Critical Public Health

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/ccph20

Doing ‘healthier’ food in everyday life? A qualitative study of how Pakistani Danes handle nutritional communication

Bente Halkier & Iben Jensen

Department of Communication, Business and Information Technologies, Roskilde University, Roskilde, Denmark


To cite this article: Bente Halkier & Iben Jensen (2011): Doing ‘healthier’ food in everyday life? A qualitative study of how Pakistani Danes handle nutritional communication, Critical Public Health, 21:4, 471-483

To link to this article: http://dx.doi.org/10.1080/09581596.2011.594873

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.tandfonline.com/page/terms-and-conditions

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
Doing ‘healthier’ food in everyday life? A qualitative study of how Pakistani Danes handle nutritional communication

Bente Halkier* and Iben Jensen

Department of Communication, Business and Information Technologies, Roskilde University, Roskilde, Denmark

(Received 14 December 2010; final version received 26 May 2011)

Denmark has a strong tradition of public health communication, but the majority of these initiatives draw upon the deficit model where the so called target groups are seen as passive recipients that lack resources to change their lifestyle. The article contributes to the critique of the deficit model in public health communication by the way of two steps. First, by arguing in favour of using a contextual theoretical perspective, that includes multiple social conditions and dynamics, a combination of practice theory and intersectionality. Second, by presenting an ideal-typology of ways of doing ‘healthier’ food among Pakistani Danes, based on a qualitative empirical study of food habits, everyday life and dealings with nutritional communication.

Keywords: food; health behaviour; everyday life; communication; practice theory; intersectionality

Introduction

Denmark has a strong tradition of public health promotion in the food consumption area via information campaigns and dietary advice (Vallgårda 2001). But a majority of the Danish dietary advice and communication campaigns about a healthy diet usually do not consider how food is embedded in the multiple social relations and conditions of everyday life. Typically, dietary advice and communication campaigns also do not take into account what the resources of the particular target group are. Or rather, it is assumed that the target group lacks resources to carry out the changes of habits that are being communicated.

These two characteristics of the bulk of communication campaigns about healthier food habits are based on the traditional sender–receiver model in communication (McQuail 1998, Jensen 2002, Craig 2007). From this perspective, users of informational advice and communication campaigns are seen as passive receivers of knowledge, values, and guidelines. One specific version of the traditional sender–receiver framework is called ‘the deficit model’. It highlights the lack of resources among receivers in addition to the passive character of receiving (Hansen et al. 2003, Eden 2009). In other words, members of the specific target

*Corresponding author. Email: bha@ruc.dk

ISSN 0958–1596 print/ISSN 1469–3682 online
© 2011 Taylor & Francis
http://dx.doi.org/10.1080/09581596.2011.594873
http://www.tandfonline.com
group are typically seen as lacking correct knowledge or lacking the ‘right’ attitudes in order to change their behaviour in the communicated direction. Ethnic minorities are characterised as having even fewer resources due to loss of social relations, cultural points of reference, mother tongue in communication, social status, national membership, community membership, meaning of life, and happiness (Mygind 2006). In this way the existing public intercultural health communication can be described as a double-deficit approach (Jensen and Halkier 2011).

This type of public communication has also been criticised on the basis of empirical research in the field of public health for being unrealistic in relation to achieving healthier everyday practices, as well as being disrespectful and potentially disempowering in relation to citizens (Holm 2003, Green 2008, Hankivsky and Christoffersen 2008, Carlisle and Cropper 2009, Sulkunen 2009, Lindsay 2010). The critics of the deficit model argue that food practices are embedded in the social and practical complexities of everyday life, and what healthier eating might consist in and how to do it is constructed differently in different social relations, situations, and fields of activity. In order to grasp the complexities of people’s dealings with health recommendations in everyday life, a contextual perspective that includes multiple social conditions and dynamics is needed (Hankivsky and Christoffersen 2008, pp. 275–276).

In this article, we contribute to the critique of the deficit model in public health communication in two ways. We build upon a contextual theoretical perspective, and we present an empirical typology of ways of handling official nutritional guidelines among Pakistani Danes. The empirical typology shows that there are variations and multiplexity in mundane practical and normative regulation of ‘healthier’ food practicing, even within a relatively narrowly defined target group of citizens, in this case a minority ethnic group of Danes. The article is structured as follows: first, we position the argumentation of the article in relation to the Danish context of food and health and in relation to the international literature in the field. Second, we clarify our theoretical basis in practice theory and the methodological design of the empirical study. Third, the typology of ways of handling official nutritional guidelines is presented.

### Rationalised and individualised ‘healthier’ food

The Danish tradition of public food information has become increasingly nutritionalised and individualised (Holm 2003). The most important public institution in this respect is the Agency of Consumer Affairs, which since 1936 has informed the general Danish population about what is considered proper nutrition. A diachronic text analysis of information campaign material from the Agency of Consumer Affairs to households from 1936 to 1985 shows that proper nutrition became increasingly and exclusively discursively framed as prevention of specific modern lifestyle and food-related diseases, such as obesity. As a part of this development, proper food practices were constructed as being based upon scientific nutritional knowledge and rational planning rather than other everyday considerations such as satiety, economic resources, taste preferences, and cooking skills. Also, communication about food practices became targeted to individuals as the ones to be nutritionally regulated, rather than families and communities (Christensen 1998).
In a more recent comparative European study, the tendency to individualise the responsibility for a nutritionally healthier diet in Denmark was also reflected. An analysis of the understanding of the food consumer among a broad variety of representatives of societal actors in the food sector – producers, manufacturers, retailers, public authorities, scientists, media, and consumer organisations – in four European countries showed that in relation to nutrition and health, all types of actors in Denmark ascribed the main responsibility to individual consumers themselves (Halkier et al. 2007, p. 389). Also, in comparison with other Scandinavian countries, Danish preventive lifestyle policies are individualised (Vallgårda 2007).

The latest big initiative in public health in Denmark was the report launched by the Danish Commission for Prevention on diet, smoking, alcohol and exercise (Forebyggelseskommissionen 2009). The recommendations for public health initiatives in the report fall in two types in all four areas: individually targeted regulations such as taxes and prohibitions, and regulations targeted towards communities and institutions such as school lunches. In the area of dietary recommendations, there are nearly twice as many individually targeted initiatives as there are initiatives targeted towards communities and institutions.

New target groups, such as ethnic minority Danes, become included in this kind of individualised official public health initiatives on food. Pakistani Danes become particularly targeted, because they have a comparatively high risk of getting Type 2 diabetes and coronary heart disease, which is characteristic of this social group also in other national contexts (Bush et al. 1998, Mellin-Olsen and Wandel 2005, Ristovski-Slijepcevic et al. 2008). But in communication to and with ethnic minority Danes about healthier diets, social and cultural conditions and resources are seldom taken into account (Jensen and Halkier 2011).

In the following quote from our empirical case study – which we will present later – two Pakistani Danish women discuss the type of dietary advice people in their social networks who are diagnosed with Type 2 diabetes have experienced:

Rushy: The problem is when there is an interpreter, right, people who get this kind of diabetes, they get sent to Gentofte or out to Klampenborg somewhere there’s a centre, right, and then this sort of dietician turns up and tells you about rye bread and dairy products, mayonnaise and tartare sauce and such things.

Ishiita: We can’t really use that for anything.

The reported experience is that dieticians give advice that is based on majority Danish food habits, which include rye bread, dairy products and mayonnaise. The women’s conclusion is quite clear: they cannot really use that sort of advice. Studies from other national contexts with Pakistani minority citizens show similar patterns: that even in direct dietary communication between, for example, health workers and patients with minority ethnic background, the minority cultural food traditions are not acknowledged (Fagerli et al. 2005, p. 299).

A number of studies in the current international literature on food and health view food provisioning, cooking, and eating as practical activities that are socially and symbolically organised and entangled in the conditions, resources, relations, and negotiations of everyday life (e.g. Coveney 2000, Jabs and Devine 2006, Bava et al. 2008, Ristovski-Slijepcevic et al. 2008, Delormier et al. 2009). That is the perspective on which this article is based. This perspective is quite different from other strands in the current literature that are based on cognitivist approaches, such as the theory of planned behaviour (e.g. Aikman et al. 2006, Fishbein and
In cognitivist studies, changes of food habits in healthier directions are assumed to result from obtaining more information, parallel to the assumptions in the ‘deficit model’.

In the next two sections, the specific theoretical framework and the methodological design in our empirical case study are briefly presented.

**Practice theory and intersectionality**

A practice theoretical perspective is a particular reading of an assembly of theoretical elements from, among others, early Pierre Bourdieu (1990), Judith Butler (1990), early Anthony Giddens (1984), and late Michel Foucault (1978). The shared assumptions among these theoreticians about how social action is carried out and carried through are central in practice theory. Recent conceptual systematisation (Reckwitz 2002, Schatzki 2002, Warde 2005) turns the elements into a distinct analytical approach to the performativity of social life. A much-quoted definition of the concept of practice is the following:

> A practice...is a routinised type of behaviour which consists of several elements, interconnected to one other: forms of bodily activities, forms of mental activities, things and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge. A practice – a way of cooking, of consuming, of working, of investigating, of taking care of oneself or of other etc. – forms so to speak a ‘block’ whose existence necessarily depends on the existence and specific interconnectedness of these elements, and which cannot be reduced to any one of these single elements (Reckwitz 2002, pp. 249–250).

In the sociology of consumption, analytical ‘translations’ of the practice theoretical approach have been produced in order to make the concepts more operative in relation to empirical research in, for example, food practices. Alan Warde (2005, p. 14) clarifies the concept of practice as constituting a nexus of practical activity and its representations (doings and sayings), which become coordinated by understandings, procedures, and engagements. Understandings are the practical interpretations of what and how to do; knowledge and know-how in a broad sense. Procedures are instructions, principles, and rules of how to do. Engagements are emotional and normative orientations related to what and how to do. Each of the three elements that coordinate practices – understandings, procedures and engagements – comprises both tacit as well as discursive processes, and they cover bodily as well as mental processes. The characteristics of a particular practice, such as eating or cooking, are the qualities of the routinely repeated activities and their coordinating elements – understandings, procedures and engagements – rather than qualities of the individual food practitioner (Warde 2005, pp. 133–135).

Each individual participates in many different intersecting practices in his or her everyday contexts, whereby the different normative expectations connected to the performing of each practice create negotiations among practitioners about how to behave properly. The practice theoretical approach enables us to analyse the unfolding of practical morality in everyday practices among food practitioners as they enact and negotiate acceptable and expectable food conduct. To eat ‘healthier food’ or to cook ‘a good meal’ are not essential categories but rather contextual and often negotiated accomplishments among practitioners in intersections between food practices and many other practices; for example, job practices, mothering practices and socialising practices. Such processes of continuous practical and discursive
accomplishments of conduct are what we call ‘doing healthier food’. This perspective is inspired by the intersectionality approaches (e.g. Collins 2000, Fenstermaker and West 2002, Salih and Butler 2004) that share some of the assumptions of practice theory, such as the processual performative character of social life and the multi-relational character of the conditions of social life. For example, Hankivsky and Christoffersen (2008) argue on the basis of an intersectionality approach that health determinants and inequalities in health relate to complicated and dynamic intersections of aspects such as class, gender and ethnicity in everyday life conditions and practices. In our empirical case study with Pakistani Danes, ‘doing healthier food’ is continuously done, re-done, adapted, negotiated, and experimented within intersections of different practices, relations and conditions such as mothering practices and socialising practices.

Research design
The empirical research drawn upon in this article is a qualitative in-depth study of the food habits of ethnic Pakistani Danes and how ‘doing healthy food’ is handled among them. The overall selective sampling strategy was one of maximum variation regarding the following criteria: age (15–65); education (with and without high school degree); gender; whether participants were born in Denmark or Pakistan; whether a person in the family had been diagnosed with diabetes 2; and whether participants worked in the health sector. A total of 19 Pakistani Danes participated in individual interviews, family interviews or group interviews.

The qualitative data in this study were produced by several methods. One part of the data was produced through individual in-depth interviews (Spradley 1979, Holstein and Gubrium 2003) with the main cooking practitioner in the family interviewed about provisioning, cooking and eating in their everyday life, in relation to other people in their network, and in relation to constructions of healthy food. Another part of the data was produced by auto-photography (Heisley and Levy 1991) of food and drinks consumed during weekdays and the weekend. The photos were used as data in themselves and as input in family interviews and group interviews (Frey and Fontana 1993). During all of these interviews, which were held in the home of the family, participant observation (Hammersley and Atkinson 1995) was also used.

The analysis of the data material was done by using ordinary qualitative coding and categorising (Coffey and Atkinson 1996); visual data analysis techniques (Hurdley 2007) and positioning analysis (Harré and Langenhove 1998), combined with the more operative concepts from practice theory. The categories and types based on the data material were also constructed in relation to intersectionality analysis, as all practices are intersected by more general social categories such as ethnicity, age and gender (Collins 2000). Furthermore, food practices are intersected by more specific social categories such as ‘good cooking’ and ‘unhealthy food’. Food practices are also intersected with other everyday life practices such as job practices, socialising practices and family practices. The ideal-types presented in the following section were constructed on the basis of all the data, but in this article we mainly draw on the interview material in the presentation of the types.
Ways of doing ‘healthier’ food

In this section, an ideal typology of variations of doing healthier food is presented. We suggest on the basis of our empirical analysis that at least four different ideal-typical ways of doing healthier food can be constructed. The four ideal-types are: I: Engaging proactively in healthier food; II: Fitting in healthier food; III: Doing healthier food ambivalently; and IV: Ignoring healthier food as social practicality.

The ideal-types are related to practices, and not to specific individuals. Each of the types (ways of doing healthier food) in the ideal typology is performed by multiple participants. Likewise, every participant conducts food practices as shifting or gliding between several ways of doing healthier food in different contexts or relations, and each participant performs multiple food practices in one context. In methodological terms, the typology is not based on methodological individualism. This means that each of the types in the typology represents enactments from several participants, and the enactments of each individual participant may align with different ways of doing healthier food. In other words, the ideal typology represents inferences made about the performances of social categories of food practicing – and not about individual food practitioners.

Each ideal-type is presented in accordance with the practice theoretical perspective. First, activities done in a practice, ‘doings and sayings’, are described. Second, ‘understandings’, ‘procedures’, and ‘engagement’ for doing healthy food in relation to the different ideal-types are presented. Third, examples of multiplicity and contradiction in doing healthier food are highlighted.

Ideal-type I: Engaging proactively in healthier food

In this ideal-type, the activities (doing and sayings) consist in enactments of how what is constructed as healthier food is made and talked about. There are references to all the main elements of public Danish dietary advice: more vegetables and fruit, more fish, more whole grain products, less sugar and less animal fat (Andersson and Bryngelsson 2007, pp. 36–38). The ‘understandings’ of healthiness of cooking and eating are taken for granted, normatively.

Examples of cooking ‘procedures’ constructed as healthier are to make chicken, fish and kebab in the oven instead of in a pot or pan in order to use less oil; to steam vegetables instead of roasting them for a long time in a curry in order to maintain more vitamins; and to make ‘biriani’ instead of ‘pilao’ in order to use less oil. In this example, one of the food practitioners describes how she makes her chicken, marinated in yogurt and spices:

But it’s usually that chicken in the oven. [...] Because the only thing is just to peel off the skin of the chicken. Some people make it with the skin, but as I’ve told you, I prefer not to because of all that fat. So, you know, off with the skin, and it also becomes better marinated. It gives more taste of the spices instead of the skin just getting it. (Sada, female nurse).

This means that the procedures of cooking activities have been changed in order to make what is constructed as healthier food in modern nutritional terms. This is parallel to a discourse called ‘the mainstream healthy eating discourse’ analysed among Punjabis in a Canadian study (Ristovski-Slijepcevic et al. 2008, pp. 72–73). However, using the oven is at the same time constructed as a way of saving and flexing time (Southerton 2006) spent on cooking. So cooking ‘healthier’ also
accomplishes cooking more conveniently, which again provides time for other practices such as helping children with homework. Such multiplicity in practicing healthier food and intersectings with other social categories and practices can be analysed across the four different ideal-types.

Eating activities and procedures have been changed too. Food practitioners explain, for example, that they have cut down on how often they eat the traditional Pakistani breakfast meal parathas. This is a flat bread or thick pancake made by puff-paste, roasted in butter on a pan and buttered once again before eating. Typically, food practitioners eat it only on weekends, instead of every morning, and to avoid this, food is constructed as reflecting and taking care of your body:

The whole family eats it, emh I think parathas are a bit heavy, I like the dry ones better, gradually a lot of people ... you know, those who are conscious about their bodies, they probably don’t eat them so often. They love them, but they don’t eat them so often. (Rushy, female academic).

Pakistani Danish guest food is understood as tasteful but also unhealthy due to the high contents of fat and sugar. Thus, the food practitioners find ways of handling these situations. Here is an exchange about such procedures from one of the family interviews where the two women (Sada, female nurse, and her sister-in-law Maria, female pedagogue) have just discussed scraping off oil from dishes:

Interviewer: Is it allowed to take it off when you are at parties and so?
Sada: We try.
Maria: With quick movements! [showing with her hands]
Sada: But you cannot avoid it. I can feel that it’s probably one of the cheap kinds of fat that is usually being used in that sort of food.

In this ideal-type, the ‘engagement’ in healthier food is considerable. New knowledge about what is healthy and what is not healthy is questioned, discussed and actively pursued in magazines, books, from television shows and the Internet, and from other people in the social network. Communication and negotiation about food in a health context and serving of healthier dishes is being initiated both with members of the ‘in-group’ – mothers, daughters, sisters and sisters-in-law – but also with members of the larger social network.

**Ideal-type II: Fitting in healthier food**

This way of doing healthier food can be distinguished from the first type by the focus among practitioners on what is practically do-able. The activities in this ideal-type and the way of dealing with public food advice revolve around the practicalities of tacitly adjusting some of the ‘procedures’ in daily food practices to become healthier. Knowledge about healthier food is gained from books, television, Internet, cooking programmes, and the children’s schools. ‘Understandings’ of nutrition and healthy food are taken for granted as something that is already a part of the activities of food practitioners. One of the husbands from a family interview puts it like this:

Actually, we know already really well what is healthy and what is not healthy ... And we also try to make that, so actually we don’t have to seek any advice ... But we do what we can. (Ahmed, male taxi driver).

The ‘engagement’ in doing healthy food is in this ideal-type expressed in the way food practitioners tacitly adapt some of their cooking and eating ‘procedures’,
e.g. to bake chapattis with wholemeal flour. There is not as much discussion and communication going on as in the first ideal-type, but it seems on the other hand to be socially legitimate to talk about it with people in the intimate circles of the social network. One of the food practitioners explains after having been asked if she serves her less oily masalas for guests:

Then we just tell them that this is what we have made and that here in our home we don’t use very much oil. And that’s how it is. (Shabana, female schoolteacher).

However, fitting in healthier food can also be part of a struggle of the power over family meals, enacted on the basis of reproduction of gender relations (Fenstermaker and West 2002). Solejma (female office clerk) explains that she is frustrated about her sister-in-law making dishes with lots of fat and sugar to her brother who is diagnosed with diabetes 2:

You know, I tried (ehm) to explain to her from these leaflets my brother has from the organisation about (ehm) how he has to relate to food and what he must eat and what he should not (ehm), and tried to explain it to her. This is just where it goes wrong, that she doesn’t understand what is written in these leaflets and catalogues that my brother has got.

Trying to fit in healthier food for Solejma, who cooks low-fat food to her brother, is intersected with gender relations, family positionings and negotiations on proper Pakistani food.

**Ideal-type III: Doing healthier food ambivalently**

Contradictions characterise this way of doing healthier food. ‘Understandings’ of healthier food are in accordance with public Danish dietary advice, just like in the first two ideal-types; some of the same ‘procedures’ are practiced; and there is also ‘engagement’ in cooking and eating healthier dishes and meals. But other types of engagements in food practices are also important, so what is constructed as healthier food activities and procedures are incorporated in food practices when they do not conflict too much with the other types of engagement in food practices. One such type of engagement is the managing of family time around the production and consumption of meals. This ambivalence was described in one of the family interviews:

Aysha: We don’t eat so much take-away.
Hussein: Because we hate that junk food.
Aysha: We make it, even though we hardly have any time to cook when we come home.
He’s just arrived too.

The exchange shows the potential ambivalence between managing family time and cooking what is constructed as proper food and healthier meals. This potential ambivalence in doing healthier food was also performed another day when we unexpectedly visited Aysha’s family to deliver a camera. When we arrived they were all enjoying eating take-away pizza for dinner, showing us how to ‘spice it up’, while simultaneously insistently explaining that this kind of dinner happened very rarely. A further interpretation of the examples is that they seem to reflect the dilemmas of providing proper food related to intersectings of gender, ethnicity and health. Take-away pizza can be necessary because of the gendered division of food labour in the family and Aysha’s full-time job. Take-away pizza is also seen as unhealthy food to
be avoided, because it is not homemade, but at the same time, such pizza can be made into more proper food by adding Pakistani spices.

**Ideal-type IV: Ignoring healthier food as social practicality**

Here, there is little normative ‘engagement’ in healthier food. Rather, the engagements in food practices revolve around the pleasures of food, around ‘understandings’ of appropriate Pakistani food, and around prioritising the practising of food as care and upholding family relations. Food practitioners know and reproduce elements of public Danish dietary advice such as the food pyramid. But these understandings are not necessarily put into practical ‘procedures’ in their everyday life, since the other engagements fit the social relations around cooking and eating better.

Engagement in cooking as family care is a typical example. To be able to cater for every family member’s individual needs is a way of showing family love and reproducing the bonds within the family (Holm 2004, Moisio et al. 2004). Here the teenage daughter of Zabel, female kitchen worker, interprets her mother’s caregiving understanding of cooking:

> You know, all of us are a bit spoiled, right. You know, a lot of times when my brother comes home from work, or maybe just suddenly at 11 o’clock in the evening, then he just feels like eating French fries or something like that, right. So sometimes he makes it himself, but he also says, mum, I need to have something now at eleven o’clock, and then she has to make it.

For Zabel it is more important to make the food that her son loves than to make a healthier dish. From the perspective of intersectionality, this example at the same time clearly shows how all social actions are intersected by gender, age and power (Collins 2000). Traditional gender is reconstructed in this example, as mother and son at the same time draw upon traditional gender relations.

**Across ideal-types**

As mentioned above, these ideal-types are related to practices and not to individuals. This means that to use the oven, avoid parathas, seek information on the Internet and serve fat free and sugar free cakes at parties do not mean that fish fingers and French fries are not served on an ordinary Tuesday, or that parathas are not enjoyed thoroughly on a Saturday morning. Across all the social differences among the participants in the research project, the pleasure of the taste of good food is never questioned. Food practitioners who enact engagement in healthier food and specific procedures for how to cook e.g. with less fat also enact how unpleasant and inappropriate healthier food can be. Here is an example where one of the food practitioners, Maria, Sada’s sister-in-law, gives an account of her own sister’s cooking, just after Sada has concluded that reduction of fat constitutes proper cooking:

> Sada: I never use fat.
> Maria: My sister, do you know what she does? She only uses two teaspoons [of oil], and then when the onions have coloured, she takes the oil out and throws it away. And then she finishes the dish, that’s why her food tastes so bad. […]
> Sada: That’s not good. That definitely doesn’t taste nice.
Maria: No, it doesn’t taste good, but then she feels she has done a good deed, right... NOW we’re eating healthy!

Thus, a gliding in the construction of the category of good cooking takes place: from food without fat to food with fat. Experiences from life trajectories of having learned how to cook and eat proper Pakistani food are negotiated in relation to ways of cooking nutritionally healthier food (Mellin-Olsen and Wandel 2005, p. 334).

Conclusion
In this article, we have contributed to the analytical critique of the deficit model in public health communication by drawing upon a theoretical perspective that includes multiple social dynamics and by presenting an empirical typology of different ways of doing healthier food among Pakistani Danes. In contrast to the implicit deficit model assumptions of much public health communication, ordinary food practitioners are shown to be knowledgeable and resourceful. Across the social differences among the participants in the study, the public dietary advices are well-known.

On the basis of the constructed ideal-types, our study suggests that public health communication should build upon the following ideas: First, users (food practitioners) are to be seen as knowing and resourceful – which is in contrast to the implicit deficit model assumption. Second, communication strategies towards ideal-types II and III need to be focusing upon practices that are easy to fit into a modern, busy, everyday life. Third, it might be possible to suggest new, time-consuming and at the same time healthier food practices – like making less unhealthy snacks from scratch – as use of time indicates caring in this ideal-type.

However, the food practitioners also strive to accomplish healthier food in intersections of many different practicalities, food engagements, expectations in network relations, and socio-cultural conditions. The variety of ways of doing healthier food, and the multiplicities and negotiations of the categories of ‘good’ food show that it is never the belonging to just one category that explains health-related patterns in everyday life. Even in this relatively narrowly defined target group, there is quite a lot of variation and complexity in the practical and social regulation of how to cook and eat healthier.

Acknowledgement
The research project ‘Network communication and changes in food practices – a case-study of food habits and social network among ethnic Pakistani Danes in risk of diabetes 2’ was financed by the National Danish Social Science Research Council (FSE), 2008 – 2010.

Notes
1. We use the term ‘normative’ instead of ‘moral’, because ‘normative’ is related to social norms. Social norms are more specific, practical, and flexible ways of regulating human conduct than moral values, which are often more general and abstract and tend to be treated as more rule-bound (Mortensen 1992).
2. ‘Healthier’ here is understood as the current official Danish nutritional advice (Andersson and Bryngelsson 2007, pp. 36–38).
3. Denmark, Italy, Norway and Portugal.
4. A notable exception in Denmark is the education programme in some of the local municipalities called ‘Healthy in your own language’, where representatives from different
ethnic minority groups get a short education in order to work as ‘health ambassadors’ in their own social networks afterwards, based on ‘peer-to-peer’ principles.

5. The participants in the case study have been given pseudonyms in order to preserve their anonymity.

6. In biriani, the roasted ingredients (vegetables, spices etc.) are mixed into the steamed rice just before being served, whereas in pilao, the rice is roasted together with the other ingredients, requiring more oil in order not to stick to the pot.

7. The food pyramid has staples in the bottom, vegetables and fruit in the middle, and meat, eggs and dairy products in the top. The advice is to eat most from the bottom and least from the top.

References


Forebyggelseskommissionen, 2009. Vi kan Leve Længere og Sundere [We can live longer and healthier]. Copenhagen.