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Sugar consumption in Aboriginal children explored from a social practice perspective

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ABSTRACT

Australian Aboriginal children have higher sugar intake and are disproportionately affected by sugar-related diseases such as obesity, diabetes and dental caries than non-Aboriginal children. The intention of this paper was to highlight the need for approaches that can capture the complexity of health practices without reducing them to either individual choice or structural determination. We explore sugar consumption in Aboriginal children from a social practice perspective. Here, the unit of analysis is the practice, not the individual, where the elements of a social practice (competence, materials and meanings) are integrated into its performance. We conducted qualitative research using elements of focused ethnography with Aboriginal families in Western Australia to offer an alternative understanding of sugar and Aboriginal children's health. Findings highlight specific practices related to sugar consumption, indicating different social contexts: shopping with children, treats and rewards and family sporting participation. This reflects a complex system of interconnected practices, suggesting more insight is needed to understand the nature and complexity of influences on practices to design more successful policies and interventions. Reframing Aboriginal children's health within a social practice context may assist in mitigating the effects of sugar consumption and offer a different perspective on influencing factors.

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Introduction

Substantial sugar consumption (as free sugar) may seriously impact children's health and is associated with morbidity, including obesity, diabetes and dental caries (Christian & Blinkhorn, 2012; Ha et al., 2016; Russell et al., 2022; Sheiham & James, 2015; Yoshida

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& Simoes, 2018). Free sugar is either added to foods and drinks or naturally present in foods such as fruit juices, honeys, and syrups (World Health Organization, 2015). The majority of Australian children and adults exceed the World Health Organization recommendation of <10% of total energy intake from free sugar (Lei et al., 2016).

Aboriginal families have moved away from traditional diets (Hardy et al., 2014) to current diets high in processed foods, low in nutritional value and often high in free sugars (Poirier et al., 2021; Whalan et al., 2017). Aboriginal children are reported as having higher sugar consumption and higher resultant morbidity than non-Aboriginal children (Thurber et al., 2020). This high sugar consumption is associated with increasing diabetes type 2 diabetes, while obesity is reported to be increasing faster in Aboriginal children than in non-Aboriginal children (Hardy et al., 2014). Obesity is associated long-term with heart disease, type 2 diabetes, kidney and urinary diseases, some cancers, respiratory and joint problems, sleep disorders and social problems (Australian Institute of Health and Welfare, 2024). Research has indicated that Aboriginal communities are concerned that limited evidence-based information about the negative effects of sugar consumption is reaching their families (Durey et al., 2017; Eades et al., 2010).

Current responses to address the issue can vary from individual responsibility to social, commercial, and environmental determinants impacting health outcomes (Blue & Riggs, 2016; Kickbusch et al., 2016; WHO, 2025). Cohen et al. (2017) observed that dentistry as a profession has had little impact on reducing oral health inequities globally, with clinical interventions playing only a small part in improving oral health outcomes. Instead, they suggest a more equitable approach to care is needed that includes holding to account industries marketing products damaging to health, such as adding sugars to foods and drinks, by labelling their products as harmful. Watt (2007) suggests a radical reorientation in dentistry is required, away from an individual/biomedical/behavioural downstream approach that has failed to reduce oral health inequalities to a more upstream focus addressing the social determinants of oral health through a combination of complementary public health strategies. While broadening the context to include the social determinants of oral health is desirable: Chenhall and Senior (2018, p. 178) suggest that reductionist assumptions also underlie a 'social determinants' approach where 'The social determinants framework does not enable us to adequately think about the many layered connections between relational affects in the interactions between social, political, economic, and environmental processes and individuals' lives.' This exploration raises the question of the nexus between structure and agency, which, according to Binder (2012), queries where power resides in effecting change and whether social structures such as gender, race and class determine individual behaviour or whether individual agents are free to make their own choices devoid of such influences. Chenhall and Senior (2018) drew on Deleuze and Guattari's (1988) philosophical framework of assemblages. Assemblages note the importance of social complexity of contexts and investigate how to better understand individual experiences of health, illness and recovery in social contexts by analysing how they interact with, for example, material, social and structural elements in their daily lives (Chenhall & Senior, 2018; Deleuze & Guattari, 1988).

These theoretical gaps highlight the need for approaches that can capture the complexity of health practices without reducing them to either individual choice or structural determination. Social practice theory offers such an alternative by shifting the unit of analysis from the individual to the practice itself, examining how competence, materials,

and meanings are integrated into everyday activities within specific social contexts (Shove et al., 2012). Focusing on social practices provides a powerful concept that can add to the concept of assemblages and offer further insight to understand the nature and complexity of influences in order to design more successful policies and interventions.

Social practice theory is an innovative way to reframe the problem. While social practices are not directly focused on structural issues, applying a social practice lens does assist in seeing the influences beyond the individual. For example, rather than prescriptively banning sugar, this paper focuses on Shove et al.'s (2012) concept of social practices that redirects attention onto activities within a social context involving elements that make up the practice. The social practice is the unit of analysis, not individual behaviour, and to be recruited into the practice requires three elements: competence or know-how to engage in the practice, materials and infrastructure involved and meanings related to why people engage in the practice, for example, around sugar consumption. All three elements are linked and integrated into the performance of the practice (Shove et al., 2012). The practice is often 'performed in a routinized, culturally normative way' (Spotswood, 2015, p. 2). This moves away from the more common focus on changing individual behaviour, which often ignores the social context and how it can compromise good health outcomes, and instead blames the individual (Watt, 2007). We argue that a social practice approach helps in better understanding sugar consumption and consider ways to mitigate the effects of Aboriginal children's sugar consumption on health outcomes. The social practice lens helps to identify factors that support or inhibit Aboriginal families from being recruited into healthy food practices. Increasingly, evidence is highlighting the limitations of individual-based behavioural approaches in exploring health issues and potential value of a social practice approach, (Keane et al., 2017; Latimer et al., 2012; Maller, 2012; Owen et al., 2004) prompting new approaches to 'social behaviour' in areas including obesity, (Delormier et al., 2009) alcohol (Lunnay et al., 2011; Maller, 2012; P. Meier, Holmes, et al., 2018; P. S. Meier, Warde, et al., 2018) vaping (Blank & Hoek, 2023; Keane et al., 2017; Lewis et al., 2022) and oral health (Durey et al., 2021; Girard et al., 2023). Our research in oral health in Aboriginal communities found that parents want their children to have good oral health outcomes, for example, but structural issues such as discrimination from service providers, cost of dental services and consistently providing a healthy diet was out of reach financially for many families, inhibiting their capacity to make optimum choices around their children's health (Durey et al., 2017). Such issues are often beyond the realm of the individual to make a change, raising the question of where the problem lies.

Social practice theory is an alternative unifying approach that can be applied in this case to Aboriginal children's health, suggesting new levers and mechanisms for change, by reframing children's sugar consumption as part of social practices (Maller, 2015), and of families' level of engagement with those social practices.

An example of social practice is the 'Crunch & Sip' (<https://www.crunchandsip.com.au/>) program that results in low-sugar consumption, to illustrate the different elements of a social practice. Crunch & Sip is a primary school nutrition program developed in Western Australia to encourage the consumption of vegetables, fruits, and water by children at school. In this example, the **materials** include the fruits and vegetables provided, and the school infrastructure to support the program; the **competences** include

knowledge of what foods are permitted (e.g. fresh fruit, not canned fruit); and the **meanings** involve understanding of the health benefits of eating more fruit and vegetables.

All elements of a practice need to be available across time and place for the practice to occur. These elements can also be shared between different social practices – Crunch & Sip is connected to attending school in person, not online, for example, making them ‘coordinated and synchronised with other aspects of daily life’ (Blue & Riggs, 2016, p. 40) in complex ways to understand how practices can support or undermine other practices. This approach centres on the practice and its elements as the unit of enquiry rather than on the people who engage in the practice (i.e. the ‘practitioners’) (Shove et al., 2012). By shifting the focus of analysis from individual behaviours to social practices, we can ask new questions about these wicked problems. For example, we can ask why some practices that result in less consumption of sugar (such as reducing sugar products available at school canteens) are successful at ‘recruiting’ practitioners, while others only recruit a few members of a group, or fail to recruit practitioners and, over time, disappear altogether.

A social practice approach disrupts the conventional, top-down and often prescriptive and individualist narrative around young Aboriginal children’s health by offering instead a perspective that centres the voice and experience of Aboriginal families that can assist in better appreciating the problem and guiding solutions. This paper begins to shift the focus from trying to change individual behaviour to a deeper understanding of the issues by reimagining a more effective way of approaching poor health in Aboriginal children, taking into account their social context and how it influences choices.

It is recognised that food systems and marketing food for profit are highly detrimental to current eating practices, with the strong encouragement of consumption of highly processed foods (Swinburn et al., 2011, 2019). Friel et al. (2023) add to calls from Cohen et al. (2017) and Watt (2007) for a shift away from ‘consumptogenic’ systems that encourage excessive production and consumption of products damaging to health. A social practice approach enables us to go beyond the structure/individual agency binary to explore the nexus between the two in a social context to better understand their relationship (Connell, 1987, p. 94).

The aim of this paper is to explore the complex problem of free sugar consumption in Aboriginal children, given the strong evidence of its impact on their health outcomes and consider the value of a social practices approach to explore this health problem.

Methodology

Research Design This qualitative study focuses on the social practice of sugar consumption in Aboriginal children and analyses data collected as part of a larger study that looked at many practices associated with oral health, including sugar consumption (Australian Research Council under Grant DP210101166). For this paper, we focus specifically on social practices involving sugar consumption.

This qualitative study utilised elements of focused ethnography (Knoblauch, 2005; Rashid et al., 2019) that enabled the exploration of a defined issue – in this case, sugar-related practices – within a particular community context over a relatively short period of fieldwork (Trundle & Phillips, 2023). Research is conducted in social contexts often familiar to the researcher and involves short intermittent visits to various sites

(Knoblauch, 2005; Trundle & Phillips, 2023). We draw on Braun and Clarke's (Braun & Clarke, 2021, p. 330) Reflexive Thematic Analysis approach, which emphasises the 'researcher's subjectivity as an analytic *resource*, and their reflexive engagement with theory, data and interpretation'. We followed, where relevant and not necessarily sequentially, their six phases for engaging with data, coding and developing themes: (1) data familiarisation and writing reflective notes; (2) systematic data coding; (3) generating initial themes from coded and collated data; (4) developing and reviewing themes; (5) refining, defining and naming themes; and (6) writing the report. Given the subjective nature of qualitative research, we aimed for a more reflexive approach that deepened our understanding and interpretation of findings and developed researchers' insights related to the data (Braun & Clarke, 2019).

Positionality of researchers; This multidisciplinary team comprises two Aboriginal and five non-Aboriginal researchers experienced in public health who bring expertise in Aboriginal health, oral health, sociology, anthropology, paediatric dentistry and social epidemiology.

Recruitment Our project advisory group included long-standing Aboriginal representatives across sectors who assisted in identifying the need for this project and assisted with recruitment. We also distributed informational posters through local childcare and parent groups attended by Aboriginal families. Criteria for involvement included participants being caregivers of young (0–5 years old) children and self-identified as Aboriginal. Following informed consent to participate in the research, participants were provided with a \$30 voucher for their time.

Data collection We conducted semi-structured interviews and focus groups in the style of yarning to be an appropriate method for exploring social practices in Aboriginal families. Yarning is 'an informal and relaxed discussion through which both the researcher and participant journey together visiting places and topics of interest relevant to the research study' (Bessarab & Ng'andu, 2018, p. 38). As anticipated and confirmed by many participants in this study, Aboriginal families already feel highly observed and scrutinised about their health practices and caretaking practices in general. Partly for this reason, one of the authors, RW, who is Aboriginal and a respected Noongar Elder in the community, was involved in the interviews and focus groups to reassure participants that we were genuinely interested in their experiences and perspectives and not to judge. Also, due to the private nature of health practices, we felt that yarning sessions were more appropriate than direct observation of families' activities. All yarning sessions and focus groups were audio-recorded with participants' consent and professionally transcribed. Unlike structured interviews, yarning allowed conversations to flow naturally, with participants guiding the discussion towards topics most relevant to their experiences. This approach pays respect to Aboriginal ways of sharing knowledge while maintaining research rigour.

We conducted nine yarning sessions with caregivers whom we met individually. We also held two focus groups as requested by the caregivers when meeting at early learning centres, with four and eight caregivers in the groups, respectively. The first author (AB) also conducted a semi-structured interview with author RW as a project 'champion', to provide a historical perspective. The interviews (yarning sessions) were conducted jointly by the first author and RW. The interviews were between 10 and 45 min and took place at

a location convenient to the participant or focus group, usually the participant's home, early learning centres, or mothers' groups.

The researchers spent some time chatting with participants before the interviews and focus groups, to explain the project and develop rapport, largely focusing on RW's knowledge of the participants' family lineage and background. Yarning sessions (as interviews and focus groups) began with questions about practices that emerged from a review of the literature as correlating with good health outcomes, diet and feeding, and health care. More specific questions included demographic information, family routines including shopping, food and consumption of sugary food and drinks, including at sporting activities. We then followed the participants' lead to discuss a range of adjacent activities.

Data analysis A social constructivist approach (Williamson, 2006) and Shove et al.'s (2012) social practice theory guided the analysis. The interviews and focus group audio were transcribed by an external agency. As noted, the analysis focused on the social practice rather than individual behaviour and was guided by Braun and Clarke's Reflexive Thematic Analysis mentioned earlier (Braun & Clarke, 2021) using NVivo software to assist. Analysis included identifying materials, competency and meaning associated with children's sugar consumption. These were discussed between RW and the research team to help interpret findings and deepen researchers' understanding of the issue and process (Braun & Clarke, 2021).

Though practice theory focuses on practices instead of individual characteristics, we provide participant demographics to contextualise the social and material conditions in which the practices occur. Twenty-two Aboriginal caregivers living in Perth, mothers, aunts, and grandmothers – of young children in Western Australia (Table 1) participated in the research. All were female and lived in the Perth metropolitan area. Nineteen participants were mothers, three were grandmothers, and one participant was an aunt. The mothers and aunts ranged in age from 24 to 32 years, and the grandmothers were 55–78 years. Participants had up to four children living at home, for a total of 45 children, with the majority ($n = 31$) between 1 and 5 years old (Table 2).

Ethics approval Ethics approval was granted by the Western Australian Aboriginal Health Ethics Committee (WAAHEC) [HREC1088], and Edith Cowan University's Human Research Ethics Committee [2021-03053-MCAULLAY].

Table 1. Participant characteristics.

Participants		<i>N</i> = 22
Age bracket	20–29	14
	30–39	5
	40–49	0
	> 50	3
Caregiver role (dual roles)	Mother	19
	Aunt	1
	Grandmother	3
Number of children at home (Total children at home = 45)	Zero	2
	One	5
	Two	7
	Three	6
Age bracket of children	Four	2
	<12 months	2
	1–5 years	31
	> 5 years	12

Table 2. Participant codes.

Participants	Pseudonym
Individual interviews	ID 1–10
Focus groups x2	FG1; FG2

Findings

We focus on social practices discussed with parents and caregivers that are typically associated with consuming sugar, and how they are linked. Following Blue et al. (2016), we have chosen these practices as our units of enquiry in this paper because of the attention drawn to them in relevant literature and practice, making it pertinent to re-view them from a social practice perspective, given the role of sugar in the health of Aboriginal children (Thurber et al., 2020).

Participants shared their views and experiences about sugar and related activities in their lives and those of their family. Consumption of sugar may perhaps be considered a social practice itself with potential materials (such as sugar-sweetened beverages, chocolate), meanings (such as sweetness, something special, energy) and competence (determining what you can consume, mindful eating). However, given the complexity of sugar in people's lives, it may be more useful to consider a constellation of practices around consuming sugar. Participants interviewed and from other studies identified a range of practices that involve sugar consumption with young children that we present here, including giving treats, sporting activities, contact with relatives and grocery shopping. Commercial interests, intergenerational influences and food systems all played a role in sugar consumption, reflecting the interplay between structural factors and individual agency.

Shopping

Our findings demonstrated how, in the case of shopping, structural factors such as commercial interests were reflected in heavy advertising of sugar products, which were often placed near the checkout, aimed at influencing parents to buy such products for their children. However, this practice sometimes changed due to sugary products being marketed directly at children who pressured their parents and caregivers to buy the advertised brands of sugary treats, which led parents to want to avoid that shopping aisle altogether or take children shopping.

So, every time we go down there, we have to try to skip that aisle, or else he'll just go mad. Because he's now identifying what sugar ones belong to which boxes, what colour, and everything. So, he knows that that brown one is those [chocolate biscuits]. (FG2)

Conversely, participants often went grocery shopping with their children, where part of the practice involved being given lollies as a treat if the children 'are good'. This illustrates how meanings associated with sugar consumption can change and how different practices can be linked, with the practice of shopping being linked to that of giving treats.

But that's when they're most likely to get lollies, if they are at the shop with us, and they're being good then they get to pick. (FG2)

Shopping was a routine social practice where participants reflected on how stores were generally designed to sell high-sugar products. The challenge of taking young children, often at a demanding stage of their development, and the design of shops to capture their attention to sugar products (along with marketing) often leads to parents' stress and frustration and buying the products for their children to keep them quiet (meaning).

Treats and rewards

The meanings associated with sugary foods often changed in different contexts. When sugary products were consumed as a 'treat' embedded in other social practices, such as rewarding the family at weekends, where drinking frozen sugar-sweetened beverages and eating chocolate (materials) after dinner or visiting grandparents, where these were routines that parents accepted.

I mean, you can talk about lollies and sweet drinks and everything. But then when mum or dad gets that money in, my kid hasn't had this for a while so they get that. (ID10).

Focusing on the practice identifies how meanings can change around the children's consumption of sugary foods and drinks depending on context, indicating the need for a more complex approach to understand and respond to the issue.

Family sporting participation

Participants noted that within sports practice, drinking high-sugar sports drinks – provided by the sporting club, and reinforced by the members of the team doing the same was seen as providing energy. Consuming a high-sugar drink (such as a soft drink) in the context of picking up takeaway food *after* sports practice is associated with the convenience of fast food on a busy day

Sugar consumption as part of sporting activities, where eating lollies at half-time, drinking sugar-sweetened sports beverages and consuming fast food/takeaway after sport was often a routine practice. While this was accepted by some participants, others expressed concern about consuming certain products containing sugar and caffeine in this context. This again highlights the importance of context and the link in sugar consumption between different practices and associated meanings – treats and children's sport.

Half time they normally share out a pack of lollies.

Yes, oranges and lollies, yes to help when their spirits run low.

They try and have [sugar and electrolyte energy drink], but I don't like it when it kids have [energy drink]. They try push it, but I'm pretty sick of the [sugar and electrolyte energy drink]. (FG2)

Intergenerational influences

Sugar consumption was often embedded in different practices across generations of a family. Participants talked about feeling conflicted when family members (often grandparents) provide help with childcare, often giving children sugary treats, particularly as grandparents may be looking after the children for the parents.

Sugary treats were often brought when other family members visited:

My sister, every time she comes over, she comes over with a bag full of lollies (FG1)

leading one parent to note that:

All kids eat now is sugar, lollies (ID9)

One participant noted the damaging effects of sugar on her child's oral health and how to mitigate that (e.g. by brushing teeth), but sometimes found it hard to implement as a practice given the competing demands around parenting:

My kids, they love sugar. My whole family and stuff, they just give them ... cool drinks ... I try not to let anyone give her too much junk, but she still eats junk. I try to curb it. I try to get her to brush her teeth too, but she doesn't really. (FG1)

Another participant discussed how her child's medical diagnosis shifted her understanding and meaning of the materials or products related to sugar and its negative effects on health and led to reducing consumption of sugar-sweetened beverages:

... so we swapped out the sugary ones for the more natural ones, but they still have sugar in them. (FG2)

Health issues were often raised, and while there were generational practices around consuming sugar, the observation that many in families were sick with diabetes and other sugar-related morbidity was also a concern for participants.

Discussion and conclusion

This paper explores a relatively novel perspective in looking at sugar consumption in Aboriginal children from a social practice perspective. It moves away from a focus on individual behaviour, with its inherent risk of blame, to explore a more upstream approach, noting the influence of sociostructural factors on decision-making related to sugar consumption. It adds to the work of Chenhall and Senior (2018), who argue the need to avoid reductionism and address complexity to identify how social determinants are embodied into the lived experience of health and wellbeing at individual and community levels. There is limited explicit work in this area in an Aboriginal context, and our findings add to this body of knowledge by focusing on the practice rather than the individual or the social determinants. Nicolini noted a distinctive feature of practice theory common across different scholars is that they 'foreground the centrality of interest in all human elements and put emphasis on the importance of power, conflict and politics as constituent elements of the social reality we experience' (Nicolini, 2012, p. 6). This approach recalls Binder's (2012) notion of considering whether power resides in upstream, structural factors or in individual agency when making changes to the practice. Watson (2016, p. 171) notes, 'If power is understood at the most basic level as acting with effect, then practice theory can be understood as essentially being all about power'.

A social practice perspective would suggest that, similar to drinking alcohol or smoking (Blue et al., 2016), there isn't a recognisable social practice of 'consuming sugar'. Rather, the activity of consuming sugary foods and drinks exists and is embedded in a range of different practices, with different meanings, competences, and materials,

where sugar can be a material in some practices. As such, our focus of enquiry and intervention was less on prescriptively limiting sugar and more on understanding social practices where consuming sugary foods and drinks may be a component, including how children and families are 'recruited' into or 'defect' from those practices such as family influence and the desire to provide a healthy diet for children (Blue & Riggs, 2016). This approach enabled us to more fully understand the role of sugar in Aboriginal children's oral health.

Participants also noted ways to mitigate the negative effects of sugar consumption, where, for example, buying sugary treats for children at the supermarket can be considered part of the practice of going shopping, but can also be mitigated by avoiding confectionery aisles or parents knowing that engaging their children in oral hygiene as a routine practice promoted health. However, despite knowledge of its positive health effects (competence and meanings), addressing the sociostructural context of people's lives is important in understanding how upstream factors such as the marketing of sugar despite its damaging effects on health, and often the prohibitive cost of oral health products and services (materials and infrastructure) that can influence decision making and prevent Aboriginal families engaging in the practice despite wanting good oral health for their children (Cohen et al., 2017; Friel et al., 2023; Watt, 2007).

Each of these meanings, associated material and competence elements, and the timings and linked practices, suggests a different pathway or approach for interventions to 'eat less sugar'. It highlights the importance of context and understanding the function sugar plays in each of the practices, to know what may be a successful alternative.

The power of social practice theory here is to look again at what's hiding in plain sight, unnoticed or even taken for granted. It moves away from a more reductionist biomedical approach focusing on individual behaviour change towards understanding the importance of social context and developing insights into societal issues that are beyond individual control yet can impede underserved populations accessing appropriate education and health care (see Cohen et al., 2017; Friel et al., 2023; Watt, 2007). This highlights the importance of thinking differently about what constitutes knowledge when considering ways to resolve the problem (Levitas, 2013).

Taking as a central concept of social practice theory the idea that practices only recruit practitioners for whom all the elements of the practice are available, our study noted how embedded sugar consumption was in various practices, such as sporting activities, shopping and family visits. Some of the practices explored, such as children's sport and family engagement, can play an important part in family life and deviating from the 'norm' may be challenging. This raises the question of identifying and addressing which element in a practice needs to change for Aboriginal children to be recruited into better health practices and less into unhealthy ones? This approach also speaks to upstream factors beyond individual control, such as ubiquitous advertising of sugar products often targeting children, influencing caregivers' decision-making (Watt, 2007). For us to reimagine a society where young Aboriginal children's health outcomes improve, a holistic and equitable approach is necessary that considers links between social, economic and political processes that facilitate rather than impede human flourishing (Levitas, 2013).

A key theme threading through social practice theory is recognising the importance of the social context of Aboriginal families' lived experience. This raises the question of where the problem lies. It calls into question whether certain policies and practices

support or inhibit Aboriginal families' capacity to engage in healthy practices and mitigate the damaging effects of sugar consumption by, for example, routine toothbrushing for young children. This requires health systems to rethink ideas around facilitating healthy practices for Aboriginal children that reflect human needs and foster human flourishing into the future (Levitas, 2013).

Finally, social practices – the routinised, socially-conditioned way things are done now – reflect a complex system of interconnected practices that are difficult to predict or manipulate the desired activities for Aboriginal children's health than a more rational individual approach might have us believe. We suggest policymakers and health professionals can help mitigate the ubiquity of sugar consumption in our society and its negative effects on children's health by better understanding the social contexts of Aboriginal families in which elements in a social practice (competence, materials and meanings) that are linked and integrated into its performance are embedded. Decisions by families to engage in the practice can be influenced by upstream factors, beyond individual control, that can either promote or undermine achieving good health outcomes for their children. Seeking to understand the social context of people's lives from a social practice perspective reveals which elements either facilitate or block recruitment into a practice, offering a pathway to guide solutions.

Limitations

We note there are limitations in this work, as this is an early exploration of applying the theory of social practice to this health issue; we believe it warrants further future investigation. Furthermore, all participants were from the Perth metropolitan area, so the findings might not apply to Aboriginal families in rural, remote, or other geographic settings, where access to resources, cultural practices, and community structures could differ. Additionally, the study concentrated on sugar intake specifically, with the full scope of dietary habits or other social determinants of health falling outside its focus. The study data provide a snapshot of practices at a specific point in time and may not reflect how these practices evolve over time or in response to changing circumstances.

Conclusion

The use of a social practice framework provided a new lens to explore health issues around sugar consumption in Aboriginal children. It reframes more reductionist approaches of social determinants or individual behaviour that are embodied in the lived experience of Aboriginal families. Instead, it addresses the complexity inherent in engaging in certain practices where specific elements can encourage or inhibit engagement in ways that acknowledge the importance of context. We identified a number of related practices and opened up a new area to explore that may lead to rethinking how best to encourage and support Aboriginal families to engage with practices that promote health.

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Data availability statement

Given the ethics requirements, data will not be available.

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