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Australian children's perceptions of discretionary foods

Stefania Velardo [a, b, *], Murray Drummond [a, b]

[a] School of Education, Flinders University, GPO Box 2100, Adelaide, SA 5001, Australia
[b] Sport, Health & Physical Education Research Centre, Flinders University, GPO Box 2100, Adelaide, SA 5001, Australia

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ABSTRACT

Energy-dense nutrient poor foods and drinks, often referred to as discretionary choices, can contribute a significant amount of energy, fat, sodium and sugar to the diet if consumed in large quantities. Currently many Australian children are consuming a diet that is characterised by large quantities of discretionary items. We undertook a qualitative study to gain a descriptive account of preadolescent children's attitudes and perceptions towards health and nutrition. A series of 6 focus groups and 14 individual semi-structured interviews were conducted with thirty-eight children aged 11–12 years, across three state government schools in a socially disadvantaged region of metropolitan South Australia. The naturalistic manner of qualitative inquiry led to several unintended yet highly pertinent emergent themes, including children's perceptions and practices surrounding discretionary food consumption. Our results indicate that while Australian guidelines recommend that discretionary foods are consumed 'only sometimes and in small amounts', children generally held a different belief with respect to what constituted 'sometimes'. Many children identified that discretionary foods should be consumed in moderation to maintain a balanced diet, yet reported consuming these foods frequently. Self-reported discretionary food consumption was grounded in socially constructed experiences valued by the children, who made situational attributions to foods and legitimised discretionary food consumption in certain contexts, for example during the weekend. Overall, there is variability between children's opinions about the acceptable frequency of consumption of discretionary foods compared with national guidelines.

1. Introduction

Good nutrition plays a fundamental role in promoting physical and mental health throughout the lifespan (National Health and Medical Research Council, 2003). In an effort to optimise population health nutrition, the Australian Government has developed a number of public health guidelines that provide advice in relation to dietary practices. The most recent guidelines, the Australian Dietary Guidelines, encourage children aged 4–18 years to consume a nutritious diet enriched with vegetables, fruits, grains, lean meats and dairy (National Health and Medical Research Council, 2013). Such foods comprise the five core food groups. Discretionary choices is the term used to describe foods and drinks that do not fit into the five core foods groups. Discretionary foods are characterised by high energy density and a lack of essential nutrients, and include items such as sweet biscuits, cakes, ice cream, confectionary, commercially fried foods and other fatty, sweet and salty snack foods. Although these foods may form part of a balanced diet, the Australian Dietary Guidelines recommend that they are kept to a minimum and consumed 'only sometimes and in small amounts' (National Health and Medical Research Council, 2013). The recommended number of serves of discretionary foods that should be consumed varies by age, sex, height and level of activity. For example, more active 2–3 year-olds are recommended 0–1 serve per day, while older boys and girls aged 14–18 who are not overweight but are taller or more active should consume no more than 5 serves or 2.5 serves per day, respectively. It is important to note that these servings would also include additional consumption of unsaturated spreads and oils, beyond the baseline daily allowance. The Australian Dietary Guidelines discourage discretionary foods since they contribute to excess energy intake and increased risk of chronic disease (National Health and Medical Research Council, 2013). In Australia, childhood chronic disease levels remain high. Currently 25% of 2–17 year olds are overweight or obese (Australian Bureau of Statistics, 2013a).

Many Australian children are not fulfilling dietary requirements.

* Corresponding author. Flinders University, GPO Box 2100, Adelaide, SA 5001, Australia.
E-mail address: Stefania.velardo@flinders.edu.au (S. Velardo).

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In 2011/12, almost 70% of children aged 5–11 (68.6%) ate two or more serves of fruit on a usual day, compared with 54.4% of 12–17-year-olds. Only 5.2% of adolescents consumed five or more vegetables per day, compared to 3.8% of younger children (Australian Bureau of Statistics, 2014). Australian children are also consuming a diet high in foods with limited nutrient content. In 2007/08 non-compliance with government guidelines was high for saturated fat and sugar, and excess consumption was evident for various macronutrients, with only a minority of children reporting a limited intake of sugar and dietary sodium in line with recommendations (Department of Health and Ageing, 2007). This is further reflected in recent data, which reinforce the significance of this issue. In 2011/12, discretionary foods on average constituted 37% and 39% of total intake for 4-8 year-olds and 9- 13 year-olds in Australia, respectively. For these age groups, items including cakes, muffins, scones and cake-type desserts were the largest food contributors (Australian Bureau of Statistics, 2014). A more recent study also demonstrated high consumption of discretionary foods amongst 9-10 year-old Australian children. Withrow et al. found that child participants in a cross-sectional community sample obtained almost half of their daily energy intake from discretionary foods (Whitrow et al., 2016). Evidently, there is considerable scope for improving children's dietary choices by replacing discretionary food items with recommended foods from the five core food groups.

Previous Australian research has investigated discretionary food provision from the parental perspective. One study indicated that most parents consider it acceptable to provide discretionary foods to children on a daily basis (Hesketh et al., 2005). Another study showed similar results, by investigating parental attitudes and practices related to discretionary food choices with pre-school aged children. Participants justified the provision of discretionary foods on the basis that their children were still consuming healthy items alongside discretionary choices (Petrunoff et al., 2014). For many parents this could translate to the provision of discretionary foods every day. Another qualitative study conducted with parents in Western Australia revealed that most parents provide discretionary foods to their children on a daily basis, as a result of using food as a reward/bribe, demonstrating affection and avoiding feelings of deprivation (Pescud & Pettigrew, 2014).

Research on Australian children's discretionary food consumption tends to prioritize views of parents and caregivers, on the basis that they are responsible for acquiring and purchasing household food. Such research is clearly warranted, given adults' influence on children's dietary behaviours, however it is also important to acknowledge that children are active agents in their social contexts. Specifically, children's progression towards adolescence corresponds to increased independence, self-management and autonomy in food-related decision making (van der Horst et al., 2007). Eating habits established during this stage are also likely to translate into adult behaviours (Mikkilä et al., 2004). Understanding children's own needs and interests, as distinct from their parents, thereby constitutes and important step in understanding how children think about health, which provides valuable information for public health practitioners and policy makers (Velardo & Drummond, 2017). The research reported here is drawn from a larger study that fundamentally positioned children as active, engaged citizens capable of making meaningful contributions to research. We adopted an interpretive approach to elicit the voices of children, in order to understand their attitudes and perceptions towards health and nutrition. The naturalistic manner of qualitative inquiry led to several unintended yet highly pertinent emergent themes (See Table 1 for summary of results). In this paper, we focus exclusively on data pertaining to children's understanding and experiences surrounding discretionary food consumption. This is a significant topic worthy of discussion in its own right, given the lack of child-centred studies in this space. Other study results will be reported elsewhere.

2. Methods

This paper draws on data collected within three government primary schools located in a local metropolitan government area of South Australia. Participating schools were selected from a socially disadvantaged area in metropolitan Adelaide. The area was identified using the Socio Economic Index for Areas (SEIFA) (Australian Bureau of Statistics, 2013b). Preadolescent boys and girls aged 11–12 years were invited to participate in the research. Once the lead author identified three consenting schools, information about the project was disseminated to children and their parents by means of scheduled school talks, printed information sheets and forms requesting parental consent. Overall there were 38 children who chose to participate in the study, comprised of 14 boys and 24 girls. Sampling continued until the point of theoretical data saturation, but the final number of participants was also reflective of the number of children who took a genuine interest in the study and wanted to participate by free will. Parents provided written informed consent and children provided verbal and written assent. The study was approved by the Flinders University Social and Behavioural Research Ethics Committee and the South Australian Department of Education and Child Development Research Unit.

The study was guided by a socio-ecological framework (McLeroy, Bibeau, Steckler, & Glanz, 1988) to identify diverse sociocultural facilitators and barriers to children's interaction with, and use of, nutrition information and messages. The framework is widely adopted in public health research as it acknowledges multiple influences on health behaviours and outcomes, at the individual, interpersonal, organisation, community and public policy levels. The research was also grounded in social constructionist theory, which posits that aspects of reality, including health-related experiences and understandings, are fundamentally shaped by social interactions and collective meaning-making (Burr, 2015).

A range of data collection methods were employed to facilitate data richness and accommodate for individual preferences. Children were offered the choice to participate in either a group or one-to-one interview onsite at the school, to ensure that they felt safe and comfortable in their surroundings. Focus groups are shown to be an extremely effective data collection method for childhood research, since children are often familiar with the process of a group discussion in school (Morgan et al., 2002). However, while some children express a preference for the group mode of communication, others are more comfortable engaging in a private discussion. Across the three schools, data emerged from a series of focus groups ($n = 6$) and in-depth individual interviews ($n = 14$). All focus groups comprised four participants and were homogenous with respect to sex, in line with literature recommendations (Morgan et al., 2002). Four focus groups were completed with girls and the additional two with boys. Eight individual interviews were subsequently conducted with girls and the remaining six interviews with boys.

The lead author, who is skilled in qualitative health research, conducted all of the focus group and individual interviews. In order to prevent disengagement, all group and individual interviews lasted between 30 and 45 min and light refreshments were provided to the children at the conclusion of each interview. A semi-structured interview guide was developed and similar questions were used across focus groups and individual interviews, however data from the initial focus groups played an integral role in refining some of the wording of the subsequent interview guide to assist children's understanding of the concepts (See Table 2). For