Competing food consumption discourses and proper gendered behaviour among over 50s: are you really what you eat?

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ABSTRACT

The national narratives about proper food consumption and its relationship to health and wellbeing has been articulated in many Australian public health campaigns. These shape awareness, knowledge and behaviours as well as reporting on food consumption. This paper reports on the findings of a large-scale community health survey, conducted in four Victorian regional areas, related to the self-reported eating practices of respondents aged 50 years and over. It was found that women were more likely to report trying to eat a diet consistent with public health messages than men. Overall, however there was strong agreement amongst respondents that they tried to eat a healthy diet. These findings are contextualised within broader societal discourses, including the Australian national narrative about food consumption, proper gendered behaviour, good, moral, responsible citizenship, and the competing social meanings attached to food and food consumption. It is argued that understanding the social circumstances in which people report their dietary behaviours is essential to understanding why behavioural change is such a complex goal for public health and health promotion.

KEYWORDS

Food consumption, fruits, vegetables, discourse, social meaning

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From a nutritional perspective, the regular consumption of a wide variety of nutrient-rich foods is vital for human health and wellbeing across the lifespan (NHMRC 2013). Healthy foods, predominately constructed as fresh fruits and vegetables, play a considerable protective role against chronic ill health including cardiovascular disease, diabetes, and many cancers (Strategic Inter-Governmental Nutrition Alliance 2000, Burns et al. 2004, VicHealth 2007). The consumption of fruits and vegetables is understood to positively impact children's mental health, educational learning, social development, and behaviour (Carr et al. 2013). Conversely, poor nutrition in adolescence is related to increased symptoms of depression and suicide risk (Burns, Jones, and Frongillo 2010, White, Horwath, and Conner 2013).

In adulthood, the amount of fruits and vegetables consumed directly correlates with mental as well as physical wellbeing (Blanchflower, Oswald, and Stewart-Brown 2013, Stranges et al. 2014) and parents influence children's food choices through modelling, purchasing and preparing food for children's consumption (Birch and Fisher 1998, Anving and Sellerberg 2010). Physiological changes later in life make the consumption of fruits and vegetables particularly important to maintaining good health (Pettigrew, Pescud, and Donovan 2012, 261).

This national narrative about proper food consumption and its relationship to health and wellbeing has been articulated in many Australian public health campaigns, including the 2005 '2 & 5' and more recently 'Healthy Weight'(Elliott and Walker 2007). These campaigns have been formulated in the context of the significant burden of disease related to the inadequate consumption of healthy foods. Inadequate diet is credited with more than 9% of the total burden of disease in Australia and has an estimated annual cost of more than $AUD 60 billion (Begg et al. 2007). Consequently, increasing Australians consumption of fruits and vegetables and decreasing their consumption of processed foods is an important objective for public health and health promotion.

It is in the context of national debt and economic productivity that contemporary health discourses of morality operate. These discourses draw a connection between looking after one's health and being a good, moral and responsible citizen (Lupton 1999), which is increasingly applied to older citizens (see Clarke and Bennett 2013). Discourses guide how people think and interpret their experiences, assigning meaning to behaviours and practices (Foucault 1971). Human bodies develop 'in interaction with the social world' (Annandale and Hammarström 2011, 583). There are multiple discourses operating in the social field and each individual is positioned in unique ways. Thus, while many Australians may be aware of what they *should* eat according to the national narrative about food consumption, there are many meanings attached to the social practice of selecting and eating particular foods (see Madden and Chamberlain 2010). These meanings construct particular identities.

Aspects of peoples' identities are constructed through food consumption (Valentine 1999). Individuals lay claim to particular social positions and statuses through what, when, where and how they eat (Dixon and Isaacs 2013, Terry and Quynh 2014). Using foods for non-nutritional purposes is a cross-cultural phenomenon, intrinsically connected to social organisation and relations of power within communities (Frank 2014, 320). Consequently, food practices are shaped by the complex social, economic, cultural and political conditions surrounding individuals (Bonnekessen 2010, Dixon and Isaacs 2013, Rieffestahl 2014, Terry and Quynh 2014). Thus, non-awareness fails to explain why people do not eat more fruits and vegetables. While public health campaigns have been successful in increasing the general public's awareness about the connections between consuming these foods and good health (Elliott and Walker 2007, Pettigrew, Pescud, and Donovan 2012, Dixon and Isaacs 2013), these campaigns have not addressed the underlying social meanings associated with food, which inform behaviour.

People's behaviours are influenced by many discourses, which shape thoughts about food consumption in different ways. For example, dominant discourses constructing the 'normal', healthy body influence individual's intentions to eat a healthy diet. However, the directives of these discourses are mediated by others, such as those constructing the 'normal consumer', which 'involves the ability to let oneself be seduced by, and to act spontaneously when faced with, a good offer' (Nielsen and Holm 2014, 218). In many Western industrialised countries like Australia, 'splurging' is a highly 'celebrated' form of

consumption, which carries connotations of social class and constructs a particular social identity (see Dixon and Isaacs 2013, 69). Non-participation may be read as resistance to social norms, but it may also be read as 'personal failure', resulting from poverty (Dixon and Isaacs 2013, 69).

Fresh fruits and vegetables may often be cheaper than processed foods and readily available. However, processed foods may be what people can afford to 'splurge' on (Gillies 2007, see Lindsay and Maher 2013). In this way, 'not all consumers are equal in their ability to mediate their identities and link to new forms of sociality through their consumer behaviours' (Isenhour 2010, 466). Further, what are considered acceptable food choices vary with context; it can be socially acceptable to consume non-fresh foods (Dixon and Isaacs 2013, 75). Human emotions and emotional work are embedded within food consumption practices (Davis and Cappellini 2014, Farrow 2014). Thus, multiple facets of identity play a role in determining people's food-related behaviours.

Gender, like social class, positions particular subjects in different ways. Gender is not a stable identity, rather it is historically and culturally contingent, 'instituted through a stylised repetition of acts...enactments of various kinds' (Butler 1988, 519), including food consumption which is a gendered practice (Madden and Chamberlain 2010, Mallyon et al. 2010, Ristovski-Slijepcevic et al. 2010, McPhail, Beagan, and Chapman 2012). It is used to construct and maintain a particular gendered identity. Dieting or a specific focus on eating healthy foods is predominately constructed as a feminine activity throughout the lifespan

(see Mallyon et al. 2010, Ristovski-Slijepcevic et al. 2010, Farrimond 2012). Consequently, for some men in some contexts (see Farrimond 2012) focusing on eating healthy food can undermine masculinity; it is a practice contrary to dominant constructions of masculine behaviour (see Mallyon et al. 2010, 336).

The local economies of many regional and rural communities in the Australian state of Victoria are agriculturally-driven, including dairy production, cropping, meat production as well as the production of stone, pome (apples and pears), and citrus fruit, grapes and an array of vegetables. Due to the availability of water and temperate to semi-arid climates, the Goulburn Murray Irrigation District of North and North Eastern Victoria is often considered the 'fruit bowl' of the state, where more than 50% of the state's food production occurs. However, many residents living in these agriculturally abundant areas, consume relatively few fruits and vegetables (ABS 2011, Department of Health 2013).

In this region, which is driven by fruit and dairy production and processing, artefacts, slogans and text such as 'MooovingArt', 'fruit salad city', 'farm gate to plate', 'farm fresh', and 'paddock to plate' dominate. These messages adorn the countryside, and are marketed through tourism, media, industry and government (Tourism Victoria 2014, Greater Shepparton City Council 2014, Shepparton Moooving Art 2014). Such sites, and the language used to describe them, are praised and awarded, to the benefit of those who visit, partake and pay homage to their (re)creation. This 'garden of Eden' environment improves the quality of life in local communities and enhances local economies. However, there is a

mismatch between the high fresh food production that occurs and what is being promoted with the relative poor fresh food consumption in the area.

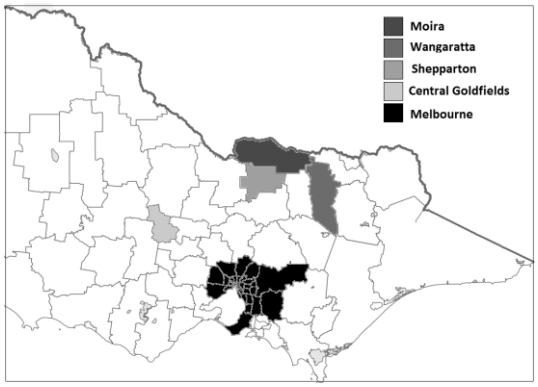
In this paper, we aim to examine the responses of rural Victorian residents living in parts of the food bowl, aged 50 years and over, to a series of questions related to their consumption of fruits and vegetables. Some questions related to factors that may disable/enable these foods to be consumed and respondents' intentions to eat a healthy diet. We also asked respondents for their weight and height to calculate Body Mass Index (BMI). It is contended that such responses need to be considered in the context of broader societal discourses and the various social meanings attached to food and food consumption that form the basis of people's everyday decisions about and behaviours related to food.

Methods

This paper reports the findings of a community health survey undertaken in four regions of Victoria: the Shire of Central Goldfields (population 12,582) in Central West Victoria, the Shire of Moira (population 28,675) and the rural cities of Greater Shepparton (population 62,352) and Wangaratta (population 27,236) in North East Victoria, presented in Figure 1 (ABS 2011). Within these four regions, the leading industries are broad acre cereals and livestock production. In addition, large production of apples and pears, grapes, vegetables, dairy, and food processing occurs within Moira, Greater Shepparton and Wangaratta (Deloitte Access Economics 2013, ABS 2011). The study was undertaken at a time of year when there is an abundance of fruits and vegetables in these regions. This study sought the

perspectives of residents in each of the four locations regarding diet, potential barriers to accessing fresh foods and overall dietary intentions.

Figure 1: Study sites within Victoria



Data collection

Ethical approval for the study was granted in September 2014. The survey was distributed to 5000 households between September and October 2014 using randomly generated household addresses from the telephone directory. However, 1360 surveys were never delivered resulting in the distribution of 3640 questionnaires to households. Using a landline telephone directory meant that residents who relied solely on mobile phones were excluded (Brick et al. 2006). A follow-up reminder was mailed 10 days later and letters and questionnaires were mailed to those who had not responded four weeks later (see Dillman 2000). A total of 1271 surveys were returned representing a 34.9% response rate.

Data analysis

Data were entered into SPSS v20.0 (Calnan 2007). The healthy eating questions included five statements with a Likert scale which asked respondents to agree or disagree with statements about their eating and food consumption habits generally. These statements reflected various social values relating to food and diet. Two of the five questions were developed to gauge reported healthy eating practices in the context of familiar guidelines, including 'I eat more than one piece of fruit each day' and 'I eat several serves of vegetables each day'. A further two questions asked about possible barriers to consuming fruit and vegetables, including the statements 'I often don't buy fruit or vegetables due to cost' and 'Sometimes I do not purchase fruit and vegetables as they are not readily available in my town.' Lastly, the statement 'I try to eat a healthy diet' was used to provide an overall impression of participants' intentions to eat healthily. Descriptive and inferential statistics, Chi-square (χ^2) and Fisher exact tests, were used to compare responses to these statements (Munro 2005). Results are shown as percentages because more questionnaires were distributed in Greater Shepparton due to the larger population. For easier presentation, responses in the tables condensed 'agreed' and 'strongly agreed' and 'disagreed' and 'strongly disagreed', while the middle response, 'neither agree nor disagree' remained. Further, confidence intervals (CI 95%), range or standard deviation (SD) are presented. Significance was determined by a two-tailed $p < 0.05$.

Results

Demographic characteristics of the study participants

This paper reports on the responses from participants aged 50 years or older. There were 285 respondents aged 50 years or younger and 36 respondents who did not disclose their age. These participants were excluded from the sample described here given that the overall sample was not normally distributed and heavily skewed towards the older age cohorts.

It was found that 64% of the remaining 950 respondents identified as male and 36% as female, ranging in age from 50 to 93 years. Sixty one percent of respondents reported completing year 11 or below, 13% reported completing a Diploma or Advanced Diploma, while 11% reported completing a Bachelor Degree or higher. Almost half, 48%, of respondents reported being in full-time or part-time employment and 28% of respondents reported incomes less than AUD$400 a week, as presented in Table 1. Additionally, participants from the region of Wangaratta were less likely to be retired, while Central Goldfields residents were more likely to report an income lower than AUD$400 a week. Women living in the Moira Shire had the lowest reported BMIs, the closest to the healthy weight range of 18.5 to 24.9, according to current national guidelines (Australian Government Department of Health 2013).

Table 1: *Characteristics of community health questionnaire respondents aged 50 years and older*

Variables	Shepparton (%)	Moira (%)	Wangaratta (%)	Central Goldfields (%)	Total respondents (%)
Sex (N=939)					
– Male	67	66	60	64	64
– Female	34	34	40	36	36
Age Groups (N=941)					
– 50-59 yrs	35	30	31	28	32
– 60-69 yrs	35	31	39	36	35
– 70-79 yrs	19	25	20	26	22
– 80yrs and over	(12	14	10	10	11
Currently living (N=923)					
– In a large town or regional centre	53	10	51	24	38
– In a small town	21	57	12	37	29
– On a property or farm	26	33	36	39	33
Education (N=908)					
– Year 9 or less	31	29	24	32	29
– Year 10 or 11	31	33	33	34	32
– Year 12 equivalent	7	8	10	13	9
– TAFE Course/Certificate	6	6	6	5	6
– Diploma or trade	15	13	13	10	13
– University degree	11	12	14	6	11
Current employment status (N=928)					
– Student	1	1	0	0	0
– Retired	42	47	39	50	44
– Working full-time	39	33	40	25	35
– Working part-time	13	13	12	13	13
– Looking for work	1	1	2	1	1
– Not in paid labour force	5	5	6	11	7
Family weekly income N=893)					
– > $400/week	24	26	30	36	28
– $400 to $799/week	34	42	40	39	38
– $800 to $11499/week	31	21	21	19	24
– $1500 to $3000/week	9	9	8	4	8
– < $3000/week	2	2	2	2	2
Mean BMI (N=864)					
– Male	27.8	28.7	29.0	28.7	28.5
– Female	28.3	25.7	27.2	28.2	27.3
Total	27.9	28.0	28.2	28.6	28.1

Perceptions and barriers of healthy eating between local government areas

Around six in ten reported eating more than one piece of fruit each day. There was little difference between the location of respondents and reporting eating more than one piece of fruit and several serves of vegetables a day. Further, there was little difference between responses from the various locations and identifying cost of purchasing fruit and vegetables as a barrier. However, it was found that Moira residents were more likely to agree that they did not purchase fruits and vegetables due to their lack of availability, as indicated in Table 2. In addition, when further analysis between education, employment status, income, household size and the four locations of respondents was undertaken (Chi-square (χ^2) tests and Fisher exact tests), no additional associations were found. Similar responses across the four regions suggest that wider, societal level discourses are impacting local communities.

Table 2: *Healthy eating measures and barriers between shire residents aged 50 years and older*

Variables	Shepparton (%)	Moira (%)	Wangaratta (%)	Goldfields (%)	Chi-square (χ^2) test	*p*
Overall perceptions of healthy eating						
I try to eat a healthy diet						
– Disagree	8	5	3	8	χ^2 (2,	.041*
– Neither	19	16	13	20	N=904)	
– Agree	73	80	84	73	= 13.12	
Self-reported healthy eating						
I eat more than one piece of fruit each day						
– Disagree	23	18	20	25	χ^2 (2,	.497
– Neither	18	24	20	19	N=896)	
– Agree	59	58	61	56	= 5.37	
I eat several serves of vegetables each day						
– Disagree	14	11	11	17		
– Neither	22	21	16	15	χ^2 (2,	.088
– Agree	64	69	73	68	N=890)	
					= 11.01	
Perceived barriers						
I often don't buy fruit and vegetables due to cost						
– Disagree	79	75	81	79	χ^2 (2,	.657
– Neither	9	10	10	8	N=856)	
– Agree	13	15	9	13	= 4.14	
Sometimes I do not purchase fruits and vegetables as they are not readily available in my town						
– Disagree	84	74	81	84	χ^2 (2,	.030*
– Neither	8	8	7	3	N=585)	
– Agree	9	18	12	13	= 13.96	

* Significance p≤.05

Perceptions and barriers of health eating between genders

To analyse participants' responses to statements about healthy eating, Chi-square (χ^2) tests were performed to determine if there was an association reported between gender and responses to these healthy eating statements. There was a statistically significant difference between women and men's responses to eating more than one piece of fruit a day, while there was little difference in their response to eating several serves of vegetables a day. In addition, there was little difference between women and men reporting trying to eat a healthy diet and the impact of cost on their ability to purchase fruits and vegetables. However, it was found that men were more likely to agree that they did not purchase fruits and vegetables due to their lack of availability, as indicated in Table 3. Similarly, men reported higher mean BMIs than women; however, men reported lower BMIs compared to women in Shepparton.

Table 3: *Healthy eating measures and barriers between respondents identifying as female and male aged 50 years and older*

Variables	Disagree (%)	Neither Agree nor Disagree (%)	Agree (%)	Chi-square (χ^2) test	*p*
Overall perceptions of healthy eating					
I try to eat a healthy diet	8	14	78	χ^2 (2, N=902) =	.092
– Female	5	18	76	4.76	
– Male					
Measures of healthy eating					
I eat more than one piece of fruit each day					
– Female	17	17	66	χ^2 (2,	.003*
– Male	25	21	54	N=894)=11.67	
I eat several serves of vegetables each day					
– Female	11	18	71	χ^2 (2, N=889) =	.210
– Male	15	20	66	3.11	
Perceived barriers					
I often don't buy fruit and vegetables due to cost					
– Female	80	10	10	χ^2 (2, N=856) =	.281
– Male	78	9	14	2.54	
Sometimes I do not purchase fruits and vegetables as they are not readily available in my town	85	7	9	χ^2 (2, N=857) =	.035*
– Female	79	7	14	4.75	
– Male					

* Significance p≤.05

Discussion

Viewing these findings within the context of broader societal discourses and the competing social meanings attached to food and food consumption practices brings new understanding to participants' responses. Here we contextualise participants' responses within the national narrative about food consumption, gendered behaviour, and moral and responsible citizenship. By doing so, we suggest that changing consumer behaviour is complex because it is constrained within various societal discourses and the meanings they generate for subjects.

The '2 and 5' campaign spread the message that, in order to eat a good, healthy diet, two pieces of fruit and five serves of vegetables should be consumed per day. Other research has indicated that this message has been internalised by many senior Australians (Pettigrew, Pescud, and Donovan 2012, 262). A greater proportion of women than men in this study reported eating more than one piece of fruit and several serves of vegetables per day. This suggests that there are synergies between women's reported food consumption practices, familiar national guidelines and broader societal discourses of good femininity and morality.

Dieting or 'eating healthily' is conventionally understood as a key tool women use to control their bodily appearance (see Shilling 2003). It is women rather than men who traditionally 'watch their weight' through monitoring food consumption (Malatzky 2013a). Women are particularly subject to discourses that construct fat as symbolic of individual inadequacy (Bordo 1993, Lupton 2013). For women, discourses of healthism are often connected to

discourses of aesthetic beauty, which concentrate on thinness and weight loss to obtain a particularly narrow definition of a sexy body rather than to achieve a particular health status (Malatzky 2013a).

These discourses of femininity and their preoccupation with thinness and the eradication of fat remain relevant for older women. In their review of body image for older women, Marshall, Lengyel and Menec (2014) found that body image efforts span women's whole lives. A thin body remains critical to many older women's identities and sense of social value, and many focus on dieting to maintain their bodies (Marshall, Lengyel, and Menec 2014). Further, women have been found to be the most responsive subjects to workplace diet or nutrition interventions, specifically targeting older employees (see Gibson 2014).

Women also continue to be the primary caregivers for Australian families. More women than men act as primary caregivers for infants, children, and increasingly, grandchildren, whilst also contributing to the household through paid employment (Cassells et al. 2007). Importantly, it is women who are predominately responsible for negotiating the two worlds of family and paid work (Malatzky 2013b). As women age, many continue to play an important role in organising family life. Many older Australian women have been socialised through these discourses of good femininity that centre on caring for family.

For women then, contemporary health discourses of morality can manifest in very personal ways; maintaining good health, and following national guidelines to do so, becomes important for a good woman's family and identity (see Dean et al. 2010, Madden and

Chamberlain 2010, Clarke and Bennett 2013). Thus, reporting 'good' eating practices, consistent with the national narrative about food consumption, is one avenue available to women to construct their identities as good, moral and responsible women, who care about the (economic) health of the nation, as well as their families. This construction may help to contextualise why cost was not frequently reported as a barrier to the consumption of fruits and vegetables in this study, and why gender, rather than education or income, was a significant factor in relation to respondents' reported behaviours. It is an important perception that consuming fresh foods is a priority for all good citizens.

Across the four locations in this study, a lower percentage of respondents reported that they often did not purchase fruits and vegetables because of cost. This may indicate that for most respondents, fresh food is frequently an affordable choice. However, fruits and vegetables were not reported to be easily available by all participants across these locations. Along with men, residents of Moira Shire were more likely to report sometimes not purchasing fruits and vegetables because they are not readily available in their town. Here, availability may be conflated with accessibility, such as transport and scheduling issues (see McKie 1999, Elliott and Hunsley 2015, 2) and acceptability, including feelings of safety and motivation (see Elliott and Hunsley 2015, 2).

Participants' responses may also be interpreted to mean that fruits and vegetables are frequently purchased regardless of cost. This suggests that older rural residents assign a high social value to these foods. This is consistent with previous research finding that older

people often associate 'proper food' with fresh food (McKie 1999, 532). In rural communities, there may also be more opportunities for older people to produce fresh foods at home in gardens, and to exchange these foods with one another (Quandt et al. 2001, 159). Exchanging fresh produce ensures that everyone within a social network has a variety of fresh foods, and provides opportunities for social connectedness (Quandt et al. 2001, 159). Fresh fruits and vegetables may then represent important social commodities as well as quality foods for older rural residents, which is consistent with respondents reported intentions to eat a healthy diet.

There was strong agreement amongst respondents that they tried to eat a healthy diet. This was particularly the case for respondents from the Wangaratta region, who were also less likely to be retired. A desire to continue participating in paid employment may explain why these respondents in particular reported an intention to eat a healthy diet. Older employees continuing their paid working lives in the United States, for example, have been found to report participating in more 'healthy' diet and exercise regimes than younger employees (ComPsych Corporation 2008).

Other research has indicated that older Australians have a 'high level of awareness of the importance of diet in healthy ageing' (Pettigrew, Pescud, and Donovan 2012, 261). This may explain respondents' intentions when it comes to eating healthy foods – subjects are guided by the national narrative about food consumption. It is through this discourse that Australians learn what is considered 'good' and 'bad' behaviour, directing individuals

intentions when it comes to what they 'should' be eating (see Foucault 2002). Eating a healthy diet becomes good, moral, responsible behaviour (Lupton 2013). However, healthy eating has also been described by older Australians as a 'particularly problematic part of life' (Pettigrew, Pescud, and Donovan 2012, 262) and discrepancies between what people intend and what they actually do are not uncommon (Pettigrew, Pescud, and Donovan 2012, Dixon and Isaacs 2013). Many respondents in this study stated that they attempted to eat healthily, yet the self-reported mean BMIs between genders and within regions showed that on average, according to current guidelines, the cohort would be considered 'overweight' (BMI, 25kg/m^2 or greater) (Australian Government Department of Health 2013).

There are competing discourses around food consumption practices, which attach different meanings to food and eating. For example, older women, as we have discussed, are particularly implicated in discourses of healthism, which are associated with good moral citizenship. However, Gustafsson and Sidenvall (2002, 170) found that for older women, health is also 'about wellbeing when eating meals in companionship, allowing oneself something extra'. Here, the meaning attached to food is related to good health, but good health also requires a certain level of social connectedness. Thus, many Australians may know how they are supposed to respond to questions about their eating habits, and their intentions may align with the national narrative. But people's actual behaviours are guided by other discourses, often centred on family and social connection, which some may consider 'higher order moral concerns' (Dixon and Isaacs 2013, 69).

Conclusion and implications for theory, practice and policy

In this article, we have presented the findings from a community health survey administered across four rural Victorian communities located in a 'food bowl' region. Respondents were asked a series of questions relating to their consumption of fruits and vegetables, and their height and weight. We have argued that participants' responses can be read in the context of broader societal discourses and the competing social meanings attached to food and food consumption. Considering the conditions within which people respond to such questions assists researchers to focus on explanations for reported food consumption practices, and what this means for intervention strategies.

The strong agreement amongst participants in this study about trying to eat a healthy diet suggests that national and gendered discourses of food consumption are powerful forces shaping people's intentions and reported food consumption practices. Women reported trying to eat more healthily than men, and men were more likely to agree with statements indicating barriers to fresh food consumption in rural Australia. This indicates that women in particular understand what is expected of them as good, moral citizens, and as good ageing women. However, when these reported intentions and consumption patterns are considered in the context of reported heights and weights, it becomes clear that many rural Victorians are not meeting these expectations. Simplistic nutritional messages ignore the broader cultural context of food. Our analysis suggests that campaigners need to consider

the social as well as the nutritional aspects of food consumption to understand why affecting change in consumer behaviour is such a complex goal.

It is critical that the inseparability of the social and health (Malatzky and Bourke 2016), and thus the complexities involved in changing food-related behaviours is recognised by policy makers and health promoters. To this end, it is suggested that more attention, from within the health promotion space be levelled at structural rather than individualistic concerns. For example, policies and programs that support and enable older residents to become or remain engaged in workplaces may assist in maintaining good health. Further, challenging rather than reinforcing some of the narratives about good citizenship may empower individuals and communities to have more honest discussions about their situations and challenges and design localised programs that sponsor social connections and support healthy lifestyles in ways that recognise need and context.

The implication is that discussion of healthy diets needs to move beyond what people should do to genuine understanding of diet, nutrition and the social values placed on food. Robust discussion about what people really eat and why would enable effective change. Such change might focus on healthy weights rather than attributing value (i.e., good and bad) to food. Clearly, little is known about actual diets; rather what is known is that healthy eating messages are heard and can be repeated. How these can be more widely adopted is the next step. Furthermore, promotion of unhealthy foods is a powerful market internationally that for decades has resulted in women not breastfeeding, low income

people buying Coca-Cola and dramatic increases in processed and sugary foods (Gewertz and Errington 2010). It may be that public health campaigns struggle to compete with the capitalist markets that promote unhealthy foods and ensure access to these unhealthy foods in diverse places. The tension between these markets and health identities is present for many people, particularly women (Malatzky 2017).

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