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Chapter 7

Healthy eating, social class, and ethnicity: exploring the food practices of South Asian mothers.

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Abstract

The diets of South Asian populations are of particular concern due to poorer health outcomes associated with the consumption of traditional food in the UK. However, this concern has not been translated into a high-quality evidence base and evidence is often small scale and sometimes contradictory. The influence of social class on South Asian food practices is particularly neglected in the literature. This chapter draws on Bourdieu's exposition of class as a structured and structuring micro-practice and adopts an intersectional paradigm in exploring the narratives of mothers from diverse socioeconomic, ethnic and migration backgrounds regarding their healthy eating practices. These mothers are both first and second-generation migrants with dependent children from two South Asian groups: Pakistani Muslims and Gujarati Hindus, living in five cities of the UK. The findings show class-based distinction in narratives of healthy eating involving symbolic and social value of food. Surprisingly, the class based distinction did not translate into eating practices which were often influenced by time and resources. Both time and budget constraints impacted on women's ability to eat and feed healthily. The chapter argues for a reconsideration of how cultural capital is conceptualised and enacted in context of healthy eating. It challenges the assumption that South Asian food practices are class-neutral, static and unhealthy and that healthy eating messages and initiatives will therefore engender transformative changes.

The diets of South Asian populations are of particular concern due to poorer health outcomes associated with the consumption of traditional food in the UK (Lawton et al., 2008; Ludwig et al., 2011; Qureshi 2019). However, this concern has not been translated into a high-quality evidence base. Most research till date has focussed on healthy eating in context of health issues such as diabetes and growing obesity resulting from the dietary habits of South Asians (for example, Lawton et al. 2008; Pallan & Adab 2012). Much of this literature has examined diets and physical activities side by side and has often focused on the type and composition of food consumed by South Asians, for example the consumption of amount of saturated fat and fruits and vegetables (Savak et al., 2004; Anderson et al., 2005; Ludwig et al., 2011; Lawton et al., 2008) .

Some studies have attempted to understand the meaning of healthy eating and rationale for food choice among South Asians. The majority of these studies show that South Asians tend to report some aspects of 'Asian food' such as spice and use of oil as being bad for health and at the same time the use traditional system based on food being digestible/indigestible, hot/cold, strong/weak that informs the food choice that are considered healthy (Bradby, 1997; Chowdhury et al. 2010; Qureshi 2019; Jamal 1998). Qureshi (2019) in her study of long-term health conditions among Pakistanis shows that her respondents had internalised the idea of 'Asian food' being bad and ill-health resulting from fat, spices and sugar content of the 'Asian diet', often under the influence of health providers' advice. . However, they also sometimes positively judged 'home food' as compared with 'English food' which was taken as a synonym for junk. Brady's (1997) study in Glasgow revealed women's understanding of healthy eating in terms of combination of medical orthodoxy of healthy eating and alternative beliefs of food rooted in the folk beliefs and advice of elders. Some studies suggested resistance against stereotypes such as Asian food being only curry and respondents reporting eating from a variety of cuisine (Wyke and Landman, 1997).

Researchers have also attempted to study influences on healthy eating in the British South Asian population (Chowbey & Harrop 2016; Pallan & Adab 2012; Anderson et al. 2005; Lawrence et al. 2007). For example, Pallan & Adab (2012) examine influences on the development of obesity in British South Asian children and have identified a range of influences including individual, family, cultural influences as well as influences of school and local and macro-environment. Chowdhury et al. (2010) identified structural and economic factors such as affordability and availability as well as cultural influences on British Bangladeshi's food beliefs and practices. They identified religious restrictions on food items as an important factor in food practices. Emadian et al. (2017) have identified cultural commitments including faith events, motivation and time as key barriers to eating healthy in their research with obese South Asian men living in the UK. They identify family support as an important facilitator to dietary change. There has also been an increased interest in role of migration history on food practices where research has suggested more fat and sugar is consumed following migration (Williams et al., 1998; Chowdhury et al., 2000; Anderson et al. 2005). Further, changes in food habits over generations have also been noted, with fewer traditional meals amongst members of the so-called 'second-generation' than among first-generation migrants (Gilbert and Khokhar, 2008; Lofink 2012). However, such research overlooks how transnational marriage and caregiving practices affect household food practices, such as when new migrant family members join households. A few studies have noted diversity in food practices among the various South

Asian ethno-religious groups. For example, a preference for English-style breakfasts consisting of bread and cereals was found to be more common among Bangladeshi and Pakistani than Hindus and Sikhs, who preferred a cooked breakfast of chapattis and parathas (Gilbert and Khokhar, 2008). In spite of this recognition of diversity, however, and perhaps surprisingly, the influence of social class on South Asian food practices has been neglected in the literature. There does not appear to be any study published to date which examines South Asian food practices in relation to socioeconomic differentiation within the population. Class-based distinctions in food preferences, which have been studied in the white British population, are often conflated with ethnicity-based preferences. Social class, which 'acts as a structural determinant shaping access to food, and especially to food that is healthy, appealing and desired' (Smith Maguire, 2016, p. 12) is an important dimension currently missing from the literature on food practices among South Asian population.

Further, employment has been shown to have an impact on household food practices in terms of the consumption of home-cooked food and types of food prepared at home (Blake et al. 2011; Devine et al. 2006; 2003; Roos et al. 2007). These studies suggest that households from low-income backgrounds; employed in non-standard working hours; single parenthood are likely to eat less home cooked meals and rely on unhealthy frozen and chilled convenience food. For example, Blake et. al (2011) found that married men with non-employed spouse had more home-cooked meals. However, the majority of these studies examining the impact of income and time on household shopping, cooking and eating practices has been done with the White British families or in western countries. Research on South Asian women's experiences of food practices in context of motherhood and (re)entry to labour market is scant. An exception to this is Ellen's (2017) work with British South Asian women, in which she has explored their ability to negotiate new gender identities as both good mothers and independent women through mothering and consumption practices including food.

South Asians comprise 4.9 percent of the total UK population (2011, UK Census). Indians (including the Gujarati Hindus who were the focus of my study) and Pakistanis are the two largest ethnic groups. Gujarati Hindus and Pakistani Muslims are culturally similar in several respects, such as transnational practices in the areas of marriage, caring and financial obligations. At the same time, significant differences exist in their socioeconomic positions and migration histories. Women's employment differs across both groups. Pakistani women (aged 25-49 years) have relatively lower employment rates with 43.29 percent women being economically active and with an unemployment rate three times that of White British women in the UK (Nazroo and Kapadia, 2013). For Indian groups, including Gujarati Hindus, the economic activity rate for women aged 25-49 years was 79% (Nazroo and Kapadia, 2013). Evidence suggests that being a mother of young children and educational qualifications have more impact than their migration history (Dale and Ahmed 2011). Having young children further compromises women's position in the labour market, leading sometimes to withdrawal from work, underemployment or significant effort to maintain participation in the context of gender and ethnic labour market discrimination. The existing research shows demands of work having impact on food choices and the need to balance family values such as closeness and personal achievement (Devine et al., 2003). However such evidence is negligible in the context of intersection of ethnicity and social class.

Against this background, the chapter explores the narratives of mothers from diverse socioeconomic and ethnic backgrounds regarding food practices in the context of healthy eating. These mothers are both first and second-

generation migrants with dependent children from two South Asian groups in Britain: Pakistani Muslims and Gujarati Hindus. It will explore women's understanding of eating healthily, the practices they engage in and their experiences of healthy eating interventions and messages within diverse socioeconomic locations. The chapter will also examine how social class, as indicated by their occupation and income, influences healthy eating narratives, practices and aspirations among this sample. It challenges class-neutral policies and practices pertaining to healthy eating and the assumption that South Asian food practices are homogeneous, static and unhealthy and that healthy eating messages and initiatives will therefore engender transformative change.

Understanding food practices and social class among South Asians

To analyse food practices based on social class, I draw upon Bourdieu's (1984; 1987) exposition of class as a structured and structuring micro-practice to understand how people's differing access to social, cultural, economic, and symbolic capital translates into food practices embedded in socioeconomic and cultural locations. For example, food-related cultural capital (in an '*embodied'*, '*objectified'* and '*institutionalised'* state, Bourdieu, 2011, p.47) includes visits to restaurants, knowledge of various aspects of healthy eating and references to research and possession of books, especially on food. I also consider respondents' social capital through spontaneous references made to eating and hanging out with friends, colleagues and relatives. Symbolic capital, 'which is the form the different types of capital take once they are perceived and recognised as legitimate' (Bourdieu, 1987, p.4) is manifested as the legitimacy, honour, or prestige attached to food choice and practices.

Bourdieu (1984, p.166) argues that 'The habitus is necessity internalized and converted into a disposition that generates meaningful practices and meaning - giving perceptions; it is a general, transposable disposition which carries out a systematic, universal application - beyond the limits of what has been directly learnt-of the necessity inherent in the learning conditions.' He maintains that our practices and behaviours are a result of habituated ways of thinking, talking and behaving (our *habitus*) which we take as given. Bourdieu (1984, p.173) distinguishes between 'substance' and 'form' and identifies taste as 'the real principle of preference' which is shaped very early on in life. He argues that taste is a forced choice as it exists in the absence of alternatives. Bourdieu's theorisation of various forms of capitals and *habitus* challenges the issues of life-style simply in terms of personal choice (Williams 1995). Williams argues that Bourdieu's analysis is helpful in understanding the issues of class, life-style and health and argues for ' an approach which recognises the dialectical interplay of freedom and constraint in daily life and accords equal weight to both elements' (Williams 1995, p 601).

However, recent research has begun to challenge the relevance of the supposed divide between middle-class discernment and working-class necessity in food practices while maintaining the relevance of class dynamics (Smith Maguire, 2016; Beagan et al., 2016; Flemmen et al., 2018). Smith Maguire has argued to look beyond the affordability and necessity in working class food practices and revisit ' Bourdieu's (1984) conceptualization of working class habitus and taste, and the notion of a "taste of necessity". There is a need to develop a more nuanced, dynamic account of the tastes of low-income and economically marginal groups' (2016, p.16).

Moreover, given the cumulative effects of migration history and minority status, it is difficult to apply the existing class discourses denoted by social, human, cultural, and symbolic capital to South Asians in the UK.

Research has highlighted the complexities involved in identifying ethnicity with a specific social class (Song, 2003; Modood, 2004; Daye, 2016; Maylor and Williams, 2011; Rollock et al., 2013). Rollock et al. attribute some of these complexities to 'the relative newness of the Black middle classes and respondents' broadly similar working-class trajectories alongside ongoing experiences of racism within a society that privileges and gives legitimacy to a dominant White middle-class norm' (2013, p.262). However, a class-based analysis remains relevant in the context of ethnicity because it resonates with the lived experiences of individuals and families (Blake et al. 2011; Archer 2011).

Methods

The aim of the study was to explore the relationship between access to and control over resources in household food practices amongst women from diverse migration backgrounds in Britain, India, and Pakistan. This chapter presents findings from fieldwork conducted in Britain which was conducted in five cities in England (Sheffield, Rotherham, Bradford, London, and Nottingham). The research was informed by an intersectional paradigm '… that establishes that social existence is never singular, but rather that everybody belongs simultaneously to multiple categories that are historically and geographically located and that shift over time' (Phoenix, 2006, p.28). The research design recognises the differences and similarities in women's experiences based on their ethnicity, nationality, socioeconomic status, occupation, household composition (joint and nuclear), education, and migration histories. The constructivist grounded theory approach (Charmaz, 2006) was employed as it lends itself to interpreting complex phenomena. This approach provides 'systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories "grounded" in data themselves' (Charmaz, 2006, p.2). It therefore enabled connection between women's experiences of household food practices and the broader socioeconomic context shaping broader healthy eating discourses and subsequent interventions.

Data collection took place from 2013-2016. The initial fieldwork included visits to community organisations, attending group sessions on cooking and eating, and going to religious celebrations in temples and community organisations. This was followed by three focus groups that included a participatory exercise involving a matrix of needs, opportunities and constraints to understand household resource allocations and food practices pertaining to eating healthily. These included preferences, knowledge about food, and supplies of food. These were followed by three interviews with community leaders to inform the areas to be explored in the interviews. A total of 35 interviews were conducted with first and second-generation mothers from South Asian backgrounds with dependent children (Pakistani Muslims and Gujarati Hindus) in their preferred languages (Hindi, English, and Urdu). These women were recruited through community networks by word of mouth and through visits to various groups. As a mother of a dependent child who is from a South Asian background, I did not find it difficult to access respondents and was able to build a rapport that led to lengthy interviews lasting between 1.5 to 4 hours. However, my familiarity with their experiences also required me to be reflexive and aware of my own beliefs and experiences in constructing rather than discovering research. All the interviews took place at respondents' homes, except for one that took place in a car and two at a community organisation. Data was analysed according to the grounded theory method which involved at least two phases of coding: initial coding which identified 'fragments of data', and focused coding which identified the most useful initial codes (Charmaz, 2006, p. 42). This stage was followed by theoretical coding, which specifies possible

relationships between coding categories (Charmaz, 2006). Ethical approval for this research was granted by the Sheffield Hallam University Ethics Committee.

Findings

To address the complexities of a class informed analysis of South Asian mothers' practices, views, and experiences of healthy eating, I utilised the following occupational categories as a proxy for mothers' income: homemaker, both high-income and low-income; professional/managerial; skilled/clerical/assistant; and manual employment. All manual workers at the time of the research, except one Gujarati mother, had given up work and were looking after children; these were included in the category of low-income homemakers. The category of homemaker was divided into high-income and low-income categories. High-income homemakers were often highly qualified; several held professional positions in the past and were married to professionals or successful businessmen. For example, one of the Gujarati homemakers had a degree, lived in an affluent area, and was married to a consultant, whilst another homemaker did not have a formal qualification, had worked in a factory, and was married to a gardener. Their economic position is explained where necessary by providing qualifiers about their backgrounds such as husband's occupation. Similarly, those in the professional category may be married to someone in manual employment and live in a poor neighbourhood. Further, some respondents were underemployed at the time of the research; they were educated and had professional employment in their home country but had to accept a low-skilled job following their migration. These categories are therefore complex and fluid; however, they are meaningful as they resonated with respondents' lived experiences and had an impact on their economic and social capital, the time available for cooking, and their ability to access information. The findings are presented in three sections: meaning of healthy eating understood by the respondents in terms of their symbolic and social value instead of nutritional values; healthy eating practices in the context of resources (time and money); and response to healthy eating initiatives.

Meaning of healthy eating-symbolic and social value

Healthy eating was generally understood, across all occupations, as consuming more fruit and vegetables and less oil. Overall, there were few mentions of portion sizes or five food categories, although there were some differences in this area as mothers from professional and some from skilled employment backgrounds made more references to these categories. In comparison, skilled mothers and homemakers from low-income backgrounds tended to focus more on the food itself and volunteered fewer details about eating healthily. Their narratives focussed on eating fruit and vegetables or eating certain types of food, Asian or 'English'. For example, Gazala, a first-generation Pakistani homemaker with no formal education who is married to a professional and lives in a poor neighbourhood, offered the following opinion of healthy eating:

> *'I want to say everything is available in [UK] that is normally good and healthy foods, sometimes it depends upon our choice what we are going to cook for ourselves, so we don't see any problem in here…you see my health is very good. But there is nothing like specific for healthy food'.*

Professional mothers' accounts of healthy eating were more expansive and included not only fruits, vegetables, and less fatty products but the quality of the food items, references to organic food, and the use of preservatives

and additives. Professional mothers and some skilled workers provided details about food expectations, rules around food, and aspirations for healthiness and variety in food practices. Food expectations varied for mothers and included meal timings, presentation, portion, manners, and cuisine. Their narratives placed value on what food consumption symbolises in their households - ideals of equality, egalitarian gender roles, intimacy between couples, and parental ideologies. Some mothers aspired to present a picture of a family united in its food choice and practices; a family that is egalitarian through the rejection of women serving hot *rotis* (chapattis) and eating only at the end. Professionals who were married to other professionals and high-income homemakers were more likely to present healthy eating practices in unitary terms. Their narratives showed an aspiration to be united as a family regarding their understanding and practice of healthy eating: A second-generation British Gujarati professional, Neha, talked at length about herself and her husband's goals of eating healthily, and of going to the gym and using cooking methods to facilitate this:

> *'I've got a grill that we use occasionally, but with the actifryer it's really a lot healthier. And I'm not really into eating like samosas and things every day ...but now that we're both in our forties, we don't really think it's a good idea ... and I'm a member at the gym, as he is, but he's a lot better at going to it.'*

However, the small number of professionals married to those in manual employment reported differences in food-related expectations. Hora, a second-generation British Pakistani professional described the culture shock she experienced when she moved to her husband's house following her marriage. She described the dinner table as a democratic space where everyone was equal and free to say or behave as they wished. However, her husband, who left school after GCSEs and started a restaurant business, had grown up in a very different food environment. She stated that:

> *'So, for me I think that [mother-in-law scolding her for wanting chicken she was cooking for her son] set the tone of food expectations. And I think because I had never ever had to deal with something like this before. I grew up where it was more to do, there was so much equality that yes if there was suddenly chicken curry on the table whoever got a piece first got their favourite piece first. Nobody took out a piece like "oh that's for my son", or "that's for my daughter" or anybody. But this is what I noticed was happening here. And I felt there was priorities given over the best cut of meat. It was unusual, it was very strange.'*

Hora linked her mother's eating practices with education and gender equality. For Hora, food communicated equality, sharing, and togetherness; however, for Veena, a first-generation British Gujarati professional and daughter of a prominent bureaucrat in India married to another professional, how one ate was symbolic of a proper upbringing and a medium through which to communicate values and spend time together. She discussed the rules about eating in her maternal home at length. She described food time as having a 'set of rules' everyone adhered to and a 'proper' way to eat healthy food that was nourishing and ethical.

> *'Like in my parents' household, there are a few set rules about food. One was that at least one meal, which normally is the dinner, the whole family will have together. And the second was whatever was served, whatever is at the table, you either ate that or you did not.'*

The narratives of professional and high-income homemakers tended to be more varied than low-income homemakers and skilled mothers. Specifically, there were notable differences across occupations in the language, depth, and content of healthy eating discourses. Professional and some skilled mothers often described encouraging their children to try new food, particularly international food, so that they were familiar with different cuisines and could eat in different countries with confidence. They often used negation to express what they do or do not consider to be healthy practices to differentiate themselves from others. For instance, Nasreen, a second-generation British Pakistani professional, commented on her family's stance towards giving fizzy drinks to the children: *'We don't have fizzy, we don't buy fizzy. They've never had, I never stock fizzy drinks at home. If for some reason there is fizzy drink in the home, they won't touch it without asking.'*

These references were often made with respect to the practices and food they considered unhealthy or sometimes traditional food such as curry. For some mothers, curry symbolised not only traditional ways of eating but also labour and a lack of taste for healthy, international and English food. Faridah, a second-generation Pakistani homemaker and a psychology graduate from a prestigious university, distanced her household food practices from those of her relatives and friends who like curry and chapattis: *'He likes both. Yeah. Because there's some men I know like, they want to have their curries and chapattis every single day or at least once a day at least, whereas he's not.'*

Professional mothers and some high-income homemakers often referred to discipline and self-regulation. Similarly, low-income homemakers and some skilled workers made frequent reference to the need for discipline and to teach children self-control. Several professional mothers mentioned having a snack drawer/cupboard/container accessible to the children who were only allowed to take snacks at fixed times, often after school. For instance, a second-generation British Gujarati professional, Rohini, who is married to a second-generation British professional described a fixed snack drawer time of 4pm for her children:

> *'Treats, chocolates and stuff, yeah, we have a snack drawer and then the children can have something, limited something, from the snack drawer at four o 'clock when they come from school.'*

In terms of the social context of healthy eating, most mothers from both ethnic groups and all occupational categories reported eating socially at home with friends and family more often than going out for drinks or meals. References to eating out in McDonalds and Burger King were made by several mothers across all four occupational categories. However, there were some differences based on occupation. For example, some professionals described eating out with other professional friends across different ethnicities and trying new food. Hora describes her experience of eating out as follows:

> *'And so I used to go to restaurants, because a lot of socialising was done around food for me and my friends. And we would actually try out new restaurants. London is so huge, you hear about something and even if it's like 20 miles away you will get the tube and get there if you know the food is good. And I wasn't a food snob. So I could happily eat like in a five, like a Michelin star restaurant, but I would happily go to the café, you know, where there's like an auntie at the back who cooks the food, because for me it was to do with taste.'*

Whereas Hora stressed an appreciation for taste, several low-income homemakers and some skilled mothers described social eating at home with their friends and relatives, which often involved traditional food. For instance, Johara, a second-generation Pakistani mother in skilled employment married to a first-generation Pakistani migrant in the taxi trade, explained eating at home and the diverse strategies employed for different social networks as follows:

> *'It depends who is coming over. Some of my, like, if they're older relatives or anything and they're used to the traditional chapattis and curries and stuff so then I'll make something like that, but if it's my friends or something like that I'll do like a quiche or a lasagne.'*

Overall, although there were diverse responses in each occupational category, there appeared to be significant differences in the way they discussed healthy eating, the symbolic and social meaning of food practices, and aspirations to eat healthily. In the next section, I examine how occupational and income-related differences translate into healthy eating practices at home.

Healthy eating practices in the context of resources: time and money

In contrast to narratives of healthy eating, there were no clear occupational differences in mothers' reports regarding whether they cook and eat healthily. Both ethnic groups often reported eating healthily and all four occupational categories referred to not being able to eat healthily, although their reasons varied. This contrasts with the diversity in knowledge of healthy eating displayed by professionals and high-income homemakers compared to those in skilled work and low-income homemakers. There was no clear pattern based on occupation in terms of what mothers from different backgrounds cooked on a day to day basis, although low-income homemakers and some skilled workers from a Pakistani background reported cooking *roti* and *salan* more often than professional mothers. Gujarati mothers often referred to cooking vegetarian meals, less use of meat, and aspirations for a variety of food per meal. Mothers from a Pakistani Muslim background often referred to having meat or chicken in their diet. Mothers across all occupations referred not only to cooking traditional food but also regularly cooking 'English' food such as pizza, pasta, quiche, jacket potatoes, fish and chips, burgers, and sandwiches. However, professionals and high-income homemakers were more likely to differentiate between healthy and unhealthy western food than low-income homemakers and some skilled workers. Several mothers from all four categories reported cooking 'English' /international food in combination with Asian food for the same meal or on different days of the week. For instance, Faridah, a second-generation British Pakistani mother with a university degree recalled what she had cooked for the last three days*:*

> *'Shepherd's pie yesterday with salad, and the day before what did we have? I made chicken palak [spinach] and we had some chapattis and stuff with it, and day before that I think - what did I make? We had some kebabs, mincemeat ones with sandwich and salad and stuff.'*

A first-generation Gujarati mother in manual work also reported that:

'I try and give my kids...I try and give them and give them [South Asian food] at least 4 days a week ...our food like sabji, roti...you know. On the other three days they might have chips or may be jacket potatoes... sandwiches.'

Many mothers referred to cooking a variety of hot foods. A second-generation Pakistani professional, Shahida, who is married to a first-generation Pakistani manual worker, reported what she had cooked for the last two days:

'We are really good with diet to be honest, because we like our veg, we like our meat and also we like our lentils, so I always do a variety of different things that I do and I also cook for two days, so whatever I make next day, it's easier for me, so specially curry that lasts two days.'

Although mothers from all classes and both ethnic groups reported cooking from scratch and using fresh ingredients, this was more commonly reported by homemakers. They expressed their dislike for convenience food although references to the occasional take away, burger, or pizza cooked in the oven were not uncommon. However, most strived for home cooked hot food and nutritious meals for family members.

Some mothers from all occupational backgrounds who were married to men with lower educational qualifications and occupational status, reported dissent in their food practices. In many cases, such practices appeared to be influenced by the husbands' preferences although mothers often carved out a parallel sub-practice for their own food and that of their children. In the following quotation, a second-generation British Pakistani mother, Amira, a skilled and university-educated worker married to a first-generation Pakistani in manual employment, talks about how she prepares two different types of meals due to a divergent understanding of healthy food and associated food choices:

'Because he likes his curry and chapatti a lot, so probably I'll be cooking that and may be a few times in the week for him, but me and my son we can eat anything, so … …I'm like preparing two meals...we tend to have English food'.

Instead of cooking two separate meals, Bilquis, a second-generation British Pakistani low-income homemaker married to a first-generation Pakistani in semi-skilled employment, described how her food expectations and aspirations to eat healthily have now changed, although she did not offer a clear explanation as to why. She talked about her husband's preference for *salan* and roti and how she had now come to like it as well:

'Mainly I used to have like sandwiches or I used to have, I don't know, fish and chips, pilau, grilled fish with vegetables. I used to mainly I preferred it on the English side. Now I've come to the greasy side, salan and roti'!

Reports by professional mothers and some high-income homemakers on cooking and feeding children healthily was often made in the context of wider issues linked to emotional, physical, and career outcomes for their children and themselves. Compared to mothers from other occupations, their narratives focused less on food per se and included physical activities, weight loss goals, and time for self and children. A second-generation

British Pakistani, professional mother Nasreen, explained how food is one of the many aspects of caring for her children's needs. She emphasised how spending time helping them to read was an important part of her evening:

> *'Today I know that I'm working so yesterday I cooked for them, so I know that when they get back from school the food's cooked, that's the main thing… I know that I'll feed him, then if he needs a bath I'll give him a bath, brush his teeth. By 6.30/6.45 I'll say come on, you choose a couple of books and we'll go upstairs. I'll read to him and then he'll fall asleep, and I have to sit next to him while he falls asleep. And then he'll fall asleep eventually'.*

In contrast, most of the skilled workers and homemakers often reported prioritising fresh cooking over other things, despite time being a constraint. Jahanara, a second-generation Pakistani mother employed in a secretarial position married to a first-generation Pakistani cab driver, stated that:

> *'No, no, I don't [spend huge amount of time cooking] but it adds up, you know, just feeding them. But by the time I'm finished and they have finished I'm exhausted and they're exhausted. So some days I miss, I forget to think about the homework, and then when we're just relaxing, and then we're just so tired, do you know what I mean'?*

Thus, while Nasreen reported being organised and feeding her children food cooked a day earlier so that she could spend time with them, Jahanara always cooked fresh meals for her children. Prioritising fresh food leaves little time to help her children with their homework. In some professional households, mothers were able to feed children early and spend time with them because eating and bed times were separate for children, as in Nasreen's home. Conversely, in Jahanara's family the rules were more relaxed and children and adults ate when the meal was ready.

As a sub-group, mothers in demanding professions such as consultants working in hospitals and senior academics, often reported not being able to eat healthily due to time constraints. Some mothers in highly paid employment talked of cooking as something that had to be fitted in around their work. Kishwar, a first-generation Pakistani professional in a very demanding job, was often unable to find time to cook food for her children:

> *'I have only recently started making chapatti, otherwise, we used to have Naan [shop bought] or pita bread. Because, my son loves chapatti, so, I have started kneading flour at home, however the chapatti turns out, I am getting better at it. So, I make these things, when I am off, or when I am feeling energetic enough to do it, around the weekend and stuff.'*

Although working mothers from all occupational backgrounds talked about the things that they could do to eat healthily but were not able to due to work commitments, professional mothers expressed this viewed frequently and sometimes unapologetically. Muskan, a first-generation Pakistani professional, expressed her inability to spend time in the kitchen as follows:

> *'Last week has been a disaster, so I'm not sure if that's a good week to talk about… but generally, yeah we would prefer that we eat food cooked at home, but then what affects is what work you are doing,*

how much time do you have, that kind of thing ... if I am at work , when I come back at 6.30-7 in the evening , so then do I have the capacity to stand and cook, that tends to affect a bit.'

Muskan further suggests the need for her to work longer hours than others to be accepted and respected due to being from minority ethnic background. Whereas professional mothers often cited time as a major factor in not being able to eat healthily, for mothers in other categories the reasons were more varied and included time, the influences of other family members, and budget. Compared to professional mothers, most homemakers from all income backgrounds reported prioritising cooking fresh food, sometimes at the expense of other chores or children's homework, as seen above in Jahanra's account. However, women from both ethnic groups and across all occupations resented time spent on cooking and shared strategies to reduce the drudgery involved in preparing hot meals for the family and, in many cases, the extended family. Strategies involved cooking a big pot that lasts several days, creating several meals from one base item (for example frying chicken for chicken curry, wraps, and with salad) and freezing half-prepared food items. Johara explained her reasons for these strategies*: 'I'll only want to do one thing cooking. I don't want to be stood there all day cooking in the kitchen and stuff'.*

A cursory glance suggests there are no clear occupational differences based on budget when eating healthily. Some mothers cited budget as a constraint to eating healthily whereas others felt that, although healthy food can be more expensive, there are cheaper ways of eating healthily and cost should not be a constraint. For instance, Fari, a first-generation Pakistani high-income homemaker who was in professional employment prior to having children and is married to a professional, reported:

'No, I think in any kind of budget you can have things; it depends how you manage things. You can go out and spend a fiver on one small two people lasagne, and then if you buy from that fiver, you know, just the meat, minced meat, that's 1kg of minced meat for £5.50, and then you make your own dough and that costs you, what, 20p of butter and things like that, and then you can make more out of it'.

Similarly, Bilquis, a second-generation Pakistani low-income mother married to a first-generation Pakistani migrant cab driver, felt that when she was eating healthily she saved more money: ' I don't know how, but I don't know because I changed my chocolate and my crisps to my fruit and veg and I realised I was saving money too. But it's when you're cooking at home.'

Although some mothers from all class backgrounds felt eating healthily was more expensive, they also stated there were creative ways of doing so on a budget. However, compared to professionals and high -income homemakers, the narratives of low-income homemakers and skilled mothers contained more references to the cost of healthy eating. Their narratives also contained reasons for their food practices – for instance, it is cheaper to eat in an 'Asian way' on a budget as this makes food last longer, and it is economical to cook one big pot for many people. Soha, a second-generation British Pakistani low-income homemaker married to a first-generation Pakistani manual worker, reported that:

'Healthy food is a waste of money as well isn't it? How? Tuna is healthy, it's only going to fill you up two sandwiches, yeah, and how expensive are three packets of tuna, £4? How many sandwiches can

you make? How many big families can you have? I've got six people in my property living. If it's £4 I buy £2 or £3 chicken, make a curry and fill everybody up for two days, add a few potatoes in it. I show you a 60p curry, Lehsuni curry'.

Amira also reported that she only bought vegetables when they are on offer because of the cost involved, otherwise she buys from a man who provides reasonably priced fruits and vegetables:

'Healthy eating is expensive ... I mean sometimes, I tend to buy fruits and vegetables [from superstores] if there is a deal ... but it is expensive, we have, the vegetable and fruit van comes every Thursday, and he is quite reasonable ..., so I tend to buy my fruit and vegetables from him'.

Many manual workers and low-income homemaker mothers spoke of several strategies they adopted to feed their family healthy meals, such as shopping around for cheaper food items, buying items on offer, cooking in bulk, and choosing dishes that are nutritious but filling and cheap.

Perhaps surprisingly, there was no clear pattern regarding healthy cooking and eating across the four occupational categories. All categories contained mothers who cooked and ate healthily and mothers who did not. Although time was a constraint for all mothers, low-income homemakers and some skilled workers were able to prioritise shopping and cooking healthy meals for their family despite budgetary constraints although for a variety of reasons which included cheaper ways to feeding family members and demands of husbands and in-laws as well influence of social networks. Conversely, some high earning professional mothers more often reported not being able to eat as healthily as they wished to due to long working hours and other commitments. Overall, low-income homemakers therefore reported eating more healthily than some professional high-earning mothers.

The reasons for not eating healthily varied and included resources including time and money discussed here but other factors such as relationship dynamics, domestic and economic abuse (Chowbey 2016; 2017), that I have discussed elsewhere. In addition to time and budget, the knowledge and skills involved in cooking and eating healthily were regularly mentioned. These will be examined in the following section in the context of experiences of healthy eating initiatives.

Response to healthy eating initiatives:

Less than half of the mothers had received information from formal sources such as healthy eating courses at the community centre, children's schools, or from health visitors and GPs. Professional and skilled workers were more likely to cite the internet as a source of information than those in manual work or low-income homemakers; however, a minority of mothers from all occupational backgrounds had engaged with some form of formal education/information on healthy eating. Among those who had access to these services, most either found the courses to be irrelevant or to have little impact on their day to day food practices. Some mothers felt their traditional food choices were being scrutinised. Meher, a first-generation Pakistani high-income homemaker married to a professional, expressed her frustration at Asian food being thought of as unhealthy:

'.. So I said that we don't eat parathas every day... Like you eat Weetabix so we use wheat to make roti which is healthy. We use yogurt and salad…Some people make food really spicy, so maybe that's why they think that what we eat it's not healthy'.

Some others thought that healthy eating courses were not for Asian people because they did not include everyday South Asian food. Kajal, a Gujarati high-income homemaker married to a professional and living in a middle-class neighbourhood, shared her views on attending a healthy eating course at her son's school:

'I had done a course in [name of son]'s school for healthy eating. It was about salt content and sugar content in food, fats and saturated fats, unsaturated fats etc. we should buy I mean ...after reading the label we should compare the salt levels and sugar levels and things like that…then healthy recipes like how we can include salad in our food or like if we have cous-cous then add some salad to couscous... it was not for Asian people'.

Some mothers thought it was not cooking that was a problem for individuals from South Asian backgrounds but wider issues such as money, employment, and a poor neighbourhood. Soha explained her reasons thus:

'These cookery courses are not really helpful. This is how your life is, you can't change life anyway. It is the way it is, you can't change it. It's very hard to change life, you can't, it's too hard. And cookery courses, I don't think so, nobody needs it really. I don't believe in cookery courses, honest. Only for the English community, not Asian community'.

She goes on to say that Asian food is cheaper and healthier:

'Even SuperScrimpers they come out expensive sometimes, we [Asian] are cheaper than them. We know all this basically anyway from, what they're learning now, the Asian community know that ages ago, they just don't want to use it because they got lazier, that's it'.

Like Soha, most of the mothers felt that Asian food is healthy if cooked properly with less oil. Amira explained how she fed her family healthily using traditional food*: 'So yesterday I made a chicken biryani …so it's kind of healthy because I put some chickpeas in, I put some green peas in and I add a bit of chicken in and it 's rice'.* At the same time, there were some mothers across all three classes who felt that Asian food was less healthy.

Most mothers expressed doubts about any long-term benefits accrued from the healthy eating promotion messages they had received from various sources. Two mothers had attended a course that focused on understanding nutritional and calorific information on food items. They only found it helpful for a small number of items because most of the ethnic food they purchased did not have this information. Furthermore, they did not buy many ready to consume food items and could control how much salt or oil they put in their food. Many mothers from across all occupations, especially professional and skilled backgrounds, referred to the internet or books as their main source of information. Ameena, a skilled worker and first-generation Pakistani mother married to a professional, cited her sources of information on healthy eating:

'I already have information about what is good, how much does it cost, maybe you can call it research. Nowadays everyone has access to the internet and you can find out about healthy eating, what is good for kids' growth and everything'.

Contrary to their lack of desire to engage with practitioners and health professionals regarding healthy eating, several mothers from across a range of occupations, especially professionals and skilled workers, had made substantial financial investments in purchasing utensils or machines that enabled them to eat healthily. Some bought a set of pans worth £2000 that can be used to make traditional Asian food without using any oil. Others reported investing in expensive fryers and grills. TV was an important source of information and some mothers also referred to weight watchers and slimming world as sources of information about healthy eating.

Discussion and conclusions:

In this chapter, I examined the diverse meanings and practices of healthy eating and experiences of healthy eating initiatives among two South Asian groups in the UK: Pakistani Muslims and Gujarati Hindus. I explored these from social class perspectives through the narratives of mothers who were employed in a range of occupations and had one or more dependent children. My research built on recent research that critically examines the relevance of class distinctions and taste in contemporary times and argues for a new perspective that recognises the dynamic and fluid nature of taste and the extensive cultural capital employed by people from low-income backgrounds to achieve their desired nutritional outcome (Beagan et al., 2016; Smith Maguire, 2016; Flemmen et al., 2018). The novel contribution of this chapter is to illustrate the intersection of ethnicity, gender and social class in healthy eating among these mothers. Class based practices were dynamic and fluid and thus a nuanced understanding of healthy eating practices across diverse occupations is required.

Mothers' narratives showed considerable diversity in terms of the meaning and value of healthy eating. Professionals and some high-income homemakers provided an expansive account of what they meant by healthy eating which encompassed not only food categories but quality of food, manners, cuisine, and rules around eating. Their narratives suggested the symbolic value of healthy eating practices in their households such as ideals of equality, egalitarian gender roles, intimacy between couples, and parental ideologies. In contrast, low-income homemakers and those in skilled work provided a brief description of healthy eating that was often limited to the consumption of fruit and vegetables and a reduction in salt and oil; although they emphasised cooking and eating fresh food and expressed their dislike for convenience food more often that professional mothers. Notably, being able to articulate an expansive discourse about eating healthily did not necessarily translate into healthy cooking and eating practices, and there appeared to be no significant difference in terms of how healthily respondents ate across occupations. Mothers from all four occupational backgrounds and both ethnicity reported eating healthily as well as not eating healthily, although their reasons varied, as discussed above. Overall, both in cases of transnational as well as same generation marriages Gujarati mothers reported more consensus with regard to the meaning and practices of eating healthily in their household than Pakistani mothers. Gujarati mothers often reported cooking vegetarian meals for the whole family without much dispute. Pakistani mothers reported more disparities in meaning of healthy eating within the household and as a

consequence more than one meal being cooked. There are four distinct areas that necessitate a reconsideration of Bourdieu's theory to make it relevant in context of race/ethnicity:

Firstly, how class intersects with migration especially in context of transnational marriages needs to be considered. Some research has shown that second and third-generation migrants differ from first-generations in terms of eating fewer traditional meals (Gilbert and Khokhar, 2008). However, my findings suggest a more nuanced approach is needed towards the way food changes over generations, including recognition of cyclicity in food practices. For example, in transnational marriages, a second or third-generation person may marry a first-generation migrant and their food practices revert to being more traditional, as was seen in several of the narratives. In some of these marriages, husbands and wives may occupy different class positions in terms of their education, employment and possession of cultural capital and in these 'mixed class' households, as several Pakistani mothers had reported, several meals were cooked at the same time catering to different tastes.

Secondly, in addition to cultural and economic capital; the chapter shows influence of ethnicity on food choice in two ways: 1.) Asian food sometimes portrayed as versatile and healthy other times spicy and oily was presented in comparison with the mainstream British food which was considered the norm, healthy option (although often more expensive) sometimes despite of its obvious fat content such as fish and chips. This internalization of Asian food as being bad and western food being healthy and legitimate need to be considered alongside class based practices (Qureshi 2019). 2.) mothers often desired for their children to develop a taste for ethnic food irrespective of its nutritional content, to enable them to become a respectable member of their religoethnic community, as seen in previous research (Salway et al. 2009) which affected their food choice.

Thirdly, a need for reconsideration of cultural capital in healthy cooking is required. Many mothers from both Gujarati and Pakistani backgrounds were able to cook and eat healthily because they knew how to purchase cheap and fresh food for example from a van man or food market as opposed to super store and buying groceries in bulk. They had extensive knowledge of various low budget and versatile recipes and ways to cook from scratch, and had developed relatively advanced cooking skills over the years. This necessitates a reconsideration of how cultural capital in healthy eating food practices is conceptualised and enacted (Beagan et al., 2016 ; Smith Maguire, 2016).

Fourthly, the need to consider effects of wider gendered and racial discrimination on household food practices. Those employed in demanding professions often made reference to long working hours and a lack of energy and time for cooking. Although, time is often an issue with those working long hours and have implications for food practices as shown with other populations (Blake et al. 2011); the additional pressure of being a woman and from racial minority occupying higher positions were expressed as a concern. This is not surprising considering the gendered and ethnic labour market inequalities (Nazroo & Kapadia 2013). Time appeared to be a major factor for some high earners who, compared to some manual workers and homemakers (both low-income and high-income) who were more often able to adopt strategies that allowed them to eat healthily on a budget more often reported cooking and eating less healthily despite of possessing high levels of economic and cultural capital.

The above findings challenge the assumptions enshrined in healthy eating initiatives, such as South Asian populations are not already versed in healthy eating messages and a lack of diversity in the meaning of food practices among them. These initiatives fail to recognise temporality and cyclicity in food practices, a lack of appreciation of the cultural capital displayed in advanced cooking skills and the ability to cook food on a budget, and assume that healthy eating messages and initiatives such as healthy eating courses will engender transformative change. The findings suggest a more nuanced understanding of individual and familial circumstances and socio-economic location is required to engage with individuals and communities from diverse ethnic and social backgrounds. There are also wider factors related to affordability, availability of healthy food, access to relevant and accessible information about healthy eating, and its impact on food practices within households. To engender transformative changes in food practices, these need to be addressed simultaneously alongside initiatives focused on enhancing the capabilities of individuals, families and communities to eat healthily.

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