The promotion of healthy eating: food availability and choice in Scottish island communities

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Abstract

Communities in rural areas are in receipt of health education messages on healthy eating aimed at the population. These messages are invariably composed without regard to where people reside, and, in particular, to the availability of, and access to, foodstuffs in rural areas. In this paper the authors present data derived from a participative health needs assessment on the topic of food, diet and health. The research was conducted in a number of islands of the Western Isles of Scotland and comprised seven focus groups, 33 semi-structured interviews, one community and one policy workshop, and a final community feedback session. The needs assessment demonstrated a dichotomy between local experiences of food availability, island food cultures and the contents of healthy eating advice. As a result of the research, local people and health care professionals developed a range of activities on the topic of the traditional island diet. People noted the potentially positive elements of this diet for health but also the possibility of promoting social cohesion through the consideration of food and diet histories. In addition, lobbying at a national level was also identified as necessary to the development of a 'healthy food policy'.

Introduction

In this paper we present data from a participative health needs assessment project on the topic of diet and health. This comprised focus groups, semi-structured interviews, community and policy workshops, and a final community feedback session. The needs assessment took place in seven islands of the Western Isles (or Outer Hebrides) which are located in the far north west of Scotland. Funded by the Health Education Board for Scotland (HEBS) and organized in collaboration with the Western Isles Health Board, the project was part of a wider HEBS initiative to enhance community participation in health needs assessment (Clark et al., 1996). The health needs assessment exercise was premised upon a key principle of the Ottawa Charter (WHO, 1986), i.e. the active participation of communities in research, together with the design and implementation of related activities.

The focus of the health needs assessment, i.e. community perceptions of diet, health and healthy eating, is one which has received major attention in both health policy and health promotion in the UK (DoH, 1992; Scottish Office, 1993). Scotland’s diet has been described as 'notoriously unhealthy and worse than that of almost any other country in the Western world' (Scottish Office, 1996, p. 25) and a diet action plan for Scotland published (Scottish Office, 1996). Whilst this plan calls for action amongst a range of groups (e.g. primary producers, manufacturers and processors, the retail sector, and communities), and in a number of
settings such as schools, workplaces and homes, the issues of availability and choice of foodstuffs for communities in rural areas of Scotland are not actively considered. These are important issues as a third of the Scottish population resides in areas defined by the Scottish Office as rural (Shucksmith et al., 1996). Communities in rural areas are in receipt of health education messages on healthy eating aimed at the Scottish population as a whole and these messages are invariably composed without regard to where people reside.

The paper opens with a consideration of community participation in health needs assessment and issues of diet and health. The health needs assessment project is then introduced, the methods discussed, data are presented and feedback workshops reviewed. In the discussion section the dichotomy between local experiences of food availability, island food cultures and the content of current healthy eating advice is identified and considered. The concluding section notes the need for a 'healthy food policy' which, like a healthy public policy, considers and involves structural, infrastructural and individual variables.

Community participation in health needs assessment

In the context of health promotion the aim of health needs assessment is to understand people’s point of view, and appreciate their experience and knowledge of health, illness, and health care and related services. As a result health promotion activities may be grounded in an appreciation of local cultures, priorities, and secure and enhance participation by potential service users (WHO, 1985; Stacey, 1994; Tones, 1996).

Qualitative research methods are often considered appropriate to enhancing participation in data collection and ensuring a depth of understanding of local issues. A number of philosophical traditions have informed the development of qualitative methods and, as a consequence, there is no one set of methodological principles (Mason, 1996). However, Beattie (1995) comments that qualitative methods emphasize:

...process, working with people in a non-judgmental manner that is sensitive to local cultures, collecting and negotiating an agenda of concerns from the participants...

Regardless of the potential for qualitative methods to enhance an understanding of the social world of participants and the social context there is, as Whitehead (1994) notes, an imbalance between the various stakeholders in research. This imbalance is evident in considering who designs and controls the research process, and the emphasis placed upon results. It is, therefore, unrealistic to consider health needs assessment research employing qualitative methods an empowering process. However, the research process does raise voices and expectations that views will be listened to and change follow (Ardener, 1977; Israel et al., 1994). There is no obligation on the part of those who commission research to act upon the findings (Popay, 1996) and as Ribbens (1988) has pointed out research results can be used to validate work already in consideration or practice. Yet health needs assessment for health promotion should seek to achieve a synergistic relationship between local participants and policy makers by ensuring what Tones (1996) has termed as a 'critical consciousness raising'; creating an awareness of, and acting upon, issues of public concern.

Healthy eating and health promotion

Evidence from a number of studies (e.g. Doll and Peto, 1981; Scottish Office, 1993) have demonstrated a clear association between food consumption, socio-economic status and disease. The over-consumption of fats, sugars and salt together with the under-consumption of fruits and vegetables have been implicated in a wide range of diseases, e.g. cancers, cerebrovascular disease and stroke, coronary heart disease, and increasing rates of obesity.

The Scottish diet action plan identified a number of targets for dietary change including the increased consumption of fruit and vegetables (Scottish Office, 1993). Recommendations suggest that indi-
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Individuals should aim to consume five portions of fruit and vegetables per day. As part of the action plan every household in Scotland was sent a leaflet on healthy eating which detailed the contents of a healthy diet, and promoted the enhanced consumption of fruit and vegetables.

This population approach to the promotion of healthy eating is not necessarily premised upon issues of local availability, quality and choice of foodstuffs, but rather emphasizes the role of individual behaviours. Cummins and Macintyre (1997) note that most current food policy guidelines contain an implicit acceptance that where you live can have an impact on dietary health, but policy research has traditionally focused upon the individual and their apparent reluctance to change their diet (Beardsworth and Keil, 1997).

Confusion amongst nutritionists, conflicting advertising campaigns and recent food scares have caused people to doubt the basis and relevance of health eating advice (McKie et al., 1993). Messages often focus upon individual and household purchasing and consumption patterns, and because of the gendered nature of food work, invariably reinforce notions of female responsibility for diet and health (Pill, 1983; Charles and Kerr, 1986).

Behavioural causes of ill-health are not immune to influence and change, but individual behaviour is strongly linked to the social and material circumstances in which people live (Graham, 1993; Cummins and Macintyre, 1997). The relevance of social and economic structures in the availability and choice of foodstuffs may be conceived of in a limited fashion yet there is a need to conceptualize of a food system (rather than individual food behaviours) as a necessary pre-requisite to a healthy food policy (Beardsworth and Keil, 1997).

Introducing the case study: food availability and choice in Scottish island communities

The general topic of diet and health originated in debates conducted by the Western Isles Health Board, Food and Health Group during 1994. Comprising health care professionals, food distributors and retailers, and regional council officers, the group considered results from the 1993 health and lifestyle survey conducted by the Health Board. Those who responded to the survey demonstrated a good general knowledge of the relationship between diet and health, and 57% of respondents stated that they would like to eat what they conceived of as a healthier diet. Yet a range of barriers to change were identified. These included (in the priority of respondents) the availability of ‘healthy’ foodstuffs at affordable prices, advice and practical tips, encouragement and support from family and friends, need for advice from a doctor, and the availability of ‘healthier’ foodstuffs. Thus the issues of availability and choice were clearly identified as barriers to change (Western Isles Health Board, 1993). As noted earlier HEBS funded the needs assessment project as a component of a wider programme on community participation in health needs assessment. The choice of the qualitative approach was both sympathetic to the aims of the project and complementary to the 1993 health and lifestyle survey.

Remote island communities

The needs assessment was conducted in the islands in the south of the Western Isles of Scotland, i.e. Berneray, North Uist, Benbecula, South Uist, Eriskay, Barra and Vatersay. These are sparsely but widely populated localities with approximately 7000 people residing across the seven islands.

The climate in the islands is harsh. It is difficult to grow anything which lives more than a few inches above the soil and the many small lochs dotted across the islands make the land marshy. Whilst in previous centuries the population lived from subsistence croft farming and fishing, the introduction of a wage economy, changing social values and recreational preferences has reduced the amount of time island residents are prepared to devote to crofting.

Access to food retail outlets is also limited. There are no supermarkets and in the few villages there are generally one or two small shops devoted to food and the local post office may also sell a few food items. Apart from a bakery on one of
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the islands, residents growing potatoes, turnips and carrots, and a few fish farms, there is no local production of food. As virtually all foodstuffs and milk have to be imported the weekly shopping bill can be up to 15% higher than that on the mainland and at times access to food may be restricted due to limited deliveries. Many island residents express the view that they are on the 'edge' in political, geographical, social and economic terms, and verbal expressions of isolation and alienation are common.

Research methods

In summary, seven focus groups took place with both new and existing groups; 29 semi-structured interviews were conducted with people resident on the islands, four further interviews with senior staff in distribution and haulage companies on mainland Scotland, and two workshops were held for the purposes of participant validation. In addition, a feedback workshop was held on completion of the project to ensure that participants and the local population were updated and involved in the development of future activities on health and diet.

Data collection

Data were collected over a 7 month period during 1995. Work commenced in January and the research team sought to complete data collection by April. This was considered crucial as in the summer months people are active in the tourist trade and related work, receiving visitors from the mainland, and undertaking maintenance work on homes and buildings. Clearly the research team benefited from the knowledge of the resident member of the team and the experience of a member of the team who was involved in another project in the same locality. An appreciation of the rhythm of community life is necessary; it suggests a consideration of local culture as well as establishing the impact of the seasons upon local participation (McKie, 1996).

The member of the research team who is resident on one of the islands piloted the focus group method in month 1. Another member of the research team resided on Benbecula and Barra for 5 weeks during months 2 and 3. She conducted the semi-structured interviews, initially drawing on data from the focus groups to construct the interview schedule. The other members of the team took the main responsibility for the data analysis and the organization of the workshops.

Focus groups

The focus groups comprised existing groups, e.g. men's health group; groups constructed for the purposes of the research, e.g. army wives group; and groups which were a combination of existing groups with others participating in one meeting for the research, e.g. slimming group. In the case of existing groups the topic was placed on an agenda for a future meeting and the request considered. Those interested then joined one of the researchers at a pre-determined time and location to debate the project topic. Groups formed specifically for the research were comprised of people in a given locality or group (e.g. a school year or army wives residing on a housing estate) and were approached in person or by letter. In all cases we found an enthusiasm for the topic and group formation proved to be time consuming but unproblematic.

A profile of the focus groups is presented in Table I. The groups largely comprised women, with the exception of the all male group, the men's health group, but there was a wide spread of ages with groups being conducted with senior school children (14–18 years of age) and older age groups (50+) in the Women's Institute. In total 60 people took part in the focus groups.

The groups were asked to consider four topics:

- Where do we get ideas about food from?
- What do people on these island eat?
- Food availability and choice.
- Ideas about promoting healthy eating.

Group discussions were guided by these topics and the researcher present worked with the group's interests.

Participants in pre-existing groups also noted how the request to consider the general topic of
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Table I. Profile of focus groups

<table>
<thead>
<tr>
<th>Code</th>
<th>Focus group</th>
<th>M/F/mixed</th>
<th>Age bands (years)</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Look After Your Heart</td>
<td>F</td>
<td>25-60</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>community school senior pupils</td>
<td>mixed</td>
<td>15-18</td>
<td>7</td>
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<td>community school senior pupils</td>
<td>mixed</td>
<td>14-18</td>
<td>9</td>
</tr>
<tr>
<td>4</td>
<td>men's health group</td>
<td>M</td>
<td>25-60</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>army wives</td>
<td>F</td>
<td>20-44</td>
<td>8</td>
</tr>
<tr>
<td>6</td>
<td>slimming group</td>
<td>mixed</td>
<td>25-44</td>
<td>16</td>
</tr>
<tr>
<td>7</td>
<td>Women's Institute</td>
<td>F</td>
<td>20-60</td>
<td>7</td>
</tr>
</tbody>
</table>

Food and health had prompted thoughts and debate on food and diet issues prior to the focus group. Yet the topic was one new to the pre-existing groups, and even the members of the slimming group remarked that they largely considered how to avoid food and eating rather than the promotion of healthy eating. Given that the topics were generally new to debate those in pre-existing groups did not consider prior knowledge of group members had impacted on what they contributed. However, a number of participants in the focus groups expressed concern that responses should be treated as anonymous for there was a fear that concerns expressed about food retailing might negatively impact on local retailers and thus availability. As one participant noted 'we want things to improve; we don't want to put anyone out of business because of what we've said'.

Semi-structured interviews conducted on the islands and the mainland

A snowball technique was employed for sampling purposes, i.e. those interviewed were asked to propose further individuals for interview within the range of shoppers, shop workers, shop managers, and health and care workers. The research team monitored the snowballing process to ensure that people from a diverse range of backgrounds were interviewed but this process compensated for the research team's lack of local knowledge across all the islands. Anonymity was guaranteed in terms of data analysis, although it proved difficult to achieve confidentiality about who was interviewed as the research team and their movements were readily observed by island residents.

A profile of the interviewees resident on the islands is presented in Table II.

The semi-structured interview schedule considered a range of topics including: perceptions of what local people buy and eat; shopping and access to fresh foods; local food production and the impact of tourism; beliefs about diet, health and healthy eating, and health promotion.

During the interviews and focus groups a majority of participants expressed frustration that their concerns were never verbalized to bodies outwith the islands. We were asked on numerous occasions whether we would be interviewing senior staff at the major food distribution, haulage and ferry companies located on mainland Scotland. As a consequence it was agreed that four interviews with relevant individuals would be conducted after the first community workshop was held. Through this process it was possible that community views might be conveyed to representatives of these organizations.

Data analysis and validation

Data were available in the form of transcripts from the focus groups and detailed notes from the semi-structured interviews. Whilst an initial analysis of data from the early focus groups formed the basis for the first version of the semi-structured interview schedule it was ultimately decided to pool data derived from both methods.

The validity of this method of analysis and thus interpretation must be considered (Crabtree and Miller, 1992; Mason, 1996). The researchers chose to weave data sets together and analyse these data in a thematic fashion. On an initial, but separate
analysis, it became evident that neither data set provided any distinct differences in content. Combined, the data sets provided a fuller explanation of the social and economic processes of food systems in the islands. In addition, the weaving together of data sets enhanced anonymity for participants.

The analysis of data was based on a thematic approach, but during analysis issues which were raised by, or in relation to, particular individuals or groups were considered as separate topics. Throughout the analysis of data, the views of one group or individual were not given priority over any others and comments from participants, whatever their background or specialist knowledge, were regarded as equally valid.

Participant responses to an early analysis of data

The process of community participation in both the research and subsequent activities was also promoted by local consideration of the research data. This process took place at two workshops: (1) a community workshop held on Benbecula in month 3, and (2) a policy and practitioners workshop held in Stornoway (the central point for health service and local government management) in month 6 of the project.

Both workshops were widely publicized through letters and leaflets, and invitations extended beyond those involved in earlier stages of the project. At both of these events an initial review of the research findings was presented and small workshops were conducted which considered the relevance of findings to the development of future initiatives. Notes were kept by the research team of feedback from the small group work, and this assisted in verifying the content of the findings and the emphasis placed upon issues in our analysis. Twenty people participated in the community workshop. Participants were predominately female and many had participated in earlier stages of the research. In the second workshop 15 people participated. These included local politicians, senior policy staff and health care practitioners. A minority had participated in earlier stages of the research. Most were based in the north of the Western Isles on the islands of Harris and Lewis but did have a responsibility for the provision or delivery of related services in the islands on which the research was conducted.

Final community feedback session

In the 10th month of the project and to coincide with the local distribution of a research report, a final community workshop was held at the community school in Benbecula. Invitations were sent to all those who participated in earlier stages of the project and leaflets distributed across a range of organizations and locations in the islands. Fifteen people attended along with several health care professionals from Stornoway. The session considered how the outcomes of the research might
be furthered through local and regional health promotion and related policy activities.

**Research findings**

Data are presented thematically, in accordance with the priorities of local participants. Most of the quotations used in association with the text are illustrative of the general view of the majority of participants and are intended to highlight particular issues, or are used where the comments of individual participants were particularly apposite. Where different views have implications for the food system and local perceptions of this, these are noted.

Data on the two major concerns of the local people are presented, i.e. the traditional diet and the contemporary diet. Other findings are detailed in the final report (Clark et al., 1996), and include, in summary, low levels of disposable income and the high cost of foodstuffs; conflicting definitions of a healthy diet; changing work patterns; and changes in gender relations in rural society.

**The ‘traditional island diet’**

Many participants, notably those who had spent much of their lives in remote rural areas, felt that there was a distinctive ‘traditional diet’ of rural Scotland and a ‘traditional island diet’. The former was predicted on food products derived from crops, especially oat-based products and root vegetables, while the traditional island diet also comprised fish, in particular salted herring. The traditional island diet was viewed as an integral part of pre-second world war history, and a large proportion of participants summarized this era as a time of: plenty; thrift; community; good health; regular eating habits; family values; arduous but rewarding manual labour; and self-sufficiency in food production.

The traditional island diet was said to comprise a simple and wholesome balanced diet based on fish and other seafood, and produce from the croft, most notably milk and other dairy products from the house cow and root vegetables. The participants who had experienced the ‘traditional island diet’ (generally those over 50 years of age) regularly contrasted the contemporary diet with that of the past, and asserted that, despite the high salt and high fat content of the traditional diet, the past had been a time of comparatively low levels of ill-health amongst the general population. Several participants theorized that elements of the traditional diet which would now be viewed as damaging to health, notably high fat foods, were counter-balanced by hard physical labour carried out by adult men and women, and by the outdoor energetic play activities of children. The following comments are typical of the views of many participants who thought that people who once enjoyed the ‘unhealthy’ elements of the traditional island diet were healthier than many of the contemporary population:

- Nowadays, all the medical folk tell you not to take too much salt. Then [in the past], we didn’t have as much heart trouble. My own family, when they see me putting salt on food, they’re up against me. (Man who grew up on a croft, aged over 60.)

- The men—I never heard of them getting heart attacks; they ate good [high fat/salt] meals and burnt it all up. (Male, aged over 60.)

- When my mother was 88, she used to say ‘you can’t beat a good fry’. I used to annoy her with grilling things and using ‘Flora’. (Crofter’s daughter, aged over 60.)

Many participants emphasized the labour-intensive nature of island living, and reflected on the associated lifestyle which they claimed bound crofters to their land and their livestock. The majority of participants felt that producing or procuring elements of the traditional island diet was an accepted part of an inherently healthy ‘way of life’ on the islands before the war, which contrasted with what many saw as the inherently ‘unhealthy’ contemporary sedentary lifestyle:

- They think about health more now. There was no keep fit classes and the classes for losing weight. Women then were carrying creels of fish and of peat, and working in the fields. A
lot of women have more desk jobs now. And there's such a lot of cars now, and people don't do so much walking in the fresh air...When I was young, I wouldn't have known what 'Weight Watchers' was!' (Female crofter, in age band 45–60.)

The decline of the traditional diet and 'modernization'
The introduction of electricity, and consequently fridges, freezers, and processed and convenience food products to the Isles during the 1950s and 1960s, was viewed as the key factor in the decline of the island diet. Many participants felt that Islanders' current enthusiasm for convenience foods originated during this period when tinned and processed foods were associated with 'progress' and 'modernization', and were restricted to households with a high disposable income:

In the mid 1950s everybody was living on condensed milk out of cans; home baking stopped in favour of white bread from Glasgow. You were considered a bit above the rest if you were eating pre-packaged, high processed food. The 50s and 60s was a low point because of this. (Mother of teenage children, in age band 45–60.)

According to some participants, after the 1950s 'self sufficiency' in household food production came to be associated by many with 'backwardness':

In general, there's a wish to use convenience foods out here; there's a need to come out of the 'back woods'...They had to milk the cow, collect the eggs and plant the potatoes: so people want to modernize. (Migrant to the islands, in age band 45–60.)

Some participants alleged that many of these attitudes prevailed in the 1990s and that some Islanders felt under pressure to demonstrate that they were no longer reliant on producing their own food. The era of the traditional island diet was remembered by some as a time of harsh economic constraints, poverty and hardship, rather than the idealized lifestyle remembered by others, and some felt that members of the community still wished to demonstrate that they had 'moved on' from days of self-sufficiency through necessity, to a time of relative prosperity, through their food choices:

There is a feeling that if you are buying processed foods, then you're more affluent than if you are making up meals. People eat home-made soups and potatoes, but generally they have something processed with it. (Mother, in age band 25–34.)

Older participants felt that the comparative ease of modern life meant that young people would simply not be prepared to work on the land and sea in the way that their parents and grandparents had done in the past in order to secure food for the household. These participants felt that an entire way of life had changed on the islands, not merely restricted to food consumption patterns:

My own neighbours grow vegetables every year, carrots, potatoes, cabbage, cauliflower and things like that, and they do that because that's the tradition, and because they have the time to do it, and because they want to do it. I am sure it's something to do with the taste, but it is also to do with the fact that they would expect to use some of their time to grow vegetables and potatoes rather than somebody go and pay exorbitant prices for them. It would almost be a matter of need in some cases with them, they are on very low incomes, and they would see that, along with cutting peats and doing a whole range of other things, that would be securing their life for the winter, they cut their peats, they grow vegetables, they store their potatoes very carefully, and that kind of thing. So it is a kind of tradition and a need in their case. (Participant in the men's group, in age band 35–44.)

The tastes and textures of the traditional island diet, distinctive recipes and associated traditional remedies were, however, viewed as an important part of the island heritage, and many participants
were very conscious of the existence of a traditional island diet from which the contemporary diet allegedly evolved. Many participants were hopeful that future generations would be able to draw inspiration from these traditions and combine the high food quality of the traditional island diet with the less arduous lifestyle of the present.

The contemporary diet in the Isles

The contemporary diet in the islands was evaluated by participants against a variety of criteria. Older participants who had lived on the islands for much of their lives generally contrasted the contemporary diet with food availability and the diet of the past, whereas younger participants and those who had moved to the islands from the mainland generally contrasted food availability, choice and the contemporary diet with that of mainland communities. The overwhelming majority of participants were, however, united in their view that the contemporary diet consumed by members of the island communities was unhealthy and unbalanced.

Shopping for food: availability and choice

The participants’ view of the island shops was that they were sub-standard. Participants alleged that the quality and quantity of food in the island shops was inadequate, and that goods were displayed in an unattractive fashion and were frequently of poor quality. Participants also complained about irregular supply patterns and the difficulty of obtaining seasonal goods, notably at Christmas time. The shop owners were deemed to be lacking in entrepreneurial flair and were viewed as operating under conditions of an ‘unfair’ monopoly driven by a ‘profit’ rather than a ‘service’ motive.

Participants reported that shopping for food was an extremely time consuming daily chore, performed almost exclusively by women. Many participants contrasted the advertising images of enjoyable food shopping in supermarkets with the constant forward planning and budgeting required in the islands. Most women felt that there was no scope for spontaneity in food shopping on the islands and described the numerous ‘shopping strategies’ they felt it was necessary to employ to ensure an adequate supply of food for their households. For example, it was reported that it was necessary for women to be at certain shops at specific times to ensure that they could buy produce from a delivery before stocks were sold out. The participants made frequent reference to ‘stocking up’ and felt that there was a ‘siege mentality’ in the Isles which encouraged women to buy up goods and produce as and when they were available rather than when the goods were needed by the household. The following comment typified the views of the majority of participants:

We have a siege mentality because we have a fear that there won’t be a boat. They [food deliveries] only come every other day, so you have to stock up. (Single woman, in age band 25–34.)

Participants reported patterns of panic buying and on occasions ‘stampedes’ when goods came into the island shops. Several participants made an analogy between their situation and that of women during war time, notably in terms of rationing the food supply for their households. Storage facilities in the island shops were also viewed as inadequate, allegedly resulting in soured milk and an extremely short shelf-life for any fresh produce.

Given the emphasis in health promotion and dietary advice on the consumption of five portions of fruit and vegetables per day it is relevant to note that fruits and vegetables proved to be limited in supply and of questionable quality. In fact the poor quality, small quantities and high costs of fresh fruit and vegetables on the islands were viewed as a major obstacle to islanders attempting to improve their diet. Despite what participants viewed as a strong demand for fruit and vegetables, they reported that the island shops were reluctant to provide more shelf space for fresh produce and it was alleged by participants that the shopkeepers
preferred to devote shelf space to more profitable goods, most notably alcohol.

The description of the fruit and vegetables provided in the island shops by one participant as 'absolutely tasteless' was typical and many participants felt that it was a 'risk' to buy fresh produce, as in their view, produce would often prove to be over-ripe, depleted of any vitamin content it once had; 'infested', 'soggy' or 'rotten'. Many participants felt that it was ironic that foods which the majority of people on the mainland would take for granted, such as fruit and vegetables, were regarded as luxury goods on the islands. One participant described how her mainland 'emergency standby' meal of vegetable curry had become a 'special treat' on the Uists.

Despite the consistent problems with the cost and quality of fresh fruit and vegetables, participants reported that they were reluctant to return poor quality produce to the shops or to make public complaints about the produce because they believed that poor quality fruit and vegetables were accepted as the norm on the islands and shopkeepers received stock which had taken some time to reach the islands.

Discussion: participants views of research data and process

Responses to the themes, as presented above, were positive. Participants in the workshops stated that the changes in island food cultures and the sense of 'being on the margins' of food supply systems were captured. As several participants noted, they were not immune to population-based messages on healthy eating, as illustrated in leaflets and adverts. So it appeared to some that their limited access to a choice of quality fruits and vegetables, at affordable prices, had been ignored in the promotion of healthy eating.

The potential for social activity based upon a core element of a 'remembered' culture—the traditional island diet—prized for its sense of cohesion was noted by a number of participants at the community workshop. One local women's group was especially keen to initiate a traditional island diet group. Subsequently, the local community health project conducted a discussion group on food issues, and through reminiscence work drew upon food issues from discussions amongst grandmothers, mothers and daughters.

At the policy workshop these developments were viewed with interest by the health practitioners whose main concern was to develop activities that would promote healthy eating through the increased consumption of fruit and vegetables. However, they became more aware of the limitations on healthy eating of food availability and it was accepted that recipes in health promotion booklets often contained ingredients that could not be purchased locally. It was apparent that wider issues on food distribution and food costs required consideration, and this would necessitate lobbying and policy activities at a national and regional level with distributors and haulage companies. The potential for local activities to promote food availability and the quality of fresh foods was necessarily limited but the need for a 'healthy food policy' combining action across a number of sectors was stated.

At the final community feedback session we presented the views of mainland haulage and distribution companies. Keen to respond to local perceptions of food availability and choice they noted the additional costs of supplying the islands. This and transport difficulties placed a strain upon company profits. The need for lobbying at the Scottish Office, the Convention of Scottish Local Authorities, and across a range of private and voluntary sector organizations was noted, and at the workshop this was considered the responsibility of the Health Board, the Local Health Council and politicians. The health care professionals present proposed the setting up of a local food and health group. Keen to ensure that the momentum developed by the research was not lost, nine local people volunteered to participate. In these islands this is a large number of volunteers. The agenda of this group was defined as one concentrating upon working with local shopkeepers to promote better storage and display of fresh foods.
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that work was required at a number of levels to ensure a 'healthy policy' framework for the promotion of healthy eating.

Conclusions

The contemporary diet was perceived as a generally poor one. Elements of the traditional diet were also considered unhealthy, especially the dominance of salt and fat in many dishes, but the oat elements (porridge and oatcakes) and vegetables (potatoes and turnips) were considered positive components of a diet which might be promoted through recipes and traditional island diet evenings. However, the traditional island diet was also viewed by some as linked to 'backwardness' and associated with a lower socio-economic status. Those who positively viewed the traditional island diet also noted the changing pattern of physical labour and exercise.

Local activity commenced on the topic of the traditional island diet prior to the end of the research project. The traditional island diet 'activities' evolved from islanders' views that elements of the past could be usefully considered as both food and health issues, and in doing so possibly enhance social cohesion. These activities have ranged widely and involved many. They are led by local people with a limited involvement from local health practitioners. By contrast, the food and health group was formed as a result of a 'top down' request from professionals.

The research findings demonstrated the need to consider the enhanced consumption of fruits and vegetables as requiring action in terms of supply and availability, and this did not validate previous agendas on personal skills training and healthy eating information (Ribbens, 1988; Popay, 1996). So voices were raised and wider policy issues recognized by professionals (Ardener, 1988). Ultimately the research demonstrated the need to consider the food history and infrastructure of a community (Cummins and Macintyre, 1997). To divorce barriers to change from social and material circumstances also denies the complexity of the process of diet change (Graham, 1993; Beardsworth and Keil, 1997).

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