourse used for describing practices of eating well: 'I used to love fried bologna [as a child]. And every once in a while I will buy bologna. I don't fry it...It's a little

healthier' (European NS Woman, 46). Similarly, the 'meat and potatoes' meal, almost never mentioned as a practice of eating well by participants in Vancouver was often discussed by European NS participants in Halifax: '*Growing up*], you had a roast beef dinner every Sunday without fail... So typically if we're going to have a big meal it's Sunday dinner' (European NS Woman, 41). Childhood food practices were important because that food was part of how they defined who they are today:

It's just something that your, when you grow up that way, [it's] something that you just carry on with you. I know a lot of my meals is still from what I used to get when I was growing up (African NS Woman, 43).

In addition, integrating health concerns with historically and culturally-meaningful considerations of food – 'soul food' for the African NS and 'roti meals' for the Punjabi BC – were of primary importance for eating well to these two groups. African NS believed that eating well needed to reflect Black culture, meanings that drew on the history of Black people moving to and living in Nova Scotia '*when Black people were limited to just certain jobs, grew most of their food and depended a lot of the farm animals that they raised themselves... on the cheap food instead of the steaks*' (African NS Woman, 43) or as another woman said:

[S]ome of my white friends are looking at me: 'Pig tails, that's a meal?' And they never heard of it before and it just goes back to when our ancestors would have to use every part of the animal to survive. So you still eat it, but not everyday (African NS Woman, 38).

Similarly, eating well for Punjabi BC was food that provided continuity to tradition and health-providing practices in India:

[The roti meal] has a lot of vitamins and provides strength. It is very good. It is this, that whatever we used to eat in India, that is what we are [also] eating here... that is what I'm used to from the beginning
(Punjabi BC woman, 70).

The phrase 'from the beginning' was used very often by older Punjabi BC participants, in particular, and conveyed a strong conviction in the health-promoting aspects of the food practices of the Indian community. They believed that eating traditional foods that have provided strength and health over centuries in India would continue to do so in Canada.

The interrelationship between health and ethical considerations, therefore, while an important value in the food discourses in Vancouver, needs to be understood as part of the social and historical contexts in which people interact with and draw from different food structures to (re)construct meanings for eating well over time. While health and ethics were salient particularly to European BC, other discourses such as tradition/culture – given the weight of historical processes and situated in place – took more prominent role for some groups, displacing attention from health and ethical concerns.

2.3.2. CONSTRUCTING MEANINGS OF PLACE

Reflecting the different concerns for eating well, participants also interacted differently with the food resources around them. Discussions with European BC participants about food resources revolved around their observations of the growing

availability of health-oriented and ethical foods around the city of Vancouver.

Despite ethical developments being part of events occurring in the broader social sphere, participants in Vancouver believed these experiences to be partly unique to Vancouver compared to other parts in Canada:

[T]he world's changed and we have so much available and especially here [in Vancouver]... I know things changed in Saskatchewan too... but I think people still eat very traditionally. When I go home... it's still really fairly just bland, kind of just white bread food (European BC Woman, 47).

They were aware of a number of food markets opening in recent years that carry food and information about health-promoting and ethical ways of eating focusing on local, organic, natural and environmentally-friendly food choices. That these food values are booming in Vancouver is exemplified by two local chains: one priding itself in being '*Western Canada's largest grocer of natural and organic food*' (Choices Market, 2006), the other planning to '*bring even more high quality, local organic foods and natural living products to residents across the [Greater Vancouver] region*' (Capers Community Market, 2006).

Many European BC participants felt they themselves contribute to this trend through a keen interest in and initiative for this type of consumption. They talked about searching out more natural/organic/local food as well as learning resources. Reading books by food writers such as Adelle Davis and M.F.K. Fisher, magazines such as Organic Farming and food and health columns in newspapers were important resources, as were the increased number of above-mentioned markets: '*I read a book from Dr. Zoltan, started going to Capers... Choices... browsed through*

the books that they had there, so there was many, many different articles that I started to read' (European BC Woman, 42).

These participants were also able to critique both past and current structural constraints in making further ethical decisions about food. The unavailability of food resources outside the city centre – where most of the local markets and health food stores are located – was a strong deterrent for interacting with food resources for those living toward the suburbs. One woman described how accessibility of foods raised a dilemma for her in attempting ethical consumption:

The city is set up that I can't walk to do my grocery shopping. I have to drive from here, WAY over there a couple of miles to get my groceries. If I want organic produce I have to drive about five miles, five kilometres, whatever it is, and then drive home again. So, you know, you're weighing on the one hand, okay, well I'm spending five bucks of gas to go get my environmental produce over here that I specifically buy because it was produce that was raised locally and wasn't trucked from California (European BC Woman, 47).

Similarly, even though some participants had intentions to purchase such foods cost was prohibitive of integrating ethical choices with healthy choices. Organic and local foods *'get traded off. I still eat the salad [as a healthy choice] because it's cheap but it's from California'* (European BC woman, 52). In general, however, with the growing availability of ethical food resources in Vancouver and as a result of people's responses to these availabilities, participants noticed a parallel increase in affordability of ethically-produced foods: *'Most of the stuff [I*

buy] is organic because I like to support the industry and I noticed that the prices have been coming down as I've been buying it' (European BC Woman, 42).

The extent to which participants in Halifax spoke of similar sources of information about food or made references to similar types of food resources was significantly less. A few participants referred to their parents' more 'natural' ways of growing and eating food. However, this reference represented less of a concern with ethical consumption than a commentary on tradition and the naturalness of food when grown at home: *'[Parents] did their own growing, they grow their own vegetables... they raised their own animals, like we had pigs, ox, cows, chickens... everything was all pure, you know, all natural'* (African NS Woman, 59).

Instead, African NS critiqued the lack of availability and/or accessibility of culturally-specific foods and ingredients in Halifax, having access to such products only when journeying to other cities in Canada:

[Y]ou can't get a lot of spices here [in Halifax]... I pick up spices when I go [to Toronto or Montreal], because it's not readily available here, and if you do get something here the price is double or quadruple... and I find the spices here are not as good... the flavour is just not there
(African NS Woman, 44).

In turn, health and ethical food products and markets are less available in Halifax. Although organic food options are increasing in the two major grocery store chains, otherwise options are very limited in and around Halifax. Pete's Frootique is a local high profile grocer, but while making references to health and quality of food products it does not advertise based on ideals of ethical consumption (Pete's Frootique, 2006).

Even within Vancouver, the experience of place in relation to ethical consumption differed for European BC and Punjabi BC participants. In contrast to European BC participants' prevalent comments regarding health and ethical considerations about food, these were largely absent in Punjabi BC participants' interviews. Instead, Punjabi BC's descriptions of food resources centred on the availability of culturally meaningful foods in Vancouver. Vancouver was conceptualized by these participants as a place where food needs in general, as well as their specific cultural food-related needs, were met to a satisfying degree. As a new home to many, Vancouver offered foods that were not easily accessible in their country of origin:

Here as we live in the city and everything is available, [in India] we used to live in the villages and everything is not available in the villages. So we have to drive 10 kilometers to the city to buy meat (Punjabi BC Man, 38).

Many Punjabi BC discussions also centred on food markets managed by persons of Indian origin, that provide the particular foods and spices larger grocery store chains do not carry: *'I go to Fruiticana to buy any of the Indian groceries. Some of the Indian vegetables or any of the dahls that I make or anything, I go there'* (Punjabi BC Woman, 52). Fruiticana, the most prominent fruit and vegetable market Punjabi BC participants mentioned frequenting, originally opened in 1994 but had expanded to nine different locations in Vancouver by 2006. Speaking to the different kind of interaction between Punjabi BC and food resources in Vancouver, Fruiticana opened as a response to the needs of the Punjabi BC community for

whom *'there was no produce store that offered a wide variety of fresh, high-quality Indian produce'* (Fruiticana, 2006).

Overall, the different groups appear to have unique interactions with the food resources around them. While the interactions of some produced experiences of place that assessed opportunities for ethical food consumption, the interactions of others produced experiences of place primarily through assessments of culturally-appropriate food resources. This suggests that as long as simply accessing culturally-appropriate foods remains highly salient, ethical consumption may remain of lesser significance.

2.3.3. CONSTRUCTING BOUNDARIES FOR COMMUNITY

The ways participants interacted with food-related discourses and resources also shaped how they perceived boundaries for communities. Several participants concerned about ethical food consumption indicated that their choices as consumers affect not only their own (or their family's) health, but they also have political and ethical impacts within the food system in the larger global community: *'It's that conundrum that – I want to protect my family from the excesses of one extreme of the factory farms and pesticides but I also want to be realistic... [that] we're just disassociating ourselves from food and its production'* (European BC Woman, 47). Food decision-making for these participants brought to surface deeper meanings of food that involve community connections at various levels, including considerations of health of loved ones as well as well-being of people and the environment in a more global sense. Some of these participants, for example, spoke about making the

decision to purchase Canadian rather than imported meat as a political statement to protect what they felt was their own community:

I want to make sure it's Canadian and not U.S. or New Zealand [steak]... I trust Canadian beef... I want to make sure that even though most of the money's going into IGA and the secondary industries, that some of it would get back to Canadian producers, so it's a political belief of mine (European BC Woman, 47).

This woman was setting wider boundaries for the idea of community. Rather than being based on proximity, her community was a national concept, encompassing people across the country with whom she felt politically and economically connected. At the same time she suggested a 'community' of commodity producers; she could identify with a disparate aggregate of Canadian meat producers. Her food practices, as an enactment of structuration, allow for the creation of new ways of performing community without the requirement of physical proximity.

Yet at the same time, ethical food concerns were perceived as an individual choice in the family. For example, being vegetarian among European BC was almost always explained as an ethical consideration and often an individual decision to make a change in established food norms. These participants were sometimes the only vegetarian members in their families. The prevailing theme in this group was that each family member needed to be treated as an individual, capable of making their own choices about food. Among Punjabi BC participants, however, to be a vegetarian was a choice made by the family as a whole or the women in the family. These decisions were grounded in cultural and/or religious

values, rather than considered an individual choice based on ethical or health concerns. Many participants did not explicitly talk about making the decision to be vegetarian and some were not sure about how they came to be so – it was just something that was always practiced in their family and/or community. The rooted nature of vegetarianism in this group seemed to reconfirm and reproduce the already established norms about food choice:

I don't remember making that decision. I've always been [vegetarian]. I think in our culture, it's easy being a vegetarian. There are a lot of people that are vegetarians so it's not that you're doing something out of the norm (Punjabi BC Woman, 45).

The particular discourses of food situated participants' food decisions in the midst of experiences of different levels of community. Community for ethically-concerned participants was based on a sense of nationalism and similarity in goals for food systems rather than ethnic identity or family ties. Instead, rather than attempting to show agency that would produce a new sense of community through food practices, community for European NS, African NS and Punjabi BC was predominantly based on reproducing (albeit sometimes with modifications) already established traditional, ethnocultural or religious norms.

2.4. DISCUSSION

This paper attempted to explicate some of the complexity in food decision-making by exploring how people's decisions about food, as a form of social practice (Giddens, 1984; Hobson, 2003), are shaped by but also shape food structures to construct varying meanings for healthy eating/eating well, place, and

community. The food-related constructions differed both between participants of the same ethnocultural group in different places (European NS in Halifax and European BC in Vancouver) as well as between participants of different ethnocultural groups in the same place (African and European NS in Halifax; Punjabi and European BC in Vancouver). The differences speak to the various ways in which people can participate in the creation and re-creation of values and norms with regard to food.

The most distinct of the groups were European BC participants, who differentiated themselves from the others with their participation in ethically-oriented food practices in Vancouver. The nature of concerns in decisions about food as well as the socio-demographic characteristics of our participants with ethical food concerns resonated with those raised elsewhere in the literature (Cunningham, 2001; Davies et al., 1995; Lockie et al., 2002). European BC participants also give support to the trend of West Coast Canada being the home to those more likely to turn to organic consumption (Cunningham, 2001) and alternative health practices (Wiles & Rosenberg, 2001). Ethical food concerns seemed to have evolved for these participants through parallel paths as those of health concerns over the last few decades. Many spoke of their past experiences with food, health and ethics in integrative ways and may stem from similar concerns and intersecting goals – the questioning of science’s and industrial progression’s inability to answer larger health and social problems (Belasco, 2005; Brown & Zavestoski, 2004; Lockie et al., 2002).

Ethically-oriented food practices can be viewed as one of several (or many) ways in which people participate in a reciprocal relationship with food structures to

produce or reproduce social food practices. Participants were able themselves to reflexively discuss the nature of this relationship, describing the enabling and constraining properties of food structures that influence their everyday food decisions. For example, European BC in Vancouver described how as they began shopping at ethically-oriented food markets, these markets were able to expand, increasing the visibility and subsequent use of these markets. These participants were also able to point out some constraining properties in current food structures that they would like to be resolved in the future. Their participation, thus, contributes to the creation of Vancouver as a place where people include ethical issues in their food decisions. But at the same time, Vancouver's food system has also evolved in other ways, partially as a result of the different reciprocal relationship between Punjabi BC and food-related structures. Punjabi BC were also able to interact with the enabling and constraining properties of food structures in the past, constructing Vancouver as place that meets many of their current cultural needs. The processes are yet again different in Halifax, interactions playing out differently for African and European NS and ethical food consumption being a much less obvious component of food practices. In this way we take Popay and colleagues' (1998) view that, as uniquely shaped places, Halifax and Vancouver can be conceived as the locations for structuration – 'the interrelationship of the conscious intentions and actions of individuals and groups and the environment of cultural, social and economic forces in which people exist' (Popay et al., 1998, p, 635).

While one might be tempted to interpret these findings as one group showing more agency than others, Giddens' (1984) analysis also points that

through particular agentic aims participants may perpetuate other taken-for-granted food values and norms – a notion he terms unintended consequences. For example, while no patterns emerged for age and socio-economic status, our findings suggest that gender may interact with health and ethical considerations. Few men in either place raised ethical considerations, while substantial proportions of women did, especially in Vancouver. Women's relationships with other practices such as food provisioning, health maintenance (Fagerli & Wandel, 1999), and engagement with complementary and alternative medicine (Doel & Segrott, 2003; Wiles & Rosenberg, 2001) may lead to ethical food concerns holding higher salience for women. While individual agency seeking social change in terms of ethical food production may move toward restructuring food systems, at the same time the gendered patterns of ethical concerns about food may simultaneously contribute to the persistence of gendered food relations in the family.

Similarly, cultural and traditional considerations as food values can be viewed to play a role at the practical rather than the discursive level of consciousness (Giddens, 1984), and may be perceived to contrast the continually reflective character of health and ethical considerations. Whether implicit or explicit, however, cultural and traditional meanings about food need to be viewed through their contribution to the daily food practices that are constantly creating and re-creating social practices (Hobson, 2003). People produce different understandings of and experiences with food, even when exposed to similar food resources and discourses. For example, while Punjabi BC and European BC both live in Vancouver and potentially have access to similar food resources and discourses, Punjabi BC bring different experiences, knowledges and needs, thus

leading them to interact differently with the resources and discourses and enact different food practices. While their food practices reproduce the continuity of traditional food norms and values, they also influence the reshaping of Vancouver's food system.

In conclusion, in this paper we illustrated how Halifax and Vancouver can each be viewed as unique historically and socially constructed food places (Hudson, 1987), whereby people are interdependently shaped by and are shaping the food structures within each place. Paying attention to how people's food practices co-create the social world helps to gain a better understanding of the processes of transformation and change (Williams, 2003). In particular, attention to the interdependence of relationships around food provides clues as to why populations with similar ethnocultural or socioeconomic characteristics in different places in Canada can have different food practices (Statistics Canada, 2006) and health profiles (Statistics Canada, 2004).

2.5. REFERENCES

- Belasco, W. (1989). *Appetite for Change: How the Counterculture Took on the Food Industry, 1966-1988*. New York: Pantheon Books.
- Belasco, W. (2005). Food and the counterculture: a story of bread and politics. In J.L. Watson, & M.L. Caldwell (Eds.), *The Cultural Politics of Food and Eating: A Reader*, (pp. 217-234). Malden: Blackwell Publishing.
- Brown, P., & Zavestoski, S. (2004). Social movements in health: An introduction. *Sociology of Health & Illness*, 26, 679-694.
- Capers Community Market.
<http://www.capersmarkets.com>, accessed August 29th, 2006.
- Choices Markets.
<http://www.choicesmarket.com>, accessed August 29th, 2006.
- Connors, M., Bisogni, C.A., Sobal, J., & Devine, C.M. (2001). Managing values in personal food systems. *Appetite*, 36, 189-200.
- Cunningham, R. (2001). *The organic consumer profile: not only who you think it is!* Alberta: Strategic Information Services Unit, Agriculture, Food and Rural Development.
- Davies, A., Titterington, A., & Cochrane, C. (1995). Who buys organic food: A profile of the purchases of organic food in Northern Ireland. *British Food Journal*, 10, 17-23.
- Denzin, N.K., & Lincoln, Y.S. (2000). *Handbook of Qualitative Research: 2nd edition*. Thousand Oaks: Sage Publications,

- Doel, M.A., & Segrott, J. (2003). Self, health, and gender: Complementary and alternative medicine in the British mass media. *Gender, Place and Culture*, 10, 131-144.
- Fagerli, R. Aa., & Wandel, M. (1999). Gender differences in opinions and practices with regard to a “healthy diet“. *Appetite*, 32, 171-190.
- Frohlich, K.L., Corin, E., & Potvin, L. (2001). A theoretical proposal for the relationship between context and disease. *Sociology of Health & Illness*, 23, 776-797.
- Fruiticana.
<http://www.fruiticana.com/ourcompany.cfm>, accessed October 27th, 2006.
- Furst, T., Connors, M., Bisogni, C.A., Sobal, J., & Falk, L.W. (1996). Food choice: a conceptual model of the process. *Appetite*, 26, 247-266.
- Gesler, W.M., & Kearns, R.A. (2002). *Culture/Place/Health*. New York: Routledge.
- Harrison, R., Newholm, T., & Shaw, D. (2005). Introduction. In R. Harrison, T. Newholm, & D. Shaw (Eds.), *The Ethical Consumer*, (pp. 1-8). London: SAGE Publications Ltd.
- Hobson, K. (2003). Thinking habits into action: the role of knowledge and process in questioning household consumption practices. *Local Environment*, 8, 95-112.
- Hudson, R. (1987). Re-thinking regions: some preliminary considerations on regions and social change. In: R.J. Johnston, J. Hauer, & G.A. Hoekveld (Eds.), *Regional Geography: Current Developments and Future Prospects*, (pp.67-84). London: Routledge.

- Lang, T., & Gabriel, Y. (2005). A brief history of consumer activism. In R. Harrison, T. Newholm, & D. Shaw (Eds.), *The Ethical Consumer*, (pp. 39-53). London: SAGE Publications Ltd.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic Enquiry*. Beverly Hills: Sage Publications.
- Lockie, S., Lyons, K., Lawrence, G., & Mummery, K. (2002). Eating 'green': motivations behind organic food consumption in Australia. *Sociologia Ruralis*, 42, 23-39.
- Pete's Frootique, 2006.
<http://www.petesfrootique.com/index.asp>, accessed September 18th, 2006.
- Phillimore, P. (1993). How do places shape health? Rethinking locality and lifestyle in North-East England. In S. Platt, H. Thomas, S. Scott, & G. Williams (Eds.), *Locating Health: Sociological and Historical Explorations*, (pp. 163-177). Aldershot: Avebury.
- Popay, J., Williams, G., Thomas, C., & Gatrell, A. (1998). Theorizing inequalities in health: The place of lay knowledge. *Sociology of Health & Illness*, 20, 619-644.
- Racism, Violence and Health Project. (2006). Halifax community profile.
<http://rvh.socialwork.dal.ca/04%20Community%20Profiles/Halifax/profile2006hfx.html>, accessed November 1st, 2006.
- Shaw, M., Dorling, D., & Mitchell, R. (2001). *Health, Place and Society*. New York: Prentice Hall.

Statistics Canada. (2001). Community profiles.

<http://www12.statcan.ca/english/profil01/CP01/Index.cfm?Lang=E>,

accessed September 18th, 2006.

Statistics Canada. (2004). Adult obesity in Canada: Measured height and weight. Nutrition: Findings from the Canadian Community Health Survey. Catalogue no. 82-620-MWE2005001.

Statistics Canada. (2006). Overview of Canadians' Eating Habits 2004. Nutrition: Findings from the Canadian Community Health Survey. Catalogue no. 82-620-MIE – No.2.

Tunstall, N V Z., Shaw, M., & Dorling, D. (2004). Places and health, *Journal of Epidemiology and Community Health*, 58, 6-10.

Wiles, J., & Rosenberg, M.W. (2001). 'Gentle caring experience:' Seeking alternative health care in Canada. *Health & Place*, 7, 209-224.

Williams, G.H. (2003). The determinants of health: Structure, context and agency. *Sociology of Health & Illness*, 25, 131-154.

CHAPTER 3: Engaging with Healthy Eating Discourse(s): Ways of Knowing about Food and Health in Three Ethnocultural Groups in Canada ⁶

3.1. INTRODUCTION

A population that is well-nourished is healthier, more productive, contributes to lower health care and social costs, and enjoys better quality of life (Health Canada, 1996). Because of the role of nutrition in promoting and maintaining health, messages about healthy eating have become widespread, occurring at various levels in society. Canada's Food Guide and the USDA's Food Pyramid are two examples of such messages – pictorial guides designed to promote a pattern of healthful eating. However, despite the wide availability of information, a gap between healthy eating messages and people's actual eating practices persists (Dixon, Cronin, & Kebs-Smith, 2001; Jacobs Starkey, Johnson-Down, & Gray-Donald, 2001).

Recent research exploring food choice processes suggests that this gap can partially be explained by the multiple factors shaping food choice. Food decisions are not based solely on people's health and nutrition beliefs, but involve financial, social, lifestyle, environmental and family issues (Furst, Connors, Bisogni, Sobal, & Falk 1996; Wetter, Goldberg, King, Sigman-Grant, Baer et al, 2001). But other research looking specifically at health/nutrition beliefs suggests that these beliefs themselves need to be more fully explored. Overall, people generally consider healthy eating as important (Patterson et al., 2001). For example, in a 2001 Canadian survey, 92% of women and 85% of men said that nutrition was an important consideration for them when choosing food (Health Canada, 2002). But there are also indications that people may be confused by or are rejecting the

⁶ A version of this chapter has been accepted for publication. Ristovski-Slijepcevic, S., Chapman, G.E., & Beagan, B. (2007). Engaging with Healthy Eating Discourse(s): Ways of Knowing about Food and Health in Three Ethnocultural Groups in Canada, *Appetite*. [doi:10.1016/j.appet.2007.07.001](https://doi.org/10.1016/j.appet.2007.07.001)

plethora of nutrition and health messages available today (Goldberg, 1992; Patterson, Satia, Kristal, Neuhouser, & Drewnowski, 2001). Scepticism towards such messages appears to be higher in men than women, the younger and older than the middle aged, and those with lower socioeconomic status.

In response to evidence of confusion and scepticism, institutions providing nutrition guidance have attempted to improve their efforts to educate people about how to eat healthier. Both the USDA Pyramid and Health Canada's Food Guide have recently been reviewed and revised (Health Canada, 2004; Health Canada, 2007; USDA, 2005). But a food guide, while an important resource, is only one among a plethora of information sources about healthy eating currently available to people. Even though health professionals are perceived to have the highest expertise (Hiddink, Hautvast, van Woerkum, & Fieren, 1997; Holgado, Martinez-Gonzalez, De Irala-Estevez, Gibney, Kearney, & Martinez, 2000), it is often friends and family (Ankeny, Oakland, & Terry, 1991; Hiddink et al., 1997), media sources such as books/magazines, newspaper, TV/radio (Ankeny et al., 1991; Hiddink et al., 1997; Holgado et al., 2000; Medeiros, Russell, & Shipp, 1991) and more recently the internet (Goldberg, 2000) that people turn to for information about healthy eating. Sources used vary to an extent based on country of residence (Holgado et al., 2000; Lappalainen, Kearney, & Gibney, 1998) as well as the existence of an illness (Ankeny et al., 1991).

The available literature about people's interpretations of healthy eating has shown that people are quite familiar with the concept and its basic assumptions. Although they may not specifically refer to official nutritional guidelines as information sources, people often use basic messages from guidelines such as decreasing high-fat foods and increasing fruits and vegetables (Health Canada, 2003; Keane & Willetts, 1996; Paquette, 2005). But

beyond the general guidelines, people may define healthy eating in different ways (Chapman & Beagan, 2003; Falk, Sobal, Bisogni, Connors, & Devine, 2001; Keane & Willets, 1996; Povey, Conner, Sparks, James, & Shepherd, 1998) by, for example, expressing different orientations to healthy eating (Chapman & Beagan, 2003), or speaking of healthy eating in either general (“eating the right sort of food at the right time”) or specific terms (proportions of protein, grains, vegetables and carbohydrates that should be consumed) (Keane & Willets, 1996).

That people interpret healthy eating in different ways may thus be another clue to answering the question of why the discrepancy between healthy eating messages and behaviour remains. While it has been acknowledged that the diversity in interpretations may be due the broad nature of the concept ‘healthy eating’ (Povey et al., 1998), as well as differences in interpretations about food and health-related issues across age/lifestage (Patterson et al., 2001; Van Dillen et al., 2004), gender (Fagerli & Wandel, 1999; Patterson et al., 2001; Rozin, Fischler, Imada, Sarubin, & Wrzesniewski, 1999), social class (Coveney, 2005; Patterson et al., 2001), and national/cultural differences (Lappalainen et al., 1998; Rozin et al., 1999), most research on healthy eating has focused at the individual level.

The emphasis on individual beliefs about healthy eating is problematic because, while everyday decisions about food are individual acts, they are also reflective of societal norms about modes of being. These norms are conveyed through discourses –patterned systems of language and practices about phenomena through which individuals come to understand themselves (Foucault, 1972; Lupton, 1996; McNay, 1994). Discourses provide a ‘language’ for conveying meanings and practices in society. Meanings and practices, however, are socially and historically situated and change with time and context (Brandt &

Rozin, 1997; Coveney, 2000; Rotberg, 2000; Rosen, 1993). Within Western culture, for example, current social representations of health and illness are predominantly commonsense versions of scientific theories practiced at the level of everyday discourse (Moscovici, 2001). Norms about being healthy are represented through discourses of risk that focus on promoting health and preventing illness by the monitoring and modification of risk factors (Castel, 1991). While promoting individual free choice with concurrent responsibility for one's health (Beck-Gernsheim, 2000; Petersen, 1996), the appropriate site for action is the individual who is expected to adopt a self-regulating, calculating and prudent attitude toward prevention and risk (Petersen, 1997).

Similarly, notions of healthy eating can be seen as representations conveyed through discourses, where nutritional guidelines act as an official discourse for explaining the relationships between healthy eating, health and well-being in Western societies. People are expected to learn and enact the messages by incorporating these discourses into the practicalities of everyday food practices, for example in the form of diet regimes for the family (Coveney, 2000; Petersen, 1996). However, this is by no means the only way to view these relationships. Throughout time, societies have developed complex ways of explaining health and illness (many with longer histories of health and illness representations than the current Western one) drawing on different ways to conceptualize health, with discourses often encompassing more integrated relationships between the individual and the environment (Airhihenbuwa, 1995; Jovchelovitch & Gervais, 1999). Despite this, the majority of healthy eating research has drawn on Caucasian participants and has neglected to include an examination that reflects the cultural and immigration patterns in Western societies. While some food research on particular sub-cultural groups

does exist, synchronic studies examining sub-cultural variations within a society have remained largely unexamined (Sobal, 1998).

Although it is increasingly apparent that different populations have diverse views of the role of food in health and well-being, there is a paucity of knowledge about how various people make sense of discourses about healthy eating and how they incorporate this knowledge into their everyday experiences. Theoretically, Foucault's work on how people come to know about themselves, particularly his work on the 'technologies of the self' (Foucault, 1988; McNay, 1994), provides a useful point of departure for answering such questions. In an attempt to outline the "different ways in our culture that humans develop knowledge about themselves" (Foucault, 1988:17-8), Foucault saw 'technologies of the self,' as a set of practices:

"permitting individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain sense of happiness, purity, wisdom, perfection, or immortality"
(Foucault, 1988:18).

Rather than viewing human practices from the perspective of their being the result of coercive forces, 'technologies of the self' are most concerned with how individuals act upon themselves "*as an exercise of the self on the self, by which one attempts to develop and transform oneself, and to attain to a certain mode of being*" (Foucault, 1996:433).

Foucault demonstrated the social and historical contingency of the particular ways we do so by showing how an understanding of 'the concern for the self' changed from the time of the Greco-Roman period to the one of early Christianity. The concern for the self in the Greco-Roman period was understood as the "*progressive consideration of self, or mastery*

over oneself... through the acquisition and assimilation of truth" (Foucault, 1988:35), whereby one would seek authority in order to improve and develop oneself as a person without giving up one's autonomy. Practices of the self in the early Christian period were changed to resemble self-denial and obedience via "*a certain renunciation of the self and of reality*" (Foucault, 1988:35) where one's autonomy was to be relinquished to authority.

In an attempt to make sense of the different ways that people engage with healthy eating discourses, our aim in this paper, therefore, is to explore the ways that people from three different ethnocultural groups in Canada draw on, interpret and use healthy eating discourses. What we have broadly termed 'ways of knowing' about healthy eating are people's discussions of experiences, interpretations, and reasoning used in learning and deciding what to believe, reject, and/or act upon regarding healthy eating. We use Foucault's conceptualization of the 'technologies of the self' to interpret healthy eating knowledges and practices as embodied forms of discourses about healthy eating. We also focus on the varied social and cultural influences that shape the ways that people draw from, interpret and use healthy eating discourses within the context of their everyday lives.

3.2. METHODS

This paper is based on data collected with adult participants whose families participated in a qualitative study of family food decision-making conducted in Halifax and Vancouver. The two cities are situated on the opposite coasts of Canada, Halifax in the East Coast province of Nova Scotia (NS) with a population of nearly 400,000 and Vancouver in the West Coast province of British Columbia (BC) with a population of over 2.2 million (Statistics Canada, 2001). Nova Scotia was first occupied by Europeans in 1604; the vast majority of Nova Scotians today are of British, Irish or French heritage.

British Columbia was first settled by Europeans in the 1860s; Vancouver is one of Canada's most ethnically diverse cities with a large proportion of recent immigrants, particularly from Asia and South Asia.

Apart from the dominant ethnocultural group in Halifax (European NS) and Vancouver (European BC), two minority groups were included: African NS in Halifax and Punjabi BC in Vancouver. Both groups represent a sizeable community in their respective places, and offer differing perspectives on culture and history of immigration and integration in Canada. African NS have a much longer presence in Canada, imbued with a history of oppression, and lead a more isolated way of life in Halifax. In contrast, Punjabi BC's immigration to Canada is more recent, but the community, while remaining distinct, is larger and more integrated in Vancouver's society.

In this paper we differentiate among four groups of participants from three ethnocultural backgrounds: 26 African NS (19 females and 7 males) and 20 European NS (13 females and 7 males) in Halifax, as well as 34 Punjabi BC (23 females and 11 males) and 25 European BC (17 females and 8 males) in Vancouver. For reasons that include recruitment criteria (families with at least one woman aged 25-55 years, no specific requirement of male partners to be interviewed), the nature of households (households with no male partners), as well as the potential for gendered interest in food-related issues, our sample consists of a larger number of women than men.

Ethical approval was obtained from Research Ethics Boards at both Dalhousie University in Halifax and the University of British Columbia in Vancouver. Participant families were recruited through community-based organizations, community contacts and notices posted in public locations. Each participant read and signed an informed consent form at the onset of data collection. Qualitative methods were used to collect data as they

are best suited for depicting the complexity of human behaviour within the context of where they occur (Denzin & Lincoln, 2000; Lincoln & Guba, 1985). Individual interviews were carried out in parallel ways in Halifax with families of African and European origin and in Vancouver with families of Punjabi and European origin. The research assistants collecting data with the African NS and Punjabi BC participants were members of those respective ethnocultural groups. The interviews were tape-recorded and transcribed verbatim. Summary memos about healthy eating interpretations were written for each participant. Atlas/Ti software was used in the initial stages of analysis to facilitate coding of the data. Codes were developed both at the onset of the study, as well as during the progression of data collection and analysis. Overarching codes (e.g., 'healthy eating,' 'ways of knowing,' 'culture') as well as more specific codes ('sources of info,' 'trust in info' and 'control/monitor') were used to develop the thematic analysis in this paper. Our interpretations during analysis were guided by the assumption that human beings construct knowledge by inventing concepts, models, and schemes to make sense of experience, and modifying these constructions in light of new experiences. Because humans are social beings, all of this occurs against a backdrop of shared understandings and practices (Schwandt, 1994).

3.3. RESULTS

In examining the data on participants' discussions about healthy eating, three broad discourses became apparent, each with its own 'ways of knowing' about healthy eating. The three discourses are termed here as the 'cultural/traditional', 'mainstream', and 'complementary/ethical' discourses. Participants' 'ways of knowing' about healthy eating became apparent through their explanations of how they made sense of healthy eating by

evaluating, drawing upon or resisting various healthy eating discourses, the sources from which they obtained information about healthy eating, as well as through their views about expertise and trust in information in healthy eating. The themes that run across each of the discourses are: the foods and/or preparation methods considered healthy, the food-health relationship (how do they see food contributing to health), making sense of the evidence in everyday life (how do they know what they know about healthy eating) and responses to/evaluations of healthy eating discourses. We use the plural ‘discourses’ rather than the singular ‘discourse’ for each of the groupings to promote the sense that participants in each grouping articulated similar rather than identical ways of expressing views about healthy eating, complicated by a sense of fluidity between discourses.

3.3.1. CULTURAL/TRADITIONAL HEALTHY EATING DISCOURSES: PROMOTING THE POSITIVE ASPECTS OF FOOD

Very few European BC, but a sizeable number of European NS, as well as the majority of older African NS and Punjabi BC and newer immigrant Punjabi BC tended to draw on what we are calling *cultural/traditional* discourses in describing healthy eating. These discourses incorporated accounts of cultural/traditional food choices that were considered to be healthy. While the food choices may or may not have actual cultural/traditional roots, they were perceived in that way by participants themselves. Each of the ethnocultural groups had particular foods that they associated with their own cultural/traditional background such as corn bread, curry chicken, and boiled dinner for African NS; the roti meal (roti bread + lentil dish + vegetable dish) for Punjabi BC; and boiled dinner, the meat-potatoes-vegetables meal for European NS. These participants deemed aspects of their eating patterns as children to be healthier than their current ones, one reason being the unavailability of junk or convenience foods in their youth: “*We just*

didn't have quick food. You know quick food was corn on the cob" (European NS woman, 42yr).

Those using cultural/traditional healthy eating discourses also interpreted traditional and natural ways of producing food as more healthful:

We grew up on a farm, so the eggs were from the chickens, if you had bread it was wheat bread, because we were wheat farmers... We always do vegetables in the garden. So it was just natural, the food that you had available, and that's what you ate. My mom and grandma and my dad, that was just the way it was done and still is (European NS woman, 33yr).

The more natural and simpler ways of producing food during childhood were also coupled with healthier preparation and consumption patterns in the home. The way food was made by mothers was considered more wholesome and natural, the non-use of sweeteners and other food additives making it healthier than current ways of eating. One African NS participant said of her mother's ways of preparing porridge:

My mom always had that hot porridge...my mother would just take it out of the pot like clay, and just throw it on the plate. The way they used to do it, because it was healthy for you, was to stick more to your bones. So, but now you got to make it with the brown sugar, cinnamon, and make it all nice and stuff (African NS woman, 59yr).

In addition to preparation methods, the African NS woman's reflection of her mother's food preparation also illustrates the positive aspects of food contributing to health that were apparent in representations of these discourses. While the different ethnocultural groups drew on these discourses in culturally specific ways, they all spoke of food in relation to its positive effects on health. The 'stick more to your bones' phrase was

particularly used by African NS to illustrate the healthfulness of food in terms of functionality, a healthy person being one who has some ‘meat’ on their body. Similar roles of food were discussed by Punjabi BC participants with healthy eating themes of the roti meal ‘providing strength’ as an attribute of health:

I feel [roti meal] has a lot of vitamins and provides strength. It is very good.

If one eats roti, they stay full for longer too... Roti has a lot of strength in it.

Dahl and subjee. They have a lot of strengths. Here they don't make as much dahl, but in India, they make a lot at home and it is really good for you. It is very good for the health (Punjabi BC woman, 70yr).

In the cultural/traditional discourses, healthy eating knowledge was learned from family and community members, through knowledge that was seen as having accumulated over many generations. This knowledge, due to its long history became accepted as common sense, learned as part of everyday life:

Well ever since I was a kid, down through the Black generation and whatever they always preach to you, eat as healthy as you can. It just stuck out in the back of your mind, in mine anyway, since I was a kid (African NS woman, 45yr).

Similar ways of knowing about healthy eating by reference to learned common-sense notions of health were noted by Punjabi BC typically by observing others in the community: *In India, old people used to drink less tea and eat more of these things and say that these are good (Punjabi BC woman, 62yr).* Punjabi BC in particular made reference to how things have always been done, learning about common understandings through advice given by wise elders or shared ways of eating stretching back for generations. Due perhaps to the historically rooted nature of the knowledge, there was a tendency in this

group to accept knowledge acquired about healthy eating in this way as given without much questioning, often responding to probes with “*it’s been like this from the very beginning.*” When asked about why they eat certain foods or how they knew about certain diet-health links, participants replied that: *In India, from the very beginning, we eat roti only, so we are used to eating roti, vegetables and dahl* (Punjabi BC woman, 35yr).

In Canada, the knowledge African NS and Punjabi BC learned from family and community was supplemented by the expertise of health professionals advising them how to eat healthy even when participants did not understand why: *I take [supplements] sometimes... because they are said to be good... the doctor asked me to eat them* (Punjabi BC woman, 62yr). Often, because of language and literacy barriers, Punjabi media sources such as Indian programs on TV and radio were the sources that taught them about what doctors suggest they should eat.

In addition to the cultural/traditional repertoires and experts’ advice about healthy eating, interpretations of healthy eating were also shaped by participants’ observations of the health-promoting effects of foods in everyday life – a kind of embodied way of knowing. One African NS man reflected that he does not get colds due to the foods he eats:

[K]nock on wood, I’ve never been sick... Right now, right as we speak my household is sick. They all have colds right, and [my partner] has been sort down for that last week or more as well as the other people in my house. That cold doesn’t even touch me, and that’s because of how I eat... those spices [in Soul food], I tend to believe it’s the spices, because spices they flush out your system, and everything. So and everything I eat...has a hot spice on it, you know. And I tell those fellows and part of that when I first

used to tell them that, they didn't pay me no mind. Then my son got old enough where he will watch and see (African NS man, 39yr).

Similarly, immigration to Canada provided Punjabi BC with another layer of analysis for interpreting healthy eating where participants were able to observe, compare and reflexively critique eating practices in India and Canada. In comparison to the perceived healthfulness of the flat bread, lentils and vegetables they eat on a daily basis, many Western foods such as pasta were viewed as less healthy and “*too heavy*” to digest. Western patterns of eating were also critiqued, often through observations of their own children and grandchildren in the family:

[Children] go to work, then one goes swimming, to play, to get groceries, life is so busy and lots of responsibilities that they do not have the time to eat... [T]hey have a little bit of milk and a couple of cookies, how long is that going to sustain a person? [In India] if you've eaten two rotis, dahl, subjee, yogurt, and a glass of water it will last you... Here, kids don't fill up on their food. That's why they eat so frequently, they eat bread, banana, candy, I'm hungry, have pop, cookies, chips. Me, I don't eat anything between my meals. I eat roti and I stay full until it's time to eat again (Punjabi BC woman, 70yr).

Further comparisons of contextual lifestyle differences in India and Canada that affected the way they organized their eating were used to make sense of healthy eating. Participants reflected on being able to eat more food in India because of the amount of physical work they used to do in the fields or in the house. In Canada, most elderly participants did not work outside the home and, therefore, made appropriate changes to eat less food and take daily walks to circumvent digestion issues and weight gain. These changes, however, were not done in the spirit of ‘risk prevention,’ but rather as a response

to the natural and inevitable physical changes due to age: *As my body is getting older, there are certain things that my body cannot tolerate...So slowly I change my habits* (Punjabi BC woman, 69yr).

Through these learned knowledges about healthy eating – an accumulation of common sense cultural/traditional forms of eating, acceptance of experts’ advice and their own observations of the effects of food – participants found conflicting meanings in food that needed to be negotiated. For the most part, while changes such as reducing portion sizes or taking supplements occurred, foods eaten remained the same because participants could not see themselves avoiding the foods they were used to. Habitual ways of eating were infused with complex meanings about culture, identity and health that conflicted with other learned knowledge about healthy eating:

The way I eat it reflects who I am. I like hot meals, you know I like a lot of Soul food, it reflects who I am and I’m not changing that for nobody... my mom has Caribbean descent in her. So I like a lot of curry, curry chicken, curry goat, curry ox tail...I love all of those things and I cook all of those things. That’s who I am, and that’s my acquired taste (African NS man, 39yr).

For this group of participants, therefore, perceived cultural/traditional food, preparation methods and eating patterns were viewed as healthy ways of eating with particular emphasis being placed on the positive characteristics of food which contribute to one’s health. Healthy eating knowledge was accumulated in complex ways over many generations through family and community relations, supplemented more recently with new knowledge from scientific expertise from health professionals, personal observations of the body and comparisons in ways of eating between India and Canada.

3.3.2. MAINSTREAM HEALTHY EATING DISCOURSES: CONTROLLING THE EFFECTS OF FOOD AND NUTRIENTS

Categorized under the *mainstream* healthy eating discourses are participants' reflections about healthy eating based primarily on official nutritional guidelines: *all four food groups, low in fat and high in fruit and vegetables... more fibre* (European NS woman, 46yr). Perhaps due to the pervasiveness of these messages in Canada and other Western societies, the mainstream healthy eating discourses were used by participants from all four groups and a wide range of socioeconomic statuses. However, with higher education and particularly for women, there was a tendency for descriptions of the mainstream healthy eating discourses to include not only the foods considered to be healthy, but also differentiation of the effects of particular nutrients in food as well as the amounts of each that should be consumed. Healthy eating was described with precision at a level of detail that often incorporated naming specific nutrients beyond what one could see with an eye:

[Healthy eating means] making sure you get all the vitamins and nutrition that you need, like protein, vitamin C and E and all the nutritional value you can get from food and eating lots of fruits and vegetables... I supplement with vitamin C, vitamin E, Gluteine, what else? 'One-a-day' (supplements) with vitamin B (European BC woman, 51yr).

Rather than general themes such as the 'strength-giving' and 'functionality' of food, the themes in the mainstream healthy eating discourses were those of 'controlling' and 'monitoring' both food and nutrient intake. The use of phrases such as "*I am trying to cut down*", "*I am watching*" or "*I am avoiding*" a particular food or nutrient were well pronounced in these discourses with a sense that discipline is needed to achieve healthy

food consumption. One participant, who often traveled due to work requirements, discussed his food choices when eating out by saying:

I just stopped eating French fries at all, I like French fries but I just stopped ordering anything that includes them because they just pile on so many and it's just one of those hazards of always having French fries. So I avoid greasy things, I never buy pasta dishes, as much as I like pasta (European NS man, 47yr).

This kind of monitoring of food also went down to the level of nutrients, with further considerations of 'risk factors' such as one's gender and life-stage. In contrast to participants who predominantly drew on the cultural/traditional discourses and who were more accepting of the life-course processes of declining health, participants in this group exerted efforts to prevent some of these processes even when they could not see or feel them. For example, some women talked about taking into consideration factors such as being a woman, knowing about the risk of osteoporosis for women later in life, the negative effects of caffeine as well as the preventative effect of calcium in this relationship, and their efforts to consume calcium through food:

I have two cups (of coffee) but it's latte so it's like only one cup of caffeine (laughs) and then I'll have yogurt... I am concerned. I want more calcium. You know, I realize having coffee and tea and all those kinds of things at my age I have to keep the calcium intake so that's why the yogurt (European BC woman, 47yr).

These participants were not only well versed in the current scientific evidence in particular nutritional areas of interest, but they also paid attention to the change in messages over time. Via these observations of the trends in the nutrition

literature, participants' food and nutrient decisions went through changes accordingly:

I remember quite a few years ago people said beta carotene was the best thing and then now it's being linked to certain forms of lung cancer and so, you know, too much of a good thing. You've got to watch what you take
(European BC woman, 51yr).

Many of these participants felt that healthy eating information was easily accessible and all around them. Their own knowledge thus far was a gradual process learned over time often beginning with their parents and/or past nutritional guidelines learned in school. The most common current sources of information for these participants were TV, newspapers, the internet, as well as health professionals (e.g., dietitians they knew informally), family and friends. Doctors were not consulted for nutrition information, perhaps due to the accessibility of information elsewhere in everyday life. Men often credited their female partners as being more knowledgeable on nutrition issues, becoming sources of healthy eating information. Women in turn credited their general interest in food and nutrition and becoming mothers as prominent factors for paying close attention to healthy eating.

Mainstream healthy eating discourses were also used by some African NS and Punjabi BC, particularly those with higher formal education and for the Punjabi BC, those who had lived in Canada longer. The mainstream ways of knowing about healthy eating, however, were often contextualized in their own particular cultural ways of preparing food or culturally relevant health concerns. For Punjabi BC, for example, priorities were often about preparing cultural foods modified by mainstream notions of healthy eating:

Our culture uses a lot of butter and margarine, you know, when they're making their curries. It's almost part of the base. I try to cut down on a lot of the stuff that I'm using, like cut the quantity down so, you know, instead of using a tablespoon I'll try to use a teaspoon of it (Punjabi BC woman, 45yr).

From this quote, it also becomes evident that mainstream healthy eating discourses were used to question cultural notions of healthy eating. While participants found it important to eat culturally appropriate foods, the new ways of eating learned in Canada generated a critique of certain culturally-informed eating habits. The cultural significance of foods needed to be balanced with healthier practices learned from the mainstream healthy eating discourses. The two discourses were combined to interpret optimal ways of eating in an attempt for the two different notions of healthy eating to co-exist. Cultural notions of healthy eating were important for the continuity of traditional understandings of health through generations, as were new notions of healthy eating learned via mainstream discourses in Canada:

I try to introduce my children to all kinds of food. They eat roti also, as it is healthy food and it is not junk food. And they will remain healthy; if we remained healthy then even they will stay healthy. Nothing has happened to us as we have been eating roti for so long, so even our kids will stay healthy... [but] we do not get all the nutrition from roti, so we eat food from different cultures... sometimes when we cook dahls, we lose its nutritional value as we cook it for a long time. When we cook it less, the vegetables are not overcooked, we get more nutrition (Punjabi BC woman, 37yr).

Similarly, some African NS also felt that negotiations needed to be made between cultural and mainstream healthy eating because of community concerns with heart health. Like

some of the Punjabi BC, these participants attributed unhealthy ways of preparing food to their own cultural traditions, rather than attributing poor health to Western influences:

Yes, there is [a Black way of eating]. It's not healthy... It's a lot of deep-fried and fried foods and stuff like that... I just want to incorporate a more healthier way... [The Black way of eating is important] because food like cornbread and stuff like that and it seems like Black people are always – at any function they always have food... I don't think it's going to affect the culture if you stop – you know, we start eating a lot more healthier. I think it would prolong our lives. We have a high rate of heart disease (African NS man, 42yr).

Therefore, due to the ubiquity and easy accessibility of messages, mainstream healthy eating discourses were prominent in discussions of participants from all three ethnocultural groups. Those of European descent in NS and BC, and particularly the women in these groups, used food as a way of managing health, trusting information about the effects of food and nutrients that went beyond what was observable in everyday life. While these participants may have been following cultural/traditional conceptualizations about healthy eating, their ways of eating fit easily with mainstream guidelines emerging and changing over time. In contrast, African NS and Punjabi BC used discourses to integrate two ways of eating – that of their culture/tradition and that of mainstream guidelines. Their process was thus more explicitly negotiated. Interestingly, while this process led to some questioning of their own cultural ways of eating, it did not seem to raise questions about mainstream ways of healthy eating for participants most closely aligned with the mainstream healthy eating discourses.

3.3.3. COMPLEMENTARY/ETHICAL HEALTHY EATING DISCOURSES: HEALTHY EATING IN THE LARGER FOOD SYSTEM

In the *complementary/ethical* healthy eating discourses, participants emphasized complex interactions in the food system where, in addition to health values, food decisions encompassed explicit moral and ethical values. Participants with these discourses were primarily women from the European BC group, but a few European NS also drew on certain aspects of it. While there was a tendency for the well-educated to have more to say about these issues, there were also those of lower socioeconomic status who made use of these discourses. Specific foods incorporated in complementary/ethical definitions of healthy eating varied to an extent. Some participants mentioned only vegetarian foods or food produced as a result of the ethical treatment of animals, while most mentioned local, natural and organic foods as the way to healthy eating. Their discourses viewed decisions about healthy eating as part of larger food sustainability concerns and relationships with local people involved in the food process:

Healthy eating – how would I define it? (pause) I think it's eating food to nurture your spirit as well as your body and, you know, so it's really being connected to where it comes from as well as where it's going, like to feel good. Like when I eat Swiss chard that came from my friend's garden up in Lytton and then, you know, I'm putting the balsamic vinegar on it that's from the people in the Okanagan who make it with special stuff in it and apricots, and I eat that, I feel connected to the land that it grew in. Like I feel I'm getting – I can feel the iron go into my body because I know it's really got iron in it and it really has the things in it that I need (European BC woman, 52yr).

As may be noted by the incorporation of iron in the discussion by this woman, these discourses were not necessarily in opposition to the overall messages the nutritional guidelines provided and in fact participants incorporated many of those messages in their food decisions. But they also included further concerns about food such as the politics of food and the trust they had in people producing and consuming food locally. The same woman continued:

[I] used to choose to buy [fruit] from growers in the Okanagan who'd bring them up to a market here and then I'd buy it from them, and they grew it, and their family, and their parents planted the trees and I'm all happy, right? But they're not there anymore though. Because you see, it's very hard for those people to actually make a living bringing it here now because of the gas prices (European BC Woman, 52yr).

Some participants questioned certain aspects of the mainstream healthy eating discourses such as the ethical development of food guidelines. Some believed that the meat and dairy food groups of the CFGHE were over-emphasized despite knowledge that current production and consumption of meat and dairy runs contrary to environmental sustainability concerns. They believed these food groups are emphasized only because of the involvement of food industries in the development process of the guidelines:

...Canada's Food Guide, which I have a real issue with that because of the way that it was put together. The beef industry and the dairy industry spent, you know, millions of dollars lobbying in Ottawa ... that's incredibly biasing... those industries have been very successful at kind of still staying on that national agenda in that way (European BC woman, 47yr).

Instead of relying on health professionals, these participants considered themselves knowledgeable about very specific health issues through their own research. They depended on themselves for healthy eating information by actively searching out and evaluating information about healthy eating using a diverse set of resources: *I read a lot of magazines... online cookbooks... food writers... M.F.K. Fisher or Eve Johnson... newspapers... health columns or the food columns... Margaret Visser* (European BC woman, 47yr). Therefore, while both of the groups using the cultural/traditional and mainstream healthy eating discourses relied to some extent on health professionals as sources of expertise regarding healthy eating, those using complementary/ethical discourses questioned health professionals' knowledge as applied to their own bodies and health. One woman said:

My doctor, who I've had for 25 years, her and I have had many arguments over the years because she's the - what I call the older thing of, you know, the total worry about protein and she was always, ALWAYS, testing me for anemia and all that kind of things and then when I wasn't eating meat when I was pregnant she was, like, mortified. And none of it's ever panned out (European BC woman, 47yr).

These participants believed that scientific knowledge needs to be integrated with personalized nutrition for each individual, paying particular attention to the individual's knowledge of their own body:

Well, it's not really about the amount of nutrition. It's about the amount of nutrients that you absorb. And that's what I believe. I mean you can take lots of vitamins or whatever but if your body's not absorbing them they won't do you any good, so it's really what works for one person is going to be a little

different than what works for another. One person, their source of protein that's more valuable to them may be in legumes. They may process that a lot better. Like for me, for example, I like fish but every once in a while it just doesn't sit well with me. My body, you know, I've thrown up a few times and my body's just kind of like, so obviously on those particular days, whatever, it wasn't going down well so it wasn't doing me much good. So I think it really depends on your system (European BC woman, 50yr).

In summary, for participants using the complementary/ethical healthy eating discourses, conceptualizations of healthy eating drew to an extent from mainstream definitions, but were also incorporative of discourses about the ethical aspects of food production and consumption. Therefore, healthy eating was seen not only as a collection of scientific evidence about the effects of food on health, but also as playing a role in providing answers to sustainability and ethical issues for the health and well-being of society. In this way, these participants viewed science and health professionals as having credibility only to the extent that nutritional and health knowledge could be incorporated with people's own assessments of their body and health. They viewed themselves as capable of evaluating food and health issues, and took an ethical stance that individuals have a responsibility to safeguard their own wellbeing and the wellbeing of communities, food systems and the earth.

3.4. DISCUSSION

When gaps are noted between healthy eating messages and people's eating practices, one of the main assumptions by health professionals is that messages are not reaching the public and that education about the messages themselves or the processes by

which the messages are communicated needs to be improved. Our study suggests the possibility of two other considerations for the disconnect between nutritional guidelines and people's ways of understanding and practicing healthy eating, one referring to the ways in which healthy eating is conceptualized in society and another referring to the ways in which healthy eating conceptualizations are enacted through food practices of the self.

With regard to the first consideration, our findings present clear evidence of multiplicity of healthy eating discourses that people in two areas of Canada can currently draw upon. In addition to mainstream discourses, participants were able to also draw upon cultural/traditional and complementary/ethical discourses suggesting that official health-promotion messages need to be positioned in the larger historical and social context of everyday food experiences where forms of knowledge in addition to nutritional guidelines are recognized. While what is considered 'traditional' knowledge and what is considered 'official' knowledge concerning health changes over time, currently both Coveney (2000, 2005) and Lupton (1996) have noted the centrality of nutritional science in people's understandings of food and health in contemporary Western societies, promoting the management of health via people's individual responsibility and limited direct governance by health authorities. These discourses focus on the ability of people to self-regulate through monitoring and influencing the course of risk factors (Castel, 1991; Petersen, 1996; Petersen, 1997). Healthy eating understandings as suggested by official discourses of healthy eating were part of the ways of knowing for most participants in our study through incorporation of knowledge from nutritional guidelines. For those using the mainstream discourses, rationality, reasoning and practices were based solely on scientific discourses about healthy eating, where participants not only incorporated knowledge about food practices but also about potential health risks that are invisible in everyday

experience. In these discourses of healthy eating, it was understood that the management of health through healthy eating included individual responsibility not only for one's observable food practices but also prevention of potential risks to one's future health.

In the context of the participants' daily food practices, however, health professionals' discourses about healthy eating provide only one of potentially many food and health discourses that they could draw upon to interpret healthy eating (Petersen, 1997). Some participants in our study also drew on the cultural/traditional and complementary/ethical discourses in addition to the mainstream healthy eating discourses. Similarly, in our earlier Vancouver study (Chapman & Beagan, 2003) with women, some of whom were breast cancer survivors, we found that the women drew on two additional broad perspectives about healthful eating in addition to the mainstream/health professional perspective where overall perspectives were related to how the women viewed the food-breast cancer relationship. Coveney (2005) also highlighted different forms of lay knowledge about food and health between parents living in high income and low income suburbs in Adelaide, Australia. The additional discourses represent distinctive but no less rational ways than the mainstream to conceptualize healthy eating. For example, with the cultural/traditional understandings described here, healthy eating was conceptualized through values of culture and tradition, and was considered to be proven as valid through observations of the effects of food on health over centuries. The mode of thinking this group utilized was that of 'orality' where knowledge is conveyed in oral ways. In this mode of thinking, knowledge comes about over time through accumulation and combining of ideas, with little potential for conflict in the acquiring of new/different knowledges (Nayar, 2004). This mode of thinking may help explain why even though the participants who drew upon these discourses may not have identified with their doctor's advice as

much as they identify with healthy eating messages from their own culture, they were able to incorporate some messages from authorities easily into their food practices.

Specific ethnocultural interpretations of healthy eating were utilized not only by the older and less acculturated participants, but were also drawn upon to an extent by some participants well versed in the mainstream discourses, suggesting that even with higher levels of acculturation, people still hold on to certain traditional ways of cooking and eating (Axelson, 1986; Satia-Abouta, Patterson, Neuhouser, & Elder, 2002). Many food-related changes cannot be explained by food availability or by change in socioeconomic status of individuals. The strong effect of cultural/traditional understandings beyond these determinants (Axelson, 1986) seems to remain even when it is acknowledged that some cultural/traditional food practices are nutritionally poor (Airhihenbuwa & Kumanyika, 1996). While the nutritional inadequacy of some cultural/traditional foods may be a factor as to why certain ethnic groups have higher-than average risk and/or prevalence for developing diet-related chronic diseases, the opposite has also been found: acculturation to the Western diet has also been associated with decreased health (Satia-Abouta et al., 2002), while a stronger cultural identity, on the other hand, has been associated with healthier dietary behaviours (Bedaiko, Kwate, & Rucker, 2004). It may be important to promote cultural/traditional interpretations of healthy eating through the values and reflective critiques these discourses offer. For example, that the roti meal was perceived as healthier than many options in Canada by some Punjabi BC may illustrate a legitimate knowledge of the healthfulness of cultural/traditional food practices. Interpretations of healthy eating identified as cultural/traditional in our study were not only grounded in perceived knowledges of past practices, but were also rational reasonings based on observations of the effects of food on health over time, comparisons between food and eating patterns of

different social groups, as well as scientific evidence as presented by doctors' advice.

While coming from a different set of knowledges, a similar range of knowledges was also drawn on by participants in the complementary/ethical discourses. Their reflections about healthy eating and health were more encompassing so that in addition to scientific evidence of the mainstream discourses, healthy eating included knowledges with respect to one's own body, ethical consumption, and sustainable ways of eating.

With regard to the second consideration for the disconnect between nutritional guidelines and people's ways of understanding and practicing healthy eating, our findings also extend previous work on nutrition discourses by exploring the different ways they are enacted through food practices of the self. One view of the nature of practices may be that individuals are seen as having to conform to and undertake practices as offered by the discourses of governance. Another view may be that the relationship between discourses and individuals is more flexible and negotiable, with the possibility of people's resistance to discourses (McNay, 1994). The form of governance favoured by people drawing on particular healthy eating discourses may be at least partially influenced by social and cultural worldviews of expertise in knowledge. Participants drawing on cultural/traditional healthy eating discourses seemed to believe in expert knowledge about healthy eating, a belief that was shared by those drawing on the mainstream healthy eating discourses. However, the approach taken towards influencing their own health via food was different, with those drawing on the cultural/traditional discourses showing more acceptance for the possibility of certain life-course processes such as aging and illness and limited monitoring of the self through food practices. In contrast, healthy eating for participants drawing on the mainstream discourses was approached through practices of the self that resembled the self-examination practices in the Christian era. Foucault used

the analogy of the mill to describe the nature of self-examination practices required in this period.

“Thoughts are like grains, and consciousness is the mill store. It is our role as the miller to sort out amongst the grains those which are bad and those which can be admitted to the mill store to give good flour and good bread of our salvation” (Foucault, 1988:46).

The analogy of the mill where the sorting of good grains gives good flour can easily be re-applied as the compliance in the sorting of nutrients to give good health in the mainstream healthy eating discourses.

Participants drawing on the complementary/ethical healthy eating discourses saw themselves as responsible to participate in the construction of knowledge about their own health by finding and evaluating information about healthy eating. Similarly, while acknowledging expert advice, participants in the cultural/traditional discourses who critiqued Western eating patterns were also able to show agency in healthy eating through practices drawing on discourses different than the mainstream. These participants shared the Greco-Roman view of authority where the relationship of individuals with health professionals was founded on the ability of the health professionals to give good advice leading to a happy but still autonomous life (Foucault, 1988). The autonomy for making decisions about healthy eating where people are resisting being passive receivers of information, and instead actively seek out information about topics beyond the basic dietary guidelines has also been observed elsewhere (Van Dillen, Hiddink, Koelen, de Graaf, & van Woerkum, 2004). These participants can thus be viewed as knowledgeable/experts of their own lives, perhaps even seen as offering knowledgeable resistance to official discourses about healthy eating. Whether the motivations behind

these discourses are more to do with concerns about personal health or the health of the environment/society (Belasco, 2005) remains to be resolved, but both concerns seem to intersect in their critique of science's inability to answer larger health and social problems (Belasco, 2005; Brown & Zavestoski, 2004).

The above distinctions do not promote the view that mainstream healthy eating discourses were deemed unworthy or resisted in entirety; both cultural/traditional and complementary/ethical conceptualizations were in fact often combined with current mainstream conceptualizations of healthy eating, providing illustrations that different accounts about the relationship between food and health can co-exist, even if they seem contradictory (Coveney, 2005; Jovchelovitch & Gervais, 1999). The larger issue may lie in mainstream discourses' lacking in consideration and incorporation of other ways of knowing healthy eating. Alternative discourses to health and well-being have previously been described as providing more meaningful conceptualizations of healthy eating beyond the focus of a person's physiological health (Sointu, 2006) and individual responsibility as in mainstream health discourses (Petersen, 1997). Bottorff, Johnson, Venables, Grewal, Popatia et al., (2001) have noted that the ways immigrant South Asian women express health concerns reflect broader cultural notions about being a woman and a sense of belonging to a cultural group. They argue that an individualistic philosophy and differentiation between physical and emotional problems represented in the biomedical model are inconsistent with South Asian worldviews of family and community involvement in health decisions and an integrative perspective of health issues. We would, therefore, suggest that even if they are seen to lack the sophisticated scientific knowledge of the mainstream discourses, the cultural/traditional and the complementary/ethical discourses also provide valuable ways of perceiving health and well-being.

Overall, the findings of this paper show how analyses of non-mainstream conceptualizations of healthy eating offer opportunities not only for appreciating different ways but also for contextualizing official understandings of healthy eating. Health behaviours need to be seen in the larger context of influences that contribute to ‘well-being’ that may be even broader than the current social determinants of health of concern. Findings from other research that certain ethnic groups with high risk factors (low socioeconomic status and educational achievements) have more positive health outcomes (e.g., lower mortality) than expected point to the need to focus on the complex relationship between culture, behaviour and health (Hayes-Bautista, 2003). The ways that people choose, prepare and eat their food need to be seen in the broader context of socially and culturally constructed ways of life with respect to family and community relationships (Hayes-Bautista, 2003), orientations to work, stress, and pleasure, so that the interdependence of socially and culturally influenced perceptions, behaviour and health is considered. As people live, they learn, observe and experience their lives, aware of the multitude of factors that encourage and/or constrain their food decisions. Clearly, the way in which individuals express their agency is the result of the complex interaction of a variety of factors, health promotion norms about eating being one. The process of culturalizing health perspectives and practices affirms diversity in the way people construct their individual and collective realities within the possibilities of their living conditions. What is positive or negative cannot be based on a singular view (Airhihenbuwa, 1995); instead, different kinds of knowledges (e.g., scientific, local and situated) should be engaged to creatively contribute to constructing health-promoting knowledges and well-being. Lay knowledges have a logic and rationality and it is important that we understand the social origins of their sense-making and the role they play in structuring worldviews

(Coveney, 2005). Through the cultural/traditional and complementary/ethical healthy eating discourses, participants may help question whether the current taken-for-granted notions of health are indeed health-promoting. Dialogues between discourses are needed where different forms of knowledge interact to realize the optimal paths to health and well-being of the society as healthy eating is as much about the everyday as it is about the scientific.

3.5. REFERENCES

- Airhihenbuwa, C. O. (1995). *Health and culture: Beyond the Western paradigm*. London, UK: SAGE Publications.
- Airhihenbuwa, C. O., & Kumanyika, S. (1996). Cultural aspects of African American eating patterns. *Ethnicity & Health, 1*, 145-260.
- Ankeny, K., Oakland, M. J., & Terry, R. D. (1991). Dietary fat: Sources of information used by men. *Journal of the American Dietetic Association, 91*, 1116-1117.
- Axelson, M. L. (1986). The impact of culture on food-related behavior. *Annual Reviews of Nutrition, 6*, 345-363.
- Beck-Gernsheim, E. (2000). Health and responsibility. In B. Adam, U. Beck & J. Van Loon (Eds.), *The Risk Society and Beyond: Critical Issues for Social Theory* (pp. 122-135). London, UK: SAGE Publications Ltd.
- Bedaiko, S. M., Kwate, N. O. A., & Rucker, R. (2004). Dietary behavior among African Americans: Assessing cultural identity and health consciousness. *Ethnicity & Disease, 14*, 527-532.
- Belasco, W. (2005). Food and the counterculture: A story of bread and politics. In J.L. Watson, & M.L. Caldwell (Eds.), *The Cultural Politics of Food and Eating: A Reader* (pp.217-234). Malden: Blackwell Publishing.
- Bottorff, J. L., Johnson, J. L., Venables, L. J., Grewal, S., Popatia, N., et al. (2001). Voices of immigrant South Asian women: Expressions of health concerns. *Journal of Health Care for the Poor and Underserved, 12*, 392-403.
- Brandt, A.M., & Rozin, P. (Eds.), (1997). *Morality and Health*. New York, NY: Routledge.

- Brown, P. & Zavestoski, S. (2004). Social movements in health: An introduction, *Sociology of Health & Illness*, 26, 679-694.
- Castel, R. (1991). From dangerousness to risk. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault effect: Studies in governmentality*, (pp. 281-289). Chicago, IL: Chicago University Press.
- Chapman, G. E., & Beagan, B. (2003). Women's perspectives on nutrition, health, and breast cancer. *Journal of Nutrition Education and Behavior*, 35, 135-141.
- Coveney, J. (2000). *Food, Morals and Meaning: The Pleasure and Anxiety of Eating*. London, UK: Routledge.
- Coveney, J. (2005). A qualitative study exploring socio-economic differences in parental lay knowledge of food and health: Implications for public health nutrition. *Public Health Nutrition*, 8, 290-297.
- Denzin, N.K., Lincoln, Y.S. (2000). *Handbook of Qualitative Research: 2nd edition*. Thousand Oaks: Sage Publications.
- Dixon, L. B., Cronin, F. J., & Kebs-Smith, S. M. (2001). Let the pyramid guide your food choices: Capturing the total diet concept. *Journal of Nutrition*, 131, 461S-472S.
- Fagerli, R. Aa., & Wandel, M. (1999). Gender differences in opinions and practices with regard to a "healthy diet", *Appetite*, 32, 171-190.
- Falk, L. W., Sobal, J., Bisogni, C. A., Connors, M., & Devine, C.M. (2001). Managing healthy eating: Definitions, classifications, and strategies. *Health Education & Behavior*, 28, 425-439.
- Foucault, M. (1972). *The Archaeology of Knowledge*. New York: Pantheon Books.

Foucault, M. (1988). Technologies of the self. In L. H. Martin, H. Gutman & P.H. Hutton (Eds.), *Technologies of the Self: A Seminar with Michel Foucault* (pp. 16-49).

Amherst, MA: University of Massachusetts Press.

Foucault, M. (1996). The ethics of the concern for self. In S. Lotringer (Ed.), *Foucault Live: Collected Interviews, 1961-1984* (pp. 432-449). New York, NY:

Semiotext(e).

Furst, T., Connors, M., Bisogni, C.A., Sobal, J., & Falk, L.W. (1996). Food choice: A conceptual model of the process. *Appetite*, 26, 247-266.

Goldberg, J. P. (1992). Nutrition and health communication: The message and the media over half a century. *Nutrition Reviews*, 50, 71-77.

Goldberg, J. (2000). Nutrition communication in the 21st century: What are the challenges and how can we meet them? *Nutrition*, 16, 644-646.

Hayes-Bautista, D. E. (2003). Research on culturally competent healthcare systems: Less sensitivity, more statistics. *American Journal of Preventive Medicine*, 24, S8-S9.

Health Canada. (1996). Joint Steering Committee: Nutrition for health: An agenda for action.

http://www.hc-sc.gc.ca/fn-an/nutrition/pol/nutrition_health_agenda-nutrition_virage_sante_e.html, accessed October 14th, 2004.

Health Canada. (2002). What Do Canadians Think About Nutrition?

http://www.hc-sc.gc.ca/fn-an/surveill/facts-faits/factsheet_canada_thinks-dossier_canada_pense_e.html, accessed February 16th, 2007.

Health Canada. (2003). Healthy Eating - Consumer Perspectives - How do Consumer Perspectives on Healthy Eating Relate to Canada's Food Guide to Healthy Eating?

- http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/review-examen/cons_persp_cfghe-vue_cons_gacms-06-26_e.html, accessed October 14th, 2004.
- Health Canada. (2004). Office of nutrition policy and promotion. Review of Canada's Food Guide to Healthy Eating - Interpretation of Findings and Next Steps.
http://www.hc-sc.gc.ca/hpfb-dgpsa/onpp-bppn/review_interpret_findings_e.html, accessed October 14th, 2004.
- Health Canada. (2007). Eating well with Canada's Food Guide.
http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html, accessed February 16, 2007.
- Hiddink, G. J., Hautvast, G. A. J., van Woerkum, C. M. J., & Fieren, C. J. (1997). Consumers' expectations about nutrition guidance: The importance of primary care physicians. *American Journal of Clinical Nutrition*, 65, 1974S-1979S.
- Holgado, B., Martinez-Gonzalez, M. A., De Irala-Estevez, J., Gibney, M., Kearney, J., & Martinez, J. A. (2000). Sources of information about diet and health in a Mediterranean country: Comparison with other European member states. *European Journal of Public Health*, 10, 185-191.
- Jacobs Starkey, L., Johnson-Down, L., & Gray-Donald, K. (2001). Food habits of Canadians: Comparison of intakes in adults and adolescents to Canada's Food Guide to Healthy Eating. *Canadian Journal of Dietetic Practice and Research*, 62, 61-69.
- Jovchelovitch, S., & Gervais, M-C. (1999). Social representations of health and illness: The case of the Chinese community in England. *Journal of Community & Applied Social Psychology*, 9, 247-260.

- Keane, A., & Willetts, A. (1996). *Concepts of Healthy Eating: An Anthropological Investigation in South-East London*. London: Goldsmith College.
- Lappalainen, R., Kearney, J., & Gibney, M. (1998). A PAN EU survey of consumer attitudes to food, nutrition, and health: An overview. *Food Quality and Preference*, 9, 467-478.
- Lincoln, Y.S., Guba, E.G. (1985). *Naturalistic Enquiry*. Beverly Hills: Sage Publications.
- Lupton, D. (1996). *Food, the Body and the Self*. London, UK: SAGE Publications.
- McNay, L. (1994). Foucault: A critical introduction. Cambridge, UK: Polity Press.
- Medeiros, L., Russell, W., & Shipp, R. (1991). Nutrition knowledge as influenced by source of nutrition information. *Nutrition Research*, 11, 979-988.
- Moscovici, S. (2001). The phenomenon of social representations. In G. Duveen. (Ed.), *Social Representations: Explorations in Social Psychology* (pp. 18-77). New York, NY: New York University Press.
- Nayar, K. E. (2004). *The Sikh Diaspora in Vancouver: Three Generations amid Tradition, Modernity, and Multiculturalism*. Toronto, ON: University of Toronto Press.
- Paquette, M-C. (2005). Perceptions of healthy eating: State of knowledge and research gaps. *Canadian Journal of Public Health*, 96, S15-S19.
- Patterson, R. E., Satia, J. A., Kristal, A. R., Neuhouser, M. L., & Drewnowski, A. (2001). Is there consumer backlash against the diet and health message? *Journal of the American Dietetic Association*, 101, 37-41.
- Petersen, A. (1997). The new morality: Public health and personal conduct. In C. O'Farrell (Ed.) *Foucault: The Legacy* (pp. 696-706). Brisbane, AU: Queensland University of Technology.

- Petersen, A. R. (1996). Risk and the regulated self: The discourse of health promotion as politics of uncertainty. *Australian & New Zealand Journal of Statistics*, 32, 44-57.
- Povey, R., Conner, M., Sparks, P., James, R., & Shepherd, R. (1998). Interpretations of healthy and unhealthy eating, and implications for dietary change. *Health Education Research*, 13, 171-183.
- Rosen, G. (1993). *A History of Public Health*. Baltimore, MA: John Hopkins University Press.
- Rotberg, R.I. (Ed). (2000). *Health and Disease in Human History: A Journal of Interdisciplinary History Reader*. Cambridge, MASS: MIT Press.
- Rozin, P., Fischler, C., Imada, S., Sarubin, A & Wrzesniewski, A. (1999). Attitudes to food and the role of food in life in the U.S.A., Japan, Flemish Belgium and France: Possible implications for the diet-health debate. *Appetite*, 33, 163-180.
- Satia-Abouta, J., Patterson, R. E., Neuhouser, M. L., & Elder, J. (2002). Dietary acculturation: Applications to nutrition research and dietetics. *Journal of the American Dietetic Association*, 102, 1105-1118.
- Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 118-137). Thousand Oaks, CA: Sage Publications.
- Sobal, J. (1998). Cultural comparison research designs in food, eating, and nutrition. *Food Quality and Preference*, 9, 385-392.
- Sointu, E. (2006). The search for wellbeing in alternative and complementary health practices. *Sociology of Health & Illness*, 28, 330-349.

Statistics Canada. (2001) Community profiles.

<http://www12.statcan.ca/english/profil01/CP01/Index.cfm?Lang=E>, accessed September 18th, 2006.

USDA. MyPyramid.gov. <http://www.mypyramid.gov/index.html>, accessed February 16, 2007.

Van Dillen, S. M. E., Hiddink, G. J., Koelen, M. A., de Graaf, C., & van Woerkum, C. M. J. (2004). Perceived relevance and information needs regarding food topics and preferred information sources among Dutch adults: Results of a quantitative consumer study. *European Journal of Clinical Nutrition*, 58, 1306-1313.

Wetter, A.C., Goldberg, J.P., King, A.C., Sigman-Grant, M., Baer, R., et al. (2001). How and why do individuals make food and physical activity choices? *Nutrition Reviews*, 59, (3):S11-S20.

CHAPTER 4: Intergenerational transmission of healthy eating knowledge in three ethnocultural groups in Canada ⁷

4.1. INTRODUCTION

In contemporary Western society, food choice is understood to play a role in health and illness both in expert (WHO/FAO, 2003) and lay (Keane, 1997) discourses. Within these ideological contexts, health promotion and nutrition education are thus considered important for the promotion and maintenance of health. Dietary guidelines based on scientific evidence about healthy eating are translated into practical ways of eating that meet nutrient needs, promote health and minimize risk for nutrition-related chronic diseases (Health Canada, 2007). By translating scientific knowledge about food into recommendations about how people should eat, however, dietary guidelines also provide normative social standards for how people should behave with respect to their food and health practices (Backett, 1992; Coveney, 1999; Coveney, 2000). Advances in scientific knowledge about the properties of food and nutrients have been associated with changes in moral concerns about how one should eat (Coveney, 1999). Food choices have come to connote moral acceptability based on their nutritionally ‘good’ or ‘bad’ elements, with judgements of those who eat ‘unhealthy’ foods as less moral and those who eat ‘healthy’ foods as more moral persons (Backett, 1992; Stein & Nemeroff, 1995). Food choices, therefore, as other health-related behaviours, can be understood as part of everyday decisions and practices that reflect norms and standards for appropriate social behaviour (Backett, 1992).

⁷ A version of this chapter has been submitted for publication. Ristovski-Slijepcevic, S., Chapman, G.E., & Beagan, B.L. Intergenerational transmission of healthy eating knowledge in three ethnocultural groups in Canada, *Sociology of Health & Illness*.

4.1.1. GOVERNMENTALITY AND ITS TECHNIQUES

The provision of social standards for people's behaviour with regard to food can be understood as a means of governmentality. As described by Foucault (1991), governmentality refers to the common means by which contemporary society is governed. Governing is accomplished through the development of expert knowledges that then shape or guide the conduct of people, populations or society (Coveney, 1998; Hindess, 1996, Lupton, 1999). Through governmentality, an ethics is established for how people should behave and a means is provided by which people should assess their desires, attitudes and conduct in order to understand themselves as moral, ethical or 'good' individuals (Coveney, 1998).

Rather than being necessarily repressive or violent, governmentality has the potential for being productive, resting its regulation of conduct on rational means for the betterment of people and society – a purpose being *'not the act of government itself but the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health, etc'* (Foucault, 1991, p. 100). It operates through dispersing social standards in capillary or 'net-like' form (Foucault, 1980), so that governing occurs both through surveillance-like regulation of populations, as well as through the voluntary compliance of individuals to regulate themselves (Foucault, 1988). As such, it aims to affect the actions of individuals by working on their conduct – the ways in which they regulate their own behaviour (Hindess, 1996).

4.1.2. DIETARY GOVERNMENTALITY WITHIN THE FAMILY

Dietary governmentality can thus be understood as a social standard for food practices that is disseminated through nutritional expertise and individuals' own regulation

of dietary practices. Expert nutrition knowledges provide rational principles by which populations are examined, assessed, evaluated and compared to dietary norms, as well as guidelines and instructions by which populations are trained to conform to norms (Lupton, 1999). The result is the ‘normalizing’ of particular ways of thinking and behaving with respect to food.

Nutrition (Coveney, 2000), as well as other closely-related disciplines – nursing (Holmes & Gastaldo, 2002), public health (Lupton, 1995), health education (Gastaldo, 1997) and health promotion (Coveney, 1998) – have been shown to participate in the normalizing of particular standards about health behaviour through constructing notions of the ‘healthy citizen’ and the ‘caring mother’ (Holmes & Gastaldo, 2002). Within these constructions, the mother’s role in caring for the health of her children is linked to gendered assumptions about food provision in the family and her identity as a woman. It is often taken for granted that women will be the family cook and gatekeeper of family food choices (Bell & Valentine, 1997). Preparing food provides a way in which women define themselves and relate to others. Binding both her identities as a food provider and a woman is the mother’s identity as a parent. Her moral obligations for her children’s health begin with her own food choices during pregnancy and breast-feeding, and continue with monitoring, assessing and disciplining the food choices of her growing children later in life (Lupton, 1996; Nettleton, 1991).

Women’s role in food and family matters is further solidified through notions of the ‘proper meal’ and ‘proper family’ (Charles & Kerr, 1988). The ‘proper meal’ here acts as a key indicator of a ‘proper family,’ necessitating the provision and modelling of food that is home-made, wholesome and nutritious, with the family sitting together, talking to each

other and enjoying both the food and each other's company – combining the significance of both nutrition and the social context of family (Charles & Kerr, 1988).

Adolescent children in particular are understood as being at a critical point in the development of food habits for adulthood. While adolescents are expected to resist healthy eating for the sake of autonomy and identity with peers, parents are considered to play a crucial role in directing them toward developing healthy eating habits. Nutrition experts present mothers with particular styles and strategies that are thought to influence adolescents toward consuming healthy foods (Kremers et al., 2003; Videon & Manning, 2003). These styles and strategies that view the family as a site for healthy eating activity become prevailing approaches toward food and health in the family, as they are internalized by family members themselves (Fulkerson et al., 2006). However, such expectations of parents often do not acknowledge the bidirectional negotiation required between parents and adolescents when making family decisions about food (Eldridge & Murcott, 2000) or how healthy eating concerns fit into the larger social worlds of being an adolescent (Backett-Milburn et al., 2006).

In summary, in contemporary Western societies dietary guidelines and advice can be seen as a means of governmentality whereby they, along with other sources of governmentality, contribute to normalizing particular standards for family food practices through particular constructions of 'good mothers,' 'proper meals' and 'proper families' – and the mothers in turn, through enacting these ideals, further normalize particular standards for their family around healthy eating. These understandings of governmentality, however, are based on particular perspectives from Western cultures and may not be applicable across societies. Orality, for example, is a concept that conveys traditional societies' dependence on oral communication of ideas from one generation to the next.

Rather than confirming validity of ideas through expert knowledges, verification in oral traditions rests on personal experience, telling and retelling of stories and a collective and cumulative orientation (Nayar, 2004). Previous research has shown that while migrants attempt to merge traditional with new (Western-dominated) food knowledges in intricate ways, traditional knowledges continue to play an important role in explanations about health (Bradby, 1997; Dyck, 2006; Dyck & Dossa, 2007; Satia-Abouta et al., 2002). However, we know little about how dietary governmentality may operate in these families.

The purpose of this paper is to examine the forms of dietary governmentality apparent in the food practices of families from three different ethnocultural groups in Canada – African Nova Scotians (NS), Punjabi British Columbians (BC) and Canadian-born Europeans in Nova Scotia and British Columbia. In particular we ask the questions: What social standards for ‘healthful food practices’ are evident? What modes of regulation are evident? We examine these questions by comparing and contrasting participants’ accounts about how notions of healthy eating are communicated and transmitted between different generations in these families. The accounts, which come primarily from interview data with different family members, supplemented with some observational data, allow us to explore how differing notions of ‘expert knowledges’ may get invoked in diverse ways to govern food choices within families.

4.2. METHODS

Drawing on data collected in a qualitative study of family food decision-making, this paper focuses attention on described interactions between family members of different generations (e.g., parents and children) around the concept of healthy eating. Participants were from three different ethnocultural groups in two regions of Canada: African NS (13

families), Punjabi BC (12 families) and Canadian-born Europeans in NS (10 families) and BC (11 families). European NS and BC participants needed to be born in Canada, but of European heritage, while African NS and Punjabi BC self-identified as such. These groups were chosen for their potential differences in healthy eating perspectives based on ethnocultural background, region and histories of immigration to Canada. Canadians of European heritage represent the views of the dominant culture in both NS and BC, while also allowing us to explore potential differences in food practices between the East and West coasts. African NS and Punjabi BC are among the largest minority groups in the respective locations, with very different histories of migration to Canada – the recent immigration patterns of Punjabi BC primarily since the 1970s contrasted with an African NS presence for several centuries.

Ethical approval was obtained from Research Ethics Boards at both Dalhousie University in Halifax, NS and the University of British Columbia in Vancouver, BC. Participant families were recruited through community-based organizations, community contacts and notices posted in public locations. In total, this paper draws on data from 38 African NS, 39 Punjabi BC, 32 European NS and 35 European BC adult and youth participants. Research assistants belonged to the same ethnocultural group as the families with whom they collected data. This would not necessarily prevent families from putting forward public fronts both in terms of the food they were serving and the kind of family they were presenting themselves to be. For example, some participants made an effort to prepare more ‘special’ meals or have every family member at the table during meal observations. However, using multiple data collection methods with multiple family members may have countered this to some extent.

Data collection consisted of individual interviews with three or more family members aged 13 and older, grocery shopping trip interviews/observations and family meal observations that were carried out in parallel ways in Halifax and in Vancouver. The nature of data collection allowed us to look for similarities and differences in accounts of healthy eating communication and transmission between family members of different generations. We conceptualized transmission of healthy eating knowledge as active construction by participants through their interactions with people and discourses or beliefs about dietary practices they considered 'good' or 'healthful.' Such constructions occur against a backdrop of cultural and familial shared understandings and practices (Schwandt, 1994). Accounts of healthy eating communication and transmission between family members come primarily from the individual interviews, bolstered by the observations made of interactions between family members during grocery trips (where two family members went) and family meals.

Family structures differed among the ethnocultural groups in the study. All of the families of European origin in both NS and BC were 'nuclear' families – 2-generation families consisting of one or two parent(s) and children living in the household. In some of these families, the adults' parents (the elderly generation) were mentioned (e.g., as part of childhood experiences with food), but for the most part did not influence current day-to-day decisions about food in the family. In some African NS (N=4) and Punjabi BC (N=7) families, however, households consisted of extended families, with 3 generations living together. The elderly members, particularly the women, often had significant involvement in daily food activities. Because of the different patterns of family structure, participants' ages in each life-stage differ somewhat between the ethnocultural groups. The 'youth' interviewed in the European NS and BC families ranged between 13 and 23, while there

were somewhat older ‘youth’ living in many Punjabi BC and some African NS families (13 to 29).

Interviews lasted between 45 to 120 minutes, following an interview guide that included questions about how food-related decisions were made in the family as well as how decisions related to culture and health. Interviews and grocery shopping trips were tape-recorded and transcribed verbatim. Fieldnotes were written for the family meal observations. From the transcripts and fieldnotes summary memos about notions of healthy eating were written for each participant. Further analysis followed common strategies in qualitative research including coding, memoing and development of thematic interpretations (Coffey & Atkinson, 1996; Hammersley & Atkinson, 1995). Atlas/Ti software was used to facilitate coding of the data with codes developed during the progression of data collection and analysis. Overarching codes (e.g., ‘family/gender roles,’ ‘child,’ ‘self’) were used in combination with more specific codes about healthy eating (‘sources of info,’ ‘trust in info’ and ‘control/monitor’) to develop the themes in this paper.

4.3. RESULTS

In the broadest sense, our analysis led us to differentiate two groups based on within-family congruence in understandings about healthy eating as part of family food practices. We use the term ‘congruent’⁸ to refer to those families in which there was congruence in the healthy eating standards family members of different generations were referring to (i.e., both parents and youth used definitions and terminology for

⁸ In this chapter, the terms ‘congruent’ and ‘incongruent’ are taken up as heuristic. I do not mean to imply any value judgements about families with or without ‘congruence’ in communication/transmission of healthy eating knowledge. Similarly, the term ‘incongruent’ is not meant to imply unnatural or abnormal way of communicating; on the contrary, I wish to use it as another, legitimate, way of communicating that stands to challenge a taken-for-granted, normalized, one.

understanding healthy eating that drew on similar social standards). ‘Incongruent’ on the other hand, refers to those families in which family members of different generations used definitions and terminology for understanding healthy eating that drew on different social standards (e.g., adults drew on community-derived social standards for understanding healthy eating while youth drew on official dietary guidelines). Congruent families consisted disproportionately of European NS and BC families, while the incongruent families consisted disproportionately of Punjabi BC and African NS families.

In comparing the two groups we can see how dietary guidelines comprise a particular worldview concerning ‘healthy eating’ that marginalizes other understandings of the relationship between food and health. Processes of normalization and marginalization lead to different patterns of transmission of healthy eating in families between groups and construct in particular ways the mother’s role in contributing to the health of her child(ren) as well as the youth’s role in making food decisions for themselves. At the same time, strategies of governmentality are not totalizing; we note and contextualize exceptions (e.g., resistance by participants) to these constructions.

4.3.1. TRANSMITTING HEALTHY EATING KNOWLEDGE IN FAMILIES WITH CONGRUENT GENERATIONAL KNOWLEDGES ABOUT FOOD AND HEALTH

In the congruent families, there was general consensus regarding foods considered healthy by adult participants and their children. Healthy eating was conceptualized via common social standards, both parents and children drawing on shared understandings of current nutritional knowledge. When describing healthy eating, both parents and children referred to messages from official sources such as eating low fat foods, avoiding junk foods and meeting their nutritional needs by eating foods from all four food groups.

Within these families, the role of the mother, in addition to her role as the primary food preparer, included being the family's expert on healthy eating knowledge and the regulator of healthy eating practices. Partners and children acknowledged this role, all mentioning the woman in their household as the first person they would turn to with questions about healthy eating. Many men attributed the healthful eating patterns of their family to their female partners' food provision and decisions: *[Partner]'s kind of designed a diet for us that is really, I think, fairly well balanced in that there's lots of fresh greens, either salad or, you know, vegetables* (European BC father, 56).

The children also considered their mothers to be very knowledgeable about healthy eating and *a constant source of information... about healthy food* (European BC daughter, 19). When asked where he learns about healthy eating, a 14 year old boy said: *Mom encourages me to eat healthy... She encourages me not to snack, to eat three or four proper meals each day and make sure they're both good things* (European BC son, 14). Constructed as experts on the subject, mothers regularly communicated common messages suggested in various dietary guidelines and took on the role of guiding and regulating their children's food choices. For example, in describing her son's food decisions, the 14 year old boy's mother said she *usually suggest[s] in the morning what would be a good thing to put in his wrap*. Similarly, while at the grocery store with her son they both bypassed the snack food aisle because: *I never buy that stuff so it's pointless... We occasionally get popcorn but that's the only thing we'll ever buy there. He knows that stuff is just for once in a while* (European BC mother, 47). The rule about that particular grocery store aisle was in stark contrast to the trip to the produce market where her son was given much more freedom to choose among the fruits and vegetables available. Thus the transmission of

normalizing healthy eating standards occurred through verbal encouragement, concrete meal suggestions, provision of information, and restricting food purchases.

For many families, grocery shopping with the children was an opportunity to train and regulate the food choices children ‘should’ make. Other regulatory techniques included involving children in food tasks. During most family meal observations, children were involved in setting and cleaning the table as well as the preparation of the meal. Younger children were given tasks to do (e.g., chopping vegetables, shredding cheese, layering food in a casserole) while older youth were sometimes responsible for a share or all of the cooking on a given night. Cooking together seemed an ideal opportunity for some mothers to communicate with children about healthy eating. Not only were mothers given a chance to talk about healthy food and teach them how to prepare it, but children were also able to observe how health concerns entered into mothers’ decision-making during meal preparation.

The healthful food provision and communication strategies were employed in an attempt to compensate for outside risks to healthy eating:

We’ve all talked about Trans Fats, you know that sort of controversy... because the influences out there, peers... and the media, they’re just swimming in all of this... [B]asically at home, because we control what they eat in the home, you know they are getting the basics here (European NS mother, 46).

Adolescents were seen as requiring monitoring or intervention: *the kids, the age they are, I know they’re probably not eating right (European BC mother, 42).* This led to mothers feeling a moral responsibility to protect the children’s future health from a potential lack of nutrition due to lifestage-related food practices – eating ‘junk food.’ Some

were also concerned about inadequate nutrient quality of foods consumed: *a lot of the food these days is not as nutritious as it was in the past* (European BC mother, 42). Thus mothers explicitly articulated a discourse in which ‘good mother’ is constructed in part around ensuring the health of children

In order to be able to guide, monitor and educate their children, many mothers also took on the responsibility of translating complicated scientific evidence about the relationship between food and health/disease into food choices for the family:

We try to have at least two meatless meals a week... because of all the research and everything I have been reading about meats... there is a higher cancer rate and everything in North America and it's associated with red meats and high meat consumption. And also where I have girls I have been kind of worried about how much meat they have because they are associating really high protein North American diets with osteoporosis, even though [the girls] are drinking lots of milk ... I am always trying to make sure that they have enough calcium and stuff like that because they're small boned, ... [and] small framed people have a tendency to have osteoporosis (European NS mother, 40).

This mother demonstrates concrete practices of converting expert healthy eating discourses into daily feeding practices.

In general, children responded positively to their mothers’ messages about healthy eating, even though those messages sometimes conflicted with their priorities as adolescents/young adults:

I guess it's good to think about your health a lot... Well I think about it a lot now. It's just – I don't know. I'm a teenager so it's kind of like just not THAT

important right now. But I guess if you eat really bad now then you'll regret it later on (European BC daughter, 14).

Thus they articulated official messages about healthy eating – what you eat now has long-term consequences – though they also resisted or ignored them in practice. Many mothers noticed a gradual acceptance by their children of maternal messages about healthy eating, attributing some of this to the prevalence of similar messages in society:

[I]t's been extremely sort of gradual, little bit by little bit process. You know, when you're young you think you can do anything but... [they are] listening more... [I]n this last year I've noticed that they – maybe they've gotten feedback from the outside world that a lot of people are taking this stuff seriously so then, you know, "Mom's not so way off anymore" (European BC mother, 42).

Governmentality is most effective when the familial 'expert' messages match the extra-familial expert discourses.

The transmission strategies described here – communicating what foods are healthy, monitoring and guiding children's food choices, making concrete scientific information, involving children in food tasks – were less prevalent in African NS and Punjabi BC families, though not absent. One Punjabi BC man (who interestingly was the family healthy eating expert, although the mother was the food preparer) said:

I'm also trying to educate [daughter] at this stage. If parents – you know, we're fortunate that we can read and we've got information as to what's good and what's bad. So I process it. If we instil these things at that sort of age for a child they can start appreciating them (Punjabi BC father, 43).

Healthy eating discourses had played a role in the food decisions of some participants for most of their lives. Many European NS and European BC adults had grown up in families where, as one woman said, *there was always the health awareness. Like, it was always part of our family, you know, watching what you ate and getting enough exercise* (European BC mother, 47). But while attention to healthy eating persisted, the content of messages had changed over time for some participants: *[What] just struck me is that what [mother] fed us when we were kids we thought was healthy then but... our definition of healthy at that time is different from what it is now, right?* (European BC mother, 47). Even though some participants no longer saw the meat, potatoes and vegetables meals they ate as children as particularly healthy, they did suggest that their eating patterns as children were guided in part by understandings of healthy eating that were prevalent at that time. Their current eating patterns were still guided by healthy eating discourses, though the content of those messages had gradually changed over time.

Of note also is that while most mothers in the congruent group strived to convey knowledge about healthy eating to their children in an attempt to ensure their health later in life, not all mothers did this. One European BC woman, in particular, did not consider healthy eating expertise to be among her obligations as a mother. This single mother acknowledged dominant cultural and expert dictates regarding healthy eating, which, as in the rest of the congruent families, were in line with how her three adolescent children defined healthy eating. Yet, she found herself unable or unwilling to practice them in daily routines:

Canada Food Rules... the basic rules about 'one should have a good breakfast, good lunch, good dinner,' and that there should be a certain number of grains, ya da ya da ya da, I accept all of that as being healthy and

balanced... [But] I'm busy and I just am not interested in it...I believe in [it]...

I don't necessarily live it out (European BC mother, 55).

The moral obligations about what 'one should do' with regard to healthy eating were obvious to her as common social standards in Canada. Yet, the modes of regulation of her children's food practices that other mothers in the congruent families undertook were not part of her practice, even though she did assume the role of food provisioner for her children. In the past when the family had eaten together routinely, she had exercised more control over her children's food consumption; when they hit adolescence that became more difficult, with differing schedules and lack of control. Thus, while aware of cultural and expert discourses about healthy eating, this woman refused to participate; she perceived her role as a 'good mother' in other ways – preparing food, spending time with her children and accepting their autonomy as adolescents – that did not centre on her expertise in nutrition.

While this woman did not comply with dietary guidelines, her acceptance of such discourses as 'what one should do' supports the normalization of societal healthy eating messages. As noted by another mother above, the potency of discourses about healthy eating in society meant that such messages were reaching the children without her having to take responsibility as a nutrition expert. She noted that her children occasionally criticized her food choices, based on things they had learned outside the home: *I used to always buy Italian bread... but that Italian bread was white and they felt it should be something much better. So that was a cause of some criticism (laughs). I had to give [it] up.* Again the discourses are congruent, even though here the children are regulating the parent.

In summary, families where parents and children had congruent ways of understanding healthy eating (e.g., drew on the same social standards for healthy eating) generally constructed the role of the mother to include healthy eating expertise. Mothers

expressed a perceived need to be personally responsible for providing skills and knowledge about healthy eating as well guarding children against negative nutritional influences such as the food supply, media and peers. Transmission of healthy eating knowledge occurred through information provision, monitoring in shopping and meal preparation, restricting and guiding food purchases, and directly translating expert knowledges into family food practices. While one woman, refused responsibility for her children's health, dietary messages still reached her children and were incorporated in the family's food practices, confirming the potency of the normalized nature of the techniques of dietary governmentality. For some adults these normalizing standards had meant changes over decades to eating practices they considered in keeping with healthy eating messages. It is important to note that these changes were generally not radical departures from cultural eating patterns they had experienced as children.

4.3.2. TRANSMITTING HEALTHY EATING KNOWLEDGE IN FAMILIES WITH INCONGRUENT GENERATIONAL KNOWLEDGES ABOUT FOOD AND HEALTH

In many African NS and Punjabi BC families and a few European-heritage families there was discrepancy between older and younger generations in how healthy eating was understood as they used different social standards or discourses concerning healthy eating. When asked specifically about healthy eating, some of the older African NS participants acknowledged the official messages circulating in society: *I'm eating the fruit and I'm eating the vegetables... different groups... no fried food, you know like all kinds of junk food, and all that fatty stuff, because all that stuff can clog your arteries up with fat* (African NS grandmother, 59). Official messages about healthy eating were prevalent, participants having heard them, for example, in the media and through medical advice. But in contrast to the 'congruent' families where mothers were the ones passing on this knowledge in the

family, in the ‘incongruent’ families it often entered through the youth. For example, when asked how she knew about the food groups, one woman replied:

Oh, my daughter, she do this healthy eating thing in school once a week. And she brought it up to me, so I just took it from there. I mean I knew about it a long time ago, but I just wasn't paying attention to it. But now she's got to take it in school (African NS mother, 28).

Notions of healthy eating that contradicted or ignored official discourses were incorporated in decisions about family meals. These were described by the older generations as part of the knowledge and skills learned from their mothers and traditional heritage. Meanwhile the younger generations echoed official Western dietary guidelines. This led to somewhat different perceptions of meals between the generations in a family:

My daughter will always say 'Mommy, you're cooking too much. Why are you cooking rice, you're cooking potatoes?... you're doing too many starches.' I said 'Listen, you don't know who's going to come eat at the house' (African NS grandmother, 59).

The discrepancy between this woman and her daughter was in part due to their different conceptualizations of healthy eating. Her daughter believed that eating too much food in general or starch in particular is unhealthy – a message common in European Canadian culture and in official dietary guidelines. Her mother's focus when making food decisions was illustrated by, ‘*you don't know who's going to come eat at the house.*’ This woman was a self-described ‘Big Momma’¹ in her community, known for organizing a food gathering place on Sundays where anyone is welcome after attending church in the morning. The woman and her daughter conceptualized the role of food differently, drawing on differing healthy eating discourses: a ‘nutritional’ discourse rooted in the culture of Western science versus an ‘eating well’ discourse where healthy eating is culturally

understood not in isolation but within broader conceptualizations of food and social relationships. As one African NS man said about healthy eating, *when you come from a loving home, then you see that in food... there is love in the food that you serve, and that's how I grew up* (African NS father, 39).

Such distinctions also reflected differing priorities concerning healthy eating. Educating children to eat in ways that reflected traditional food practices was of paramount importance for many African NS parents: *It is very important for us to teach our kids that 'This is what it's called, this is where this comes from'* (African NS father, 39). For these parents, even certain food choices considered nutritionally unhealthy in scientific discourse needed to persist as they represented an important way of differentiating African NS culture from the dominant culture: *[What I eat] reflects who I am and I'm not changing that for nobody... My mom has Caribbean descent in her. So I like a lot of curry chicken, curry goat, curry ox tail... That's my acquired taste* (African NS father, 39). Several African NS participants explicitly identified mainstream 'healthy eating' as a White way of eating.

Youth also perceived that there are Black ways of eating, identifying similar foods to those named by adults, such as egg washed chicken, boiled dinners, pig tails, cornbread, deep fried foods, and spicy foods. Some indicated that eating in these ways is culturally important and is not something they would readily change. Yet many youth also indicated that what they perceived as traditional African NS food patterns were unhealthy: *Black way [of eating] is we fry all our food. Chicken. We eat like chicken every day mostly, all our meals like meat, most of the time every day – fatty foods* (African NS daughter, 18). In doing so, they drew on dominant nutritional discourses.

Similar patterns were noted in the Punjabi BC families. Regarding the role of food, Punjabi BC parents and grandparents drew more heavily on notions influenced by Indian culture while youth drew on Western notions of healthy eating. Many parents and grandparents believed that eating a roti meal (a typical Punjabi meal comprised of three dishes: flat bread, lentils and a vegetable dish) was important for children's health: *Once a day the children should eat roti... For their health. There is wheat in the roti, there is a lot of nutrition and health in the subjee and dahl* (Punjabi BC grandmother, 69). Traditional notions about food properties as well as the needs and life-stage of children also influenced decision-making about food preparation: *I cook heavy breakfast sometimes...because [the children] run around a lot, so that they get lots of energy...I think that all the foods that are 'heavy' give energy, like almonds, ice cream also gives energy* (Punjabi BC mother, 44). While aware of some of these beliefs about the energetic properties of food, this woman's eldest daughter described healthy eating as: *Making sure you have all the food groups or something at least every day* (Punjabi BC daughter, 15). This young woman's definition was representative of how other Punjabi youth described healthy eating with references to including all the food groups, avoiding junk foods and eating fruits and vegetables. Many did not have much awareness about alternative Punjabi interpretations of healthful foods. Instead, their ideas about healthy eating came primarily from school and the media:

My school class, like the foods classes... We've learned about the vitamins and everything and how like how many servings you should actually eat, and then about obesity and everything. And we watched the movie Supersize Me (Punjabi BC daughter, 15).

Similar to the pattern in some African NS families, to the extent that official healthy eating messages entered the family, they often came through youth. There was little reciprocal transmission of traditional healthy eating knowledge from the older to younger family members through, for example, food preparation at home even though Indian food was prepared most days. In contrast to congruent families, young people in these families were generally uninvolved in food provision tasks, which were the responsibility of the mother or grandmother in the family. During observations, youth were rarely in the kitchen during the preparation of food, except for coming to pick up a plate of food. Adult women described their role in the family as food preparer and nurturer; educating children about healthy eating was not seen as part of that role. Women rarely described situations in interviews where they had spoken to their children about healthy eating or used strategies to involve them in food decision-making.

Mothers and grandmothers, in incongruent families, then, did not employ strategies of conveying healthy eating information, or mentoring healthy meal preparation, nor did they regulate or restrict children's food consumption. In fact, quite often household menus reflected children's preferences for eating Western food as mothers were concerned about having children eat something and not remain hungry:

If we've made dahl or subjee and the kids don't want to eat it, then we make them whatever they want to eat. We don't force the kids to eat the dahl or subjee or challenge them and ask them: 'Why don't you want to eat it?'

(Punjabi BC grandmother, 70).

In turn the children rarely identified their mothers and grandmothers as sources of knowledge about healthy eating. Healthy eating was, instead, conceptualized as learned from school, the media and friends.

As children in these families grow and become more interested in the healthful properties of food, it seemed that the youth's embeddedness in mainstream understandings about healthy eating often stifled attempts for traditional notions about food and health to be transmitted in a reciprocal manner from the older generations in the family to the younger ones. The complexity involved in making healthy eating decisions where incongruence about understanding healthy eating existed in the same family led to perceived lack of credible evidence for the effects of food on health in traditional explanations. For example, one Punjabi BC mother who otherwise used official terminology for the relationship of food and health – such as avoiding junk food, limiting carbohydrate intake and controlling her 'borderline diabetes' – at times also turned to traditional knowledges about healing and healthy eating: *If I've got a headache coming on... I'll usually boil some ginger in the water... I'll have that maybe two nights in a row* (Punjabi BC mother, 52). Alleviating headaches this way was a knowledge learned from her mother via oral communication. It was mentioned by other adults as well:

When I was younger every time I ever had a headache my mom would ask me, "Have you got water in your mouth?" And I would say, "Yes, I have. I feel nauseated. I feel I want to throw up." So she'd do me that ginger soup... that's kind of stayed with me (Punjabi BC mother, 52).

It seems that for this woman knowledge about food and health learned from her mother co-existed with mainstream knowledge. However, the two types of knowledges were in conflict for the younger generation: *The kids, they laugh when I talk about this.* As one of her daughters said, *It's mom who rants and raves about [bai]... I don't really believe it* (Punjabi BC daughter, 25). Many other Punjabi BC youth did not even recognize the term

'bai' when prompted about it, suggesting little family communication about these notions of healthy eating.

Some of the older youth, in particular young women educated in Canada and taking on the role of food provisioning in their families, had developed an appreciation for the taste of traditional foods and their role in cultural continuation. However, they, too, often judged Indian food through lenses of Western dietary guidelines and were critical of traditional foods and preparation methods they deemed unhealthy:

I look back and wish I would have eaten healthier when I was a child... We were eating a lot of fried culturally-specific foods when I was growing up like samosas, pakoras, and all the sweets that were fried (Punjabi BC daughter, 29).

While adults in congruent families were critical of their childhood eating patterns, they acknowledged a health focus was always present. Contemporary healthy eating practices constituted revisions of traditional diet over time. In contrast, in this Punjabi BC family, concepts of healthy eating differed within the same household, and were framed as “culturally-specific” eating versus “healthy eating.”

In summary, adults and youth in the incongruent families drew on different social standards in describing healthy eating such that while adults used ethnocultural perspectives youth and young adults drew on perspectives from the culture of Western science. This incongruence influenced the role of mothers: rather than enacting the techniques of dietary governmentality mothers in the congruent group did, most mothers in this group perceived their roles primarily as making sure their children were satisfied. While healthfulness in food was important, their interpretations of healthfulness drew to a

large extent from traditional knowledges about food where, instead of science-based food decision-making or monitoring/controlling the amount of food children eat, feeding and nurturing children are practices of the 'good' mother. Meanwhile, the younger generations emphasized mainly the nutritional properties of food, tending to devalue traditional knowledge about healthy eating.

4.4. DISCUSSION

Using Foucault's notion of governmentality (1988; 1991), this paper aimed to examine the forms of dietary governmentality apparent in family food practices. To explore the social standards for healthful food practices and modes of regulation that were evident in families from three different ethnocultural groups in Canada, family members' accounts about how notions of healthy eating are communicated and transmitted between different generations in the family were compared and contrasted. The forms of dietary governmentality differed in families where members of different generations held congruent understandings about healthy eating from those in which members held incongruent understandings. One important difference between the two groups was in the perceptions of the role of mothers in communicating and transmitting healthy eating knowledge within the family. In the former, congruent understandings between parents and youth validated the mother's healthy eating knowledge and her role as a healthy eating expert in the family. In the latter, incongruent understandings between parents/grandparents and youth led to devaluation of the mother's healthy eating knowledge. These differences can be considered in light of their relationship to culturally-specific assumptions about what constitutes valid knowledge and what constitutes a 'good mother.'

Communication and transmission of healthy eating understandings between generations relies upon socially-influenced knowledges. The youth from both the congruent and incongruent groups are exposed to similar interpretations about healthy eating in North American culture on a regular basis as official healthy eating messages are regularly normalized in Canada through, for example, food and nutrition classes at school and media advertising. These messages are by and large consistent with the messages parents in the congruent group are receiving – both parents and children were drawing on the same general worldview that translates dietary guidelines largely from scientific knowledge about nutritional properties of food. While healthy eating messages in Western societies do change over time – as noted in the adults’ differentiation from the healthy eating interpretations of their parents in our study as well as in generational accounts of health in other studies (Charles & Walters, 1998) – these changes are subtle and require a long period of time to evolve. The ways these parents and their children conceptualized healthy eating, therefore, were consistent with each other and with how healthy eating is officially conceptualized in Canada. It is this consistency that illustrates how this group’s conduct is regulated by (Western dietary) governmentality (Hindess, 1996).

In contrast, the healthy eating knowledges of the older generations in the incongruent group were often in discord with those of the youth. For the older generations in this group there was an ambivalent relationship to official healthy eating messages. While some recognized the normative status of these messages in society, their primary sources of healthy eating knowledge came from lived experiences and learned stories specific to their ethnic heritage (Banks-Wallace, 2002; Turton, 1997). Ways of knowing about food that were intertwined with culturally-specific histories meant decisions about healthy eating were experienced, explained and responded to in ways different than current dietary

guidelines, though no less meaningful. The youth, on the other hand, were more familiar with knowledge about healthy eating that is legitimized through a scientific rationale. The differences in healthy eating conceptualizations between the traditional knowledge of the older generations and the science-based knowledge of the younger generations represent, therefore, not only subtle generational differences, but also worldviews that are distinctive beyond language or cultural differences (Nayar, 2004). They represent worldviews in which dietary governmentality is normalized in different forms. Such intergenerational differences where family members draw on different thought forms have been noted for general communication patterns in immigrant families (Nayar, 2004), as well as for more specific dietetic knowledge (Yuhua, 2000).

Operating within a particular cultural way of acquiring and validating knowledge, dietary governmentality has potent effects for shaping the role of mother as the healthy eating expert in the family. The ways in which Western dietary guidelines are translated into advice and techniques for dietary practices of individuals and families illustrate how they can act as normalizing standards in the family for healthy eating and being a good mother – especially when they fit well with ethnocultural food practices (Coveney, 2000; Holmes & Gastaldo, 2002). The family context of the congruent families provided a site where such standards, in addition to already present food provision responsibilities, normalized healthy eating expertise responsibilities for mothers. The plethora of messages that mothers in these families voluntarily learned and supplied to the family reinforced messages children were hearing elsewhere. Mothers' healthy eating knowledge was, thus, validated through its corroboration with dietary advice from other sources. As such, mothers were in the midst of and contributing to the capillary-like spread of governmentality (Foucault, 1980) – at the same time being governed by outside dietary

experts, and, constructed as healthy eating experts by family members, governing and further normalizing acceptable dietary practices within the family.

One corollary of such standards is that normalization of healthy eating practices depends not only on the regulation of individuals by others, but also on individuals' own regulation of themselves (Foucault, 1988). Mothers in the congruent families placed the responsibility for their children's health less on outside influences such as the education system or the environment, than on themselves as knowledgeable and responsible mothers. Expert knowledges define the skills and attributes mothers should have in order to conduct themselves in proper manner (Hindess, 1996) –to practice and promote healthful eating in the family (Coveney, 1998; 2000). Through compliant behaviour, mothers further normalized such conduct (Hindess, 1996). Good families should eat nutritious meals together 'like a family' (Backett, 1992; Coveney, 2000), while good mothers should care for their children's health by providing healthy food, learning and then educating about healthy eating, monitoring what is eaten, guiding and protecting their children from the influences outside the family.

The need to guide and protect their children's health reflects current views in health behaviour research where dietary choice of youth is primarily examined as a problematic rather than part of natural life-stage progression. Lack of parental dietary guidance is considered a risk factor for adolescents' food intake (Kremers et al., 2003; Videon & Manning, 2003) despite evidence that adolescents do engage in complex food decision-making on their own (Chapman & Maclean, 1993; Contento et al., 2006), that those given autonomy in food choice are no more likely to have poor consumption patterns than those without autonomy, and that parental presence at home does not always influence food

consumption (Videon & Manning, 2003). Part of this discrepancy lies in the expectations that parents will unidirectionally 'influence' rather than enter 'negotiations' about food with their children (Bassett et al., 2007; Eldridge & Murcott, 2000) and the lack of consideration of the larger contexts within which adolescents are situated to make decisions (Backett-Milburn et al., 2006). Through the lens of expert knowledge in dietary governmentality, therefore, mothers in the congruent group observed their children as being in constant need of dietary shaping. One mother resisted shaping both her own and her children's food practices. She and another mother attributed as much (if not more) power in the shaping of food practices to societal influences as to their own ability to regulate their children's food choices. Perhaps as a sign of resistance to governmentality (Hindess, 1996), these two mothers, as well as the incongruent families, bring into question a form of dietary governmentality which places so much responsibility on mothers for moulding their children into healthy eaters.

While strongly believing in traditional understandings about healthy eating, communication about these views by older generations to youth was rarely noted in the incongruent families. Though concerned about their children's health, these mothers did not think that they needed to shape or regulate their children's food habits in the same way that mothers in the congruent families did. Under these social standards, food was not viewed as a negative thing from which children should be protected but a positive, health-giving one. Women were thus less restrictive about what their children wanted to eat, seeing their role as mothers as nurturing the (healthy) growth of children. This view illustrates how motherhood, including the role in healthy eating communication and transmission, can be constructed differently within different social, cultural, historical, political and economic contexts (Jenkins, 1998; Tardy, 2000).

The way of acquiring and validating knowledge reflected in dietary governmentality, however, influenced communication and transmission of healthy eating in the incongruent group in such a way that the knowledge mothers possessed was devalued in the family. Dietary techniques for communicating healthy eating knowledge deemed as appropriate and necessary by mothers in the congruent group were not employed by these women. Instead, there seemed to be an assumption that transmission would just happen, perhaps as it always had previously in their everyday experiences, through natural and gradual processes. The social standards for being a mother who safeguards the health of her children was not something learned via expert nutritional knowledge; rather it relied on knowledge to be learned locally from family and community observations, responsibilities, practices and orientations (Jenkins, 1998; Nayar, 2004).

Among the younger generations, however, there seemed to be a lack of reflexive awareness about the meaning and healthfulness of foods from their traditional backgrounds. As youth gained more knowledge about ways of healthy eating via different social standards from extrafamilial sources, their mothers and grandmothers became viewed as less knowledgeable in matters of healthy eating. Adults could not provide adequate explanations to their children/grandchildren for why certain traditional foods or ways of eating are healthy because youth raised in Western culture expect knowledge arrived at through a scientific rationale. In this way, the new techniques of dietary governmentality about healthy eating learned outside the family replaced and/or marginalized the already-present traditional ways of knowing in the family.

In conclusion, our study illustrated how healthy eating can be viewed as a dynamic concept both between groups and between generations of each group reflecting societal and culturally-influenced worldviews about food and health. Acknowledging its dynamic

nature brings into question current techniques of dietary governmentality in Canada that place on parents, especially mothers, a moral responsibility for the nutrition and well-being of their children and disregard how food reflects larger societal, historically and culturally-influenced conditions.

4.5. NOTES

¹ As in the movie *Soul Food* (1997), Big Mommas are well-respected women in the African community known for cooking 'Soul Foods' for Sunday gatherings after church.

4.6. REFERENCES

Backett, K. (1992). Taboos and excesses: Lay health moralities in middle class families.

Sociology of Health & Illness, 14, 255-74.

Backett-Milburn, K.C., Wills, W.J., Gregory, S. and Lawton, J. (2006). Making sense of eating, weight and risk in the early teenage years: Views and concerns of parents in poorer socio-economic circumstances. *Social Science and Medicine*, 63, 624-635.

Banks-Wallace, J. (2002). Talk that talk: Story-telling and analysis rooted in African American oral tradition. *Qualitative Health Research*, 12, 410-26.

Bassett, R., Chapman, G.E. and Beagan, B.L. (2007). Autonomy and control: The co-construction of adolescent food choice, *Appetite*, doi:10.1016/j.appet.2007.08.009.

Bell, D., & Valentine, G. (1997). *Consuming Geographies: We are Where we Eat*.

London: Routledge.

Bradby, H. (1997). Health, eating and heart attacks: Glaswegian Punjabi women's thinking about everyday food. In P. Caplan (Ed.), *Food, Health and Identity*, (pp.213-233).

London: Routledge.

Chapman, G., & MacLean, H. (1993). Junk food and healthy food: Meanings of food in adolescent women's culture. *Journal of Nutrition Education*, 25, 108-13.

Charles, N., & Kerr, M. (1988). *Women, Food and Families*. Manchester: Manchester University Press.

Charles, N., & Walters, V. (1998). Age and gender in women's accounts of their health: Interviews with women in South Wales. *Sociology of Health & Illness*, 20, 331-50.

Coffey, A., & Atkinson, P. (1996). *Making Sense of Qualitative Data: Complimentary Research Strategies*. London: SAGE Publications.

- Contento, I.R., Williams, S.S., Michela, J.L., & Franklin, A.B. (2006). Understanding the food choice process of adolescents in the context of family and friends. *Appetite*, 38, 575-82.
- Coveney, J. (1998). The government and ethics of health promotion: The importance of Michel Foucault. *Health Education Research: Theory and Practice*, 13, 459-68.
- Coveney, J. (1999). The science and spirituality of nutrition. *Critical Public Health*, 9, 23-37.
- Coveney, J. (2000). *Food, Morals and Meaning: The Pleasure and Anxiety of Eating*. London: Routledge.
- Dyck, I. (2006). Travelling tales and migratory meanings: South Asian migrant women talk of place, health and healing. *Social & Cultural Geography*, 7, 1-18.
- Dyck, I. & Dossa, P. (2007). Place, health and home: Gender and migration in the constitution of healthy space. *Health & Place*, 13, 691-701.
- Eldridge, J. & Murcott, A. (2000). Adolescents' dietary habits and attitudes: Unpacking the 'problem of (parental) influence,' *Health*, 4, 25-49.
- Foucault, M. (1980). Two lectures. In C. Gordon (Ed.), *Power/Knowledge: Selected Interviews & Other Writings, 1972-1977*, (pp. 78-108). New York: Pantheon Books.
- Foucault, M. (1988). Technologies of the self. In L.H. Martin, H. Gutman, & P.H. Hutton (Eds.), *Technologies of the Self: A Seminar with Michel Foucault* (pp. 16-49). Amherst: University of Massachusetts Press.
- Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault Effect: Studies in Governmentality with Two Lectures by and an Interview with Michel Foucault*, (pp.87-104). Chicago: University of Chicago Press.

- Fulkerson, J.A., Neumark-Sztainer, D. & Story, M. (2006). Adolescent and parent views of family meals. *Journal of the American Dietetic Association*, 106, 526-32.
- Gastaldo, D. (1997). Is health education good for you? Re-thinking health education through the concept of bio-power. In A. Petersen, & R. Bunton (Eds.), *Foucault, Health and Medicine*, (pp. 113-33). London: Routledge.
- Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in Practice*, 2nd Edition. London: Routledge.
- Health Canada. (2007). Food and Nutrition.
http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html, accessed January 31st, 2007.
- Hindess, B. (1996). *Discourses of Power: From Hobbes to Foucault*. Oxford: Blackwell Publishers Ltd.
- Holmes, D., & Gastaldo, D. (2002). Nursing as a means of governmentality. *Journal of Advanced Nursing*, 38, 557-65.
- Jenkins, N.L. (1998). Black women and the meaning of motherhood. In S. Abbey, & A. O'Reilly (Eds.), *Redefining Motherhood: Changing Identities and Patterns*, (pp. 201-13). Toronto: Second Story Press.
- Keane, A. (1997). Too hard to swallow? The palatability of healthy eating advice. In Caplan, P (Ed.), *Food, Health and Identity*, (pp. 172-192). London: Routledge.
- Kremers, S.P.J., Brug, J., de Vries, H., & Engels, R.C.M.E. (2003). Parenting style and adolescent fruit consumption. *Appetite*, 41, 43-50.
- Lupton, D. (1995). *The Imperative of Health: Public Health and the Regulated Body*. London: SAGE Publications.
- Lupton, D. (1996). *Food, the Body and the Self*. London: SAGE Publications.

- Lupton, D. (1999). *Risk*. London: Routledge.
- Nayar, K.E. (2004). *The Sikh Diaspora in Vancouver: Three Generations amid Tradition, Modernity, and Multiculturalism*. Toronto: University of Toronto Press.
- Nettleton, S. (1991). Wisdom, diligence and teeth: Discursive practices and the creation of mothers. *Sociology of Health & Illness*, 13, 98-111.
- Neumark-Sztainer, D., Story, M., Ackard, D., Moe, J., & Perry, C. (2000). Family meals among adolescents: Findings from a pilot study. *Journal of Nutrition Education*, 32, 335-40.
- Satia-Abouta, J., Patterson, R.E., Neuhouser, M.L. and Elder, J. (2002). Dietary acculturation: Applications to nutrition research and dietetics. *Journal of the American Dietetic Association*, 102, 1105-1118.
- Schwandt, T.A. (1994). Constructivist, interpretivist approaches to human inquiry. In N.K. Denzin, & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research*, (pp. 118-37). Thousand Oaks: Sage Publications.
- Stein, R.I., & Nemeroff, C.J. (1995). Moral overtones of food: Judgments of others based on what they eat. *Personality and Social Psychology Bulletin*, 21, 480-90.
- Tardy, R.W. (2000). "But I am a good mom": The social construction of motherhood through health-care conversations. *Journal of Contemporary Ethnography*, 29, 433-73.
- Turton, C.L.R. (1997). Ways of knowing about health: An Aboriginal perspective. *Advances in Nursing Science*, 19, 28-36.
- Videon, T.M., & Manning, C.K. (2003). Influences on adolescent eating patterns: The importance of family meals. *Journal of Adolescent Health*, 32, 365-73.

Yuhua, G. (2000). Family relations: The generation gap at the table. In J. Jing (Ed.), *Feeding China's Little Emperors: Food, Children, and Social Change*, (pp. 94-113). Stanford: Stanford University Press.

WHO/FAO. (2003). Technical Report Series 916. Diet, Nutrition and the Prevention of Chronic Diseases.

http://www.who.int/hpr/NPH/docs/who_fao_expert_report.pdf, accessed August 27th, 2007.

CHAPTER 5. DISCUSSION AND CONCLUSIONS

5.1. DISCUSSION and IMPLICATIONS

The findings of this study contribute to a topic that is of considerable academic and public interest today. There is a growing concern about the health of the population and the consequences an unhealthy diet and lack of physical activity can bring (WHO, 2004; WHO/FAO, 2003). Because of this, discussion about healthy eating seems to occur at various levels in society beginning with the individual in their everyday life to the collective such as the media and governmental organizations. Even so, while most people in Western societies have a basic knowledge about healthy eating (Keane & Willetts, 1996; Paquette, 2005), their further interpretations seem to be somewhat ambiguous, unclear, and diverse (Chapman & Beagan, 2003; Falk et al., 2001; Keane & Willetts, 1996; Povey et al., 1998) and their practices below health professionals' expectations (British Columbia Nutrition Survey, 2004; Dixon et al., 2001; Jacobs Starkey et al., 2001; Statistics Canada, 2005). The reasons for this divide acted as a premise for this study which attempted to address the paucity of knowledge about how people engage with socially constructed notions regarding food and health to make sense of healthy eating by focusing attention to questions loosely organized around how people access, process and use healthy eating discourses.

In particular, the purpose of this study was to explore the ways in which people of three different ethnocultural backgrounds in two locations in Canada – African NS, European NS, Punjabi BC and European BC – engage with food structures in the context of broader societal and cultural norms about conduct. As described in chapter 1, food structures refer to the range of food and health rules and resources people draw on and use

in the course of their daily food decision-making. The rationale for using perspectives from social theory was developed more fully in the previous chapters; briefly here, perspectives from social theory were used as guides for interpretation in examining questions of *how* participants interacted with food structures in the construction of everyday healthy eating perceptions and practices. Two perspectives in particular that guided the interpretation of data in this study were Giddens' work on the duality of structure (Giddens, 1984) and Foucault's work on governmentality (Foucault, 1988; Foucault, 1991) – as they both relate to the debate of whether it is structure (determinants) or agency (of individuals) that most contribute to healthy eating perceptions and practices.

The study findings were presented in three manuscript-style chapters. Each of the chapters explored how study participants engaged with various forms of food structures in different contexts, such as in: constructing notions of eating well, place and community; forming meaningful interpretations and practices about food and health by drawing on contextualized healthy eating knowledges; and normalizing particular family food practices and family members' roles through communication and transmission of healthy eating knowledge between family members of different generations. The analyses in these chapters showed that beyond common food considerations – such as food preferences, cost, and socio-demographic differences – participants presented varying ways of interacting with food structures when making decisions about food. Taking Giddens' view (1984), the food values, norms and practices were not the result of agency on the part of individuals nor were they determined solely by food discourses and resources surrounding them. They were the result of the reciprocal interaction between the two where food structures both enabled and constrained certain food practices but where participants also participated by producing new or reproducing already established food values and norms.

That the way participants interacted with food structures was different by groups – in this case both by place and ethnic culture – suggests that how people ‘choose’ to interact with food structures is at least socially, culturally and/or historically structured. Each of the four groups had a particular way of drawing on, interacting and using food-related rules and resources to inform their everyday food decisions. Drawing on Foucault’s historical analyses of ‘technologies of the self’ – where he showed that people’s practices on themselves are socially and historically contingent (Foucault, 1988; McNay, 1994) – the group differences can be interpreted as embodied forms of socially and historically contingent knowledge(s) about how people should behave with respect to healthy eating within the context of their everyday lives.

Taken together, these analyses suggest that the disconnect between healthy eating messages and people’s eating practices may not be, as previously assumed, remedied by further tweaking of the educational healthy eating messages or the processes by which the messages are communicated. Instead, these analyses suggest that *expectations for healthy eating behaviour change must reflect more broadly on the complex ways in which healthy eating conceptualizations are shaped in society, including how they become part of people’s everyday life*. Focusing on healthy eating solely as a scientific goal to be achieved by individuals (e.g., to have statistically healthy eating habits through intakes such as 5-10 fruits and vegetables a day), without taking into consideration how people’s practices reflect larger social and cultural norms and values about conduct – in which people themselves participate – may not result in meaningful outcomes. Some of the analysis in this study showed how decisions in about food in the family are imbued with social and cultural meanings about the different roles of family members for providing food, nurture

and health of the family. Therefore, considerations from the health professionals' perspectives must extend beyond interventions that provide strategies for making healthier food choices such as how to influence family members to eat certain foods, tips about minimizing cost, how to make grocery lists, what is a serving/portion size, or advice on making family meals a positive atmosphere. Health professionals must examine more holistically the larger societal and historically-dependent ways in which individuals, families and social groups behave with respect to food and health, as well as acknowledge how food-related advice and actions relate to broader sociological and philosophical questions about the nature of a good, healthy, and meaningful life.

Current official healthy eating messages, therefore, may need to be positioned in the larger historical and social context of everyday food experiences where forms of knowledge in addition to dietary guidelines are recognized. Throughout this study, an argument was put forward that in contemporary Western societies, nutritional science is central to the ways that people understand the relationship between food and health. Prominent discourses in health promotion and nutrition education focus on encouraging people (as free-willed individuals) to self-regulate themselves through continuous monitoring of their food intakes and, consequently, influence the course of risk factors for ill health (Castel, 1991; Petersen, 1996; Petersen, 1997). Coveney (1998, 2000) argues that through surveillance, normalization and categorization of experiences, health promotion and nutrition education function as a:

*form of government which is **productive** in the sense that it **produces** modern subjects: it defines empirically what it **is** to be healthy (in ever expanding ways) and it 'supervises' the proper routes to health through a*

*discipline which establishes for us a **rapport de soi**, or 'ethics' (Coveney, 1998; emphasis in original).*

People, in turn, are expected to learn and enact food and health messages by incorporating them into the practicalities of everyday food practices (Coveney, 2000; Petersen, 1996).

We are beginning to uncover and reflect on the ways in which these knowledges, as part of broader goals in health, have developed in Western society. Coveney (2000), for example, has shown how the development and progress of the discipline of nutrition has been dependent on a number of earlier contingencies – such as religion and the Enlightenment philosophy – and has led to certain ways of understanding food (Coveney, 1999; Coveney, 2000). While developments in scientific understandings of food have contributed immensely to the health of populations, they have also produced ‘technologies of the self’ through which people have redefined for themselves what it means to be ‘good’ (to make ‘good’ food choices for self and for the family). Being ‘good’ through food has come to mean making scientifically rational food choices. Coveney proposes that, in this way:

nutrition continued a moral problematisation which has been part of Western culture since antiquity in which eating cannot be justified by pleasure alone. Pleasure around food is either to be mastered and moderated as it was for the ancient Greeks, or effaced as it was for the early Christians, or rationalized in relation to scientific principles and moral reason as it is for modern subjects of nutrition” (Coveney, 2000:109).

Social and historical contingencies have, thus, aided in the view of eating as a reasoned or intellectual activity; one that emphasizes restraint and notions of sin rather than perhaps a

sensuous or aesthetic one that emphasizes moderation in conduct as it was considered in Greek antiquity. Viewed in this light, the way food is viewed in contemporary Western societies represents one possibility for the way people's relationship with food might have evolved. Under different circumstances, other societies have developed and utilized other complex ways to explain health and illness. Some of these, as shown in the literature (Airhihenbuwa, 1995; Jovchelovitch & Gervais, 1999), include knowledges that have a more integrated view of the relationships between individuals and their food environment.

In a historical perspective, therefore, while everyday decisions about food are individual acts, they are reflective of people's interactions with societal norms about modes of conduct situated in particular times and contexts (Brandt & Rozin, 1997; Coveney, 2000; Rosen, 1993; Rotberg, 2000). The healthy eating perceptions and practices of each of the four groups in this study reflected societal and culturally-influenced worldviews about food and health. While some discourses used by participants were distinctive from official guidelines, they were no less legitimate ways to conceptualize and assess the meaning and role of healthy eating in the context of daily decisions about food. By sharing the different perceptions and practices, participants illustrated the changing nature of healthy eating as it evolves both between as well as within groups that were differentiated based on place and ethnocultural background. This changing nature underlines the importance of people's interaction with food structures.

Participants' interactions with food structures also showed the fluid nature of healthy eating perceptions. Through combining different discourses, participants showed how different/contradictory accounts about the relationship between food and health can merge and/or co-exist (Coveney, 2005; Jovchelovitch & Gervais, 1999). Such amalgamation of various discourses can allow for the construction of more meaningful

conceptualizations of healthy eating that move beyond the focus of a person's physiological health (Sointu, 2006) or individual responsibility (Petersen, 1997). Analyses of conceptualizations of healthy eating that differ from official guidelines, thus, offer opportunities not only for appreciating diversity but also for contextualizing current understandings of healthy eating.

In this way, nutritional knowledge can be seen in the larger context of influences that contribute to 'well-being' beyond the physical and nutritional health. Findings that certain ethnic groups with high risk factors (low socioeconomic status and educational achievements) have more positive health outcomes (e.g., lower mortality) than expected point out that there may be more complex relationships between culture, behaviour and health (Hayes-Bautista, 2003) than just nutritionally-good diets. These findings suggest the need for an engagement of different kinds of knowledges (e.g., scientific, local and situated) about food, culture, roles, and other everyday practices relating to food that will creatively contribute to health and well-being. Lay knowledges have a logic and rationality that can play an important role in these engagements, so it is important that we understand the social origins of their sense-making and the role they play in structuring worldviews (Coveney, 2005). Bottorff, Johnson, Venables et al., (2001), for example, have noted that the ways immigrant South Asian women express health concerns reflect broader cultural notions about being a woman and a sense of belonging to a cultural group. Dialogues between discourses are needed where different forms of knowledge interact to realize the optimal paths to health and well-being of the society as healthy eating is as much about the everyday as it is about the scientific.

In fact, Buchanan (2006) argues that health educators need to begin to work from an *ethical* rather than a *scientific rationality*. Recognizing that health and nutrition

messages involve moral and ethical expectations about proper behaviour (Backett, 1992; Buchanan, 2006; Stein & Nemeroff, 1995) can have major implications for thinking about the goals and methods of health education:

“We have largely lost the site that telling people how we think they ought to live is a moral and political process, not a scientific problem to be solved... [We need to] describe a philosophy of education that might be more well suited for engaging the public in examining the way we live and how we, individually and collectively, might choose to change it” (Buchanan, 2006:291).

He proposes that health educators should continue to act as disseminators of factual information and facilitators of rational choice, but:

“[R]ather than expecting people to change their behavior based on this information (or feeling frustrated when they do not), the more interesting challenge for the field would be to help people make critical judgments about their priorities, the steps they want to take in pursuing their life plans, the place of “good” health habits in their vision of the kind of person they want to be, and the kind of society they want to live in” (Buchanan, 2006:301).

With this kind of thinking (i.e., rationality), the goals for changing human behaviour can not be examined in isolation as nutritional goals for the population and without taking into account how these goals impinge on the lives that people want to lead, the values and norms they want to produce or reproduce, and the roles they need and aspire to play in these events. Rather than assessing people’s practices based on *instrumental rationality* (e.g., having a goal that all people will be healthy, have a BMI in the ‘normal’ range, etc), there needs to be an involvement of *collective rationality* (gaining mutual/collective

understanding and agreement about the norms of “healthy” eating) to think more broadly and increase human autonomy about what values and priorities are important for people in living a ‘good’ and ‘healthy’ life (Buchanan, 2006). Health educators would, thus, need to remain open about the nature of important issues in people’s lives on which they are focusing their attention. Fulfilling familial and cultural obligations or achieving harmonious relationships may be given priority or defined as healthier than the achievement of certain healthy eating practices (Backett, 1992). For example, being a mother who nurtures may be more important to some women than being a mother who examines whether her children are eating ‘properly.’ Health educators, therefore, need to enter a dialogue with people about conceptualizing the kind of healthy life people want to lead. As Beck-Gernsheim (2000) wrote – as part of a response to the risk society some describe the we live in – there needs to be a dialogue about the vision of health we are going to pursue and the steps we are going to take to get there, while reflecting about how our steps might be enabling or constraining certain life practices. She wrote that we need to address:

*“What concept of health and what concept of responsibility are we talking about when it comes to this step [e.g., healthy eating]? Which step implied in the general promise of health is helpful and humane, which step will bring growing control and coercion, of whom and by whom? With the implementation of this step, who will carry what kind of responsibility; which burdens will be eased; which conflicts might arise here; and whose interests are at stake? Seen like this, the question is not whether or not we want health and responsibility. Rather, the question is, or could be: **What kind of health,***

what kind of responsibility do we want?" (Beck-Gernsheim, 2000:133; emphasis in original).

5.2. STRENGTHS, LIMITATIONS and SUGGESTIONS FOR FUTURE RESEARCH

This study suffered from methodological limitations that commonly occur in qualitative research (Marshall & Rossman, 1989; Maxwell, 1996; Rossman & Rallis, 1998). Practical/logistic measures that might be considered as strength can, at the same time, provided a limitation for the study. One such measure includes having different research assistants collect data with families of their own ethnocultural background in their place of residence which can, on one hand, be considered an ‘insider’ benefit to the study. These research assistants were able to locate themselves both as part of the academic and participating communities, thus mediating the process of research. They were able to recruit participants more easily within their community and, when necessary, translate documents and interviews. On the other hand, having different people collect data may contribute to inconsistency in how interviews flowed. Being aware of these challenges, every effort was made to reduce the inconsistencies through interview training of research assistants, using the same guide during interviews, as well as meeting regularly as a team to discuss emerging issues.

Another logistic measure includes the strategic sampling for families where a core woman of certain age needed to be present. While this provided a strength (e.g., to be able to compare the food roles and habits of women of similar characteristics across groups and/or with women of similar characteristics in the literature), it also limited opportunities for similar male participation and comparison. Of note is that male participation may also

have been limited due to a gendered lack of interest to participate in food-related studies. This is a challenge that will need to be addressed in sampling considerations in future research.

Because of the size of the overall study, other common challenges in qualitative research were circumvented. One such challenge was the sample size, which was sufficient enough to compare across the different groups of families. In addition, this study was able to clearly delineate not only between different socio-demographic groups within the dominant culture (participants of European background) and in the same place as has commonly been done in previous research, but also between groups from different ethnocultural background and in two different locations in Canada. While such delineation provided an important step in understanding the socio-cultural and, to an extent, historical differences in healthy eating interpretations between these groups, grounds for future research are plenty; future research will need to consider similar comparisons with other social groups, as well as the socioeconomic differences within those groups, and in other places within Canada. Many questions remain for influences of social groups other than those examined in this study: how would other ethnocultural groups in Canada relate to these findings? What do their healthy eating interpretations draw on? How would socioeconomic differences complicate healthy eating issues in these families? Seeing that different family structures were evident in the social groups of this study, how would this compare to other social groups living in Canada? How would different family structures in the dominant culture influence interpretations? Similarly, many questions remain for the influence of place: How does the size of a place, and the resources available in a place, influence healthy eating knowledge? How do different places influence a sense of

community and membership? What exactly is the nature of the rural-urban divide with regard to healthy eating?

Overall, some of the major conceptual and methodological strengths of this study were that it addressed some of the emerging questions in the literature about the ways in which participants interacted with food structures (Raine, 2005). It focused sociologically and qualitatively on how participants and various food structures interacted in naturalistic, everyday settings where they either produced new or reproduced established norms and values with regard to healthy eating (Power, 2005). Furthermore, it addressed the lack of research that ignores the characteristics of people who have or who are immigrating to Canada – individuals who may not speak English, come from very different educational, religious, ethnic and/or cultural backgrounds – by focusing on participants of different ethnocultural background and the varying worldviews they may draw on. By situating these examinations in the family context, the study allowed for food choice to be seen as a more complex process than is assumed in the worldview(s) of those working within individual responsibility/behaviour change discourses.

5.3. CONCLUSIONS

The findings from this study will contribute to the development of future health-related efforts by increasing our understanding of some of the multi-layered factors that influence people's decisions about food and healthy eating, as well as revealing some of the ways in which health and nutrition concepts are constructed through interactions between broader social discourses and people in their everyday lives. The findings highlight that improvements in healthy eating behaviour may not be reached with

‘education’ – that is educating people about the nutritional benefits or risks present in the food they eat. Rather, improvements may require recognition that the ways people view the relationship between food and health are the result of the different social and cultural worldviews in which they are situated and that influence their perceptions and practices. In a dialogue about what constitutes healthy eating, knowledge about nutritional health must be broadened to acknowledge its impact on visions of health and well-being in the everyday experience. In other words, as much as scientific explanations about nutrition need to be celebrated for their contributions to the health of people in society, there also needs to be a reflection about how/in what ways these contributions are currently shaping people’s conduct, obligations about appropriate social behaviour, and visions of health and well-being.

5.4. REFERENCES

- Airhihenbuwa, C. O. (1995). *Health and Culture: Beyond the Western paradigm*. London: SAGE Publications.
- Backett, K. (1992). Taboos and excesses: Lay health moralities in middle class families. *Sociology of Health & Illness*, 14, 255-274.
- Beck-Gernsheim, W. (2000). Health and responsibility. In B. Adam, U. Beck & J. Van Loon (Eds.), *The Risk Society and Beyond: Critical Issues for Social Theory*, (pp. 122-135). London: SAGE Publications Ltd.
- Bottorff, J. L., Johnson, J. L., Venables, L. J., Grewal, S., Popatia, N., et al. (2001). Voices of immigrant South Asian women: Expressions of health concerns. *Journal of Health Care for the Poor and Underserved*, 12, 392-403.
- Brandt, A.M., & Rozin, P. (Eds.) (1997). *Morality and Health*. New York: Routledge.
- British Columbia Nutrition Survey. (2004). Report on food group use. BC Ministry of Health Services.
- Buchanan, D.R. (2006). A new ethic for health promotion: Reflections on a philosophy of health education for the 21st Century. *Health Education & Behavior*, 33, 290-304.
- Castel, R. (1991). From dangerousness to risk. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault effect: Studies in governmentality*, (pp. 281-289). Chicago: Chicago University Press.
- Chapman, G.E., & Beagan, B. (2003). Women's orientations to nutrition, health, and disease. *Journal of Nutrition Education and Behavior*, 35, 135-141.
- Coveney, J. (1998). The government and ethics of health promotion: The importance of Michel Foucault. *Health Education Research: Theory & Practice*, 13, 459-468.

- Coveney, J. (1999). The science and spirituality of nutrition, *Critical Public Health*, 9, 23-37.
- Coveney, J. (2000). *Food, Morals and Meaning: The Pleasure and Anxiety of Eating*. London: Routledge.
- Dixon, L.B., Cronin, F.J., & Kebs-Smith, S.M. (2001). Let the pyramid guide your food choices: Capturing the total diet concept. *Journal of Nutrition*, 131, 461-472.
- Falk, L.W., Sobal, J., Bisogni, C.A., Connors, M., & Devine, C.M. (2001). Managing healthy eating: Definitions, classifications, and strategies. *Health Education & Behavior*, 28, 425-439.
- Foucault, M. (1988). Technologies of the self. In L.H. Martin, H. Gutman, & P.H. Hutton, (Eds.), *Technologies of the Self: A Seminar with Michel Foucault*, (pp. 16-49). Amherst: University of Massachusetts Press.
- Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon & P. Miller. (Eds.), *The Foucault effect: Studies in governmentality with two lectures by and an interview with Michel Foucault*, (pp.87-104). Chicago: University of Chicago Press.
- Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. Berkley: University of California Press.
- Jacobs Starkey, L., Johnson-Down, L., & Gray-Donald, K. (2001). Food habits of Canadians: Comparison of intakes in adults and adolescents to Canada's Food Guide to Healthy Eating. *Canadian Journal of Dietetic Practice and Research*, 62, 61-34.
- Jovchelovitch, S., & Gervais, M-C. (1999). Social representations of health and illness: The case of the Chinese community in England. *Journal of Community & Applied Social Psychology*, 9, 247-260.

- Keane, A., & Willetts, A. (1996). *Concepts of Healthy Eating: An Anthropological Investigation in South-East London*. London: Goldsmith College.
- Marshall, C., & Rossman, G.B. (1989). *Designing Qualitative Research*. Newbury Park: Sage Publications.
- Maxwell, J.A. (1996). *Qualitative Research Design: An Interactive Approach*. Thousand Oaks: Sage Publications.
- McNay, L. (1994). *Foucault: A Critical Introduction*. Cambridge: Polity Press.
- Moscovici, S. (2001). The phenomenon of social representations. In G. Duveen. (Ed.), *Social Representations: Explorations in Social Psychology* (pp. 18-77). New York: New York University Press.
- Paquette, M-C. (2005). Perceptions of healthy eating: State of knowledge and research gaps. *Canadian Journal of Public Health, 96*, S15-S19.
- Petersen, A. (1997). The new morality: Public health and personal conduct. In C. O'Farrell (Ed.), *Foucault: The Legacy*, (pp. 696-706). Brisbane, AU: Queensland University of Technology.
- Petersen, A. R. (1996). Risk and the regulated self: The discourse of health promotion as politics of uncertainty. *Australian & New Zealand Journal of Statistics, 32*, 44-57.
- Povey, R., Conner, M., Sparks, P., James, R., & Shepherd, R. (1998). Interpretations of healthy and unhealthy eating, and implications for dietary change. *Health Education Research, 13*, 171-183.
- Power, E.M. (2005). Determinants of healthy eating among low income Canadians. *Canadian Journal of Public Health, 96*, S37-S42.
- Raine, K.D. (2005). Determinants of healthy eating in Canada: An overview and synthesis, *Canadian Journal of Public Health, 96*, S8-S14.

Rosen, G. (1993). *A History of Public Health*. Baltimore: John Hopkins University Press.

Rossman, G.B., & Rallis, S.F. (1998). *Learning in the Field: An Introduction to Qualitative Research*. Thousand Oaks: Sage Publications.

Rotberg, R.I. (Ed). (2000). *Health and Disease in Human History: A Journal of Interdisciplinary History Reader*. Cambridge: MIT Press.

Sointu, E. (2006). The search for wellbeing in alternative and complementary health practices. *Sociology of Health & Illness*, 28, 330-349.

Statistics Canada. (2005). Canadian Community Health Survey: Obesity among children and adults.

Stein, R.I. & Nemeroff, C.J. (1995). Moral overtones of food: Judgments of others based on what they eat, *Personality and Social Psychology Bulletin*, 21, 480-90.

WHO – World Health Organization. (2004). Facts related to chronic diseases.

<http://www.who.int/dietphysicalactivity/publications/facts/chronic/en/>, accessed August 24th, 2004.

WHO/FAO – World Health Organization/Food and Agriculture Organization. (2003).

WHO Technical Report Series 916: Diet, Nutrition and the Prevention of Chronic Diseases.

http://www.who.int/hpr/NPH/docs/who_fao_expert_report.pdf, accessed April 3rd, 2007.

APPENDICES

Appendix 1: Canada's Food Guide to Healthy Eating, 1992 (Health Canada).


Health Canada / Santé Canada

CANADA'S

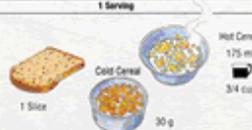
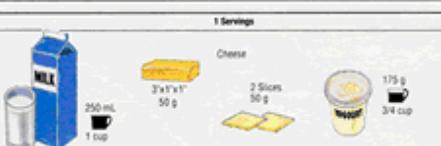
Food Guide

TO HEALTHY EATING FOR PEOPLE FOUR YEARS AND OVER

Enjoy a variety of foods from each group every day.

Choose lower-fat foods more often.



Grain Products 5-12 <small>SERVINGS PER DAY</small>	<p>1 Serving</p>  <p>1 Slice 1 cup 30 g</p> <p>2 Servings</p>  <p>175 mL 3/4 cup 1 Bagel, Pita or Bun 250 mL 1 cup</p>
Vegetables and Fruit 5-10 <small>SERVINGS PER DAY</small>	<p>1 Serving</p>  <p>1 Medium Size Vegetable or Fruit 125 mL 1 cup 125 mL 1/2 cup</p>
Milk Products <small>SERVINGS PER DAY</small> <small>Children 4-8 years: 2-3</small> <small>Youth 9-14 years: 2-4</small> <small>Adults: 2-4</small> <small>Pregnant and Breast-feeding Women: 3-4</small>	<p>1 Serving</p>  <p>250 mL 1 cup 3x1x1 50 g 2 Slices 50 g 175 g 3/4 cup</p>
Meat and Alternatives 2-3 <small>SERVINGS PER DAY</small>	<p>1 Serving</p>  <p>Meat, Poultry or Fish 50-100 g 1/3-2/3 Can 50-100 g 1-2 Eggs 125-250 mL 100 g 1/2 cup 30 mL, 2 tbsp</p>

Other Foods

Taste and enjoyment can also come from other foods and beverages that are not part of the 4 food groups. Some of these foods are higher in fat or Calories, so use these foods in moderation.

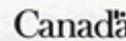
Different People Need Different Amounts of Food

The amount of food you need every day from the 4 food groups and other foods depends on your age, body size, activity level, whether you are male or female and if you are pregnant or breast-feeding. That's why the Food Guide gives a lower and higher number of servings for each food group. For example, young children can choose the lower number of servings, while male teenagers can go to the higher number. Most other people can choose servings somewhere in between.



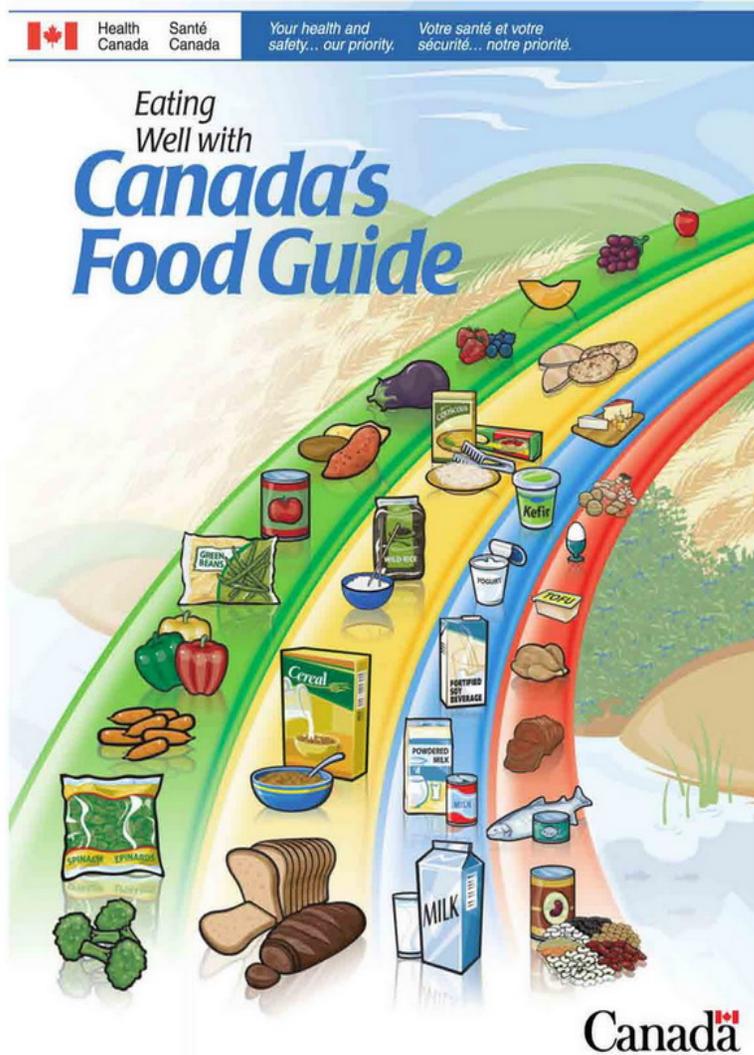
Consult Canada's Physical Activity Guide to Healthy Active Living to help you build physical activity into your daily life.

Enjoy eating well, being active and feeling good about yourself. That's **VITALITY**




© Minister of Public Works and Government Services Canada, 1997
 Cat. No. H39-262/1992E ISBN 0-662-19648-1
 No changes permitted. Reprint permission not required.

Appendix 2: Eating Well with Canada's Food Guide, 2007 (Health Canada).



Recommended Number of Food Guide Servings per Day

Age in Years	Children			Teens		Adults			
	2-3	4-8	9-13	14-18		19-50		51+	
	Sex			Females	Males	Females	Males	Females	Males
Vegetables and Fruit	4	5	6	7	8	7-8	8-10	7	7
Grain Products	3	4	6	6	7	6-7	8	6	7
Milk and Alternatives	2	2	3-4	3-4	3-4	2	2	3	3
Meat and Alternatives	1	1	1-2	2	3	2	3	2	3

The chart above shows how many Food Guide Servings you need from each of the four food groups every day.

Having the amount and type of food recommended and following the tips in *Canada's Food Guide* will help:

- Meet your needs for vitamins, minerals and other nutrients.
- Reduce your risk of obesity, type 2 diabetes, heart disease, certain types of cancer and osteoporosis.
- Contribute to your overall health and vitality.

What is One Food Guide Serving?
Look at the examples below.

 <p>Fresh, frozen or canned vegetables 125 mL (½ cup)</p>		 <p>Leafy vegetables Cooked: 125 mL (½ cup) Raw: 250 mL (1 cup)</p>		 <p>Fresh, frozen or canned fruits 1 fruit or 125 mL (½ cup)</p>		 <p>100% Juice 125 mL (½ cup)</p>					
 <p>Bread 1 slice (35 g)</p>		 <p>Bagel ½ bagel (45 g)</p>		 <p>Flat breads ¼ pita or ½ tortilla (35 g)</p>		 <p>Cooked rice, bulgur or quinoa 125 mL (½ cup)</p>		 <p>Cereal Cold: 30 g Hot: 175 mL (¾ cup)</p>		 <p>Cooked pasta or couscous 125 mL (½ cup)</p>	
 <p>Milk or powdered milk (reconstituted) 250 mL (1 cup)</p>		 <p>Canned milk (evaporated) 125 mL (½ cup)</p>		 <p>Fortified soy beverage 250 mL (1 cup)</p>		 <p>Yogurt 175 g (¾ cup)</p>		 <p>Kefir 175 g (¾ cup)</p>		 <p>Cheese 50 g (1 ½ oz.)</p>	
 <p>Cooked fish, shellfish, poultry, lean meat 75 g (2 ½ oz.)/125 mL (½ cup)</p>		 <p>Cooked legumes 175 mL (¾ cup)</p>		 <p>Tofu 150 g or 175 mL (¾ cup)</p>		 <p>Eggs 2 eggs</p>		 <p>Peanut or nut butters 30 mL (2 Tbsp)</p>		 <p>Shelled nuts and seeds 60 mL (¼ cup)</p>	

Oils and Fats

- Include a small amount – 30 to 45 mL (2 to 3 Tbsp) – of unsaturated fat each day. This includes oil used for cooking, salad dressings, margarine and mayonnaise.
- Use vegetable oils such as canola, olive and soybean.
- Choose soft margarine that are low in saturated and trans fats.
- Limit butter, hard margarine, lard and shortening.



Make each Food Guide Serving count... wherever you are – at home, at school, at work or when eating out!

▶ **Eat at least one dark green and one orange vegetable each day.**

- Go for dark green vegetables such as broccoli, romaine lettuce and spinach.
- Go for orange vegetables such as carrots, sweet potatoes and winter squash.

▶ **Choose vegetables and fruit prepared with little or no added fat, sugar or salt.**

- Enjoy vegetables steamed, baked or stir-fried instead of deep-fried.

▶ **Have vegetables and fruit more often than juice.**

▶ **Make at least half of your grain products whole grain each day.**

- Eat a variety of whole grains such as barley, brown rice, oats, quinoa and wild rice.
- Enjoy whole grain breads, oatmeal or whole wheat pasta.

▶ **Choose grain products that are lower in fat, sugar or salt.**

- Compare the Nutrition Facts table on labels to make wise choices.
- Enjoy the true taste of grain products. When adding sauces or spreads, use small amounts.

▶ **Drink skim, 1%, or 2% milk each day.**

- Have 500 mL (2 cups) of milk every day for adequate vitamin D.
- Drink fortified soy beverages if you do not drink milk.

▶ **Select lower fat milk alternatives.**

- Compare the Nutrition Facts table on yogurts or cheeses to make wise choices.

▶ **Have meat alternatives such as beans, lentils and tofu often.**

▶ **Eat at least two Food Guide Servings of fish each week.***

- Choose fish such as char, herring, mackerel, salmon, sardines and trout.

▶ **Select lean meat and alternatives prepared with little or no added fat or salt.**

- Trim the visible fat from meats. Remove the skin on poultry.
- Use cooking methods such as roasting, baking or poaching that require little or no added fat.
- If you eat luncheon meats, sausages or prepackaged meats, choose those lower in salt (sodium) and fat.



Enjoy a variety of foods from the four food groups.



Satisfy your thirst with water!

Drink water regularly. It's a calorie-free way to quench your thirst. Drink more water in hot weather or when you are very active.

* Health Canada provides advice for limiting exposure to mercury from certain types of fish. Refer to www.healthcanada.gc.ca for the latest information.

Advice for different ages and stages...

Children

Following *Canada's Food Guide* helps children grow and thrive.

Young children have small appetites and need calories for growth and development.

- Serve small nutritious meals and snacks each day.
- Do not restrict nutritious foods because of their fat content. Offer a variety of foods from the four food groups.
- Most of all... be a good role model.



Women of childbearing age

All women who could become pregnant and those who are pregnant or breastfeeding need a multivitamin containing **follic acid** every day. Pregnant women need to ensure that their multivitamin also contains **iron**. A health care professional can help you find the multivitamin that's right for you.

Pregnant and breastfeeding women need more calories. Include an extra 2 to 3 Food Guide Servings each day.

Here are two examples:

- Have fruit and yogurt for a snack, or
- Have an extra slice of toast at breakfast and an extra glass of milk at supper.



Men and women over 50

The need for **vitamin D** increases after the age of 50.

In addition to following *Canada's Food Guide*, everyone over the age of 50 should take a daily vitamin D supplement of 10 µg (400 IU).



How do I count Food Guide Servings in a meal?



Here is an example:

Vegetable and beef stir-fry with rice, a glass of milk and an apple for dessert

250 mL (1 cup) mixed broccoli, carrot and sweet red pepper	= 2 Vegetables and Fruit Food Guide Servings
75 g (2 1/2 oz.) lean beef	= 1 Meat and Alternatives Food Guide Serving
250 mL (1 cup) brown rice	= 2 Grain Products Food Guide Servings
5 mL (1 tsp) canola oil	= part of your Oils and Fats intake for the day
250 mL (1 cup) 1% milk	= 1 Milk and Alternatives Food Guide Serving
1 apple	= 1 Vegetables and Fruit Food Guide Serving

Eat well and be active today and every day!

The benefits of eating well and being active include:

- Better overall health.
- Lower risk of disease.
- A healthy body weight.
- Feeling and looking better.
- More energy.
- Stronger muscles and bones.



Be active

To be active every day is a step towards better health and a healthy body weight.

Canada's Physical Activity Guide recommends building 30 to 60 minutes of moderate physical activity into daily life for adults and at least 90 minutes a day for children and youth. You don't have to do it all at once. Add it up in periods of at least 10 minutes at a time for adults and five minutes at a time for children and youth.

Start slowly and build up.



Eat well

Another important step towards better health and a healthy body weight is to follow *Canada's Food Guide* by:

- Eating the recommended amount and type of food each day.
- Limiting foods and beverages high in calories, fat, sugar or salt (sodium) such as cakes and pastries, chocolate and candies, cookies and granola bars, doughnuts and muffins, ice cream and frozen desserts, french fries, potato chips, nachos and other salty snacks, alcohol, fruit flavoured drinks, soft drinks, sports and energy drinks, and sweetened hot or cold drinks.

Read the label

- Compare the Nutrition Facts table on food labels to choose products that contain less fat, saturated fat, trans fat, sugar and sodium.
- Keep in mind that the calories and nutrients listed are for the amount of food found at the top of the Nutrition Facts table.

Nutrition Facts

Amount	% Daily Value
Par 0 mL (0 g)	
Calories 0	
Fat 0 g	0 %
Saturated 0 g	0 %
+ Trans 0 g	
Cholesterol 0 mg	
Sodium 0 mg	0 %
Carbohydrate 0 g	0 %
Fibre 0 g	0 %
Sugars 0 g	
Protein 0 g	
Vitamin A 0 %	Vitamin C 0 %
Calcium 0 %	Iron 0 %

Limit trans fat

When a Nutrition Facts table is not available, ask for nutrition information to choose foods lower in trans and saturated fats.

Take a step today...

- ✓ Have breakfast every day. It may help control your hunger later in the day.
- ✓ Walk wherever you can – get off the bus early, use the stairs.
- ✓ Benefit from eating vegetables and fruit at all meals and as snacks.
- ✓ Spend less time being inactive such as watching TV or playing computer games.
- ✓ Request nutrition information about menu items when eating out to help you make healthier choices.
- ✓ Enjoy eating with family and friends!
- ✓ Take time to eat and savour every bite!



For more information, interactive tools, or additional copies visit *Canada's Food Guide on-line* at: www.healthcanada.gc.ca/foodguide

or contact:

Publications
Health Canada
Ottawa, Ontario K1A 0K9
E-Mail: publications@hc-sc.gc.ca
Tel.: 1-866-225-0709
Fax: (613) 941-5366
TTY: 1-800-267-1245

Également disponible en français sous le titre :
Bien manger avec le Guide alimentaire canadien

This publication can be made available on request on diskette, large print, audio-cassette and braille.

Appendix 3: The Family Context of Food Decision-Making in Diverse Ethnocultural Groups

THE UNIVERSITY OF BRITISH COLUMBIA



Food, Nutrition and Health
Faculty of Agricultural Sciences
2205 East Mall
Vancouver, BC, V6T 1Z4

RESEARCH STUDY: THE FAMILY CONTEXT OF FOOD DECISION- MAKING IN DIVERSE ETHNOCULTURAL GROUPS

Purpose of the study:

The purpose of this study is to examine how families from two diverse ethnocultural groups make decisions about what they eat. The two ethnocultural groups included in the study are Punjabi British Columbians and European Canadians. The research questions that we will address are:

1. How do Punjabi and European Canadian families in British Columbia decide what food they will eat?
2. In what ways and contexts are different family members responsible for making food-related decisions, and how do they influence each other?
3. How are food decision-making processes and outcomes affected by:
 - a. Gender roles and relations within the family?
 - b. Age and life-stage of family members?
 - c. Health concerns and beliefs of family members?

Data will be compared with similar data from African Nova Scotians and European Canadians in Nova Scotia.

Study design: The study includes three ways of gathering data. The research assistant will: 1) do face-to-face interviews with 3 or more individual members of the family, 2) accompany one or more members of the family when they go shopping for groceries, 3) join the family for a typical meal.

Who can participate: Participants for this study must be 13 years old or older. The family must self-identify as Punjabi British Columbian or Caucasian (white) of European heritage, born and raised in Canada; and must include at least 3 people, 13 years old or older, who live together and are willing to be interviewed. The family must include at least one woman aged 25-55 years who is willing to be interviewed.

Who will be conducting the research: The study is being done by researchers at the University of British Columbia, led by Dr. Gwen Chapman at (604) 822-6874, and researchers at Dalhousie University in Nova Scotia.

If you would like more information about this study, and/or if you are interested in being a study participant, please contact Lucki or Svetlana at 604.827.5764 or at foodUBC@yahoo.ca

Appendix 4: Methodology

The following sections describe my roles as a research assistant on the study as a whole and PhD student; the design, recruitment, data collection and management of the study as a whole; and the analytical procedures and strategies used to enhance rigour specifically for the healthy eating interpretations.

Researcher's role

As one of the project's **research assistants**, my role was to recruit, collect, and manage data with the European BC families in Vancouver. Recruitment consisted of posting notices around Vancouver, making contacts with health professionals from various sites who helped with recruitment, and screening potential families. Collection of data included arranging for and conducting the three different data collection methods with European BC families as well as one European NS family. Management of data included coding all of the transcripts from interviews, grocery trips and family meal observations for all the European BC families and about half of the Punjabi BC families, as well as writing family memos for the European BC families. I worked closely with two Punjabi research assistants in Vancouver who recruited, collected, and managed the majority of data with the Punjabi BC families, as well as with three research assistants in Halifax who recruited, collected, and managed the majority of data with the African and European NS families. Ongoing decisions about the recruitment, collection, and analysis of data were made with these research assistants and other team members in Vancouver and Halifax.

During the research process, my role as a **PhD student** was to take responsibility for the healthy eating data of the project such as developing questions for the interview guide about healthy eating (see questions 18, 19, 20 in Appendix 9 and 10). For the PhD

analysis, I used the data gathered about healthy eating interpretations from all Punjabi BC, African NS and European NS and European BC families. I further developed codes to capture passages in transcripts discussing various issues around healthy eating interpretations and took on the responsibility to further analyze emerging themes in this area. Building on the initial analyses of the research team for the project as a whole, the PhD thesis analysis explored emerging themes by using current social theoretical perspectives.

Research Design

Given the exploratory nature of the study, a qualitative research design was used (Denzin & Lincoln, 1994; Denzin & Lincoln, 2000). Qualitative research is used to depict the complex nature of humans as it allows for a description of individuals' perceptions of their own and others' experiences within the social context of where they occur (Guba & Lincoln, 1994; Marshall & Rossman, 1989; Maxwell, 1996; Patton, 1990). Some of the benefits of qualitative research include its *naturalistic*, inductive, *holistic*, *dynamic*, *context sensitive*, and *empathic* nature, its emphasis on *thick description*, *personal contact*, *unique case selection*, and its use of a *flexible design* (Patton, 1990; Rossman & Rallis, 1998). Questions in qualitative research are, therefore, usually broad and seek to understand why something occurs, what certain experiences mean to participants, and how these experiences influence subsequent behaviours. The questions that this study sought to understand were about people's healthy eating interpretations in their everyday context, namely how these healthy eating interpretations are shaped by larger social processes as well as how they help shape food behaviours.

Participant Recruitment

Participants were recruited as part of a study led by Dr. Gwen Chapman from UBC, Vancouver and Dr. Brenda Beagan from Dalhousie University, Halifax. Their study was about the family context of food decision-making in three ethnocultural groups: Punjabi British Columbians, African Nova Scotians and European Canadians in both British Columbia and Nova Scotia. Ethics approval for the study was obtained from the Ethics Review Boards at both Dalhousie University in Halifax and the University of British Columbia in Vancouver. Ethics approval for recruitment only was obtained from the Ethics Review Boards at Fraser Health, Vancouver Coastal Health and Providence Health Care in Vancouver (Appendix 5).

Twelve Punjabi BC and 11 European BC families were recruited in the Lower Mainland, as well as 13 indigenous African NS and 10 European NS families in the Halifax region. Each family had at least 3 members participate, all 13 years or older, including a woman between 25-55 years. The families were recruited through community-based organizations, notices posted around the city (Appendix 6) and snowball sampling with the help of community members taking part on the research advisory team. Interested families were contacted and screened through a series of questions about their demographic and health-related characteristics (Appendix 7). Data collection proceeded with families eligible to participate.

Data Collection

Data about healthy eating interpretations was collected as part of the larger food decision-making study. Six research assistants collected the data: 3 in British Columbia (two with the Punjabi BC families and one with the European BC families) and 3 in Nova

Scotia (two with the African NS and one with the European NS families). Except for the research assistant working with the European NS families, the research assistants were of the same cultural descent as the families they collected data with. Three data collection strategies were employed for each family:

- Individual, semi-structured, audio-taped interviews with 3 members of the family. Informed consent forms was signed by all who were interviewed (Appendix 8). Parents also signed consent forms for their children younger than 19 years. Interview guides were developed separately for the interviews with adults (Appendix 9) and teenagers (Appendix 10). Questions 18-20 in the guides were added to answer questions specifically about healthy eating interpretations related to this study. Questions such as ‘What does the term *healthy eating* mean to you?’, ‘Where have you learned about *healthy eating*?’ and ‘What kinds of things would you like to learn about *healthy eating*?’ along with appropriate probes acted as core areas of healthy eating to be discussed. Other questions from the guides, however, were also used to contextualize and supplement the analysis in the study.
- Accompaniment to a 'typical' grocery trip. The conversations were audio-taped and field notes were written following the trip. A guide was used (Appendix 11) to direct the conversations and make sure all important areas of interest were covered.
- Participant observation during the preparation, serving, eating and clean-up of a 'typical' meal. Field notes were taken about healthy eating interpretations as they occurred in the food decision-making during meals. Informed consent forms were signed by all who participated in these meals (Appendix 12). Parents also signed consent forms for their children younger than 19 years.

Data Management

Audio tapes from individual interviews and grocery shopping trips were transcribed verbatim. Transcripts and field notes were managed in Atlas/Ti scientific software for qualitative analysis and analyzed in an iterative process. Analysis began with coding transcript sections about healthy eating interpretations for which a code list was developed (Appendix 13). The code list contains both codes that were developed to capture research questions at the onset of the study (e.g., food choice, culture/tradition, health concerns) as well as issues that were raised by participants themselves and allowed the researchers to consider research areas either in a new light or in more depth (e.g., politics/ethics, religion/spirituality, vegetarian). Coding of transcript passages aided in the organization, retrieval, and interpretation of data (Coffey & Atkinson, 1996; Hammersley & Atkinson, 1995) about healthy eating interpretations. The codes were used as “tags or labels for assigning units of meaning” to the data (Miles & Huberman, 1994, p. 56). Further analysis consisted of writing memos (analytical and reflexive summaries), and delineating themes emerging from the coding and memoing process.

Data Analysis

Describing the process of analysis – that time between coding and disseminating some sort of findings – has proven as difficult to explain and as somewhat of an intangible process time and time again in many qualitative research books. Part of this complexity, as Hammersley and Atkinson (1995) point out, is because “*analysis of data is not a distinct stage of the research. In many ways, it begins in the pre-fieldwork phase... and continues through to the process of writing reports, articles and books*” (Hammersely & Atkinson, 1995, p. 205). It is important to note, therefore, that the generation of ideas in this thesis

has not been dependent on the data alone (Coffey & Atkinson, 1996). Unlike some approaches to qualitative research that aim to ‘bracket’ existing theory and literature around a topic in order to focus freshly on the stories and experiences of participants or on the particular disciplinary methods, my approach was to merge these two sources of knowledge. ‘Sensitizing concepts’ – those concepts that give researchers a general sense of reference and guidelines for approaching empirical instances or suggest directions along which to look (Blummer, 1954 in Hammersley & Atkinson, 1995) – have, thus been drawn not only from participants themselves, but also, to a large degree, from the literature. For example, participant-driven concepts such as ‘from the beginning’ phrase used often by Punjabi BC participants prompted the development of a code titled ‘ways of knowing’ that aimed to capture the different ways of knowledge participants used to describe how they knew about something. Similarly, theory-driven concepts such as Foucault’s ‘technologies of the self’ prompted the development of a code titled ‘control/monitor’ that aimed to capture passages of those participants who described ways in which they regulated/monitored their own or others’ eating practices (e.g., passages where participants talked about avoiding/controlling/watching certain foods). The literature, therefore, has played an important role in conceptualizing and analyzing the data for the thesis, particularly the literature in social theory. Taking Coffey and Atkinson’s (1996) view, it has been important for me to go beyond the techniques of manipulating the data into perspectives that offer ways of thinking with it and developing ideas beyond it.

Analysis for Chapter 2 began very early in data collection, with the realization that food choice influences of the first two European BC families were, among other factors, influenced strongly by ‘ethical’ considerations. Such considerations were not part of the study’s original conceptualization and were thus not captured by the existing code list. A

code titled ‘politics/ethics’ was developed soon after in order to capture relevant interview passages. In comparing food choice discussions of European BC participants with those of the other three research groups, it became clear that ethical food considerations were not prominent to the same extent in all groups. Table 1 summarizes the number of families and participants in each group which discussed ethical food choice considerations:

Table 1: Ethical Food Choice Considerations

GROUPS	#FAMILIES	#MEN	#WOMEN	TOTAL# of Adults
African NS	1	0	1	1
European NS	3	1	4	5
European BC	8	4	9	13
Punjabi BC	1	0	1	1

Attempting to understand the reasons behind these differences in ethical food choice considerations between the groups acted as an impetus for chapter 2. In addition to the ‘politics/ethics’ passages, further analysis involved reading of core codes such as ‘healthy eating’, ‘food choice’, ‘vegetarian’, ‘sources of info’, ‘trust in info’ and ‘culture/tradition’. This exercise showed that participants interacted with food resources in different ways and motivated examination of some of these resources (e.g., grocery store websites).

Interpretation was aided by the work of Anthony Giddens, as his work on the ‘theory of structuration/duality of structure’ (1984) provided an opportunity to examine ‘the duality’ (interaction) between participants and the respective food structures that leads to specific food practices for each group and in each place. After an extensive iterative process between writings and the data, the differences between groups in how they interacted with food structures were collapsed into three broader categories: ‘eating well’, ‘place’ and

‘community’. Chapter 2 lays out the intricacies of the duality of these interactions for each group.

The beginning idea for pursuing the analysis in chapter 3 came before data collection through ‘lessons’ learned from reading the relevant literature. Initially, the literature on ‘healthy eating’ pointed to lack of understanding of why individuals, beyond basic definitions, make sense of healthy eating in different ways. Michel Foucault’s work on ‘technologies of the self’ (Foucault, 1988), as well as that of Alan Petersen (1996, 1997), Petersen and Bunton (1997) and John Coveney (2000, 2005) in applying Foucault’s work to health promotion and nutrition, provided the inspiration for pursuing an analysis in this study that might provide some social, cultural and historical clues for the different healthy eating interpretations. The codes ‘control/monitor’ and ‘I shouldn’t but’ were developed to capture passages where ‘practices of the self’ applied to healthy eating practices. While these codes captured the practices for those grouped under the ‘mainstream/official’ category, they did not fit for other ways/practices about healthy eating. Queries for the codes ‘healthy eating’, ‘culture/tradition’, ‘sources of info’, ‘trust in info’ and ‘ways of knowing’ contained additional ways of making sense of evidence about healthy eating that were not captured in ‘control/monitor’ and ‘I shouldn’t but’. From this analysis, three different healthy eating discourses emerged. Table 2 summarizes how these discourses differed in conceptualization for the food/preparation methods, food-health relationship, making sense of evidence in everyday life, and responses to/evaluations of surrounding healthy eating discourses:

Table 2: Making Sense of Healthy Eating Discourses

	Cultural/ Traditional	Mainstream	Complementary/ Ethical
Healthy foods and/or prep methods	<p>ANS: corn bread, curry chicken, boiled dinner;</p> <p>PBC: roti meal (roti bread + lentil dish + vegetable dish);</p> <p>ENS: boiled dinner, meat/ potatoes/ vegetables;</p> <p>ANS, PBC and ENS: simpler/ more natural/ traditional preparation methods: without additives (e.g., sugar) to food, food from farm, less ‘snack’ foods, proper meals</p>	<p>Foods from food groups (as per CFGHE and other recommendations);</p> <p>Foods that contain specific nutrients for health (e.g., calcium to prevent osteoporosis)</p>	<p>Mainstream definitions</p> <p>natural/local/organic; vegetarian food; ethically produced animal food</p>
Food-Health Relationship	<p>Focus on positive aspects of food for health as it provides functionality/ strength;</p> <p>Inevitability of life-course body/health changes</p>	<p>Food and nutrients need to controlled/ monitored through discipline and preventative action;</p> <p>Consideration of food and ‘risk factors’</p>	<p>Foods taken in consideration as part of (preferably local) food system</p>
Making sense of the evidence in everyday life	<p>Evidence from what is visible to the eye</p> <p>Observations of self (e.g., bodily responses and changes), family, community, society</p> <p>PBC: Comparisons between eating ways in India and Canada</p> <p>Centuries-old knowledge as learned through parents, community, wise elders (how things have always been done)</p> <p>Scientific evidence as</p>	<p>Evidence beyond what is visible to the eye;</p> <p>Scientific evidence as learned through media, health professionals; all around</p>	<p>As mainstream;</p> <p>Observations of self (e.g., bodily responses, feelings)</p>

	learned through doctor's advice		
Responses/ Evaluations to Healthy Eating Discourses	<p>Accepting/ no questioning of cultural/traditional and scientific/doctor's expertise</p> <p>Critical of some mainstream ways of eating in Canada (e.g., some foods too heavy, snacking)</p> <p>Mainstream ways of eating may conflict with culture/ identity</p>	<p>Accepting of nutritional guidelines</p> <p>ANS and PBC: attempt for cultural/traditional and mainstream HE discourses to co-exist; more critical of cultural/traditional than mainstream</p>	<p>Accepting of some nutritional guidelines</p> <p>Critical of certain aspects of nutritional guidelines (e.g., guidelines as politicized, limited in scope)</p> <p>Self as capable to synthesize and evaluate evidence</p>

Analysis for chapter 4 was an amalgamation of what was emerging from the data with what seemed particularly relevant and helpful to understand it in the literature. From the data, patterns for communication/transmission about healthy eating between parents (mothers in particular) and their children/youth differed in families. In chapter 4, I explain how this related to whether the mother was acknowledged as a healthy eating expert in the family. Overarching codes (e.g., 'family/gender roles,' 'child,' 'self') were used in combination with more specific codes about healthy eating ('sources of info,' 'trust in info' and 'control/monitor') to develop the themes in this chapter. At the same, the literature pointed to several different trends that seemed to be relevant in attempting to understand the differences in communication/transmission between families: the gendered roles and moralization of mothers (Charles & Kerr, 1988; Nettleton, 1991; Tardy, 2000), the moralization of health (Brandt and Rozin, 1997), Foucault's governmentality (Foucault, 1991) and governmentality as applied in various health-related fields (Coveney, 2000; Holmes & Gastaldo, 2002; Lupton, 1999). Chapter 4, therefore, attempts to uses

these different literatures to make sense of the different communication/transmission patterns of healthy eating between the families in the current study's data.

Strategies for Enhancing Rigour

To enhance the rigour of the study, strategies dealing with transferability and credibility in qualitative research (which are comparable to reliability and validity in quantitative research) were employed (Lincoln & Guba, 1985). Regular team conference call meetings were held between the Vancouver and Halifax groups to ensure standard procedures were followed. Data was triangulated by using multiple research methods (individual interviews, trips to the grocery store, and participant observation), researchers (involvement of different levels of researchers both from the community and academic settings) and participants (teenagers, adults, two different cultural groups). Other strategies to enhance the rigour of the study included: writing procedural memos; writing reflexive notes in fieldnotes after interviews, grocery trips and participant observations; and having regular peer debriefing sessions with the research team.

Other strategies were also employed - those that acknowledge the unique ontological and epistemological knowledges qualitative research methods offer. Adapted from Popay et al. (1998) are three criteria (with key questions) of particular significance for qualitative research that a reader may want to pay attention to when reading this thesis: interpretation of subjective meaning (does the research illuminate the subjective meaning, actions and context of those being researched?); description of/responsiveness to the social context (is there evidence of the adaptation and responsiveness to research design to the circumstances and issues of real-life social settings met during the course of the study?) life and attention to lay knowledge (has enough attention been given to the research

participants' voices to make it at least as important – if not more – as health professionals'/experts' voices).

References

- Blumer, H. (1954). What is wrong with social theory? *American Sociological Review*, 19, 3-10. In Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in Practice*, 2nd Edition. London: Routledge.
- Brandt, A.M., & Rozin, P. (Eds.), (1997). *Morality and Health*. New York, NY: Routledge.
- Charles, N. and Kerr, M. (1988) *Women, Food and Families*. Manchester: Manchester University Press.
- Coffey, A., & Atkinson, P. (1996). *Making Sense of Qualitative Data: Complimentary Research Strategies*. London: SAGE Publications.
- Coveney, J. (2000). *Food, Morals and Meaning: The Pleasure and Anxiety of Eating*. London, UK: Routledge.
- Coveney, J. (2005). A qualitative study exploring socio-economic differences in parental lay knowledge of food and health: Implications for public health nutrition. *Public Health Nutrition*, 8, 290-297.
- Denzin, N.K., & Lincoln, Y.S. (1994). *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications.
- Denzin, N.K., & Lincoln, Y.S. (2000) *Handbook of Qualitative Research: 2nd edition*. Thousand Oaks: Sage Publications.
- Foucault, M. (1988). Technologies of the self. In L. H. Martin, H. Gutman & P.H. Hutton (Eds.), *Technologies of the Self: A Seminar with Michel Foucault* (pp. 16-49). Amherst, MA: University of Massachusetts Press.

- Foucault, M. (1991) Governmentality. In Burchell, G., Gordon, C. & Miller, P. (eds) *The Foucault Effect: Studies in Governmentality with Two Lectures by and an Interview with Michel Foucault*. Chicago: University of Chicago Press. pp.87-104.
- Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. Berkley: University of California Press.
- Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In Denzin, N.K., & Lincoln, Y.S. (eds.). *Handbook of Qualitative Research* (pp. 105-117). Thousand Oaks: Sage Publications.
- Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in Practice, 2nd Edition*. London: Routledge.
- Holmes, D. and Gastaldo, D. (2002) Nursing as a means of governmentality, *Journal of Advanced Nursing*, 38, 557-65.
- Marshall, C., & Rossman, G.B. (1989). *Designing Qualitative Research*. Newbury Park: Sage Publications.
- Maxwell, J.A. (1996). *Qualitative Research Design: An Interactive Approach*. Thousand Oaks: Sage Publications.
- Miles, M.B., & Huberman, A.M. (1984). *Qualitative Data Analysis: A Sourcebook of New Methods*. Beverley Hills: Sage Publications.
- Lincoln, Y.S., & Guba, E.G. (1985) *Naturalistic Enquiry*. Beverly Hills: Sage Publications.
- Lupton, D. (1999) *Risk*. London: Routledge.
- Nettleton, S. (1991) Wisdom, diligence and teeth: Discursive practices and the creation of mothers, *Sociology of Health and Illness*, 13, 98-111.

- Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods*: 2nd edition. Newbury Park: Sage Publications.
- Petersen, A. R. (1996). Risk and the regulated self: The discourse of health promotion as politics of uncertainty. *Australian & New Zealand Journal of Statistics*, 32, 44-57.
- Petersen, A. (1997). The new morality: Public health and personal conduct. In C. O'Farrell (Ed.) *Foucault: The Legacy* (pp. 696-706). Brisbane, AU: Queensland University of Technology.
- Petersen, A., & Bunton, R. (1997). *Foucault, Health and Medicine*. London: Routledge.
- Popay, J., Rogers, A., & Williams, G. (1998). Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research*, 8, 341-351.
- Rossmann, G.B., & Rallis, S.F. (1998). *Learning in the Field: An Introduction to Qualitative Research*. Thousand Oaks: Sage Publications.
- Tardy, R.W. (2000) "But I am a good mom": The social construction of motherhood through health-care conversations, *Journal of Contemporary Ethnography*, 29, 433-73.

Appendix 5: UBC Research Ethics Board's Certificates of Approval



The University of British Columbia
Office of Research Services and Administration
Behavioural Research Ethics Board

Certificate of Approval

PRINCIPAL INVESTIGATOR Chapman, G.E.		DEPARTMENT Agricultural Sciences	NUMBER B03-0423
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT UBC Campus ,			
CO-INVESTIGATORS: Beagan, Brenda, Health Sciences; Levy Milne, Ryna, Agricultural Sciences; Raja, Shefali, ; Sekhon, Satnam,			
SPONSORING AGENCIES Canadian Institutes of Health Research			
TITLE : The Family Context of Food Decision-Making in Diverse Ethnocultural Group			
APPROVAL DATE	TERM (YEARS) 1	DOCUMENTS INCLUDED IN THIS APPROVAL: July 10, 2003, Consent forms / Assent form / Questionnaires / Advertisement	
<p>CERTIFICATION:</p> <p>The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.</p> <p style="text-align: center;"></p> <p style="text-align: center;"><i>Approval of the Behavioural Research Ethics Board by one of the following:</i> Dr. James Frankish, Chair, Dr. Cay Hollbrook, Associate Chair, Dr. Susan Rowley, Associate Chair</p> <p>This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures</p>			

Appendix 6: Recruitment Poster

THE UNIVERSITY OF BRITISH COLUMBIA



Food, Nutrition and Health
Faculty of Agricultural Sciences
2205 East Mall
Vancouver, BC, V6T 1Z4

Research Participants Needed!

Researchers from UBC are seeking participants for a study called: "THE FAMILY CONTEXT OF FOOD DECISION-MAKING IN DIVERSE ETHNOCULTURAL GROUPS"

We plan to examine how Punjabi British Columbian and Euro-Canadian* families make decisions about what they eat, and how those decisions relate to culture, gender, life-stage, and health concerns. These groups were selected because diet-related diseases such as heart disease and type 2 diabetes are significant health problems for them. Findings will help in the development of future health promotion programs.

We are looking for both
Punjabi British-Columbian & Euro-Canadian* families living in BC's Lower Mainland

Families participating in this study must include at least 3 people who live together and are willing to be interviewed, all of whom are 13 years old or older, and at least one of whom is a woman aged 25-55 years.

Families who participate in the study will receive a \$100 gift certificate for a grocery store where they usually shop and, if teenagers participate in the study, movie passes or CD gift certificates for each teenager who participates in an interview.

Participation in this study will involve a total of 2 to 10 hours per person of three or more family members' time, for a total of up to 15 hours with members of your family:

The research team:

Dr. Gwen Chapman (UBC), Dr. Brenda Beagan (Dalhousie), Dr. Ryna Levy-Milne (UBC), Shefali Raja (Vancouver Coastal Health), Satnam Sekhon (BC Cancer Agency), Svetlana Ristovski-Slijepcevic (PhD student, UBC; Parts of this research will be used for a PhD thesis in Human Nutrition at UBC), Lucki Kang (Research Assistant)

If you would like more information about this study, and/or if you are interested in being a study participant, please contact Lucki or Svetlana at 604.827.5764 or foodUBC@yahoo.ca.

***By "Euro-Canadian", we mean people who were born in Canada, and have a European / U.K heritage.**

Appendix 7: Screening Guide

Participant Screening for Food Decision-Making Project

Date _____ RA _____

Name of anticipated participant _____

Contact info. Tel: H: _____ W: _____ Email: _____

Geographic location _____

Family composition: Children # _____ Ages _____

Adults # _____ Gender _____ Ages of women _____

The required composition is at least three people, 13 years or older, with one woman between 25-55 years.

How many family members are willing to participate?

	Gender	Age	Occupation		Gender	Age	Occupation
1.	_____	_____	_____	4.	_____	_____	_____
2.	_____	_____	_____	5.	_____	_____	_____
3.	_____	_____	_____	6.	_____	_____	_____

There need to be **at least** three people, including the aforementioned woman, who are willing to be interviewed. They can be a combination of older children, adult relatives or a partner. Additional family members may also participate in the interview process with prior approval.

Ethnic background: Please note the parameters of the project require that all family members are part of the same ethnic background, i.e. self-identified as Punjabi or White, of European heritage, with the latter having all family members born and raised in North America.

Ethnic Background _____

How did participant hear about the study _____

Participant suitable/not suitable/ not required

Participant notified on _____ by _____

NOTE: To protect the confidentiality of the participants, please file ALL screening sheets.

Appendix 8: Consent Form for Interviews

THE UNIVERSITY OF BRITISH COLUMBIA



Food, Nutrition and Health
Faculty of Agricultural Sciences
2205 East Mall
Vancouver, BC, V6T 1Z4
Phone: (604) 822-6874
Fax: (604) 822-5143

Consent Form

Project Title:

THE FAMILY CONTEXT OF FOOD DECISION-MAKING IN DIVERSE
ETHNOCULTURAL GROUPS

This project has been funded by the Canadian Institutes for Health Research
(CIHR)

Principal Investigators:

Dr. Gwen Chapman
Food, Nutrition and Health
Faculty of Agricultural Sciences, UBC
Vancouver, BC
Phone: 604-822-6874

Dr. Brenda Beagan
School of Occupational Therapy
Faculty of Health Professions
Dalhousie University, Halifax, NS
Phone: 902-494-6555

Co-Investigators:

Josephine Enang
School of Nursing
Faculty of Health Professions
UBC
Dalhousie University, Halifax, NS
Phone: 902-494-6534

Ryna Levy-Milne
Food, Nutrition and Health
Faculty of Agricultural Sciences,
Vancouver, BC
Phone: 604-822-6869

Shefali Raja
Vancouver Coastal Health
Vancouver, BC
Phone: 604-707-3640

Satnam Sekhon
BC Cancer Agency
Vancouver, BC
Phone: 604-877-2394

Graduate Student:

Svetlana Ristovski-Slijepcevic, PhD student
Food, Nutrition, and Health, Faculty of Agricultural Sciences, UBC
Vancouver, BC, Phone: 604-827-5764
(Parts of this research will be used for a PhD thesis in Human Nutrition at the
University of British Columbia)

Introduction:

You have been invited to participate in this study because you are a member of one of the ethnocultural groups included in this study, and your family meets the criteria for inclusion in this study. (Families participating in this study must include at least 3 people who live together and are willing to be interviewed, all of who are 13 years old or older, and at least one of who is a woman aged 25-55 years.)

Purpose:

The purpose of this study is to examine how families from three diverse ethnocultural groups make decisions about what they eat. The three ethnocultural groups included in the study are Punjabi British Columbians, African Nova Scotians, and European Canadians living in British Columbia and Nova Scotia.

The research questions that we will address are:

4. How do Punjabi British Columbian families, African Nova Scotian families, and European Canadian families in BC and Nova Scotia decide what food they will eat?
5. In what ways and contexts are different family members responsible for making food-related decisions, and how do they influence each other?
6. How are food decision-making processes and outcomes affected by:
 - d. Gender roles and relations within the family?
 - e. Age and life-stage of family members?
 - f. Health concerns and beliefs of family members?

Study Procedures:

Your involvement in this study will include several components, involving a total of 2 to 10 hours of *your* time, and a total of up to 15 hours with members of your family.:

1. Individual interview. In a private interview, a researcher will ask you to talk about what you and other members of your family eat, and how those eating habits relate to things like your culture, health concerns and personal preferences. You will also be asked to talk about how food-related decisions are made in your family, including who makes the decisions and how family members influence each other. The interview will last approximately 1 hour, and will be tape-recorded. In addition to yourself, at least 2 other members of your family will be interviewed.
2. Grocery shopping. If you usually participate in buying groceries for your household, the same researcher who interviews you will accompany you (and other family members if they often participate in buying groceries) on a 'typical' grocery shopping trip. The researcher will observe what foods you select and ask you to talk about why you are buying those products and not others. The conversation will be tape-recorded, and the researcher will write detailed notes about the shopping trip. The researcher will provide you with a copy of those notes if you wish.

3. Family meal. The researcher will also attend one 'typical' family meal in your household, including food preparation, serving, eating and cleaning up. The researcher will observe and talk to household members about what is happening. Immediately after, the researcher will write detailed notes about the meal. The researcher will provide you with a copy of those notes if you wish.
4. Follow up interviews. You may be asked to participate in an additional interview, either alone or with other family member, to follow up on issues raised during initial interviews, the shopping trip, or participant observation. If you wish, you can decline to participate in this follow-up without affecting your previous participation or honorarium. If there are issues that you want to discuss further with the researcher, you can request this follow-up interview.

Confidentiality:

Your identity will be kept strictly confidential throughout the study and whenever we report the findings of the study. Any tapes, notes and interview transcripts will be labelled with a code number and/or false name, and stored in a locked filing cabinet. Your name will be recorded only on this consent form and on one master list that links your name to your code number and/or false name. The consent form and master list will be stored in a separate locked filing cabinet, accessible only to members of the research team. Any computer files relating to this research will be stored on password protected computers only members of the research team can access. When we report the findings of this study, we will not report details about you or your family that would allow others to identify you.

Remuneration/Compensation:

In order to compensate you and your family for the time and inconvenience involved in participating in this project, your family will receive a \$100 honorarium. This will be in the form of a gift certificate to a grocery store where your family shops and, if teenagers participate in the study, movie passes or a gift certificate for a CD for each teenager who participates in an interview.

Risks:

Participation in this research may cause you some inconvenience due to the time involved. There is also a possibility that differences of opinion within your family and tensions or grievances around food choice issues may be highlighted through the research, causing conflict. If this occurs and is a problem for your family, we can provide you with a referral to a family counselling service.

Within the relatively small Punjabi British Columbian and African Nova Scotian communities, it is possible that despite our best efforts to describe participants in ways that will not allow other community members to identify them, some families may be identifiable to other community members who know them well.

Finally, because we will be talking about specific ethnocultural groups, there is the risk that our findings could be used to create unfair stereotypes. To minimize this risk, we will analyze our data in ways that highlight diversity within ethnocultural groups. As well, our research team includes members of the two minority

ethnocultural groups, and the research assistants who will collect and analyze data with the minority groups are members of those communities. All reports will be reviewed by the entire research team to ensure that we are not unfairly stereotyping the study groups. Finally, you will be given opportunities to give us feedback on our preliminary findings to also minimize the risk that we contribute to unfair stereotyping.

Future use of data:

We do not have specific plans for use of the data collected for this study other than what is described in this form. However, the principal investigators may wish to use the data in future studies on similar topics (e.g., with different cultural groups), or for teaching purposes (e.g., qualitative research methods courses). Your identity will be kept strictly confidential in any of these situations.

Contact for information about the study:

You are welcome to ask any questions, at any time, regarding any aspect of this study. You may ask questions of the researcher who is interviewing you, and/or you may contact one of the Principal Investigators: Dr. Gwen Chapman 604-822-6874 or Dr. Brenda Beagan at 902-494-6555.

Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without any consequences to your relationship with the University, health care, or community services.

Signature page:

Your signature below indicates that:

1. You have received a copy of this consent form for your own records
2. You consent to participate in this study.

Participant Signature

Date

Printed Name of the Participant signing above.

Parental Consent (required for participants younger than 19 years of age)

I consent/I do not consent (circle one) to my child's participation in this study.

Parent or Guardian Signature

Date

Printed Name of the Parent or Guardian signing above.

Witness

Witness Signature

Date

Printed Name of the Witness signing above.

Signature page:

Your signature below indicates that:

- 3. You have received a copy of this consent form for your own records
- 4. You consent to participate in this study.

Participant Signature

Date

Printed Name of the Participant signing above.

Parental Consent (required for participants younger than 19 years of age)

I consent/I do not consent (circle one) to my child's participation in this study.

Parent or Guardian Signature

Date

Printed Name of the Parent or Guardian signing above.

Witness

Witness Signature

Date

Printed Name of the Witness signing above.

Appendix 9: Interview Guide - Adults

1. **Introductory** issues: explanation of interview procedures, informed **consent** (if not already obtained), confidentiality. We are not here to judge your diet or lifestyle but to hear about the way you decide what to eat.
2. To start with, can you tell me a **bit about yourself** and your living situation? (Probes: Occupation? Who do you live with? How long have you been in that living situation? Immigration status?)
3. Can you tell me about what you would eat on a **typical weekday** from the time you get up until the time you go to bed? How does your day usually start? (If a ‘typical’ day is hard, suggest a specific recent weekday, such as yesterday.)
(Primary focus: interviewee; Secondary focus: other family members)
(Work day vs non-work day, in terms of interviewee’s schedule)
 - What would you eat, where, when, with whom (if anyone)?
 - [if it’s not already clear] **Why** would you eat then/there/with those people?
 - How would you decide what to eat?
 - Who would prepare the food?
 - [if others eat at the same time] Would the others present also be eating? [if the others are family] Would they eat the same thing as you?
 - Family interactions around food (What’s going on – TV, talk, other? What do you talk about?)
4. What about a **typical weekend day**? What would you eat? (When, where, with whom? Probe as in question 3).
5. Who decides **what the child/ren** in the house **eat**? How? (Impact of child/ren? older sibling/s? friends? advertising?)
6. How often does it happen that you **get to eat** (or prepare) **things you really like** that maybe others in your family don’t like to eat? (How does that come to be? Responses of others?)
7. How often does it happen that you **have to eat** (or prepare) **things you really don’t like** that maybe others in your family *do* like to eat? (How does that come to be? Your response? Responses of others?)
8. When foods are served that members of your family **do not like, how do they react**?
9. What does the term **‘family meal’** mean to you? How important is this for you? **Why**?
10. How does your family **decide who will clean up** after eating, i.e. kitchen and dishes?
11. How does **grocery shopping** get done in your household? (Probes: Who shops? Where? How often? Who decides what should be purchased?)
12. To summarize, what you are saying is that (summarize gender roles)...? How do you feel about it? How did it come to be that way? Has anyone tried to make changes?

13. (Summarize factors mentioned that affect the way participant and family eat.) When thinking about your diet, what factors **influence** it most? (Probe convenience/time, cost, health/body, food preferences – self/others, culture, food quality)
14. How often do you **eat out**? (Probe: Where? What situations? With whom? Who decides where/when/what you will eat? Include friends' houses as well as restaurants) This may sound like a strange question, but it has come up through our research so far! To what extent is **cleanliness** a concern when you are eating outside your own home?
15. In many families, people argue about who should cook, who should clean up, who should shop. What kinds of **arguments or disagreements** are there in your household around food and food-related work?
16. What do you like about the way you eat? What do you think is **'good' about the way you eat**?
17. What **concerns** do you have **about the way you eat**? (Probe: supplement use, body image/weight concerns).
18. There's a lot of talk about healthy eating these days. What does the **term 'healthy eating'** mean to you? How well does that fit with your lifestyle, traditions, culture? How 'healthy' do you think your eating habits are? Why? Is this an issue for you?
19. **Where have you learned** about 'healthy eating'? (Specific examples if possible.) Has this changed over time? Do you believe the things you read or see about 'healthy eating'? Why/why not?
20. What kinds of things would you **like to learn about 'healthy eating'**? (If nothing: What would motivate you to want to learn more?) What would be the best ways for you to get information like this? (Probe: As a general statement or one detailing scientific evidence? What sources might be most trusted? Culturally specific or generic?)
21. What do you think would happen if you **decided your family should eat healthier** (vegan, more f&v, low carbs – depending on what is healthy to them)? How would people react? (What if someone else in the family – [e.g., name other potential person in family with 'power'] - decided this? How would *you* react? How would others react?)
22. Does anyone in your family have a **health problem** that is affected by diet? (What condition? How long has it been an issue?) What difference, if any, has it made in your household? How did/do different family members react to this situation?
23. How have your eating patterns been affected by **what you ate** while you were **growing up**, or your family background? (Is there a **'Maritime'** way of eating? **Black** ways of eating?) How important is it to you to eat in ways that reflect your culture? (For Whites: ask how they define their cultural background; how it affects the foods they eat)
24. Have your eating habits **changed over time**? Why?
25. I've finished all my questions. Is there anything you'd like to add in relation to what we've been talking about? Thank you. This has been very helpful...

Appendix 10: Interview Guide - Teenagers

1. **Introductory** issues: explanation of interview procedures, informed **consent** (if not already obtained), confidentiality. We are not here to judge your diet or lifestyle but to hear about the way you decide what to eat.
2. To start with, can you tell me a **bit about yourself**? (Probes: What grade are you in? Who else lives there?).
3. Can you tell me about what you would eat on a **typical weekday** from the time you get up until the time you go to bed? How does your day usually start? (If a 'typical' day is hard, suggest a specific recent weekday, such as yesterday.)
(Primary focus: interviewee; Secondary focus: other family members)
(Work day vs. non-work day, in terms of interviewee's schedule)
 - What would you eat, where, when, with whom (if anyone)?
 - [if it's not already clear] Why would you eat then/there/with those people?
 - How would you decide what to eat?
 - Who would prepare the food?
 - [if others eat at the same time] Would the other people also be eating? [if the others are family] Would they eat the same thing as you?
 - Family interactions around food (What's going on – TV, talk, other? What do you talk about?)
4. What about a **typical weekend day**? What would you eat? (When, where, with whom? Probe as in question 3 above).
5. **Who usually decides** what you (and others) will eat at a meal?
6. How often does it happen that you **get to eat things you really like** that maybe others in your family don't like to eat? (How does that come to be? Responses of others?)
7. How often does it happen that you **have to eat things you really don't like** that maybe others in your family *do* like to eat? (How does that come to be? Your response? Responses of others?)
8. When foods are served that members of your family **do not like, how do they react**?
9. What does the term '**family meal**' mean to you? How important is this for you? **Why**?
10. How does your family **decide who will clean up** after eating, i.e. kitchen and dishes?
11. How does **grocery shopping** get done in your household? (Probes: Who shops? Where? How often? Who decides what should be purchased?)
12. To summarize, what you are saying is that (summarize gender roles)...? How do you feel about it? How did it come to be that way? Has anyone tried to make changes?

13. (Summarize factors mentioned that affect the way participant and family eat.) When thinking about your diet, what factors **influence** it most? (Probe convenience/time, cost, health/body, food preferences – self/others, culture, food quality)
14. How often do you **eat out**? (Probe: Where? What situations? With whom? Who decides where/when/what you will eat? Include friends' houses as well as restaurants)
15. Lots of families argue about who should cook, who should clean up, who should shop. What kinds of **arguments or disagreements** are there in your household around food, such as what to eat? What about arguments over who should shop or clean up?
16. What do you like or think is **'good' about the way you eat**?
17. What do you think is **not so good** about the way you eat? (Probe: supplement use, body image/ weight concerns).
18. What does the **term 'healthy eating'** mean to you? How 'healthy' do you think your eating habits are? Why? Does this matter to you?
19. **Where have you learned** about 'healthy eating'? (Specific examples if possible.) Do you believe the things you read or see about 'healthy eating'? Why/why not?
20. What kinds of things would you **like to learn about 'healthy eating'**? (If nothing: What would motivate you to want to learn more?) What would be the best ways for you to get information like this? (Sources most trusted? Type of information?)
21. What do you think would happen if you **decided your family should eat healthier** (vegan, more f&v, low carb – depending on what they think is healthy) How would people react? (What if someone else in the family - [e.g., name other potential person in family with 'power'] - decided this? How would *you* react? How would others react?)
22. Does anyone in your family have a **health problem** that is affected by diet? (What is the health condition, how long has it been an issue?) What difference, if any, has it made in your house? How did/do different family members react to this?
23. How do you think your eating is influenced by your friends? By your family? By advertising? ([this may or may not fit] do you think there are Black/Maritime ways of eating?) (For White group: ask how they define their cultural background; how their cultural background affects the foods they eat)
24. Have your eating habits changed over time? Why?
25. I've finished all my questions. Is there anything you'd like to add in relation to what we've been talking about? Thank you. This has been very helpful...

Appendix 11: Grocery Store Interview Guide

Grocery Store Guiding Questions

1. I see you are choosing (name of food). Can you tell me why you are choosing that particular product)? Do you usually buy (name of food)?
2. What considerations do you make when you choose (name of food)? PROBE: Do you eat this (name of food) or are you buying it for someone else?
3. Can you tell me why you are choosing this particular brand of (name of food)?
4. I notice you are not buying (name of food). Can you say why? (or You skipped the entire _____ aisle, can you say why?)

Appendix 12: Consent Form for Meal Observation

THE UNIVERSITY OF BRITISH COLUMBIA



Food, Nutrition and Health
Faculty of Agricultural Sciences
2205 East Mall
Vancouver, BC, V6T 1Z4
Phone: (604) 822-6874
Fax: (604) 822-5143

Meal Observation Consent Form

Project Title:

THE FAMILY CONTEXT OF FOOD DECISION-MAKING IN DIVERSE
ETHNOCULTURAL GROUPS

This project has been funded by the Canadian Institutes for Health Research
(CIHR)

Principal Investigators:

Dr. Gwen Chapman
Food, Nutrition and Health
Faculty of Agricultural Sciences, UBC
Vancouver, BC
Phone: 604-822-6874

Dr. Brenda Beagan
School of Occupational Therapy
Faculty of Health Professions
Dalhousie University, Halifax, NS
Phone: 902-494-6555

Co-Investigators:

Josephine Enang
School of Nursing
Faculty of Health Professions
UBC
Dalhousie University, Halifax, NS
Phone: 902-494-6534

Ryna Levy-Milne
Food, Nutrition and Health
Faculty of Agricultural Sciences,
Vancouver, BC
Phone: 604-822-6869

Shefali Raja
Vancouver Coastal Health
Vancouver, BC
Phone: 604-707-3640

Satnam Sekhon
BC Cancer Agency
Vancouver, BC
Phone: 604-877-6000

Graduate Student:

Svetlana Ristovski-Slijepcevic, PhD student
Food, Nutrition, and Health, Faculty of Agricultural Sciences, UBC
Vancouver, BC, Phone: 604-827-5764

(Parts of this research will be used for a PhD thesis in Human Nutrition at the
University of British Columbia)

Introduction:

Your family has been invited to participate in this study because it is part of one of the ethnocultural groups included in this study, and meets the criteria for inclusion in this study. (Families participating in this study must include at least 3 people who live together and are willing to be interviewed, all of who are 13 years old or older, and at least one of who is a woman aged 25-55 years.)

Purpose:

The purpose of this study is to examine how families from three diverse ethnocultural groups make decisions about what they eat. The three ethnocultural groups included in the study are Punjabi British Columbians, African Nova Scotians, and European Canadians living in British Columbia and Nova Scotia.

The research questions that we will address are:

7. How do Punjabi British Columbian families, African Nova Scotian families, and European Canadian families in BC and Nova Scotia decide what food they will eat?
8. In what ways and contexts are different family members responsible for making food-related decisions, and how do they influence each other?
9. How are food decision-making processes and outcomes affected by:
 - g. Gender roles and relations within the family?
 - h. Age and life-stage of family members?
 - i. Health concerns and beliefs of family members?

Study Procedures:

Your involvement in this study will include being a part of a family meal that is being observed by a researcher. The researcher will attend one 'typical' family meal in your household, including food preparation, serving, eating and cleaning up. The researcher will observe and talk to household members about what is happening. Immediately after, the researcher will write detailed notes about the meal. The researcher will provide you with a copy of those notes if you wish. Your involvement in the study will take 1-3 hours.

At least 3 other members of your family are involved in additional aspects of this study, including participating in a private interview and being accompanied by the researcher on a 'typical' grocery shopping trip.

Confidentiality:

Your identity will be kept strictly confidential throughout the study and whenever we report the findings of the study. Any notes pertaining to the meal observation will be labelled with a code number and/or false name, and stored in a locked filing cabinet. Your name will be recorded only on this consent form and on one master list that links your name to your code number and/or false name. The consent form and master list will be stored in a separate locked filing cabinet, accessible only to members of the research team. Any computer files relating to this research will be stored on password protected computers only members of the research team can

access. When we report the findings of this study, we will not report details about you or your family that would allow others to identify you.

Remuneration/Compensation:

In order to compensate your family for the time and inconvenience involved in participating in this project, your family will receive a \$100 honorarium. This will be in the form of a gift certificate to a grocery store where your family shops and, if teenagers participate in the study, movie passes or a gift certificate for a CD for each teenager who participates in an interview.

Risks:

Participation in this research may cause you some inconvenience due to the time involved. There is also a possibility that differences of opinion within your family and tensions or grievances around food choice issues may be highlighted through the research, causing conflict. If this occurs and is a problem for your family, we can provide you with a referral to a family counselling service.

Within the relatively small Punjabi British Columbian and African Nova Scotian communities, it is possible that despite our best efforts to describe participants in ways that will not allow other community members to identify them, some families may be identifiable to other community members who know them well.

Finally, because we will be talking about specific ethnocultural groups, there is the risk that our findings could be used to create unfair stereotypes. To minimize this risk, we will analyze our data in ways that highlight diversity within ethnocultural groups. As well, our research team includes members of the two minority ethnocultural groups, and the research assistants who will collect and analyze data with the minority groups are members of those communities. All reports will be reviewed by the entire research team to ensure that we are not unfairly stereotyping the study groups. Finally, you will be given opportunities to give us feedback on our preliminary findings to also minimize the risk that we contribute to unfair stereotyping.

Future use of data:

We do not have specific plans for use of the data collected for this study other than what is described in this form. However, the principal investigators may wish to use the data in future studies on similar topics (e.g., with different cultural groups), or for teaching purposes (e.g., qualitative research methods courses). Your identity will be kept strictly confidential in any of these situations.

Contact for information about the study:

You are welcome to ask any questions, at any time, regarding any aspect of this study. You may ask questions of the researcher who is interviewing you, and/or you may contact one of the Principal Investigators: Dr. Gwen Chapman 604-822-6874 or Dr. Brenda Beagan at 902-494-6555.

Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without any consequences to your relationship with the University, health care, or community services.

Your signature below indicates that:

- 5. You have received a copy of this consent form for your own records
- 6. You consent to participate in this study.

Participant Signature Date

Printed Name of the Participant signing above.

Parental Consent (required for participants younger than 19 years of age)

I consent/I do not consent (circle one) to my child's participation in this study.

Parent or Guardian Signature Date

Printed Name of the Parent or Guardian signing above.

Witness

Witness Signature Date

Printed Name of the Witness signing above.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without any consequences to your relationship with the University, health care, or community services.

Your signature below indicates that:

- 7. You have received a copy of this consent form for your own records
- 8. You consent to participate in this study.

Participant Signature _____ Date _____

Printed Name of the Participant signing above. _____

Parental Consent (required for participants younger than 19 years of age)

I consent/I do not consent (circle one) to my child's participation in this study.

Parent or Guardian Signature _____ Date _____

Printed Name of the Parent or Guardian signing above. _____

Witness

Witness Signature _____ Date _____

Printed Name of the Witness signing above. _____

Appendix 13: Code List by Category

Practices:	Influences:	Processes:	Who?
Food choice	Availability/ accessibility	Control/monitor	Self
Shopping	Body image/body weight	Decision making	Partner
Planning	Childhood eating	Household food rules	Child
Preparation	Cleanliness/food safety	Reactions	Father
Gets own meal	Comfort food/ treats	Tensions/conflict	Mother
Makes own meal	Convenience	Learning within family	Sibling
Cleaning	Cost		Immediate family
Eating patterns	Creativeness		Other
Eating out	Culture/Tradition		
Family meal	Exposure to new/different foods		
Special meals	Family roles/gender		
Activities while eating	Feelings		
Supplements	Food identity/relationship		
Healthy Eating/ nutrition	Habit	Discursive	Demographics
Good eating	Health concerns	Changes occurred	Male/female
Bad eating	Health status	Changes desired	ANS/PBC/W
Physical activity	Home cooked/ home made	Ideals/values	Income1/2/3/4
	Hunger/appetite	I shouldn't but...	NS/BC
	Life stage		Child participant
	Media/ads		Adult participant
	Needs		Elder participant
	Peer norms		Cohabiting/ married
	Politics/ethics		Single
Knowing:	Preferences		
Sources of info	Quality		
Trust in info	Religion/ spirituality		
Ways of knowing	Season		
	Skills		
	Time/schedule		
	Trends/fads		
	Variety		
	Vegetarian		

Appendix 14: Guidelines for Questions and Writing Fieldnotes

With all of the food choices we want to know what kinds of considerations tend to arise when choosing specific foods, and when choosing specific brands of that food. Also *how* do food choices get made?

At the end of the trip you want to be able to answer:

To what extent are the following concerns guiding purchases? What are the shopper's priorities?

nutritional concerns

cost

brand loyalty

own food preference (taste)

others' food preferences

familiarity

a 'special' purchase

convenience of purchase (available at this store)

convenience of preparation

politics about food

If more than one person is shopping, to what extent is food purchasing negotiated (what differing priorities are being negotiated? how?) a consensus (what priorities guide decisions?) conflictual (what priorities seem to be in conflict? how are decisions made?) habitual (not able to articulate reasons for choices)

Do they shop with a list? Who made it? If no list, how do they know what to buy?

Appendix 15: Introducing the Two Minority Ethnocultural Groups: Punjabi British Columbians and African Nova Scotians

South Asian immigration began with a few hundred people coming to North America at the turn of the 20th century. More recently, there have been two larger waves of immigration. The first wave was in the period of 1960s-70s, with a demographic profile of well educated urban professionals who are said to have acculturated well upon arrival. The second wave was in the late 1980s-90s, with a demographic profile of less well-educated, rural people, whose acculturation is said to be more difficult (Kitler & Sucher, 1998). In B.C. today, there are 183,635 people who identify as 'East Indian' (Statistics Canada, 2001). In the Vancouver (Mainland/Southwest) region alone, 70,215 reported Punjabi as their mother tongue in 2001, an increase from 54,725 in 1996 (B.C. Ministry of Community, Aboriginal & Women's Services, 2001).

Typical cultural foods of South Asians include roti (flat bread), dahl (legumes), rayta (spiced yogurt), varieties of curry and masalas (spices) and meat (although a large number of Punjabis are vegetarian). Principles of Ayurvedic medicine, based on balancing three humors of the body are believed to ensure health and longevity. Food is used both for therapeutic reasons (e.g., balancing between hot and cold foods), as well as for symbolic and religious reasons (e.g., feasting and fasting) (Kitler & Sucher, 1998).

Compared to South Asians, the beginning of immigration of Africans to the southern states of U.S.A. occurred several centuries earlier. Immigration occurred not choice but by force during the slavery period between the 15th and the 19th century. Many moved up north in America and Canada after slavery was abolished in 1834. The African Nova Scotian population, in particular, remained relatively small until 1783. But the American War of Independence brought many slaves and a large number of free black

settlers to Nova Scotia. Almost 10,000 people of African descent came to Nova Scotia between 1749 and 1816. During this period, enslaved African Nova Scotians worked as domestics, agricultural labourers and seafarers. After the end of the slavery period, some emigrated elsewhere (West Africa, Trinidad), but most remained and developed strong communities in Nova Scotia (Kitler & Sucher, 1998; Nova Scotia Archives & Records Management, 2004). According to the latest reports, 6,405 people identify as ‘African (Black)’ and 3,250 identify as ‘Black’ in Nova Scotia (Statistics Canada, 2001).

Although there is almost no information about the food habits of African Nova Scotians, some information exists about the food habits of African Americans. Their current diet can be said to reflect the historical influence of foods commonly eaten in Africa (prior to their coming in North America), foods commonly eaten as slaves in the U.S., and regional foods and preparation methods common in the part of North America they reside in today. The staple foods from Africa varied between regions, but common foods included corn, millet, chicken, and peanuts. Tomatoes, hot chile peppers and onions were used as seasonings. Foods were typically cooked in palm oil and were mainly either fried or boiled. Most dishes preferred were spicy, thick, and sticky. The slave diet also varied depending on the region and what the owner provided. Typical foods were salt pork, corn, rice, and local herbs. Frying and boiling were most common preparation methods.

Today, the diet of African Americans is an amalgamation of the past and present foods available. Socioeconomic status, geographic location, availability of foods on the market, and work schedule are important food choice factors, but so are these traditional foods which, due to the historical significance associated with the slavery period, are considered “soul food” (Kittler & Sucher, 1998). Soul foods are less related to the actual food patterns (which may be somewhat similar to food patterns of Caucasians in the

region) and are more related to the symbolism and historical context associated with the foods prepared and eaten under slavery. Some of the foods are considered healthy, but others, (like the prominent use of frying) are not (Airhihenbuwa et al., 1996). These are further complicated by numerous cultural beliefs about food and health (Jackson, 1981).

References

- Airhihenbuwa, Collins O., & Kumanyika, S. (1996). Cultural aspects of African American eating patterns. *Ethnicity & Health, 1*, 145-260.
- B.C. Ministry of Community, Aboriginal & Women's Services. (2001). Profile of immigrants in B.C. communities: Mainland/Southwest.
- Jackson, J.J. (1981). Urban black Americans. In P.G. Kittler, & K.P. Sucher (Eds.), (1998). *Food and Culture in America: A Nutrition Handbook*, 2nd edition, (p.232). Belmont: West/Wadsworth.
- Kittler, P.G., & Sucher K.P. (1998). *Food and Culture in America: A Nutrition Handbook*, 2nd edition. Belmont: West/Wadsworth.
- Nova Scotia archives & records management. (2004).
<http://www.gov.ns.ca/nsarm/virtual/africanns/>, accessed November 22nd, 2004.
- Statistics Canada. (2001).
<http://www.statcan.ca/menu-en.htm>, accessed October 18th, 2004.

Appendix 16: Participants' Summary Sheet

Family Codes:

ANS – African Nova Scotian family
ENS – European Nova Scotian family
PBC – Punjabi British Columbian family
EBC – European British Columbian family

Participant Codes:

CW – core woman
P – CW's partner
D – daughter (D1 – older daughter; D2 – younger daughter)
S – son (S1 – older son; S2 – younger son)
M – CW's live-in mother
F – CW's live-in father
MinL – CW's live-in mother-in-law
FinL – CW's live-in father-in-law
Sib – CW's live-in sibling
D1'sB – CW's older daughter's live-in boyfriend

Family Income Codes:

1 – \$0-\$20,000
2 - \$21,000-50,000
3 - \$51,000-\$90,000
4 - \$90,000 +

Family Code	Participant Code	Gender	Age	Education	Occupation	Family Income	Religion	Immigration Status (Punjabi BC participants)
EBC21.1	P	F	51	MA	Admin.Educ assistant	3	United	
EBC21.2	S2	M	12	In high school			United	
EBC21.3	CW	F	43	BA	Legal assistant		United	
Not interviewed: 3 more children – 1 M (does not live with them, but comes often), 2 F.								
EBC22.1	D2	F	14	Grade 8	Home-schooled, p/t work in pet store	1		
EBC22.2	D1	F	19	High school	P/t work, college in fall			
EBC22.3	CW	F	42	2.5yrs univ	unemployed		Anglican	
All family members interviewed.								
EBC23.1	CW	F	47	PhD	Associate Director (health)	4	Jewish	
EBC23.2	S1	M	14	Grade 9			Jewish	
EBC23.3	P	M	48	PhD	UBC – Director of Business Dev't		Jewish	
Not interviewed: D, declined to participate in study altogether.								

EBC24.1	S1	M	19	High school	Cook in a restaurant	3	n/a	
EBC24.2	CW	F	47	3 yrs univ	p/t clerical, writer		n/a	
EBC24.3	P	M	56	Some college	CBC – radio journalist		n/a	
All family members interviewed.								
EBC25.1	CW	F	51	SFU	Tutor/ librarian on leave	3	n/a	
EBC25.2	P	M	47	BA-Bed	teacher		n/a	
EBC25.3	D1	F	20	UBC student	p/t clerical		n/a	
Not interviewed: S (9 year old).								
EBC26.1	CW	F	44	Univ	P/t teacher	3	United	
EBC26.2	D	F	16	Grade 9			United	
EBC26.3	P	M	44	Univ	Teacher		United	
Not interviewed: S (11 yrs old)								
EBC27.1	D	F	16	Grade 9		4	United	
EBC27.2	CW	F	47	MA	College instructor		United	
EBC27.3	P	M	58	2 yrs post secondary	Retired police officer, WCB manager		United	
Not interviewed: S (12 yrs old)								
EBC28.1	S	M	17	High school	n/a	1		
EBC28.2	P	M	30	< high school	construction			

EBC28.3	CW	F	36	college	Self employed			
Not interviewed: D (2 yrs old)								
EBC29.1	D1'sB	M	22	High school		4		
EBC29.2	D1	F	18	High school	Waitress, p/t			
EBC29.3	S	M	17	Grade 12				
EBC29.4	D2	F	16	Grade 11	Waitress, p/t			
EBC29.5	CW	F	55	Post secondary	Executive Director			
Not interviewed: none								
EBC30.1	D1	F	19	Grade 12	dishwashing, various temp	2	n/a	
EBC30.2	CW	F	52	Post secondary	Youth-Family counsellor		n/a	
EBC30.3	D2	F	16	Grade 12	Starbucks p/t		n/a	
Not interviewed: none								
EBC31.1	P	F	50(?)	college	waitress	1	Christian	
EBC31.2	CW	F	39	college	self-employed/housecleaning		Christian	
EBC31.3	D1	F	13	Grade 8	student		Christian	
Not interviewed: 4 more younger children (+ 1 older son, doesn't live with them anymore)								
ENS1.1	CW	F	46	Masters	librarian			

ENS1.2	D1	F	15	Grade 10	In school	4		
ENS1.3	P	M	47	PhD	Marine Biologist			
Not interviewed: S (12 years old), D2 (9 years old) Son has Type 1 Diabetes, CW is vegetarian								
ENS2.1	CW	F	49	BA	unemployed	2	Unitarian Universalist	
ENS2.2	D2	F	16	Grade 11	Student/Counter server (p/t)		n/a	
ENS2.3	D1	F	18	Univ 2nd year	student		n/a	
Not interviewed: None CW and D1 are vegetarian								
ENS3.1	CW	F	40	Masters	Director Client Services	4	n/a	
ENS3.2	S	M	13	Grade 9			n/a	
ENS3.3	P	F	33	Bachelor's	Music teacher		Anglican	
Not interviewed: None								
ENS4.1	CW	F	46	Diploma Respiratory Technologist	Respiratory Technologist	4	United	
ENS4.2	P	M	48	Diploma Computer Sciences	Computer Technologist		United	
ENS4.3	S	M	16	Grade 11	Student/Grocery store clerk		United	
Not interviewed: None								

ENS5.1	CW	F	40	Less than Gr 12	On social assistance	1	N/A	
ENS5.2	S1	M	23	Less than Gr 10	On social assistance		N/A	
ENS5.3	S2	M	17	Grade 11	Student/Delivers flyers		N/A	
Not interviewed: None								
ENS6.1	CW	F	46	Gr. 12	Office Administrator	3	Roman Catholic	
ENS6.2	D	F	15	Gr. 10	Student		Roman Catholic	
ENS6.3	S	M	17	Gr. 12	Student/works at movie theatre		Roman Catholic	
ENS6.4	P	M	46	GED	Self-employed truck driver		Roman Catholic	
Not interviewed: None								
ENS7.1	CW	F	44	Diploma Bus. Ed.	Does not have paid work	3	Pentecostal	
ENS7.2	D1	F	15	Gr. 10	Student		Pentecostal	
ENS7.3	P	M	45	Gr. 11	Manager, Flooring Centre		Pentecostal	
Not interviewed: S (19), D2 (12)								
ENS8.1	CW	F	43	Comm. College	Prog. Assistant, Children's Hosp.	2	Catholic	

ENS8.2	D3	F	13	Gr. 8	Student		Catholic		
ENS8.3	D2	F	14	Gr. 9	Student		Catholic		
ENS8.4	D1	F	19	Gr, 12	Retail Store Clerk		Catholic		
Not interviewed: None									
ENS9.1	CW	F	41	Gr. 12	VON	3	Anglican		
ENS9.2	P	M	43	University	Groc. Store Mgr.		Anglican		
ENS9.3	D	F	15	Gr. 9	Student/Groc. Store Clerk		Anglican		
Not interviewed: none									
ENS10.1	CW	F	40	RN	Does not have paid employment	3	Not practicing any religion, raised RC		
ENS10.2	D1	F	14	Gr.9	Student		N/A		
ENS10.3	P	M		BBACom, DMA	Revenue Canada		N/A		
Not interviewed: D2, 12 years, Gr.6.									
ANS1.1	CW	F	41	College	Dental Assistant	3	Baptist		
ANS1.2	P	M	43	College	Electrician		Baptist		
ANS1.3	D	F	14	Gr. 9	Student		Baptist		
Not interviewed: D2 (8)									

ANS2.1	CW	F	39	Gr. 10	Room Attendant	2	N/A	
ANS2.2	D1	F	16	Gr. 12	Student		N/A	
ANS2.3	D2	F	14	Gr. 9	Student		N/A	
Not interviewed: P (41) GED, cook/labourer								
ANS3.1	E	F	59	UNK	Domestic	2	Baptist	
ANS3.2	D	F	16	Gr. 10	Student		Baptist	
ANS3.3	CW	F	38	Gr. 12	Daycare worker		Baptist	
Not interviewed: F (28), F(19), F (15), M(21), M (12), M (10), foster children and biological children of E								
ANS4.1	CW	F	45	Gr. 9		2		
ANS4.2	D	F	18	Gr. 9				
Not interviewed: S (21), unwilling to be interviewed,								
ANS5.1	D	F	28	Gr. 11		2	Baptist	
ANS5.2	CW	F	46					
ANS5.3		F	71					
ANS6.1	CW	F	43	Gr. 12		2	United	
ANS6.2	D	F	13	Gr. 8	Student		United	

ANS6.3	S	M	13	Gr. 8	Student		United	
ANS7.1	CW	F	40		Unemployed	1	Baptist	
ANS7.2	S	M	20	University	Student		Baptist	
ANS7.3	S	M	14		Student		Baptist	
Not interviewed: M, 10 months								
ANS8.1	D	F	14	High School	Student	4	Baptist	
ANS8.2	CW	F	44				Baptist	
ANS8.3	P	M	46	University	Security Mgr.		Baptist	
ANS9.1	CW	F	46	Gr. 12		2		
ANS9.2	S	M	21	Gr. 10	Student			
ANS9.3	D	F	21	Gr. 11	Student			
Not interviewed: F (8), F (8), Grandchild (3)								
ANS10.1	CW	F	38	College	Support worker	2	Baptist	
ANS10.2	D	F	16	Gr.10	Student		Baptistr	
Not interviewed: M (11); M (36) refused interview								

ANS20.1	CW	F	33	Gr.10	Unemployed	1	Baptist	
ANS20.2	P	M	41	Unknown	Construction		Baptist	
ANS20.3	D	F	15	Gr.9	Student		Baptist	
ANS21.1	CW	F	42	University	Student	2	Unknown	
ANS21.2	D1	F	18	High School	Student		Unknown	
ANS21.3	D2	F	15	Jr. high	Student		Unknown	
ANS21.4	P	M	42	Secondary	Student		Unknown	
Not interviewed: M (4)								
ANS22.1	CW	F	38	Homemaker				
ANS22.2	P	M	39	Librarian				
ANS22.3	S	M	14					
Not interviewed: M (20); F (15) F (16) F (3) foster children								
PBC1.1	CW	F	29	Bachelors	Pharmacist	4	Sikh	
PBC1.2	F	M	54	College	Airline Pilot		Sikh	
PBC1.3	Sib	M	24	Bachelors	Call Centre		Sikh	
Not interviewed: mother, 54								
PBC2.1	DinL	F	27	Bachelors	Health Inspector	4	Sikh	
PBC2.2	S	M	28	Bachelors	Law Student		Sikh	

PBC2.3	CW	F	48	College diploma	Care Aide		Sikh	
Not interviewed: husband (60yrs), Son (28yrs)								
PBC3.1	D	F	15	Grade 10	Student	4	Sikh	Born in Canada
PBC3.2	D	F	21	University	Student		Sikh	Born in Canada
PBC3.3	MinL	F	70	Grade school	Retired		Sikh	15 yrs from India
PBC3.4	CW	F	45	Diploma	Audit clerk		Sikh	35 years
PBC3.5	P	M	49	BA (India)	Self-employed		Sikh	25 years from India
PBC4.1	CW	F	42	College diploma	Home maker	3	Sikh	4 yrs from England
PBC4.2	P	M	43	BA in law	Immigration consultant		Sikh	5 years from England –
PBC4.3	D	F	13	Grade 8	Student		Sikh	4 years from England-
Not interviewed: Son (3yrs)								
PBC5.1	CW	F	35	diploma	Janitor & beautician	3	Sikh	1 year from India
PBC5.2	M	F	62	No formal education	Farm worker		Sikh	5 years from India
PBC5.3	P	M	38	Grade 10	Millwright & landscaper		Sikh	3 years from India
Not interviewed: CW's F (60's)								
PBC6.1	D	F	15	Grade 10	High school student		Sikh	Born in Canada

PBC6.2	CW	F	44	Grade 8 (English classes in Canada)	janitorial	4	Sikh	24 years from India
PBC6.3	MinL	F	69	Grade 5	Retired/ home maker		Sikh	15 years from India
Not interviewed: ?S (8yrs), ?D (12 yrs), MinL's brother (60 yrs), P (age?)								
PBC7.1	S	M	13	Grade 8	student	3	Sikh	Born in Canada
PBC7.2	P	M	50	MA (India)	Airport security guard		Sikh	24 years from India
PBC7.3	CW	F	41	MA, B Ed (India)	Courier company, office work		Sikh	14 years from India
Not interviewed: S (10 yrs), ?S (older teenager), CW's MinL								
PBC8.1	CW	F	37	BA (India)	janitorial	3	Sikh	12 years from India
PBC8.2	P	M	36	Grade 10	Construction- self- employed		Sikh	8 years from India
PBC8.3	M	F	60	No formal schooling	Seasonal farm worker/homemaker		Sikh	5 years from India
Not interviewed: D (5yrs), D (4 yrs)								
PBC9.1	CW	F	40	BA (India) Care Aide course	Care Aide	3	Sikh	17 years in Canada
PBC9.2	P	M	36	MSC (India) Computer course (Canada)	Computer programmer		Sikh	12 years in Canada
PBC9.3	MinL	F	57	Grade 9	homemaker		Sikh	8 years in Canada

Not interviewed: S (8 yrs), D (7 yrs), FinL								
PBC10.1	MinL	F	60	Grade school	Retired - homemaker	4	Sikh	33 years from India
PBC10.2	CW	F	27	University	Pharmacist		Sikh	13 years from England
PBC10.3	FinL	M	62	Grade school	Disability pension -retired millwright		Sikh	36 years from India
Not interviewed: P								
PBC11.1	P	M	56	Auto mechanic course	Self-employed	3	Sikh	33 years from India
PBC11.2	CW	F	43	Grade 12 India	Homemaker		Sikh	26 years from India
PBC11.3	D	F	14	High school	student		Sikh	Born in Canada
Not interviewed: S (25 yrs), S (16 yrs)								
PBC12.1	D	F	25	University	Lawyer- articling	3	Sikh	3 years from England
PBC12.2	D	F	25	University	Teacher on Call		Sikh	3 years from England
PBC12.3	CW	F	52		Bank teller		Sikh	3 years from England
PBC12.4	D	F	23	University	Pharmacist (England)		Sikh	3 years from England

