SOCIAL MARKETING AUDIENCE RESEARCH

Healthy Eating in New Zealand Families and Whānau






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Health Sponsorship Council

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1.0 Executive Summary

1.1 Background

1.1.1 Health Sponsorship Council

The Health Sponsorship Council (HSC) is a New Zealand government agency that promotes health and healthy lifestyles through the development and delivery of health promotion and social marketing programmes[1]. Its work focuses on reducing health inequalities, particularly for Māori, Pacific peoples, and other population groups at greatest risk of poor lifestyle-related health outcomes.

1.1.2 Social Marketing Audience Research Project

The HSC wished to conduct audience research that focused on parents and caregivers, to inform the development and delivery of social marketing strategies for the Smokefree, Auahi Kore, Healthy Eating and Problem Gambling programmes. Collectively the research is known as the Social Marketing Audience Research (SMAR) project.

The project is being conducted in three phases. Phases One, Two and Three involve the exploration of healthy eating, smoking and gambling in the context of New Zealand families and whānau, respectively – a separate report is being provided for each phase. Each phase also involves the exploration of health and well-being and family/whānau functioning - a final report on this topic, incorporating information from all three phases of the SMAR project, is required on completion of Phase Three (Phase One findings are reported in a companion report, *Health and Well-Being and Family/Whānau Functioning: An Interim Report;* December 2007).

TNS was commissioned to conduct Phase One of the SMAR project. It conducted a total of 12 focus groups, 18 family/whānau groups, 48 individual in-depth interviews with parents/caregivers and 10 interviews with children. The research sample comprised a mix of Pakeha, Māori, Pacific peoples and Asian participants – see Section 3.0 for information about the research method, sample and procedure.

Phase One findings that relate to eating are the subject of this report (i.e. *Healthy Eating in New Zealand Families and Whānau; December 2007).*

1.1.3 Reader Notes

Unless specified, the findings in this report apply to both parents and caregivers (of five to 16 year old children).

Where the term 'Pacific Other' appears in the report, this signifies that the participant was a Pacific person who was not a Samoan or Tongan person.

[1] www.hsc.org.nz

1.2 Key Findings

1.2.1 Attitudes and Practices – Meals

Breakfast

- Breakfast was emphasised for children, but was not always eaten by adults.
- Weekday breakfasts were a rushed affair, with many parents eating separately (e.g. later or somewhere else) from their children.
- Weekend breakfasts represented a chance for family/whānau time and to break out of the weekday routine. They were a more relaxed affair, but may have also been less healthy than weekday breakfasts.

Lunch

- Sandwiches were no longer core to all children's lunchboxes. However, packaged lunchbox snacks such as muesli bars and chippies featured in many.
- Lunchboxes represented a major opportunity for fruit to be eaten – most lunchboxes contained at least one piece, most days.
- Schools appeared to be leading the charge in discouraging sugary drinks, promoting water as the best option for children.
- Parents had less control over what older children were buying for lunch – many left it to trust that their children were making healthy choices (or rationalised that this one meal was not so important in the scheme of things).

Dinner

- Dinner was regarded as the main meal (the biggest and most nutritionally important) of the day.
- Getting dinner on the table was a chore for time-poor families, particularly where both parents worked. Convenience foods and takeaways had significant appeal when families were busy or felt under pressure.
- Eating in front of television had replaced evening meals at the table for many families/whānau. Some of these families/whānau did not own a table; others simply did not use it for meals.
- Vegetable consumption was much more strongly associated with dinner than any other meal. However, some families did not eat vegetables on a daily basis. Not all those who did make a point of serving vegetables for dinner were willing to insist that their children eat them.

1.2.2 Attitudes and Practices – Special Occasions

- Special occasions involved more elaborate, often less healthy food.
- Any normal eating rules that applied were suspended on special occasions, with adults and children free to indulge.
- Special occasions often included fizzy drinks (and alcohol).

1.2.3 Attitudes and Practices – Snacks, Takeaways, Vegetables, Fruit, Fizzy Drinks and Alcohol

Snacks

- Parents' own snacking behaviour was often less healthy than that which they encouraged in their children.
- Packaged snacks such as muesli bars and chippies were a staple item in many children's lunchboxes. Some parents bought these products as a means of giving their children the things they never had in childhood, and/or of ensuring that their children had what 'the other children had'.
- Lunchbox snacks' nutritional value went unquestioned by some parents. Their convenience to parents and appeal to children made them a popular lunchbox choice.
- Parents and caregivers sometimes granted treats (i.e. less healthy snacks) to 'keep the peace' and buy 'time-out' from their children.

Takeaways

- Most people said takeaways had their place in the family/whānau diet. But there was little clarity on what exactly that place should be.
- Takeaways were popular with children, and represented 'time-out' for parents.
- Takeaways usage had extended far beyond *'fish and chips on Fridays'* to include a wide variety of ethnic, restaurant and even supermarket food (such as hot chickens and salads *'to go'*).

Vegetables

- Vegetables were largely confined to evening meals in many families/whānau.
- Most people believed vegetables were good for them and should be eaten, but many were not clear on exactly why this was so.
- Plenty of people were not eating vegetables daily. Some believed eating fruit made up for this deficit.

- Comment was made by some parents that vegetable eating was a habit best learned while young. A taste for vegetables appeared to be harder to acquire in adulthood.

Fruit

- Most people believed fruit was good for you and encouraged their children to eat it.
- Fruit was popular with children – few parents had to enforce fruit eating.
- Parents often reported eating a lot less fruit than their children. Children were often daily fruit eaters – their parents often were not.
- Some families/whānau were limiting children's consumption of fruit on cost grounds.

Fizzy Drinks

- There was relatively high awareness of fizzy drink's high sugar content, and this was a key reason for families/whānau limiting or avoiding fizzy drinks.
- If parents drank fizzy drink at home, their children were more likely to drink it too (or to want to).
- Fizzy drinking was often linked to eating takeaways.
- For fizzy drinking families/whānau, the relatively low cost of fizzy drink, especially compared to milk, reinforced its consumption.

Alcohol

- Many families/whānau reportedly drank alcohol sparingly or not at all in their home.
- In some instances parents hid their alcohol consumption (and its effects) from their children, in a bid to be good role models.
- Coming to grips with alcohol was seen as a rite of passage for teenagers.
- Many families/whānau were uncertain how to prepare their children to handle alcohol, and the risks associated with alcohol consumption.

1.2.4 Weekday Versus Weekend Eating Practices

Weekday Eating

- Overall, weekday eating tended to be healthier than weekend eating. The weekday routine included simpler breakfasts, and it was common for children to have fruit as part of a packed school lunch. Weekday evening meals were more likely to be home-cooked, and to include at least some vegetables.
- Eating tended to be healthiest at the start of the traditional working week, and to start to slide as the weekend approached – with families/whānau eating fewer vegetables, less fruit, and more convenience foods, and takeaways.

Weekend Eating

- Weekends for many families/whānau offered a chance to relax weekday routines – this often extended toward eating routines and rules. Weekends often involved larger and more high energy breakfasts and brunches, and less structured midday and evening meals. Vegetables may have been missing from the latter, particularly when fathers were cooking.
- Weekend eating was more spontaneous and arose out of whatever weekend activities family/whānau members were involved in. Weekend outings often involved meals and snacks that were less healthy than meals and snacks consumed at home during the week.
- Weekends often involved socialising with friends and family/whānau, as well as celebration of special occasions. Less healthy foods often featured at family/whānau get-togethers.
- Marked differences between weekday and weekend eating did not apply in all families/whānau. Where parents worked at the weekend, or there were very small children in the household, weekend eating routines were more likely to closely resemble weekday routines.
- The most committed healthy eaters tended to adhere to established eating routines and rules on weekends as well as during the week.
- The least healthy eaters made little distinction between weekdays and weekends when it came to their eating practices. Generally, their weekday eating resembled more healthy eaters' weekend eating (fewer vegetables, more takeaways, more treats, and more use of packaged and convenience foods).

1.2.5 Favourite Foods

Children

- Children frequently asked their parents to buy specific foods they had seen advertised on television (or had seen in other children's lunchboxes). Common requests included: *"fancy"* breakfast cereals and snack foods such as chippies, chocolate, biscuits, muesli bars and lollies. Children liked the sweetness of many of the above foods. Some packaged lunchbox snacks also had considerable social cachet.
- Despite their focus on sweet foods and packaged snacks, children in this study showed evidence of diverse tastes in terms of the foods they enjoyed eating; some of them liked vegetables.

Adults

- Parents also enjoyed a wide range of foods and their tastes influenced the foods they provided for their children. Parents' desire to be good eating role models sometimes led to double standards or surreptitious eating. Some parents hid or downplayed their liking for sweet and high fat foods and fizzy drink in order to be good role models. Other parents made these items freely available to their children because they wanted to consume them too.

1.2.6 Less Popular Foods

- Vegetables were a common source of friction at meal times. Some children enjoyed eating a wide range of vegetables, some would eat a more limited range, and some did not like eating vegetables at all. Parents reported that vegetables were an acquired taste for some children. Parents who were willing to enforce vegetable eating tended to find that the battles diminished with time.
- Some parents were poor role models when it came to eating vegetables. This undermined attempts to persuade children to eat them.

1.2.7 Foods and Drinks that Were Encouraged

- Fruit and vegetables were chief among foods promoted to children as healthy.
- Water was also widely encouraged, particularly in favour of sweetened drinks such as fizzy drink and cordial. (Some also included juice in this sweet drinks category).
- Meat, milk and other dairy products were also widely encouraged (with some qualifications for meat and dairy products because of concerns about fat content).
- Some parents also encouraged foods that they perceived to be nutritious by virtue of being high in fibre (e.g. whole grain breads).

1.2.8 Foods and Drinks that Were Limited

- Many parents and caregivers limited certain foods because they perceived that eating them too often, or eating too much of them at a time was unhealthy. Chief among these limited foods were takeaways, fizzy drinks, lollies, and packaged snack foods such as chippies.
- Fatty foods such as pies and fatty meats, and sweet foods such as biscuits, sweet cereals, and sweet lunchbox snacks such as 'strings' (a sweet, gelatinous-based snack) also tended to be limited. (However, some parents believed sweet lunchbox snacks such as muesli bars and 'strings' were healthier alternatives to chocolate, biscuits and lollies, and may have provided them on this basis).
- Some parents and caregivers believed that unless children were clearly overweight, there was little need to monitor or limit their consumption of sugary and high fat foods.

1.2.9 Understanding and Achieving Healthy Eating

Signifiers of Healthy Eating

- Participants regarded the inclusion of fruit and vegetables in a diet as key signifiers of healthy eating. Limiting the consumption of (obvious) sugar (e.g. biscuits, lollies and fizzy drink) and (obvious) fat, e.g. fatty meats such as sausages, fried foods, takeaways (excluding varieties perceived by some parents to be healthier, such as Subway) were also significant signifiers of healthy eating.
- Other signifiers of healthy eating were the consumption of less processed products, organic foods, having a balanced diet, eating in moderation and, to a lesser extent, opting for cooking methods that did not use fat or oils, e.g. steaming, boiling, baking or grilling, and eating food that was not overcooked so as to maximise its nutritional value.

Indicators of Healthy Eating[2]

- The indicators of healthy eating identified in this study were being physical healthy, not easily succumbing to sickness or being able to recover quickly if so afflicted through having a *"good"* immune system, not being overweight or obese, and having sufficient energy.

[2] Note: There is some overlap between the perceived benefits of healthy eating and indicators of healthy eating. Benefits were more associated with tangible and less tangible pay-offs of healthy eating, e.g. avoiding heart disease, whereas indicators were more likely to be the visible effects of healthy eating.

Perceived Benefits and Drawbacks of Healthy Eating

The following table provides a summary of the perceived benefits and drawbacks of healthy eating:

Perceived Benefits of Healthy Eating	Perceived Drawbacks of Healthy Eating
• Being physically healthy. • Not easily succumbing to sickness or being able to recover quickly if so afflicted. • Improving or effectively managing a health condition. • Protection against potential future health problems. • Not being overweight or obese. • Helping to achieve and maintain weight loss. • Having sufficient energy. • Eliminating preservatives and food colourings from diets was associated with keeping hyper children calmer. • Feeling virtuous about being a 'good parent' through providing healthy food. • Saving money through avoiding doctors' bills.	• Too expensive (in terms of the cost associated with buying healthy food). • Requires time, effort, planning, commitment and persistence to implement and maintain (not always possible or practical in the time-scarce world that many people lived in). • Resistance to healthy eating from a partner or children is a potential source of conflict – and not a 'price' some people are willing to pay because it is easier to 'operate' in a harmonious household.

Level of Concern about Healthy Eating

- Healthy eating was of low to moderate concern for most families/whānau. Not all people understood that a good diet was a key contributing factor to good physical health. The belief that being physically active and not overweight were evidence of good physical health, regardless of diet, was relatively common.
- Eating is a fact of everyday life, and continual decisions around eating (such as what to eat and how much to eat) are unavoidable. However, it takes knowledge, commitment, planning, time and energy on the part of at least one parent in the household to consistently prioritise healthy eating, and to follow through on healthy eating intentions. Other adults (parents and caregivers within and outside the household) with less commitment to healthy eating can undermine these intentions.

Achieving Healthy Eating

The following table summarises the key factors, internal and external to families/whānau, that helped families/whānau to eat healthily.

Internal Factors	External Factors
▪ Having a belief in, commitment to and having the time to make healthy eating occur. ▪ Having a parenting style that sets goals, boundaries and rules and consistently applies these. ▪ Having a supportive partner. ▪ Having the knowledge and skills with which to prepare healthy food.	▪ Healthy eating messages such as *'five plus a day'* and those coming home from schools and pre-schools. ▪ A range of healthier food options being available for purchase, e.g. Subway, sushi. ▪ Easy access to cheap fruit and vegetables. ▪ Medical advice, e.g. from one's general practitioner. ▪ Print communications, e.g. in women's magazines, and health and diet magazines.

The following table summarises the key factors, internal and external to families/whānau, that worked against families/whānau eating healthily.

Internal Factors	External Factors
▪ Repeating unhealthy eating behaviours from one's own childhood. ▪ Lack of time. ▪ Lack of support from a partner (the researchers have called this *partner drag*). ▪ Reluctance to enforce healthy eating behaviours because of potential fallout from one's partner and/or children. ▪ Lack of understanding as to what constitutes healthy eating. ▪ Lack of knowledge and skills to prepare food generally, i.e. regardless of whether it was healthy or not. ▪ Parental sweet tooth meaning that a household was more disposed towards eating sweeter foods. ▪ Desire to continue with a traditional (and less healthy[3]) diet often to uphold cultural values. Note: Some Pacific and Indian families came into this grouping. ▪ Other family/whānau members, e.g. grandparents, not supporting parent/s' healthy eating rules.	▪ Confusion resulting from many, often conflicting, health messages. ▪ Promotion of unhealthy foods, e.g. McDonalds, Burger King. ▪ Easy access to less healthy foods, e.g. at dairies and service stations and from vending machines. ▪ The perceived high cost of fruit and vegetables. ▪ Peer pressure arising from children wanting to have similar food in their lunchbox to that of peers. ▪ Pacific families found it hard to say 'no' to unhealthy food offered by someone outside their family because it went against cultural beliefs to reject offers of hospitality expressed through food.

[3] Traditional diets were associated with having a high fat content, e.g. through the use of coconut cream in curries and some Pacific dishes.

1.2.10 Eating in the Context of Family/Whānau Functioning

Roles and Responsibilities – Food Planning, Preparation and Cooking

- The adults regularly caring for children during the day had the greatest influence on their eating, because they were preparing meals and dispensing snacks for children. Adults who were in full-time work had less scope to influence healthy eating, by virtue of being absent from home during working hours.
- Grandparents and other regular caregivers may have followed their own rules regarding what to feed the children in their care. Grandparents in particular may have regarded it as their prerogative to 'treat' their grandchildren.
- Many 'home making' duties – including food planning and cooking – tended to fall on to mothers, regardless of whether they were in paid work. However, mothers re-entering the paid workforce was sometimes a trigger for fathers getting more involved in both food planning and cooking.
- Overall, mothers tended to dominate decisions about which foods made their way into the grocery trolley.
- Children were not heavily involved in food planning, but parents generally took children's food preferences into account when planning meals.
- Children were often involved in food shopping. Their specific requests tended to revolve around "fancy" breakfast cereals, and snack foods such as chippies, chocolate, biscuits, muesli bars and lollies. Usually, children would have seen these products advertised on television.
- Children exerted most influence in decisions about what packaged lunchbox snacks were bought. Some parents retained veto rights, for example, refusing to purchase lunchbox snacks that too closely resemble lollies (such as 'strings'). Price also triggered a parental veto in some instances.
- From around the age of five years children started to show an interest in baking and cooking simple meals. Many parents limited these opportunities to weekends or special occasions because it was easier, quicker and less messy to keep children out of the kitchen.
- By the teenage years, some children were cooking for the family/whānau on an occasional or regular basis.

Decision-making Dynamics – Meals and Snacks

- Breakfast cereal was a staple breakfast item (along with toast and spreads). Parents tended to categorise breakfast cereals according to their perceived healthiness (primarily related to sugar content, and use of colourings). The least healthy cereals from parents' point of view were often the most expensive, and this factor could limit purchase as much as their sugar content.
- The mother was usually the key decision-maker regarding what went into younger children's lunchboxes (e.g. up to about the age of ten years).
- Older children (e.g. eleven years plus) who purchased their lunch, generally made their own decisions regarding what they bought. Purchases from dairies, service stations and takeaway outlets featured, in addition to purchases from school canteens.
- Decisions about dinner took place on two levels: when the grocery shopping was done; and when whoever was responsible for cooking dinner on a given night had to 'get on with it'. Mood, available time, and energy levels all influenced what got cooked, or whether takeaways were on the menu.
- Children asked for specific snack foods (often treats such as lollies or packaged snacks) when they knew these were in the house. While many parents had rules and limits relating to such snacks, sometimes they were granted to 'buy peace' from children's demands.

Eating Rules and Guidelines

- This study found a large number of rules in relation to healthy eating. However, these rules were far from universal, and were sometimes randomly enforced.
- Many families/whānau had a general rule that children must eat breakfast. However, there was less routine supervision of older children (e.g. ten years plus).
- Enforcement of rules relating to lunch got harder as children got older, and the social acceptability of a lunchbox waned. Some parents did not attempt to regulate what their older children bought for lunch.
- Enforcement of lunch rules was aided by schools, many of which discouraged or banned chocolate or lollies being taken to school as part of lunch, and encouraged water consumption over that of fizzy or other sugary drinks (these were also often banned).
- Most families/whānau had rules around dinner. At least one parent was also likely to be present to monitor children's eating.

- Attempts to enforce dinner rules, particularly in relation to eating vegetables, were sometimes undermined by parents' own eating habits.
- Rules relating to snacks focused on limiting snacks deemed to be less healthy (usually packaged snacks such as chippies and biscuits), and ensuring that children did not fill up on snacks at the expense of eating proper meals.
- Snack rules tended to be less defined than other eating rules, and more open to fluctuation according to the parents' mood and stress levels.

1.2.11 Healthy Eating Messages and Communications

Messages that Supported Healthy Eating

From Within the Family/Whānau

- Messages given to children about healthy eating focused overwhelmingly on the importance of fruit and vegetables. Many parents also talked to children about the importance of meat, milk and other dairy products.
- Most parents gave their children messages about foods that should be limited because eating them too often, or in great amounts, could be unhealthy. The prime candidates for these messages were takeaways, fizzy drink and lollies. Fatty foods – such as pies, fatty meat and chippies – and sweet foods generally – such as biscuits, sweet cereals, and sweet snack foods – also came into this category.
- However, some parents believed that there was little or no need to monitor consumption of high fat foods if children were not overweight.
- Non-verbal messages could support or undermine verbal healthy eating messages. Observing adult family/whānau members eating healthily was influential, as was observing them not eating healthily (e.g. not eating fruit and vegetables despite encouraging the children to do so, or regularly indulging in snack foods and fizzy drinks that they limited for their children). Reliance on takeaways for regular meals also undermined healthy eating messages.

From Outside the Family/Whānau

- Schools and pre-schools were an influential source of healthy eating messages and information. Schools have been particularly successful in encouraging water consumption in favour of fizzy drinks (and other sweet drinks). Schools have also raised the profile of fruit and vegetables as healthy foods in promulgating the 'five plus a day' message.
- For parents, women's magazines and health and diet-focused magazines were an important source of information on nutrition, often focused on reducing fat consumption and weight loss.

- Television programmes focusing on weight loss, such as Downsize Me and The Biggest Loser were influential in alerting parents (and some older children) to unhealthy eating practices, and healthier alternatives.
- Television cooking shows were another source of messages on healthy eating options, and ways to reduce fat consumption.
- General practitioners were an important source of messages regarding the impact of diet on health. Gym instructors also fulfilled this function for some people.
- Sports people also served as healthy eating role models, whether through direct promotion of specific foods, or indirectly through television and magazine coverage.

Messages that Undermined Healthy Eating

- Food industry advertising targeting children (including promotions and sponsorships such as McDonalds' involvement in school sports).
- Promotion of sweet foods and packaged snack foods as healthy because they contained fruit or "natural" sugars.
- Promotion of takeaways such as McDonalds as part of a balanced diet.
- Heavy promotion of snack food and fizzy drink specials by supermarkets.

Influential Communications Channels

For Adults

- Women's magazines and television.
- General practitioners and other health practitioners, local health organisations affiliated with Māori organisations and rununga, and gym instructors.
- Colleagues and friends.
- The Heart Foundation tick.
- The diet industry.

For Children

- Parents and caregivers (and peers as children got older).
- Schools and pre-schools.
- Television.

1.2.12 Audience Segmentation

This study segmented participants in the in-depth interviews on the basis of their eating attitudes and behaviours. Six segments emerged: True Believers, Providers, Convertees, Complacents, Avoiders, and Inerts. The segments represented a continuum in terms of knowledge about healthy eating, and healthy eating behaviours. (The six segments and their distinctive attitudes and behaviours are detailed in Section 8.0 – Audience Segmentation of this report.)

- True Believers were most knowledgeable and consistent in terms of practising healthy eating behaviour. Healthy eating was a priority for this segment.
- Providers were moderately knowledgeable and ate fairly healthily as a by-product of using the food resources they found in their own community, and their 'do it yourself' approach to food preparation.
- Convertees were trying to eat more healthily, often as a result of a health scare or issue. As a result they were actively acquiring new eating knowledge and habits.
- Complacents generally believed that their family/whānau ate more healthily than it did. Less healthy eating habits had crept up on them over time.
- Avoiders were resistant to healthy eating messages. They may have been reasonably knowledgeable but cited conflicting health information as a reason to continue eating as they pleased (which was mainly less healthy foods).
- Inerts were the least knowledgeable about healthy eating and the least healthy eaters. Healthy eating was not on their radar.

1.3 Conclusions

1.3.1 Healthy Eating in the Context of Family/Whānau Functioning

- The research highlighted that healthy eating did not happen by chance – it took time, effort, planning, commitment and persistence on the part of parents and other significant caregivers. Good intentions with regard to healthy eating could be undermined by lack of buy-in by the wider family/whānau. HSC may wish to consider promoting healthy eating as a family/whānau concern.
- Regardless of who occupied the income earner role(s), overall, mothers were more influential than fathers in terms of global decisions about what went into the supermarket trolley. On this basis, mothers are a key target for healthy eating messages aimed at family/whānau.
- Role modelling by parents was instrumental in establishing healthy eating patterns (or otherwise) in children. The researchers note that children's eating habits generally reflected those of their parents. Fruit and vegetable consumption were key examples of parents saying one thing to their children and doing another themselves. Messages that gently address the powerful influence of adult role modelling would be valuable.
- *Partner drag* could undermine the effort of the adult in the household most concerned about healthy eating, resulting in unhealthy eating behaviours becoming the household norm. This highlights an opportunity for HSC to promote healthy eating as a team effort within households. This would work to support the theme of healthy eating being a family/whānau concern.

1.3.2 Eating Attitudes, Practices and Behaviours

- Opportunity exists to provide guidance on healthier cereal options, e.g. introducing a simple colour coding system that could be *taken in* at a glance. Examples of how to incorporate healthy foods into weekend breakfasts would also be useful.
- There is scope to define the place of packaged lunchbox snacks within children's lunchboxes, i.e. as a supplement to healthy foods, such as fruit, yoghurt, and sandwiches, and raw vegetables, rather than being the primary focus of the lunchbox. There may also be scope to consider a colour coding system for packaged lunchbox snacks (as suggested for breakfast cereals).
- There is a need to define the place of takeaways in a healthy diet (i.e. frequency). There is also scope to promote healthier takeaway options to ease pressure on busy families, e.g. supermarket-cooked chickens and salads 'to go'.

- Fruit and vegetables were the key signifiers of healthy eating regardless of the quantities or frequency with which they were eaten. People often over estimated their fruit, and particularly their vegetable, consumption. HSC may wish to consider highlighting the benefits of daily fruit and vegetable consumption as part of a balanced diet.
- The role of vegetables was very narrowly focused on the evening meal. There is scope to promote opportunities for raw vegetable consumption e.g. in lunchboxes and as a healthy snack option.
- There was already considerable traction around fizzy drink consumption, with some families/whānau having responded positively to messages regarding limiting fizzy drink and substituting with non-sugary drinks, primarily water. Messages reinforcing this movement would be valuable, as would the continued support of schools in promoting water as the first choice drink for children.
- There is also scope to show families/whānau how to transition from fizzy drinks to healthier alternatives, e.g. water and milk, and to emphasise the health benefits of these drinks.
- Parents generally recognised that their children would be confronted with alcohol as part of growing up. However, many parents were unsure how to teach their children to handle alcohol, and about the risks associated with drinking. HSC has a role to play in providing guidance in this area and, in particular, offering strategies to help parents prepare their children/young people for dealing with alcohol consumption away from home.
- Parents who were complacent in their belief that their children would not consume alcohol in inappropriate ways needed prompting to take a more preventative approach. HSC may have a role to play in communicating such preventative messages.
- The meaning of a balanced diet, and a balanced meal, have been eroded by conflicting messages from the diet, food and health industries. There is a need to redefine the meaning of both ‘balance’ and ‘moderation’ in the public mind. Ideally, this would be done in a way that cut through the clutter and seeming complexity of information ‘out there’, in a simple (perhaps visual) way. ‘Five plus a day’ is an example of a simple message that has achieved cut-through.

1.3.3 Understanding and Achieving Healthy Eating

- Some families/whānau saw healthy food as boring, bland and tasteless and preferred the taste of less healthy foods (because of their fat, salt and sugar content). There is scope to generate a shift in thinking with regard to healthy foods, so that they are seen to compete on taste, by promoting healthy food options that are widely acceptable to adults and children. Summer fruit is one obvious example.

1.3.4 Decision-making Around Healthy Eating

- Simple colour coding systems (e.g. for classification of breakfast cereals and packaged lunchbox snacks – see earlier) would aid parental decision-making regarding these commonly requested (and heavily marketed) foods.
- As stated earlier, mothers were key decision-makers with regard to household food choices, and were therefore a key target for healthy eating messages aimed at family/whānau.

1.3.5 Healthy Eating Messages and Communications

- There is a need to counteract unhelpful and conflicting eating messages, from the food industry in particular. Our suggestions for specific healthy eating messages targeting family/whānau can be found throughout this Section 1.3 – Conclusions.
- Television was an influential communication channel for adults, and particularly for children. Other influential channels include: schools, print media, general practitioners and other health organisations. A combination of channels is necessary for promoting healthy eating messages, with television providing the catalyst for seeking out information from other sources.
- Schools are a potent agent for promoting healthy eating messages that spread to the wider family/whānau.

1.3.6 Eating Audience Segmentation

- Some families/whānau were much further down the healthy eating track than others, as the audience segmentation for eating illustrates. HSC may wish to target tailored messages to those segments most in need of behaviour change (Avoiders and Inerts) and/or to those segments most open and able to change (Complacents). HSC may also wish to consider reinforcing the healthy eating behaviours of Convertees – because they are actively seeking to adopt healthy eating behaviours.
- There is an opportunity to promote as desirable a healthy eating positioning that is both attainable and sustainable: i.e. whereby people are reasonably knowledgeable about healthy eating and engage in healthy eating behaviours most of the time. As part of this it will be important to communicate an understanding that unhealthy foods have a pleasurable role within an overall balanced diet.

1.3.7 Summary

- People need reminding that healthy eating is a building block for good health, and that good health is the foundation of happy families/whānau. This latter 'truth' was recognised and articulated by participants when they were confronted by poor health, but remained largely in the background when there were no immediate and discernible health problems in the family/whānau.
- Healthy eating requires a team approach – where adults in the family/whānau are not on the *same page,* any healthy eating patterns are more vulnerable. Healthy eating can be promoted as another way of demonstrating love for family/whānau.
- The concept of a balanced meal has been replaced by many families/whānau with that of a balanced diet – as long as you have got a *bit* of everything that is fine. Both 'balance' (in terms of meals and overall diet) and 'moderation' require definition in the public mind.
- For many people, the composition of dinner was the signifier of how healthy their family/whānau diet was. Snacks in particular were often the thin end of the unhealthy eating wedge. Having vegetables with the evening meal more often than not, allowed some people to overlook their less than healthy snacking behaviour. Again, this comes back to defining a balanced diet in the public mind.

2.0 Introduction

2.1 Background

2.1.1 Health Sponsorship Council – Overall Purpose and Programmes

The Health Sponsorship Council (HSC) is a New Zealand government agency that promotes health and healthy lifestyles through the development and delivery of health promotion and social marketing programmes[4].

HSC currently works in the following areas:

- **Tobacco control** – HSC's focus in this area is on reducing smoking initiation through increasing smokefree settings, increasing young people's ability to resist taking up smoking, and reducing the inequality in smoking uptake among Māori. This work is conducted through the Smokefree and Auahi Kore programmes.
- **Healthy eating** – HSC's current focus in this area is on contributing to the prevention of obesity and maintenance of healthy weight by helping New Zealanders adopt and maintain healthy nutrition practices. Social marketing activities in this area are conducted through the Healthy Eating programme.
- **Prevention and minimisation of gambling-related harm** – HSC's main contribution to this area over the next three years will be to strengthen society's understanding and awareness of, and response to, gambling-related harms. This is being achieved through a national social marketing approach delivered through the Problem Gambling programme.
- **Sun safety** – the focus of HSC's work in this area is on reducing harmful exposure to ultraviolet radiation through increasing individual sun protective behaviour and increasing supportive environments for sun protection. This work is conducted through the SunSmart programme.

In all of its work, HSC focuses on reducing health inequalities, particularly for Māori, Pacific peoples, and other population groups at greatest risk of poor lifestyle-related health outcomes.

[4] www.hsc.org.nz

2.1.2 Role of Social Marketing in HSC

Social marketing is an approach to promoting health behaviour and outcomes that uses "marketing principles and methods to achieve change in the social determinants of health and well-being"[5]. The key features of a social marketing approach include a focus on achieving behaviour change (not just attitudinal or knowledge change), tailoring of programmes to meet target audience needs, the use of commercial marketing techniques, and segmentation of the target audience.

The concept of exchange also is integral to social marketing. This involves people understanding "what's in it for them", and deciding that what is offered in exchange for changing their behaviour or adopting new ones is worth having.

A key requirement of a social marketing approach is that it is informed by audience (or consumer) research. This type of research seeks to understand the target audience's perceptions, needs, and wants concerning the desired behaviour, and to learn about their current behaviour, including what enables and what reinforces it. Audience research also often includes competitor analysis, which involves learning about the environment in which members of the target audience are making behaviour decisions, examining competing behaviours being promoted to the target audience, and investigating how consumers' decisions are shaped by factors such as their social, cultural and physical surroundings or their economic situation. Audience research informs identification of programme goals, objectives, strategies and audience segments, development of communication tools, and refinement of the marketing mix (product, price, place and promotion).

Audience research has previously been conducted for the Smokefree and Auahi Kore programmes. This research explored motivations and barriers to parents and caregivers not smoking in their home or car[6].

As HSC has only recently started working in the areas of healthy eating and problem gambling, no such research has been conducted by HSC in relation to these health areas.

2.1.3 Research Need

The HSC wished to conduct audience research that focused on parents and caregivers, to inform the development and delivery of social marketing strategies for the Smokefree, Auahi Kore, Healthy Eating and Problem Gambling programmes.

The required research is known as the Social Marketing Audience Research (SMAR) project.

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[5] Donovan, R. J. & Henley, N. (2003). *Social Marketing. Principles and Practice.* Victoria: IP Communications.

[6] Gravitas Research and Strategy Ltd (2005). *Smokefree homes and other settings. Qualitative Research Findings.* Final report prepared for the Health Sponsorship Council.

2.2 The SMAR Project

2.2.1 Context

The HSC wished to undertake qualitative research to explore health and well-being in the context of family/whānau functioning, and the family/whānau context of eating, smoking and gambling.

The research was also required to explore the role and importance of different communication channels for messages relating to eating, smoking and gambling, and to develop an audience segmentation for each of these health areas.

2.2.2 Health and Well-being in the Context of Family/Whānau Functioning

Undertaking the SMAR project reflects the growing focus within the HSC's social marketing programmes on the role of the family/whānau environment in shaping health behaviours and outcomes, particularly for young people. Parents and other influential adults in the family/whānau environment have been identified as the key intervention groups for social marketing strategies. For example:

- The Smokefree Homes and Cars campaigns have focused on increasing the number of parents and caregivers who make their homes and cars smokefree.
- The first phase of the Healthy Eating programme seeks to increase the number of parents and caregivers adopting strategies to improve the diets of their eight to 12-year-old children.

The HSC's recent focus on the role of the family/whānau environment is consistent with the growing interest and investment in this area across the wider New Zealand public and non-government organisation sectors. This is supported by a significant body of academic and government literature that is dedicated to exploring the complex and multi-faceted relationship between the family/whānau environment and health and well-being outcomes.

While there is general agreement that strong families lead to successful and healthy outcomes for family members, more research is needed on the extent to which different aspects of the family/whānau environment influence health and well-being, and the mechanisms for this influence.

In the report entitled, 'What makes your family tick?'[7], the Families Commission described a number of levels of influence on the family. The individual, within their family/whānau group, is placed at the centre of the framework, at the 'micro' level. Neighbourhoods, community, work and friends influence the family/whānau at the 'meso' level. Educational, government and health policies and services influence the family/whānau at the 'exo' level. Global trends and economy, economic structures and living conditions, social and cultural values and beliefs influence the family/whānau at the 'macro' level. Time underpins the model.

While a large amount of research in this area has focused on the influence of factors at the meso, exo and macro levels, there is growing interest in the family as a functioning micro-system involving a complex interplay of factors within the family/whānau unit. The HSC's current interest in this area is positioned at this micro-level, i.e. at the family functioning level.

The HSC wished to undertake qualitative research to explore family/whānau functioning, and how this relates to health and well-being, among families/whānau in its social marketing audiences.

2.2.3 Family/Whānau Context of Eating

In May 2006, the Ministry of Health commissioned the HSC to develop and deliver a social marketing programme that would contribute to the Ministry's strategic framework – Healthy Eating - Healthy Action: Oranga Kai – Oranga Pumau (HEHA).

The overarching goal of the HSC's programme, known as the Healthy Eating programme, is to contribute to preventing obesity and maintaining healthy weight by helping New Zealanders adopt and maintain healthy nutrition practices.

Phase One of the Healthy Eating programme focuses on increasing the proportion of parents and caregivers adopting strategies to provide a healthy diet for children, particularly those aged eight to 12 years. Thus, the audience for Phase One of the Healthy Eating programme is parents and caregivers of children aged eight to 12 years, with a focus on Māori and Pacific peoples, and those of low socio-economic status.

The plan for the first phase of the Healthy Eating programme was developed without the benefit of audience research (although as much research as possible was conducted in the time available in the first year of the programme). Collectively, the healthy eating and health and well-being and family/whānau functioning components of the SMAR project will play a critical role in informing the future direction and implementation of the Healthy Eating programme.

[7] Families Commission (2006). *What makes your family tick? Families with dependent children - successful outcomes project. Report on public consultation.* Families Commission Wellington.

The HSC wished to conduct qualitative research to explore family/whānau eating attitudes, behaviours and practices. As mentioned, the research was also required to explore the role and importance of different communication channels for healthy eating messages, and to develop an audience segmentation (in relation to eating).

2.2.4 Family/Whānau Context of Smoking

Evidence shows that the most prominent risk factors for smoking initiation for young people are affordability of, and access to tobacco products, peer smoking, parental factors (parental smoking, pocket money provision, permitting smoking in the house and parenting style), the family environment, low self-esteem, and participation in risk-taking behaviours.

The most prominent protective factors include doing well within the school environment, participation in community or sports clubs, spiritual connectedness and family connectedness (in addition to reducing the risk factors detailed above).

A number of these risk and protective factors relate to the family/whānau environment and the role of parents and caregivers. Key areas of interest for the Smokefree and Auahi Kore programmes are:

- Reducing exposure to smoking behaviour and second-hand smoke, for example by increasing the number of smokefree homes, cars and outdoors settings frequented by children.
- Supporting parents and caregivers to quit smoking.
- Encouraging parents and caregivers to promote anti-tobacco attitudes and messages to their children.
- Supporting parents of pre-teens and teens who are less involved with their children to become more involved.

The HSC wished to conduct qualitative research to explore the dynamics of the family/whānau environment that influence the above outcomes relating to smoking, and factors that support and hinder change in the above areas. As mentioned, the research was also required to explore the role and importance of different communication channels for smoking messages, and to develop an audience segmentation (in relation to smoking).

2.2.5 Family/Whānau Context of Gambling

Gambling-related harm is an emerging public health issue in New Zealand, with significant health, social and economic implications. In the last decade, New Zealand has seen an increase in the consumption of gambling products and expenditure (player losses) paralleled by increases in the number of people seeking help for their own or someone else's gambling.

In September 2003, Parliament passed the Gambling Act, which included provisions to control, regulate and monitor gambling. The Act lists preventing and minimising gambling harm as one of its purposes. Other purposes include controlling the growth of gambling, and facilitating responsible gambling. The Act requires an integrated problem gambling strategy[8] focused on public health, that raises public awareness around the risks associated with problem gambling, provides support for appropriate community action to reduce gambling harm, and provides prevention and treatment services.

The Ministry of Health is responsible for implementing the strategy, with HSC undertaking a social marketing programme to contribute to the strategy.

A literature review[9] commissioned by the HSC has informed the development of the HSC's Problem Gambling programme. In the first three years of the programme, the goal is to prevent and minimise gambling-related harm through strategies that seek to increase public awareness of the risks and issues, increase community capacity to identify and address gambling harm, and increase community action to address gambling harm.

In terms of the family/whānau environment, the Problem Gambling programme aims to increase family/whānau awareness of the risks and issues associated with gambling for children and young people, and what they can do to prevent and minimise gambling harm for young people.

A number of modifiable and non-modifiable risk and protective factors associated with gambling-related harm were highlighted in the above literature review. These were categorised under three headings as follows:

- 'the agent' (gambling exposure)
- 'the environment' (physical, social and cultural setting)
- 'the host' (individual factors)

Familial exposure to gambling (family members who experience problem gambling, early onset of gambling participation or early introduction to gambling by the family) and inter-generational aspects of family were identified as risk factors relevant to the family/whānau environment that sit under both 'agent' and 'environment'.

[8] Ministry of Health (2005) *Preventing and minimising gambling harm: Strategic plan 2004-2010. Ministry of Health*, Wellington

[9] Auckland University of Technology. Gambling Research Centre (2005). *Literature review to inform social marketing objectives and approaches, and behaviour change indicators, to prevent and minimise gambling harm*. Final report prepared for the Health Sponsorship Council.

The HSC wished to conduct qualitative research to explore the perceptions and experiences of gambling and gambling harm for families and young people, among families/whānau with limited exposure to gambling and families/whānau with members who participate in different gambling activities. As mentioned, the research was also required to explore the role and importance of different communication channels for gambling messages, and to develop an audience segmentation (in relation to gambling).

2.2.6 Research Phases

The SMAR project comprises four phases as summarised in the table below. Healthy eating, smoking and gambling are the focus of Phases One, Two and Three, respectively. Health and well-being and family/whānau functioning are explored in Phases One to Three.

Research Phases	
PHASE ONE **Healthy Eating in New Zealand Families and Whānau** **Health and Well-being and Family/Whānau Functioning (Part I)** Fieldwork was conducted between June and September 2007	• 12 focus groups • 18 family focus groups • 48 in-depth interviews • 10 interviews with children (from families who participated in family groups)
Phase One – Healthy Eating in New Zealand Families and Whānau Report (provided in December 2007) **Phase One – Health and Well-being and Family Functioning: An Interim Report (provided in December 2007)**	
PHASE TWO **Smoking in New Zealand Families and Whānau** **Health and Well-being and Family/Whānau Functioning (Part II)** Date and design to be confirmed	**Possible Design** • **NO FOCUS GROUPS** • 15 family focus groups • 48 in-depth interviews • 10 interviews with children (from families who participate in a family group)
Phase Two – Smoking in New Zealand Families and Whānau Report	
PHASE THREE **Gambling in New Zealand Families and Whānau** **Health and Well-being and Family/Whānau Functioning (Part III)** Date and design to be confirmed	**Possible Design** • **NO FOCUS GROUPS** • 21 family focus groups • 48 in-depth interviews • **NO CHILD INTERVIEWS**
Phase Three – Gambling in New Zealand Families and Whānau Report **Phase Three – Health and Well-being and Family Functioning: Final Report**	
PHASE FOUR **An integrated analysis of healthy eating, smoking, gambling, and health and well-being and family/whānau functioning from Phases One, Two and Three of the SMAR project** Date to be confirmed	
Phase Four – Healthy Eating, Smoking, and Gambling in New Zealand Families and Whānau and Health and Well-being and Family Functioning: An Integrated Report	

2.2.7 Phase One Research

The HSC commissioned TNS New Zealand to conduct Phase One of the SMAR project, i.e. Healthy Eating in New Zealand Families and Whānau and Part I of Health and Well-being and Family/Whānau Functioning.

This document is a final report on Healthy Eating in New Zealand Families and Whānau, drawn from Phase One of the SMAR project.

2.3 Research Objectives

2.3.1 Overall Purpose of the SMAR Project

The overall purpose of the SMAR project is to increase the HSC's understanding of healthy eating, smoking and gambling in the context of family/whānau functioning.

The key objectives are to explore commonalities and differences across health behaviours and audiences, to explore the role and importance of different communication channels for disseminating and receiving health and well-being messages, and to develop audience segmentations for eating, smoking and gambling.

2.3.2 High-level SMAR Research Objectives

The high-level objectives of the SMAR project are to:

- Explore the family/whānau context, understanding and valuing, of health and well-being.
- Explore family/whānau functioning in relation to healthy eating, smoking and gambling.
- Explore the role and importance of different communication channels in relation to health and well-being issues.

Phase One of the SMAR project explored all three objectives, with a particular focus on healthy eating. It is anticipated that subsequent phases of the project will explore all three objectives but with a focus on smoking and gambling.

Phase One findings relating to the first objective - family/whānau context, understanding and valuing, of health and well-being - are the focus of a companion report (*Health and Well-being and Family Functioning: An Interim Report*; December 2007). Phase One findings relating to the second and third objectives - family/whānau functioning in relation to healthy eating and the role and importance of different communication channels - are the focus of this report, *Healthy Eating in New Zealand Families and Whānau* (December 2007).

A summary of the specific areas for exploration in Phase One, in relation to the high level research objectives for the SMAR project, follows:

Explore the family/whānau context, understanding and valuing, of health and well-being:

- What constitutes family/whānau
- Key roles and responsibilities in family/whānau
- Internal and external factors that have influenced assignment of key roles and responsibilities
- Key issues/challenges facing family/whānau on a day-to-day basis
- The importance (level of concern) placed on health and well-being relative to other key issues and challenges facing family/whānau
- The meaning of health and well-being (and contributing factors and indicators)
- Specific health issues facing family/whānau
- The importance (level of concern) placed on healthy eating, smoking, gambling, alcohol consumption and physical activity in relation to family/whānau.

Explore family/whānau functioning in relation to eating, smoking and gambling:

Eating:

- Weekday and weekend eating
- Favourite and unpopular foods and drinks
- Foods and drinks that family/whānau are encouraged to eat
- Foods and drinks that are limited in family/whānau
- The role of takeaways, fizzy drinks, fruit, vegetables, snacks and alcohol in the diet of family/whānau
- Perceived costs and benefits of different types of foods and drinks
- Similarities and differences between parents'/caregivers' eating and that of other family/whānau members
- Attitudes to eating (i.e. what constitutes healthy and unhealthy eating)
- Perceived costs and benefits of healthy and unhealthy eating
- Interest in and commitment to achieving healthy eating for family/whānau

- Family/whānau eating practices and influences on these practices (decision-making about what and how foods and drinks are consumed; meal-time practices; breakfast practices; lunch practices; special occasions; snacks; rules about eating; involvement of children in food preparation; involvement of children in food shopping)
- Messages about eating, given by parents and caregivers to children and young people
- Parent/caregiver efficacy in ensuring healthy eating for their family/whānau and internal and external factors perceived to influence their ability to ensure healthy eating for their family/whānau
- Role of government in addressing issues of healthy eating and obesity
- Views on government regulating to encourage healthy eating (e.g. rules around food and drinks to be available in school tuck-shops)
- Awareness of external messages that encourage healthy eating and those that encourage unhealthy eating
- Preferred communication channel for receiving healthy eating messages.

Smoking:

- Family/whānau smoking behaviours (who smokes, when, where and why)
- Parent/caregiver attitudes to and beliefs about influences on children/young people taking up smoking and level of concern about them taking up smoking
- Beliefs about factors that might influence children/young people to take up smoking, including the role of parents, peers and media portrayals
- Family/whānau practices that influence the likelihood of children and young people taking up smoking (e.g. rules, access to cigarettes, talking to children and young people about smoking and not smoking in front of them).

Gambling:

- Parent/caregiver perceptions of gambling (understanding of what gambling is and perceived negatives associated with it)
- Family/whānau experiences of gambling (who in the family/whānau gambles, what type of gambling activities are undertaken [and when and why this happens] and involvement of children)
- Parent/caregiver perceptions of problem gambling (awareness and understanding of problem gambling)
- Family/whānau experiences of problem gambling (in family/whānau, community, among friends and the impact of problem gambling)
- Perceived factors that might reduce the likelihood of people ending up in problem gambling situations
- Views on initiatives to make gambling safer (national, community and family/whānau level initiatives, who is responsible for these initiatives and acceptability of current initiatives)
- Awareness and practices relating to protecting family/whānau (children and young people in particular) from gambling harm (including influences on children and young people starting gambling and having a problem with gambling, steps being taken to protect family/whānau from gambling harm, e.g. having rules and talking to children about gambling and its potential for harm).

Explore the role and importance of different communication channels in relation to health and well-being issues:

- Awareness of messages about eating (healthy and unhealthy), smoking and gambling received by families/whānau from external sources
- Communication channels through which participants receive messages about healthy eating, smoking and gambling (and which is perceived as the most influential channel).

3.0 Method

3.1 Research Methods

3.1.1 Qualitative Research

TNS supported HSC's decision to use a qualitative research approach to meet its information needs.

Qualitative research is concerned with identifying the range of issues that exist on a given topic, and understanding these in-depth. It reveals the underlying factors that lead to the formation of attitudes, motivate and prevent behaviours and influence people's perceptions of the world around them. Qualitative research allows the real issues to emerge, i.e. those that are genuinely important to people, and not just those issues that researchers feel might be important.

Qualitative research explores not just the rational, top-of-mind, conscious perceptions that individuals have but also the underlying emotive feelings. These are largely unconscious, yet act as powerful drivers of human behaviour.

The key limitation of qualitative research is that small sample sizes prevent data being subjected to statistical analysis. This means that findings cannot be generalised to the whole population from which a sample is drawn. However, users of qualitative research can have confidence in findings when samples are structured to include key groups of interest, and experienced, skilled qualitative researchers conduct the research. Such researchers can readily elicit information from participants, and interpret it with accuracy and insight. TNS provided qualitative researchers of this calibre for the SMAR project.

3.1.2 Qualitative Methods

The two main methods used in qualitative research are in-depth (i.e. individual face-to-face) interviews and focus groups.

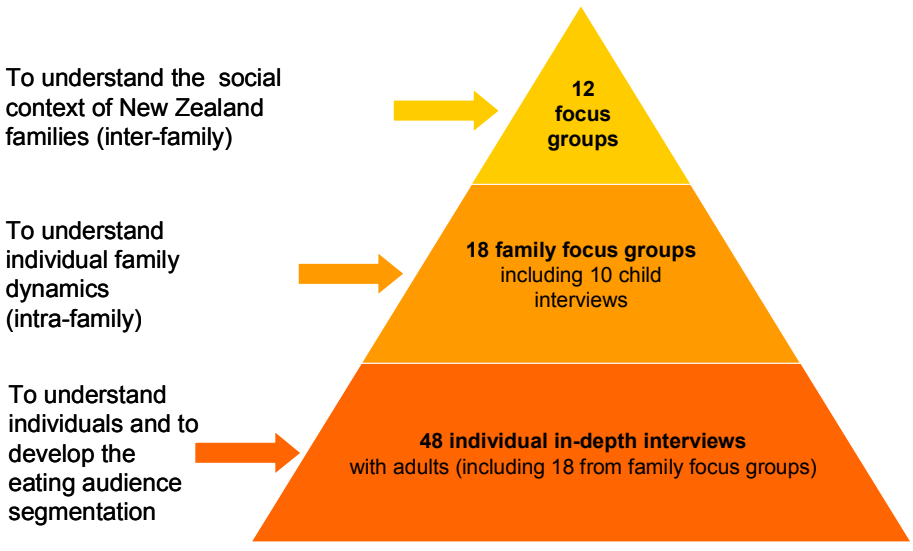
- An in-depth interview is a face-to-face dialogue between one participant and one researcher. This is the method of choice when discussing personal, sensitive or complex topics or when we want to understand people as individuals (e.g. their attitudes, behaviours, motivations and barriers) and when we need to develop an audience segmentation. In the privacy and security of the in-depth interview environment participants are typically willing to reveal their innermost thoughts and feelings, i.e. deep level information can be obtained using this method. The key limitation of in-depth interviews is that they do not allow for discussion and debate, as is possible with multiple participants in focus groups.

- Focus groups bring together six to seven individuals who have one or more shared characteristics (as defined by the research participant recruitment specifications). This is the method of choice when identifying and exploring the broad range of attitudes, behaviours and views that exist among a given audience and the social context that is driving them. The key limitations of this method are that participants may not be willing to reveal their underlying, emotive feelings in the open forum of focus groups, and may give socially desirable responses to appear good in front of others in the group.
- A derivative of focus groups is the family focus group. Such groups bring together two or more family members to discuss and debate a particular issue(s). The key advantage of family focus groups is that they can give insight into family dynamics in a way that is not possible with in-depth interviews or focus groups. The key limitation of family focus groups is that participants may not be willing to reveal their underlying, emotive feelings if there is a risk of creating conflict in the family.

3.1.3 Methods for Phase One of the SMAR Project

TNS recommended that a combination of focus groups, family focus groups and in-depth interviews be used to undertake Phase One of the SMAR project. TNS believed that this approach would best meet the objectives of the SMAR project because it could deliver understanding at multiple levels of family/whānau and operation, including the wider New Zealand social context, the family unit and the individual level. In-depth interviews with children were also included to add depth to the family focus groups and to identify children's perspectives directly, rather than by proxy from the adults in the family focus groups.

The following diagram conceptualises the approach undertaken for Phase One of the SMAR project and provides an overview of the fieldwork conducted.



The contribution of each type of interview, including which topics were discussed, and how the findings have been applied in the reporting for Phase One of the SMAR project, is outlined below.

Focus Groups

All 12 focus groups were used to explore the topics of health and well-being and family/whānau functioning, and eating in the context of family/whānau functioning.

Six focus groups were used to explore smoking in the context of family/whānau functioning – these focus groups are referred to in this report as *smoking groups* (see Table 1: Summary of SMAR Phase One Fieldwork, in Section 3.2.2 – Sample Characteristics). Six focus groups were used to explore gambling in the context of family/whānau functioning – these focus groups are referred to in this report as *gambling groups* (see Table 1: Summary of SMAR Phase One Fieldwork, in Section 3.2.2 – Sample Characteristics).

Focus group findings that relate to health and well-being and level of concern about healthy eating, smoking and gambling have been incorporated into a companion report (*Health and Well-Being and Family/Whānau Functioning: An Interim Report;* December 2007). Findings that relate to eating have been incorporated into this report (*Healthy Eating in New Zealand Families and Whānau;* December 2007*).*

Family Focus Groups and Individual In-depth Interviews with Adults and Children

Family focus groups and individual in-depth interviews with adults and children primarily explored eating in the context of family/whānau functioning, but also included some discussion on health and well-being, and smoking and gambling.

As for the focus groups, findings from the family focus groups and individual in-depth interviews that relate to health and well-being and level of concern about healthy eating, smoking and gambling, have been incorporated into the companion report, and findings that relate to eating have been incorporated into this report.

3.2 Sample

3.2.1 Sample Considerations

A number of considerations informed the sample specifications for Phase One of the SMAR project, as discussed below.

Parents and Caregivers

The sample primarily comprised parents and caregivers of children aged five to 16 years old (inclusive). This focus is consistent with the HSC's focus on parents and caregivers as critical influences on children's and young people's health behaviours and outcomes.

For the purposes of this research parents and caregivers were defined as follows:

- **Parents** – had at least one child aged between five and 16 years (inclusive) who, on average, lived with the parent for at least two days out of seven. This included adoptive parents, step-parents and legal guardians.
- **Caregivers** – lived in the same household as at least one child aged between five and 16 years (inclusive), on average, at least two days out of seven, and had a parental or supervisory role in the child's life. To be eligible for interview, the caregiver had to be aged 18 years of age or over.

The requirement that parents and caregivers had to live in the same household as the child, on average, at least two days out of seven reflected the HSC's interest in exploring health and well-being in the context of household/family/whānau dynamics and practices.

Other Family/Whānau Members

Participants in family focus group interviews included a parent or caregiver, who also participated in an in-depth interview, and up to five other family/whānau members identified by the parent or caregiver as important members of their household/family/whānau. In some instances children participated in these family group interviews.

Children

A small number of eight to 16-year-olds were interviewed individually. This group of children were drawn from the families/whānau who participated in family group interviews. The lower age threshold of eight years old was set to ensure child participants were capable of participating meaningfully in a one-on-one interview.

Ethnicity

The sample comprised Māori, Pakeha/New Zealand European, Pacific and Asian participants. The following categories were used in recruitment and sample specifications:

- Māori
- Pakeha/New Zealand European
- Pacific – Samoan
- Pacific – Tongan
- Pacific – Other (i.e. any Pacific group other than Samoan or Tongan)
- Asian – Chinese – including Chinese, Hong Kong Chinese, Cambodian Chinese, Malaysian Chinese, Singaporean Chinese, Vietnamese Chinese, Taiwanese
- Asian – South Asian - including Indian, Pakistani, Bengali (Bangladesh), Fijian Indian, Afghani (Afghanistan), Gujarati (Indian), Tamil (Indian or Sri Lankan), Punjabi (Indian), Sikh (Indian), Sri Lankan, Malaysian Malays/Indians, Singaporean Malays
- Asian – Other – including Korean, Filipino, Japanese, Cambodian, Indonesians, and all other Asian groups.

As shown in Table 1: Summary of SMAR Phase One Fieldwork in Section 3.2.2, the overall sample was biased in favour of Māori and Pacific peoples, to reflect the greater health inequalities experienced by these groups.

Gender

The sample was purposefully design to include more females than males, reflecting that women are the main caregivers in most New Zealand households.

Geographic Location

The sample comprised participants drawn from a selection of urban, provincial and rural locations throughout New Zealand, as follows:

- Urban – Auckland, Wellington and Christchurch
- Provincial and rural – Gisborne and rural environs, Wairarapa and Timaru. Note: Gisborne and rural environs were selected because of their large Māori populations.

In the larger population centres participants were recruited from areas of mid to high deprivation (deciles six to 10 in the New Zealand Deprivation Index[10]). Where necessary, a small number of exceptions were made to recruit the required ethnic group quotas. See Appendix One for list of suburbs from which participants were able to be recruited from.

Socio-economic Status

The sample comprised participants drawn from low, medium and high socio-economic status households. The inclusion of high socio-economic status households reflected the HSC's interest in exploring differences in family/whānau attitudes, beliefs and behaviours relating to health and well-being, according to socio-economic status.

For the purposes of this research, household socio-economic status was based on total household income per annum – as outlined below. Higher thresholds were applied in urban locations to reflect the higher income earning capacity in these locations.

Urban (Wellington, Auckland, Christchurch)

- Low – below $40,000
- Medium – $40,000 – $70,000
- High – above $70,000

Rural / Provincial (Gisborne City and rural environs, Wairarapa and Timaru)

- Low – below $30,000
- Medium – $30,000 – $50,000
- High - above $50,000

[10] Crampton P, Salmond C, & Kirkpatrick R. (2004). *Degrees of Deprivation in New Zealand: An atlas of socioeconomic difference. 2nd Edition*. Auckland: David Bateman Ltd.

Experiences of Healthy Eating, Smoking and Gambling

The sample comprised participants who represented a range of family/whānau experiences of healthy eating, smoking and gambling. These experiences, referred to as health behaviour experiences in this report, were categorised and specified in the following way:

Healthy Eating

Eating in the context of family/whānau functioning was explored in all 12 focus group interviews, all family group interviews, the in-depth adult interviews and the child interviews.

In an effort to ensure a range of family/whānau eating practices, attitudes and beliefs were represented in the sample, parents and caregivers participating in the in-depth interviews were categorised and recruited according to the eating practices of a selected five to 16-year-old child in their family/whānau. The decision to recruit on the basis of a child's eating practices, rather than the parent's or caregiver's practices, reflected the HSC's interest in family/whānau influences on *children's* eating practices.

Parents and caregivers participating in in-depth interviews were recruited into the following categories:

- More healthy eater (MHE)
- Less healthy eater (LHE).

Eligibility for these categories was based on the parent's or caregiver's response to questions about the frequency with which the selected five to 16-year-old consumed a range of key foods (e.g. fruit and vegetables; takeaways; sugary drinks).

It is important to note that these categories are arbitrary and should not be read as a definitive statement about the child, parent/caregiver, or family/whānau eating practices. They were developed for the purposes of this research to ensure a range of eating practices were represented in the sample.

Smoking

Smoking in the context of family/whānau functioning was explored in the six *smoking focus groups* (see Section 3.1.3). Each smoking group comprised a mix of participants from smoking and non-smoking households (where possible, an even mix of participants from each category was recruited). For the purposes of this research, these categories were defined as follows:

- Smoking household – if at least one person who lived there smoked at least one cigarette daily. Note: This meant the participant from a smoking household may or may not have been a smoker themselves.
- Non-smoking household – if no one who lived there smoked daily. Note: individuals in the household may have smoked from time-to-time but, to be eligible for this category, there had to be days where no one in the household smoked; the participant from a non-smoking household may or may not have been a smoker themselves.

Gambling

Gambling in the context of family/whānau functioning was explored in the six *gambling focus groups* (see Section 3.1.3). Participants were recruited from three categories of gambling participation, defined for the purposes of this research as:

- Category One – a person who had placed bets on races or sports events (e.g. at the TAB), played the pokies, played table games (e.g. at a casino), or played internet games for money, on average, **12 or more times a year**.
- Category Two – a person who had placed bets on races or sports events (e.g. at the TAB), played the pokies, played table games (e.g. at a casino), or played internet games for money, on average, **six to 11 times a year**.
- Category Three – a person who had placed bets on races or sports events (e.g. at the TAB), played the pokies, played table games (e.g. at a casino), or played internet games for money, on average, **one to five times per year** OR had bought a Lotto or scratch ticket, played Housie or Bingo for money, placed money bets with family or friends on activities such as card games or sweepstakes, or bought a raffle ticket for fundraising in the last 12 months.

  Note: Persons who had not participated in any of the above activities in the last 12 months were categorised as Category Three for the purposes of this research.

It was intended that each gambling focus group comprise a mix of three categories of gamblers, as outlined above. However, difficulties in obtaining Category One gamblers meant that the composition of each gambling focus group was typically biased towards Categories Two and Three gamblers.

Exclusions

Certain types of people were excluded from the research on the basis that their input could bias the research findings. People excluded from the research were those whose household had a member who:

- Worked for a tobacco company, in the gambling industry at management-level (e.g. for Lotto, TAB, the pokies, casinos) or in the food industry at management-level
- Worked as a health professional (e.g. specialist, doctor, nurse, dietician, nutritionist, public health practitioner)
- Had dietary restrictions because of allergy or medical conditions
- Worked for a market research company.

3.2.2 Sample Characteristics

A total of 12 focus groups, 18 family focus groups, 48 in-depth interviews with adults and 10 interviews with children (aged eight to 16 years old) were conducted in Phase One of the SMAR project.

Table 1 below presents a summary of the fieldwork, broken down by ethnicity, method, and health behaviour experience. Further detail on the sample characteristics according to research method follows Table 1.

Table 1: Summary of SMAR Phase One Fieldwork, by Ethnicity, Method and Health Behaviour Experience

Method	Pakeha	Māori	Pacific Peoples	Asian Peoples	Total
Focus groups	2 *1 smoking* *1 gambling*	4 *3 smoking* *1 gambling*	4 *2 smoking* *2 gambling*	2 – *2 gambling*	**12** *6 smoking* *6 gambling*
Family focus groups	4 *2 MHE* *2 LHE*	6 *4 MHE* *2 LHE*	6 *3 MHE* *3 LHE*	2 *1 MHE* *1 LHE*	**18** *10 MHE* *8 LHE*
In-depth interviews with adults[11]	11 *5 MHE* *6 LHE*	17 *8 MHE* *9 LHE*	*12* *5 MHE* *7 LHE*	8 *4 MHE* *4 LHE*	**48** *22 MHE* *26 LHE*
Interviews with children[12]	2 *1 MHE* *1 LHE*	2 *1 MHE* *1 LHE*	6 *3 MHE* *3 LHE*	-	**10** *5 MHE* *5 LHE*
Total	**2 focus groups** **4 family focus groups** **11 in-depth interviews with adults** **2 interviews with children**	**4 focus groups** **6 family focus groups** **17 in-depth interviews with adults** **2 interviews with children**	**4 focus groups** **6 family focus groups** **12 in-depth interviews with adults** **6 interviews with children**	**2 focus groups** **2 family focus groups** **8 in-depth interviews with adults**	

Key:

- MHE means 'more healthy eater'
- LHE means 'less healthy eater'.

[11] Eighteen of the in-depth interviews were conducted with parents and caregivers who had previously taken part in a family focus group.

[12] All child participants were members of a family/whānau that took part in a family focus group. These children took part in a 30 minute (individual) interview immediately prior to participating in their respective family focus group.

Focus Groups

Twelve focus groups were conducted as outlined in the table below; six focus groups were defined as 'smoking groups' and six were defined as 'gambling groups' (see Section 3.1.3).

Table 2: Focus Group Sample Details by Geographic Location, Ethnicity and Health Behaviour Experience

Ethnicity	Auckland	Wellington	Gisborne	Timaru	Total
Pakeha		Mixed gender **Smoking group**		Mixed gender **Gambling group**	**2**
Māori	Mixed gender **Smoking group** Mixed gender **Gambling group**	Mixed gender **Smoking group**	Mixed gender **Smoking group**		**4**
Pacific Peoples	Samoan females **Smoking group** Tongan/Other Males **Smoking group** Samoan Males **Gambling group**	Tongan/Other Females **Gambling group**			**4**
Asian Peoples	South Asian Mixed gender **Gambling group** Chinese/Other Mixed gender **Gambling group**[13]				**2**
Total	**7**	**3**	**1**	**1**	**12**

Four focus groups were gender-specific to take account of cultural sensitivities as follows:

- Auckland – Samoan focus group with female participants only
- Auckland – Samoan focus group with male participants only
- Auckland – Tongan/Other Pacific focus group with male participants only
- Wellington – Tongan/Other Pacific focus group with female participants only.

The other eight focus groups comprised a gender mix.

[13] The intention was that this focus group would be conducted in Christchurch. However, recruiters were unable to obtain sufficient participants in Christchurch so the group was conducted in Auckland.

Family Focus Groups

Eighteen family focus groups were conducted as outlined in the table below. Family groups were categorised as 'More' or 'Less Healthy Eater', depending on the parent's or caregiver's response to questions about the frequency with which a selected five to 16-year-old consumed certain foods (see Section 3.2.1).

Table 3: Family Focus Group Sample Details by Geographic Location, Ethnicity and Healthy Eating Category

Ethnicity	Auckland	Wellington	Gisborne	Timaru	Total
Pakeha	LHE	MHE	LHE	MHE	**4** *2 MHE* *2 LHE*
Māori	MHE LHE	MHE LHE	MHE	MHE	**6** *4 MHE* *2 LHE*
Pacific Peoples	Samoan MHE Tongan LHE Other Pacific LHE	Samoan LHE Tongan MHE Other Pacific MHE			**6** *3 MHE* *3 LHE*
Asian Peoples	South Asian LHE South Asian MHE				**2** *1 MHE* *1 LHE*
Total	**8** *3 MHE* *5 LHE*	**6** *4 MHE* *2 LHE*	**2** *1 MHE* *1 LHE*	**2** *2 MHE*	**18** *10 MHE* *8 LHE*

Key:

- MHE means 'more healthy eater'
- LHE means 'less healthy eater'.

Note: Where an individual in-depth interview with an adult was associated with a family group, the family group was conducted first. This enabled the researcher to understand the context of a particular family/whānau, prior to deeper exploration of it in an individual in-depth interview.

Individual In-depth Interviews with Adults

Forty-eight individual in-depth interviews[14] were conducted with adults as summarised in the table below. Further details on geographic location, ethnicity and gender for the in-depth interview sample are provided in Table 5.

Table 4: Summary of In-depth Interview Sample by Ethnicity, Gender, Socio-economic Status and Healthy Eating Category

Ethnicity	Number of Adult In-depth Interviews
Pakeha	11
Māori	17
Pacific Peoples	12
Asian Peoples	8
Total	**48**
Gender	
Females	29
Males	19
Total	**48**
Socio-economic status	
Low	16
Medium	16
High	16
Total	**48**
Healthy eating category	
More healthy eater	21
Less healthy eater	27
Total	**48**

[14] As mentioned, 18 in-depth interview participants had previously taken part in a family focus group.

Table 5: In-depth Interview Sample Details by Geographic Location, Ethnicity and Healthy Eating Category

Ethnicity	Auckland	Wellington	Gisborne	Wairarapa	Christchurch	Timaru	Total
Pakeha	Female LHE (3)	Male MHE Female MHE	Male LHE	Female LHE Male MHE	Male MHE Female LHE	Female MHE	**11** *5 MHE* *6 LHE*
Māori	Female MHE Female LHE (3)	Male MHE (2) Female LHE Male LHE	Female MHE Female LHE (2) Male LHE	Female MHE Male MHE Female LHE	Female MHE Female LHE		**17** *7 MHE* *10 LHE*
Pacific Peoples	Tongan male LHE Samoan male MHE Samoan female LHE Other male MHE Other female LHE Other male LHE	Tongan female LHE Tongan female MHE Samoan male LHE Other male MHE			Tongan female LHE Samoan female MHE		**12** *5 MHE* *7 LHE*
Asian Peoples	Chinese female MHE Chinese male MHE Chinese male LHE South Asian female MHE South Asian male LHE	South Asian female LHE South Asian male MHE			Chinese female LHE		**8** *4 MHE* *4 LHE*
Total	**18** *6 MHE* *12 LHE*	**12** *7 MHE* *5 LHE*	**5** *1 MHE* *4 LHE*	**5** *3 MHE* *2 LHE*	**7** *3 MHE* *4 LHE*	**1** *1 MHE*	**48** *21 MHE* *27 LHE*

Key:

- MHE means ‘more healthy eater’
- LHE means ‘less healthy eater’.

Child Interviews

The following table provides details of the 30 minute interviews conducted with ten children. Interviews with children were only conducted in Auckland and Wellington. Child participants' 'healthy eating' category was based on the parent's or caregiver's response to questions about the frequency with which a selected five to 16-year-old consumed certain foods (see Section 3.2.1).

Table 6: Child Interview Sample Details by Geographic Location, Ethnicity and Healthy Eating Category

Ethnicity	Auckland	Wellington	Total
Pakeha	Female LHE	Male MHE	**2** *1 MHE* *1 LHE*
Māori		Male LHE Male MHE	**2** *1 MHE* *1 LHE*
Pacific Peoples	Samoan female MHE Tongan female LHE Pacific Other male LHE	Samoan female LHE Tongan male MHE Pacific Other female MHE	**6** *3 MHE* *3 LHE*
Total	**4** *1 MHE* *3 LHE*	**6** *4 MHE* *2 LHE*	**10** *5 MHE* *5 LHE*

Key:

- MHE means 'more healthy eater'
- LHE means 'less healthy eater'.

3.3 Research Procedure

3.3.1 Recruitment of Participants

PFI, an Auckland-based research recruitment company, obtained the participants for this study using its database of research volunteers and networking. Participants recruited from PFI's database of research volunteers were contacted and recruited by phone. In terms of obtaining participants via networking, details of potential participants were obtained from research volunteers via phone, with participants subsequently recruited via phone.

Every effort was made to obtain as many Māori and Pacific participants as possible via referrals; a total of 17 Māori and 15 Pacific peoples participants were obtained via this means.

As discussed earlier, every effort was made in the larger population centres to recruit participants from areas of mid to high levels of deprivation (see Section 3.2.1).

Note: The participants were recruited (and treated throughout the research process) in accordance with the Market Research Society of New Zealand's Code of Practice.

3.3.2 Researchers

Every effort was made to achieve ethnic matching of qualitative researcher and participant wherever possible, to enhance rapport and ensure that cultural nuances would be identified and correctly interpreted. However, in some instances, researcher gender was prioritised over ethnicity to maximise rapport, particularly with Pacific and Asian participants. Fieldwork with some Pacific and Asian participants was undertaken by experienced Pakeha researchers.

All focus groups, family focus groups, in-depth interviews and child interviews with Māori participants were conducted by Māori researchers.

3.3.3 Venue

The focus groups in Auckland and Wellington were conducted at TNS's offices at these locations. Focus groups at other locations were conducted at a local hotel.

Family focus groups were conducted at participants' homes.

In-depth interviews were conducted at TNS's offices in Auckland and Wellington and at a local hotel at other locations. These interviews were not conducted at participants' homes because it was felt this could impede frank discussion if other family/whānau members were present at the time of interview.

3.3.4 Duration

Each focus group and family focus group lasted approximately three hours.

The individual in-depth interviews with adults lasted up to two hours, while interviews with children lasted up to 30 minutes.

3.3.5 Incentive

As is usual in research, the participants were offered a gift to acknowledge their time and input, and to defray travel costs (where these applied).

- The participants in the focus groups and adult individual in-depth interviews were each given either a $70 MTA voucher or a $70 Progressive (supermarket) voucher, according to their choice.
- Families/whānau who took part in a family focus group received a 'group' gift of either a $150 MTA voucher or a $150 Progressive (supermarket) voucher, according to their choice.
- Each child who participated in an interview received a $20 Warehouse voucher.

3.3.6 Interview and Discussion Guides

TNS developed the interview and discussion guides outlined below, in conjunction with HSC[15]:

- Interview guide for use in the adult in-depth interviews where participants had not taken part in a family focus group. Note: A specific guide was not developed for the adult in-depth interviews where participants had taken part in a family focus group (n=18) as the purpose of these interviews was to explore, in-depth, significant points that had emerged from the family focus group.
- Interview guide for use in interviews with children.
- Separate discussion guides for use in the smoking and gambling focus groups.
- Discussion guide for use in the family group interviews.

A copy of each guide is appended to this report.

[15] Interview guides refers to the guides used in individual in-depth interviews with adults and interviews with children, while discussion guides refers to the guides used in focus groups and family focus groups.

3.3.7 Recording

The focus groups conducted at TNS's Auckland and Wellington offices were video recorded with participants' consent.

With the exception of a few participants who declined their interview to be recorded, all other fieldwork was audio-recorded with participants' consent. The tapes were transcribed to aid analysis and provide verbatim responses.

3.3.8 Analysis

The researchers individually analysed the data generated from their fieldwork using transcriptions (and in a few cases, notes, where participants had declined for their interview to be recorded). The data in the transcriptions were analysed using a pre-determined analysis framework that reflected the content of the interview and discussion guides. Note: The researchers had the flexibility to add categories to the analysis framework if indicated by their data.

The research team convened at TNS's Wellington offices to merge the findings from their individual analyses. This research team met for five day-long sessions to complete this process.

Reader Notes:

Unless specified, the findings in this report apply to both parents and caregivers (of five to 16-year-old children).

Where reference is made to 'Pacific Other' in the report, this signifies that the participant was a Pacific person who was not a Samoan or Tongan person.

Research Findings

4.0 Eating Attitudes, Practices and Preferences

This section of the report explores attitudes and practices as they relate to main meals, special occasions, and five specific areas of interest to HSC: snacks, takeaways, vegetables, fruit, fizzy drinks, and alcohol. It also gives an overview of differences between weekday and weekend eating practices, and identifies participants' favourite foods and drinks, less popular foods and drinks, and foods and drinks that were limited and encouraged in families/whānau in this study.

Differences between weekday and weekend eating, as well as differences between the eating practices of adults and children, are also noted throughout this section, as are cultural differences.

4.1 Attitudes and Practices – Meals

4.1.1 Breakfast

Highlights

- Breakfast was emphasised for children, but was not always eaten by adults.
- Weekday breakfasts were a rushed affair, with many parents eating separately (e.g. later or somewhere else, such as at work) from their children.
- Weekend breakfasts represented a chance for family/whānau time and to break-out of the weekday routine. They were a more relaxed affair, but may have also been less healthy in terms of the food consumed.

Attitudes to Breakfast

Weekday Breakfast

- Weekday breakfasts tended to be fuel-focused, rather than being about pleasure or spending time with family/whānau members. Most parents believed it was important for their children to eat breakfast, but the pressure of weekday routines generally dictated that it was a quick meal, and parents did not necessarily actively supervise what their children ate.

- It was unusual for children not to eat breakfast. However, one mother of a six-year-old child reported that, although she preferred her son to eat breakfast, she did not make him do so.

  "He's not an early riser. There are some days when he doesn't want it [breakfast] – he'll say he doesn't want it. So we'll have breakfast and he won't, and we notice his behaviour – there's a difference between having breakfast and not having it."

  Māori Female – Wairarapa

- Family/whānau routines influenced what kind of meal breakfast was. The time by which parents needed to be out of the house, and the number of children to organise, both influenced how and where breakfast was eaten.
- Parents themselves often did not eat breakfast with their children during the week, with some eating it at work, others eating it once the children were at school, and some not eating it at all.

  "I always try and make them have breakfast even though I don't, which is quite bad because usually you set the example."

  Pakeha Female – Auckland

Weekend Breakfast

- Weekend breakfasts tended to be a more leisurely affair. They were more likely to be seen as a time for family/whānau togetherness. It was more likely that at least some family/whānau members would eat together, sitting down to do so. People typically looked forward to weekend breakfasts, rather than regarding them as a staging post to getting on with the day.
- As a general rule, people typically ate breakfast later at the weekend, after the parents had had a lie-in (the exception to this was in households with toddlers and babies). They also ate a wider range of foods, with cooked food such as eggs often on the menu.
- The distinction between weekday and weekend breakfasts was less significant when there was a full-time homemaker. However, most families/whānau worked to morning deadlines during the week, and were more able to take their time at the weekend.

Breakfast Practices

Weekday Breakfast

- Weekday breakfasts tended to consist of continental breakfast type foods – cereals and toast – and sometimes heated up leftovers. Children typically drank water, juice, Raro, milk or hot Milo (more usual in winter). In families/whānau where fizzy drink was unrestricted, children may have consumed this at breakfast-time.
- Older children (i.e. eight years and older) tended to get their own breakfast, choosing from a set range of breakfast foods (e.g. cereals, toast and spreads). Older children may have also got their younger siblings' breakfast for them.
- A parent (usually the mother) or other caregiver usually got breakfast for younger children.
- Children often had a say in which cereals were purchased, with parents (usually the mother) having the final say. Parents tended to discriminate between healthier cereals and less healthy cereals on the basis of sugar content, but price was often as influential as health concerns.

  "… if I would buy him Milo cereal he would probably eat breakfast every day, but I read the packet of that Milo cereal and there's no cereal in that cereal – there's no cereal in it."

  Pakeha Female – Auckland

- Breakfast may be an on-the-run meal – eaten at the kitchen bench, in the car, or even walking to school. Some children were given money to buy breakfast on their way to school.
- Weekday breakfasts may have been eaten individually, even in large families/whānau – e.g. one child ate his/her cereal while another child was in the shower, and a third child was getting dressed. Some children ate breakfast in front of television.
- Breakfast for adults could mean anything from a cup of coffee with a cigarette, to a pie, a bowl of cereal or piece of toast, or some fruit.
- Working parents may have eaten breakfast at their place of work rather than at home.
- Full-time homemakers (usually mothers) often did not eat their own breakfast until after completing the school and pre-school runs. Then it might just have been a cup of tea or coffee and a piece of toast or leftovers.

Weekend Breakfast

- Weekend breakfasts were more likely to be eaten as a family, or in stages, e.g. with children eating together in front of television and parents eating together later when they got up. Children may have snacked or eaten cereal prior to eating more breakfast later with their parents.
- Weekend breakfasts included a wider range of foods, including cooked foods such as pancakes and eggs. They were also likely to be more high-energy (due to both the nature and quantities of the food eaten).

> *"In the weekends we are a bit naughty – my children have French toast or sometimes baked beans for breakfast. We make it together and then we all have it together."*
>
> **Māori Female – Gisborne**

- Weekend breakfasts were more likely to happen around the table (if there was one). Some families/whānau ate together in front of television.
- Saturday breakfast may have been a prelude to children's sports fixtures.

> *"On Saturday mornings all the kids converge on our house because they play soccer and my brother's the coach. We make sure that they have Weetbix or porridge before soccer and we take mandarins for their half-time."*
>
> **Māori Female – Gisborne**

- Families/whānau may go out for breakfast at the weekend, eating breakfast at McDonalds, in a café, or at the local bakery or mall food-court. In this context, breakfast may have been replaced by brunch, and was often seen as a treat.

> *"If he's behaved himself we have McDonalds for breakfast on a Saturday."*
>
> **Pakeha Female – Auckland**

Breakfast Context and Dynamics

Weekday Breakfast

- The household size and routine influenced weekday breakfasts. Larger families/whānau with working parents tended to have an earlier and more hectic start to the day, than did families/whānau where there was a full-time homemaker or only one or two children to get out the door to school or pre-school.

- Many larger families/whānau described breakfast as a rushed meal, with family/whānau members eating at different times (and often in different places).
- There may have been little parental supervision of older children (i.e. eight years and over), although parents reported that children tended to eat from an established range of acceptable breakfast foods, with little variation from day-to-day. This meant there was little portion control in some families/whānau. There was more supervision of smaller children.
- In this study, it was not usual for fathers to have responsibility for organising weekday breakfast or ensuring children ate it. Many working fathers were gone from the house before their children ate breakfast, and some ate their own breakfast at work.
- Some working parents chose to eat breakfast at work (food they had brought from home or bought on the way to work) because this was more relaxing than having a rushed breakfast at home.

Weekend Breakfast

- As a rule, weekend breakfasts were more relaxed and less time constrained. They often represented an opportunity for family/whānau togetherness – for spending time with partners, and with children.
- In keeping with the more relaxed weekend schedule for many families/whānau, weekend breakfasts tended to be more elaborate – with more choice and variety of food on offer.
- Dads were often more involved with weekend breakfasts, and in some households dad was often the cook for this meal.

> *"That's when I cook – in the weekends. The kind of breakfast we have is a mixed grill all round."*
>
> **Māori Male – Gisborne**

- Breakfast-time could still be constrained for families/whānau that played weekend sport, as well as those with a parent who worked weekends. In the latter case, a breakfast outing to somewhere like McDonalds may have been used to compensate for a parent having to work weekends.

(For breakfast decision-making and rules – see Sections 6.2.1 and 6.3.1 respectively, later in this report).

4.1.2 Lunch

Highlights

- Sandwiches were no longer core to all children's lunchboxes. However, packaged lunchbox snacks such as muesli bars and chippies featured in many.
- Children's lunchboxes represented a major opportunity for fruit to be eaten – most lunchboxes contained at least one piece, most days.
- Schools appeared to be leading the charge in discouraging sugary drinks, and promoting water as the best option for children.
- Parents had less control over what older children were buying for lunch – many left it to trust that their children were making healthy choices (or rationalised that this one meal was not so important in the scheme of things).

Attitudes to Lunch

Weekday Lunch

- Weekday lunch was regarded as an important source of energy for children during the school day. A number of parents talked about their children's lunchboxes in terms of balance – making sure that their lunchbox contained fruit was seen as a way of balancing the *"snacky things".* Lunch was generally considered a less important meal nutritionally than dinner. Some families also regarded it as less nutritionally important than breakfast. From this perspective, lunch was more about energy than nutrition.
- Caregivers and homemakers often talked about lunch 'on the run'. For them, lunch was something to be fitted in between picking children up from kindergarten, and doing the housework or gardening and other daily tasks.
- For parents in paid work, lunch was often viewed as a chance to take a break from work, and to socialise with friends and colleagues. In this context, lunch was a pleasurable and relaxing meal. Other working parents used their lunch-break as an opportunity to fit in a gym session.

- Packaged snacks had become a core component of many children's lunchboxes. They were regarded as convenient and time saving for parents assembling lunches, and had a treat factor for children, meaning that they were likely to be eaten.

> *"It's probably more to do with me being too lazy to sort out four lunches in the morning than anything else. It's just easy to take a packet of that and we'll pop that in there, and I'll make the sandwiches before they go to bed."*
>
> **Pakeha Female – Wairarapa**

- For some children buying lunches was a semi-regular treat (e.g. once a term, once a month or once a week), for others buying lunch was the norm. Where lunch buying was limited, this was driven by both cost and health considerations; many people saw buying lunch as more expensive and less healthy than taking a packed lunch.
- Some parents allowed their (usually older) children to buy their lunch frequently – or every day – because the children had stopped eating their packed lunches. For some teenagers, taking a lunchbox or packed lunch from home was not cool.

> *"When they were at primary school, they didn't like any lunch, prepared lunch. But when they go to high school, I don't know if they [are] ashamed of eating their homemade lunch at school while other children are buying their lunch from the canteen. So I find that they just come home and just eat their lunch [after school]."*
>
> **Samoan Female – Christchurch**

- In one such family, the mother gave her child lunch money because she considered uneaten packed lunches a waste of money (and good food) and preferred to know that her child was eating something at lunchtime.

Weekend Lunches

- Weekend lunches differed markedly from weekday lunches. Saturday lunches were more unstructured and might have involved going out for lunch or buying takeaways or special bread as part of the day's activities (e.g. after sports).
- Sunday lunches often represented a chance for family/whānau to come together. As such, there might have been a cooked meal (e.g. a roast) and generally the meal was more elaborate.

Lunch Practices

Weekdays – Children

- Sandwiches were no longer the biggest core component of a school lunch, as they were in many parents' day. While some children's lunchboxes did contain sandwiches, many did not.
- Common lunchbox components were: sandwiches (some), packaged snacks, e.g. chippies, muesli bars, 'strings' (a sweet, gelatinous-based snack) (most); yoghurt (some), and fruit (most). Water was a common drink.
- In some lunchboxes, packaged snacks were a major part of the content (reportedly as many as six items), with sweet snacks such as muesli bars included as well as other sweet items such as biscuits or muffins.
- Children often bought lunch at school or from the dairy or bakery on the way to school. From the intermediate years on, parents typically had less control over what their children were buying and where from. Some teenagers worked part-time and used their own money to buy lunch food such as hot chips.
- Some children pooled their lunch money to buy greater quantities of (usually junk) foods such as hot chips, chippies or fizzy drink.
- Some rural Māori whānau reported that their children were instructed to share the content of their lunchboxes with whānau members such as cousins.

Weekdays – Adults

- Adults often ate leftovers at home or as part of a packed lunch.
- For mothers at home during the day (or parents working from home) lunch was often a quick sandwich or snack with coffee or tea, e.g. a banana wrapped in bread.
- Some fathers took a packed lunch from home – it may be packed by them or their partner at the same time she did the children's lunches. Mothers packing lunch for fathers could be motivated by a desire to save money, or to ensure he ate properly and/or to manage his weight.

> *"I make lunches for everyone before I go to bed, husband included … well, otherwise he spends all his money at the dairy when he comes home. So I make him lunch and it means he eats properly as well."*
>
> **Pakeha Female – Wairarapa**

- Some working parents bought lunch (and breakfast) from a work canteen.
- Other working parents bought lunch from places such as a café, a bakery, or from a takeaway outlet. Examples of lunches in the latter category included KFC, pies, Thai food, hot chips and Subway.

Weekend – Adults and Children

- Saturday lunches varied widely. If eaten at home they might have consisted of leftovers, or a mix of whatever was in the fridge and cupboards (e.g. bread and ham, salad, nachos, baked beans, or eggs).
- In families/whānau with mainly older children (e.g. about ten years plus), individuals may have helped themselves to what they felt like, or grazed on the contents of the fridge.
- In families/whānau with younger children, one parent would make or assemble lunch. This may or may not have been eaten together, depending on family/whānau members' commitments, such as sports fixtures.

Lunch Context and Dynamics

Weekday

- Making the children's lunches was a potentially time consuming chore in larger families/whānau. Mothers typically controlled what went into children's lunchboxes, directly with younger children, and indirectly with older children (i.e. by controlling what was bought at the supermarket).
- There was an element for some parents of giving the children what they knew they would eat (i.e. basing lunches around foods they knew were popular with the children). From this point of view, food that was uneaten often came home spoiled and was therefore wasted. This was an issue from a financial point of view (particularly for less well-off families/ whānau), but also from a nutritional point of view – if children were not getting fuel at midday they could not perform as well in the afternoon at school. In addition, some people simply did not like the idea of wasting food. (This was one of the reasons why packaged lunchbox snacks were popular with parents – unopened snacks that were brought home in lunchboxes could be 'recycled').

- There was an aspirational element to packaged lunchbox snacks. Parents reported that their children asked for what 'other children' had, and parents did not want them to miss out or feel that their lunches were somehow not as good (packaged lunchbox snacks reportedly also had considerable barter value).

  > *"If I sent my kids to school with just a sandwich or say two sandwiches, maybe a yoghurt and a whole lot of fruit, and no chips, no biscuits, no crackers – I'd feel so guilty because nobody else does. They come home and they go, 'Mum, why can't we have those 'strings'?' ... the cost of them for me to do the whole family is just beyond a joke."*
  >
  > **Pakeha Female – Christchurch**

- Allowing children to buy lunch was time saving for parents and won them brownie points with their children. Both cost and health factors influenced some parents to restrict bought lunches, e.g. to a monthly treat.
- While some working parents took a cut lunch or leftovers from home, many lacked the time or motivation to do so, and preferred to buy something at or near their workplace. Some saw lunchtime as an opportunity to socialise with friends and colleagues off-site, and would buy their lunch in this context.

Weekend

- Breakfast and lunch may have been replaced by brunch.
- Weekend lunches occurred in the context of family/whānau time and represented a break from weekday routines (except in households where parents worked at the weekend). Food may have reflected this by including more treat items such as fizzy drink, sweet foods, or takeaways.
- In households with a homemaker and very small children, weekend lunches may have been very similar to what was on offer at home during the week. The household routine varied less between weekdays and weekends, with parents trying to maintain structure for little children (e.g. in terms of meal times, what was eaten, and nap times).
- Sunday lunches often represented a chance for family/whānau to come together. As such, there may have been a cooked meal (e.g. a roast) and generally the meal was more elaborate, and may have included a pudding. In this context, lunch became the main and most substantial meal of the day (in contrast to all other days, where the evening meal was regarded as the main meal).

- Sunday lunch may have simply been a repeat (with variation) of Saturday lunch, i.e. a casual meal consisting of 'bits and pieces' from the fridge and cupboards, or takeaways.

(For lunch decision-making and rules – see Sections 6.2.2 and 6.3.2 respectively, later in this report).

Cultural Differences

Pakeha

Some Pakeha families in this study often had a Sunday roast with all the trimmings (e.g. various roast vegetables and gravy) and a pudding. This was often associated with having the in-laws or other guests over for lunch.

Māori

The concept of manakitanga or sharing was a key practice among Māori whānau in this study. This was evident in attitudes toward sharing food with other members of the whānau. For Māori whānau, practicing manakitanga started in childhood. For example, one mother in this study told her children that if they could not finish their lunch at school they should share it with their cousins.

Māori families/whānau often used Sunday lunch as an opportunity for the wider whānau to come together. For churchgoers, this was often an after-church ritual. However, the Sunday lunch also applied in non-church going Māori whānau.

> *"Our weekends are pretty much about our whole whānau. So because our house is the family home, they all come over with all the kids, which is a good thing."*
>
> **Māori Female – Gisborne**

It was typical for whānau to bring food with them to share with the hosts. As with Pakeha, a typical Sunday lunch might have included a roast with all the trimmings and a pudding, or a barbeque in the warmer months.

Pacific Peoples

Pacific families/whānau also regarded Sunday lunch as a wider family occasion, to be shared with grandparents, adult siblings and their children. Sunday lunches often included traditional Pacific foods such as taro, green banana, and curry and boil-up. Traditionally, Sunday lunch involved a lot of meat and carbohydrate-based dishes, but not necessarily many vegetables. One Tongan family also drank Kava as part of this Sunday ritual.

Younger New Zealand-born or educated Pacific participants often tried to inject more western dishes and healthier foods such as salads into these occasions, because they (and their children) preferred these foods and they were typically more health conscious than their parents.

For some 'white collar' Pacific families, packaged lunchbox snacks symbolised the things they were able to give their children that they had not had as a child. In one case, the parents noted that they wanted their children to have what their Pakeha peers had.

> *"I don't want my kids to go without, and so when they go to school I want them to have what the other kids are having, and I want them to have – I'm not saying this is a racial remark. I want them to have what Pakeha kids have. I know that my kids have friends that don't have that sort of stuff and I don't want to feel … because their families may be on benefits, you know …. and I don't want to have that feeling for my kids – I want my kids to have what I didn't have. I think that's it – I want my kids to have what I didn't have."*
>
> **Niuean Female – Wellington**

Some Pacific parents with older children (i.e. from intermediate school age) did not enquire into what their children were eating for lunch. Some of these parents assumed that schools would not be selling food that was really bad for their children. Others were content that as long as their children were physically active during the day, what they bought for lunch was not a big issue. (The researchers note that parents themselves may have grown up eating tuck shop food such as pies, and felt it was okay for their children to be eating the same kinds of foods at school).

Asian Peoples

Asian participants in this study were often experimenting with western foods as part of assimilating into New Zealand society. In this context, lunches often included western foods and ingredients, such as yoghurt and sandwiches filled with salad ingredients such as lettuce, grated carrot, tomato, and cheese.

4.1.3 Dinner

Highlights

- Dinner was regarded as the main meal (i.e. the biggest and most nutritionally important meal) of the day.
- 'Getting dinner on the table' was a chore for time-poor families/whānau, particularly where both parents worked. Convenience foods and takeaways had significant appeal when families/whānau were busy or felt under pressure.
- Eating in front of television had replaced evening meals at the table for many families/whānau. Some of these families/whānau did not own a table; others simply did not use it for meals.
- Vegetable consumption was much more strongly associated with dinner than any other meal. However, some families did not eat vegetables on a daily basis. Not all those who did make a point of serving vegetables were willing to insist that children ate them, because of the emotional toll this could take on the parent.

Attitudes to Dinner

- Dinner was almost always regarded as the main meal of the day (with the exception of Sunday in some households). As such, it was typically a larger meal and considered to be more important nutrition-wise than lunch. Where vegetables were eaten regularly by a family/whānau, they were most likely to be eaten as part of the evening meal.
- Dinner represented an opportunity for many families/whānau to eat together, perhaps for the first and only time that day (particularly during the working week).
- Getting dinner on the table day after day represented a significant chore for many households with children. In families/whānau with two working parents, preparing the evening meal after work was done under considerable time pressure – such families/whānau were often looking for quick, easy options. Homemakers also reported feeling the pressure as dinner-time approached. Although they may have more time in which to prepare dinner, these individuals (usually mothers) were often tired come evening, and sometimes lacked the motivation and energy to follow through on their good intentions regarding what to cook and serve the family/whānau.

- A few people reported that while there was considerable routine involved in getting evening meals on the table every day, they enjoyed planning dinners and trying out new foods or recipes on occasions. More occasional cooks may have also enjoyed the process. For example, one father noted that he particularly enjoyed cooking dinner at the weekend because he could take his time.
- Parents of small children may have been keen to get the dinner and bed-time routine out of the way, so that they could have some adult-time with their partner.

Dinner Practices

- Many families/whānau in this study were eating dinner around the television.
- In some cases, this was because the family/whānau did not have a table big enough to accommodate them, or did not have room for such a table. In other cases, the family/whānau preferred to eat in the lounge in winter because it was warmer than the room that housed the table.
- Some families/whānau did not want dinner-time to disturb their television viewing habits.
- Some families/whānau ate dinner around a table. For these families/whānau, eating dinner together at the table represented an opportunity for family/whānau togetherness.
- In some households in this study, there was fragmentation at dinner-time, with different family/whānau members eating in different places, perhaps at different times. For example, in one Pakeha family, the parents ate in front of the television with the baby, while older children sat at the dining table in an adjoining room, and a younger child sat at a child-sized table in view of his parents.
- Teenage children sometimes excluded themselves from family/whānau dinners by eating in their bedrooms. This might have been because they had friends around at dinner-time, or they did not want to eat in front of the television news with their parents.
- Some older children who arrived home late because of after-school activities were also eating separately some of the time. In such cases, the teenager might also eat a different meal from the rest of the family, e.g. a ‘heat and eat’ meal.

- Families/whānau in this study were eating a wide variety of foods at dinner-time. Meals covered a wide spectrum, but typically fell into three broad categories:
  - Home-cooked meals, 'cooked from scratch' (or making light use of packaged ingredients). Such meals were most likely to have included fresh (or frozen) vegetables.
  - Home assembled meals, incorporating convenience foods and packaged items. Such meals may also have included fresh or frozen vegetables.
  - Takeaway meals that had been bought elsewhere but were eaten at home. This study showed that a wide range of foods came under the generic takeaways label (although the term 'takeaways' was still more often associated with fried and fatty foods such as fish and chips, burgers, McDonalds and KFC).
- Weekend dinners may have closely resembled weekday dinners – in terms of what was eaten, where, and by whom – or they may have reflected the different weekend routines of families/whānau. For example, weekend dinners may have been smaller, simpler meals such as eggs or instant noodles. Such 'scratch' meals may have lacked any vegetable component (other than potato). This was particularly true of Sunday dinners, which may have been preceded by a large, cooked lunch.

Dinner Context and Dynamics

- Some families/whānau who regularly ate in front of television disputed the common wisdom that this reduced conversation at meal times. They reported that they did interact at mealtimes, with conversations arising out of what they were watching on television.
- Other families/whānau reported that one of their reasons for eating in front of television (apart from the programmes themselves) was that it provided a focus for small children, keeping them occupied long enough to finish their meal. (A number of parents reported that their pre-school children had short attention spans when it came to eating dinner at the table).

- The downside of regular meals in front of television, as reported by some families/whānau, was that children did not develop good table manners. Their bad eating habits (such as not finishing certain foods) or tendency to over-eat, may have gone undetected because their parents' focus was on the television.

  "We did have a stage where she [daughter] was being a bit sneaky and she was hiding broccoli under shelves and under the table … so now she needs to show us her plate."

  Pakeha Female – Wairarapa

- Families/whānau who regularly ate dinner at the table reported placing more emphasis on monitoring their children's manners and what was being eaten.
- Dinner-time could be a time of considerable conflict, focused on who was eating (or not eating) what. A number of mothers in particular, reported that their partners were not good role models when it came to eating vegetables. Where this was the case, it was difficult for the mother to insist that the children eat their vegetables.
- Picky eaters in families/whānau could lead to tense and prolonged meals. Some parents relaxed their eating rules, or gave up altogether, in order to keep the peace'.
- Some parents were not on the same page as each other regarding household eating rules and expectations. In a number of households in this study, one parent reported that they were willing to enforce vegetable eating, however, the other parent was not comfortable doing so (and, in some cases, would also prevent them from doing so). This lack of unity between parents undermined attempts to establish clear eating boundaries for children.

  "I started off doing it. … I said, 'no, eat your veges, eat what you're given, finish it'. After about two months it wasn't working. Our eldest daughter, quite young at the time, got rather emotional, well upset I should say. That's when [my wife] said, 'don't force my kids into eating something they don't want to eat'."

  Samoan Male – Wellington

- In this study, some teenage children were regularly eating dinner in their bedroom as a way of avoiding unwanted conversations with parents.
- Having takeaways for dinner released parents from the chore of planning, cooking and cleaning up. A relaxing, almost holiday-like atmosphere could develop as a result. In some households, takeaways also reduced conflict around getting children to eat their food.

Cultural Differences

Māori

It was common for Māori whānau in this study to eat around the table and to place a value on this. Dinner-time was often regarded as 'whānau time' – a time to come together and share time and food.

Pacific Peoples

Some Pacific parents in this study grew up in families where some or all of the family ate on the floor sitting around a table cloth, because there was no table or insufficient room for a table large enough to seat the whole family. One such father was proud of using a family dining table with his own family.

A couple of Pacific families living in state houses reported that the rooms (kitchen and lounge) were too small to easily accommodate a dining table. These houses did not have separate dining rooms. In one case, the family routinely ate most meals in front of the television in the lounge during the winter months, because the kitchen (which housed the table) was cold.

Some Pacific teenagers in this study chose to eat separately from their parents because the children did not wish to observe Pacific protocols such as prayers at meal times (and in one case, to avoid only being able to talk about topics at the dinner table that were chosen by the father).

Asian Peoples

It was common for Chinese families in this study to eat around the table and to place great value on this.

Asian participants experimented with cuisines other than their traditional cuisine. Two Indian families reported having friends over for barbeques, and cooking simple Chinese dishes such as stir-fry and Chinese rice. One Chinese mother enjoyed cooking roasts, pizzas and burritos, and baking.

(For dinner decision-making and rules – see Sections 6.2.3 and 6.3.3 respectively later in this report.

4.2 Attitudes and Practices – Special Occasions

Highlights

- Special occasions involved more elaborate, often less healthy food.
- Any normal eating rules that applied were suspended on special occasions, with adults and children free to indulge.
- Special occasions often included fizzy drinks (and alcohol).

Attitudes to Special Occasions

- There were two types of special occasions involving eating noted by families/whānau in this study: family-related special occasions, such as birthdays, and significant days associated with religious and cultural practices, such as Christmas, religious festivals, and tangi (funerals).
- Food was a significant part of special occasions to all cultural groups in this study. Special occasions often entailed rituals and traditions involving special foods and specially prepared meals. They also offered licence to suspend normal eating rules and indulge in less healthy food without guilt or restriction. If people needed any justification, the fact that these events were less frequent was sufficient.

Special Occasion Practices

Specific cultural practices are outlined under Cultural Differences later in this section. As a general rule, special occasions were marked out from more routine meals in the following ways:

- More elaborate food – dishes that were difficult or time consuming to prepare and might include unusual or expensive ingredients, and decorative elements.
- Greater quantities of food – more variety and more helpings. For example, children could eat what they liked and as much as they liked, going back for additional helpings. When celebrating children's birthdays there was a particular focus on sweet foods, and children might have got to choose what kind of foods they had at their party.
- An emphasis on desserts and puddings (this applied across all cultures).
- More people involved in the celebration (and in preparation) – usually more than one household, and sometimes large gatherings.
- Suspension of normal eating rules for both adults and children. The focus was on sharing pleasure in food and the company of others.

- More time was invested – both in preparation, and in eating, with people lingering over their food and eating greater quantities than normal.
- For some families/whānau barbeques were a feature of special occasions in the summer months. On these occasions, males tended to wield the barbeque tongs.
- There was likely to be alcohol and fizzy drink on offer at special occasion meals.
- Children and parents usually ate the same foods (although some Pacific cultures had children eating before or after the adults – see Cultural Differences below).
- All courses may be served at once – buffet style (although it was not unusual for savoury foods to be laid out separately from desserts).

Special Occasion Context and Dynamics

- Special occasions had an element of ceremony and tradition, whereby things were done a certain way. This might have involved people dressing up, decoration of the table and surroundings, and use of special crockery, tablecloths and other table decoration.
- It was usual for visitors to contribute food and/or alcohol.
- Special occasion eating was, by its nature, more relaxed and social than routine meals. Special occasions often took place at the weekend – and people lingered over their food, and often drank alcohol with it.
- On special occasions, the focus was on eating for pleasure. In this context, most people suspended normal eating rules. In some cases, not partaking of special foods might have been seen as potentially offensive to the hosts.

Cultural Differences

Pakeha

Special family occasions often included roasts with all the trimmings. Barbeques were popular in the summer months. Desserts were usually involved, sometimes more than one.

There was more emphasis on sweet foods than at other times, particularly in the case of children's birthdays, which usually involved lots of lollies and cake.

Children might have been allowed to choose the food for their birthday party, and in some cases also the venue. Parties at locales such as McDonalds were popular with some Pakeha children.

Māori

Special occasions for Māori families/whānau almost always revolved around whānau. These were times of celebration – Christmas, birthdays, whānau reunions, weddings, christenings, anniversaries and the like. These occasions could also be sad times for whānau, for example, when someone had died.

The concept of manakitanga or sharing was especially important at these times – making sure that people were well looked after – and part of that was making sure that there was plenty of kai (food) for the occasion.

Foods served at special occasions were generally delicacies, more elaborate than daily meals, and often reflected the area or region of the whānau. For example, whānau who lived close to the sea might have crayfish, paua, kina and other kai moana (seafood) on their table.

Often, the scale of the occasion and the numbers attending determined:

- Whether it would be held at home or at a bigger venue, such as a marae or local venue.
- The best way to cater and provide food for the whānau so that they were well provided for.

If the occasion was held at the whānau home, in most cases, all members of the whānau would contribute to the meal. Some may have been known for their signature dishes, which had become a traditional part of whānau gatherings. For example, one participant in this study was known for her glazed ham, and another for his boil-up.

> *"We usually take a boil-up. When he does something different people get upset. 'Uncle, are we getting a boil-up?' This time he [had] made a pie instead."*
>
> **Māori Female – Gisborne**

The special occasion meal at home could take many forms. It may have been a barbeque, a buffet, a sit-down meal or a hangi. These tended to be organised in advance, and if whānau were contributing they would often be told what to bring. Putting down a hangi required co-ordination. Whānau may have been needed to help with its preparation (preparing the hangi pit and so on).

If whānau were to sit down, tables were prepared with the best that the whānau had to offer (tablecloths, dinnerware, and cutlery) and were often decorated with flowers and a range of treats. Kaumatua (elders) were looked after first and, generally, children would be fed before the adults, or they may have their own table and eat at the same time as the adults.

If the occasion was on a larger scale, such as a wedding, it may have been held on the whānau marae. Each marae had its own way of doing things for these occasions. If wedding guests had not been on a marae before, they would be taken on through a powhiri (welcoming ceremony).

Generally, as noted above, special food was likely to be served. Tables would be elaborately set, and often there would have been a top table for the wedding party, parents and kaumatua. There may have been a buffet for guests to help themselves, or food would have been placed on tables with the top table usually always served.

Pacific Peoples

Pacific peoples tended to all contribute food for special occasions, and generally took a pot-luck approach to who brought what, in favour of a co-ordinated approach. However, some family members could traditionally be relied on to bring certain foods or dishes.

Traditional Pacific celebration foods reported in this study included: cooked pig, corned beef prepared island-style, and taro. Dessert typically involved ice cream and fruit salad, followed by pie and cake with coffee.

Some younger Pacific adults purposely took healthier, western-style foods to family gatherings, to off-set what they regarded as the fatty, starchy focus of traditional Pacific foods. They specifically encouraged water rather than fizzy drink and brought salads and fruit.

At Cook Island and Niuean gatherings it was traditional for children to eat before adults. At Samoan and Tongan gatherings it was traditional for adults to eat before children.

The researchers comment that, from a cultural perspective, Pacific communities in general had brought with them to New Zealand their own affiliative traditions and collective values that revolved around food. These related not only to its preparation, but also to its consumption and distribution within the family and/or across their own community.

The researchers also comment that while there may have been some differences between Polynesian cultures, food in general continued to fulfil a very important role across Pacific communities. This function was not limited to simple consumption and individual sustenance. Some Pacific participants made the comment that food was an important form of social currency used to express generosity, hospitality and even status between individuals, as well as across groups. Acceptance of food provided – for immediate or future consumption – was expected, and was the guest's expressed recognition of the host's hospitality and goodwill.

Pacific participants commented that, on social occasions, food was used to express generosity, hospitality and status, as well as to assist in creating and maintaining relationships between individuals and groups, which were then often perpetuated through continuous reciprocity. The researchers note that social occasions and traditionally celebrated events were thus often an important source of food distribution for more traditionally oriented Pacific peoples in New Zealand.

Some Pacific participants in this study noted a trend whereby Pacific peoples would attend a celebration specifically to stock up on food for their own family, taking it home with them rather than consuming it at the venue, perhaps returning later to socialise. This trend was not approved of by less traditionally oriented second generation Pacific peoples, who regarded it as greedy, rather than interpreting it in the context of a collective approach to food distribution.

Asian Peoples

Chinese and Malaysian participants reported that the primary special occasions their families celebrated were Chinese New Year, Christmas, and children's birthdays. These occasions often involved a pot-luck meal with family or friends where everyone brought a traditional Asian dish. There was normally wine and desserts on such occasions. At Christmas time, some of these families cooked a roast with all the trimmings.

Indian participants celebrated the auspicious days of the year according to their community or religion. For example, Diwali and Ganpati were popular Indian festivals celebrated amongst Hindus, along with Hindu New Year. On these occasions, people in this study tended to dress in traditional costumes (e.g. saris and salwar khameez) and prepared traditional, elaborate vegetarian and non-vegetarian dishes (e.g. biryani, butter chicken, matar paneer, maa ki daal, and stuffed parathas) to be shared with close friends in a pot-luck meal. Some people also prepared traditional sweets at home (e.g. kheer, jalebis, burfi, and ladoos). Other people bought these delicacies from an Indian sweet shop.

Asian migrants commented that they tended to eat less healthily than normal at special occasions hosted by New Zealand friends, due to the nature of the foods served.

4.3 Attitudes and Practices – Snacks, Takeaways, Vegetables, Fruit, Fizzy Drinks, and Alcohol

4.3.1 Snacks

Highlights

- Parents' own snacking behaviour was often less healthy than that which they encouraged in their children.
- Packaged snacks such as muesli bars and chippies were a staple item in many children's lunchboxes. Some parents bought these products as a means of giving their children the things they never had in their childhood, and/or of ensuring that their children had what 'the other children had'.
- Lunchbox snacks' nutritional value went unquestioned by some parents. Their convenience to parents and appeal to children made them a popular lunchbox choice.
- Parents and caregivers sometimes granted treats (i.e. less healthy snacks) to 'keep the peace' and buy 'time-out' from their children.

Attitudes to and the Role of Snacks

Snacks fell into two broad categories:

- Snacks that comprised 'bits and pieces' from the fridge or cupboard, for example, some of last night's dinner, a sandwich, a piece of fruit, or cheese and crackers.
- Packaged snacks and treats such as muesli bars, lollies, chippies, and biscuits. Packaged lunchbox snacks fell into this category.

Children

Families/whānau in this study perceived that snacks had an important role in staving off children's hunger between meals. This was seen as particularly important for younger children, e.g. pre-schoolers, because of their smaller tummies and relatively high energy requirements.

Some parents allowed their children to snack throughout the day, and referred to this as *"grazing".* In some cases, access to any type of snack was unrestricted. Others tried to establish set snack times, such as mid-morning and immediately after school, in order to prevent their children coming to the dinner table already full.

Some parents gave their children unrestricted access to fruit as an 'any-time' snack, but restricted their consumption of sweet snacks such as biscuits and other packaged snacks such as muesli bars and chippies. In some households, packaged snacks such as these were reserved for lunchboxes only, and not allowed at other times.

Children would often badger their parents and caregivers for sweet snacks and packaged snacks when they knew that these were in the cupboard. In some cases, parents and caregivers would use a healthier snack such as fruit as a bargaining tool – if the child ate this they could then have a less healthy snack. In other cases, parents and caregivers may have granted the requested 'treat' in order to 'buy peace' and gain 'time-out', or out of the desire to please their children and show their love for them.

After-school snacks were of prime importance, and could be quite substantial, consisting of several items, such as a piece of fruit and a couple of biscuits or a sandwich.

It was common for parents and caregivers to attempt to restrict snacking in the hour or so leading up to the family/whānau evening meal. However, fruit (or raw vegetables) was sometimes allowed, and some parents and caregivers used the offer of fruit (or raw vegetables) as a way of determining how real the child's hunger was. The thinking was that, if they were really hungry, they would take up the offer even if it was not the snack they were hoping for.

There was often a higher frequency of snacking at the weekend, when many families/whānau suspended their normal weekday routines around meal times.

Adults

Adult snacking was often more about reward and 'time-out' than it was about hunger. The main time for adult snacking was in the evening, when the children were in bed. Snacks favoured by adults in this study were often indulgent in nature, e.g. chocolate, biscuits, lollies and chippies.

Sometimes parents' reported that their snacking had an out-of-control element, with people consuming more than intended of 'naughty' foods.

> *"Sometimes when I sit down and eat my snacks I tend to relax and once I'm sitting down and relaxed, that is when I get too full. I have a full stomach once I do have my snacks. It's like getting a dinner for me. I'll just eat and eat continuously and it makes me tired and lazy and not able to do any more chores in the house … I don't really like snacking because I know it makes me lazy."*
>
> **Tongan Female – Christchurch**

Snack Practices

- Pre-schoolers snacked throughout the day. Parents were more likely to closely monitor younger children's snacking and to ensure that at least some of their snacks were healthy ones.
- After school was a key snack time for school-age children. It was accepted that children often needed quite a substantial snack when they returned from school to boost their energy levels.
- Both adults and children snacked to stave off hunger before the next meal. Outside morning and afternoon tea times, or within an hour or so of dinner, some parents and caregivers insisted that children snacked only on fruit (or, in fewer cases, raw vegetables).
- Adults often used snacks as a means of rewarding themselves or creating 'time-out' from their children or other pressures.
- Both adults and children snacked while watching television. This kind of snacking could escalate, with people going back for additional snacks, or eating more than they intended (e.g. half a packet of biscuits instead of a couple).
- When there were no children to cook for at meal time (i.e. because they were not at home) some parents said they snacked rather than cooking themselves a meal.
- Night-time snacking by adults often consisted of foods and drinks that were normally restricted or off-limits for children in the household, e.g. fizzy drink, chocolate, lollies, and sweet foods.

> *"The kids don't have lollies. No, actually [my husband] and I – it's like a Saturday night thing, once the kids go to bed and we're watching a movie we might have some lollies, but we don't eat them … I mean it's not like we sit there and eat them in front of the children."*
>
> **Pakeha Female – Wairarapa**

Snack Dynamics

- Adults who reported having a sweet tooth were more likely to ensure that there was a supply of sweet foods in the house. Even if these foods were not intended for children, they tended to sniff them out and pester their parents for them.
- Many adults and children reported snacking in front of television – and found this a pleasurable activity. Some parents encouraged their young children to snack in front of television because the distraction provided ensured that the children would eat their food happily and quietly (providing peace for the parents).
- Treat snacks (such as chippies, chocolate biscuits and lollies) could be used by parents and caregivers to express love and affection for children, or to buy household harmony or 'time-out' for parents and caregivers. Children often nagged for treat snacks if they knew they were in the house – persistent nagging could lead to the desired snacks being granted (something children seemed to understand).
- Grandparents were a major source of sweet treats. In some cases, treating by grandparents ran to trips to the dairy or McDonalds. Many grandparents (and some parents too) believed it was a grandparent's prerogative to indulge their grandchildren. When such treating caused tensions with parents, treats may be kept secret.

4.3.2 Takeaways

Highlights

- Most people said takeaways had their place in the family/whānau diet. But there was little clarity on what exactly that place should be.
- Takeaways were popular with children, and represented 'time-out' for parents.
- Takeaway usage had extended far beyond *'fish and chips on Fridays'*, to include a wide variety of ethnic, restaurant and 'ready to eat' supermarket food.

Attitudes to and the Role of Takeaways

When people spoke about takeaways, they tended to think first of traditional takeaways such as fish and chips, KFC and pizza. However, the takeaway meals eaten by families/whānau in this study extended beyond these examples, to include take-out meals from ethnic restaurants, as well as ready to eat food from supermarkets, such as cooked chickens and takeaway salads.

Takeaways figured in the eating repertoire of most families/whānau in this study. However, there was great variation in terms of the role they played in the family/whānau diet. Takeaway consumption could be seen as existing on a continuum with:

- Families/whānau who relied on them as a key source of both planned and ad hoc meals and snacks throughout the week at the high end of the consumption scale (in this study one father was eating takeaways every day) and;
- Families/whānau who reserved them for occasional treats for children (and 'time-out' from cooking for adults) at the low end of the consumption scale.

Most households lay somewhere between these two extremes, reporting that they typically ate takeaways every week or two, in place of a home-cooked evening meal, or sometimes a weekend lunch. However, some families/ whānau were eating some kind of takeaways most days of the week.

Takeaways were not all equal nutritionally, despite people regarding them as a generally unhealthy category (i.e. high in fat). Some people in this study purposely chose takeaways they considered to be healthier (e.g. Chinese or Subway sandwiches) for some or all of their takeaway meals, in a bid to eat more healthily. Takeaways perceived as at the less healthy end of the takeaway spectrum included fish and chips, McDonalds, and KFC. Takeaways perceived as at the more healthy end of the spectrum included Subway, sushi, cooked supermarket chickens and takeaway salads, and many Chinese dishes.

The researchers note that some convenience meals, such as chicken nuggets, battered fish, and fries, resembled takeaway meals in terms of nutritional value and fat content, but may not have been recognised as such by virtue of being 'cooked' at home.

A household's proximity to takeaway outlets was one of the influences on how often a family/whānau ate takeaways. Among those families/whānau eating a lot of takeaways, some reported that the plethora of takeaway outlets in their neighbourhood reinforced their takeaway habit. South Auckland was cited as a prime example of this.

> *"My community is very low [income] … so the places there are very – it's like there's not very good quality food and [lots of] junk food."*
>
> **Pacific Other Female – Auckland**

Likewise, among those families/whānau eating takeaways infrequently were rural households who lived a considerable distance from any takeaway outlets.

Takeaways appeared to have almost universal appeal to children, although not all children in a family/whānau liked the same kinds of takeaways. For parents, the strongest attraction of takeaways appeared to be their liberating effect: when takeaways were on the menu there was no cooking, no dishing up, no clearing away, and no mess in the kitchen to be dealt with.

Takeaways were an instant solution when parents could not face cooking. As such, they had strong appeal when parents were particularly busy, stressed or generally feeling time-poor. Having a takeaway meal at home often generated a relaxed atmosphere, with families who normally ate at the table eating their takeaways in front of the television.

> *"One of the good things about takeaways is that we tend to sit down and laugh and joke … we sit down here in the lounge here and we eat and we talk and we laugh . … so I think that is part of the takeaways … dinner-time when we have a cooked meal it's fine, you know, but sometimes they rush, rush, rush and they go through their meal – but when we have takeaways … we lie down, watch TV in there. It's like a family night for our family when we get takeaways."*
>
> **Tongan Female – Christchurch**

Apart from being labour saving, some parents enjoyed eating takeaways. Some reported, however, that while they enjoyed them at the time, they disliked the feeling they got after eating some kinds of takeaways (i.e. a heavy or disturbed stomach was associated with the high fat content of takeaways such as fish and chips). Some adults also reported feeling lethargic after eating takeaways.

There was quite a bit of guilt attached to eating takeaways. In this study, it was common for parents to defend consumption of takeaways by their family/ whānau with comments such as *"takeaways have their place"*. However, there was not much definition around what this *place* might be. Associated with this mantra was the idea that takeaways were *"fine"* as part of *"a balanced diet"*. When pressed on what this meant, families/whānau eating takeaways every week or two reported that their consumption was 'probably about right'. However, families eating takeaways more often than this also thought that their takeaway consumption was okay, and was balanced out by other more healthy meals.

Some families/whānau who were frequent takeaway eaters simply did not think about health concerns. For example, the mother of a whānau which ate takeaways about eight times a week bought takeaways when she was tired, and saw fish and chips as a good, cheap way of filling up her whānau.

Some families/whānau in this study were trying to reduce their takeaway consumption. This was usually part of a wider effort aimed at increasing the health of family/whānau members. Such families/whānau reported that reducing their reliance on takeaways had necessitated putting greater time and effort into meal planning, grocery shopping, and cooking. It had also created family conflict at times (e.g. when one parent wanted to opt for takeaways and the other did not), which the individual most determined to cut down on takeaways had to be prepared to weather.

> *"When [my wife] now asks me to get takeaways – I will say more than anything – eighty percent of the time – 'no, we have still got the weekend' – I will cook dinner, even when [my wife] says, 'I don't think I can be bothered waiting' – I say, 'I am still going to make it – you can go and get takeaways, but I will still make it'."*
>
> **Samoan Male – Wellington**

Takeaway Practices

Takeaways were eaten by family/whānau in the following contexts:

- As a routine planned weekly or fortnightly purchase, taking the place of a home-cooked evening meal for the family/whānau. This may have been linked to pay-day, or to other routines such as picking up children from sports practice. In some households this routine was elevated to unquestioned ritual status, e.g. Friday would not be Friday without fish and chips.
- As an ad hoc mid-week purchase, when the adults in the household did not feel like cooking an evening meal or felt inclined to treat the children (this may have been triggered by pre-dinner television advertising of takeaways, e.g. McDonalds).
- With grandparents, as a treat, or as part of a routine (e.g. when the grandparent was the after-school caregiver). This may have happened after school, or at any time in the weekend.
- On special occasions, such as a child's birthday – the researchers note that a number of takeaways outlets offered on-site children's birthday parties.

- On Saturdays around lunch-time as part of a family/whānau outing (e.g. watching children's sports, or shopping).

> *"… when they go to the rugby game to watch their brother play rugby, I'll get them a couple of scoops of chips, you know, to keep them warm because it's usually freezing down there. More to keep them warm."*
>
> **Pakeha Female – Christchurch**

- Some parents bought takeaways for their own consumption as part of their working day. This did not involve other family/whānau members.
- Takeaways may have been bought for a weekend breakfast, prior to heading on to other activities, such as children's sport fixtures, or work (for parents who worked at weekends).

Takeaway Dynamics

- Takeaways may have been used as a treat or reward by parents or caregivers. This could have involved evening meals, or spontaneous snacks between meal times (e.g. dropping in to McDonalds).
- Decisions about what kind of takeaways the family/whānau bought were sometimes made according to the parents' preferences. However, sometimes children were allowed to choose what kind of takeaways the family/whānau bought, with each child having their turn to choose. In some instances two or more different types of takeaways were purchased to meet the preferences of different family/whānau members.
- Sometimes parents tried to ameliorate their guilt at buying takeaways by opting for takeaways they perceived to be healthier (i.e. compared with other takeaway options). Examples of takeaways commonly perceived to be healthier options were: Chinese, Japanese/sushi, some pizzas, and Subway sandwiches. So-called healthier takeaways generally earned this tag by virtue of having some vegetable content. Relative fat content may also be taken into account, although people's ways of determining this tended to be rather arbitrary – focusing on obvious rather than hidden fat.
- Eating takeaways was often linked to fizzy drink consumption, whereby children were allowed to buy a fizzy drink to eat with their takeaway meal. Some families/whānau strongly associated fizzy drink and takeaways – and may only ever have them together. Some takeaway outlets reportedly offered free fizzy drinks with takeaways.

> *"Yeah [fizzy drink is consumed] mainly with dinner – wash it down with the food, and with takeouts too."*
>
> **Tongan Male – Auckland**

Cultural Differences

Pacific Peoples

Some Pacific families were trying to reduce their takeaway consumption, partly as a result of being exposed to ideas about healthy eating through the media. In such families, takeaways had formerly been relied on for evening meals and spontaneous snacks throughout the week.

Asian Peoples

Most Asian families' attitudes to takeaways reflected those attitudes found in the wider sample.

Some Chinese mothers in this study took the responsibility to feed their children healthy foods very seriously. In one such family, the mother prepared a salad to be eaten with takeaways such as fish and chips, to ensure that her children still got their daily serving of vegetables.

4.3.3 Vegetables

Highlights

- Vegetables were largely confined to evening meals in many families/whānau.
- Most people believed vegetables were good for you and should be eaten, but many were not clear on exactly why this was so.
- Plenty of people were not eating vegetables daily. Some believed eating fruit would make up for this deficit.
- Comment was made by some parents that vegetable eating was a habit best learned while young. A taste for vegetables was reportedly harder to acquire in adulthood.

Attitudes to and the Role of Vegetables

Overall, vegetables were seen by many families/whānau as one of the key planks in healthy eating (along with fruit). There was quite high awareness of the *'five plus a day'* message, and a strong link between fruit and vegetables and healthy eating.

Most parents reported that they encouraged their children to eat vegetables, however not all parents insisted that this happened. The frequency of vegetable eating reported by participants often fell considerably short of the ideal represented by the *'five plus a day'* mantra. Some parents were unsure exactly why vegetables were healthy.

> *"I have no idea, no idea at all. All I know is that it's good for you."*
>
> **Pakeha Female – Auckland**

Some people in this study distinguished between starchy vegetables (such as potatoes, kumara and yams), which they considered to be potentially fattening, and healthier (i.e. non-fattening) vegetables such as leafy and cruciferous vegetables. People who made this distinction sometimes limited or avoided the former category because of fears about weight gain, although they tended to be less concerned about these vegetables for their children on the basis that they provided 'lots of energy'.

Some families/whānau in this study spoke positively about vegetables and reported that they had no problems getting their children to eat them. There were a range of reasons, and strategies, supporting vegetable eating in these families/whānau, as follows:

- The parents enjoyed eating vegetables and so did the children.
- The children planted their own vegetables in the family/whānau garden and looked after these. Picking the children's vegetables was a highlight for one whānau in this study.
- Children had favourite vegetables that the parents served often. One mother continued to introduce new vegetables regularly. If the children did not like them, she simply tried again another time.
- Some parents emphasised the visual appeal of having lots of colour on the plate as a way of making vegetables interesting to children.

> *"Colour is a feeling. You should see the children who haven't had many veges before [when] they see the colours – some of them get excited."*
>
> **Māori Female – Gisborne**

However, some parents found vegetables to be something of a battleground. A parent's willingness to insist that his or her children ate their vegetables was a complex mix of: parenting style, willingness to be temporarily disliked by one's children, confidence in one's own judgement, and partner dynamics. Whether or not the parent themselves liked and regularly ate vegetables was also highly influential.

> *"If they're not going to have the veges, they need to at least have some fruit. They've got to have one or the other. But my next mission is the veges. I don't know how I'm going to go about that because [if I say], 'if you don't eat your tea, you go to bed', then I'd feel guilty because I don't believe in the kids going hungry either. So that's my downfall, is sticking to things."*
>
> **Pakeha Female – Christchurch**

Some parents in this study reported that their partner undermined their efforts to get their children to eat their vegetables. In some households, this happened because one parent did not eat all their vegetables, thereby undermining the other parent's case. In other households, this happened because one parent was emotionally unwilling to force children to do anything they did not want to do.

> *"I will dish it up … and I say to him [my husband], 'how am I meant to educate these kids when they say, 'dad doesn't have to'. So [my son] will leave his vegetables, which I find really bad."*
>
> **Pakeha Female – Auckland**

Families/whānau that struggled to get their children to eat vegetables sometimes used cost as a justification for not buying more vegetables. When parents saw vegetables going uneaten, they may have felt there was little point buying them and that they were better off to spend their money on foods they knew the children would eat. Some of these parents also commented that buying sufficient quantities of vegetables to feed their family on a regular basis was expensive.

For some families/whānau, the mere presence of vegetables in a dish or meal signalled that the food was healthy, regardless of the other ingredients. For example, some Indian participants felt they were eating quite healthily because of the vegetable content of many of the traditional dishes they cooked. They tended to discount the impact of deep frying or using coconut cream in curry.

When it came to vegetables, families/whānau in this study could be grouped into three broad categories:

- Families/whānau that incorporated vegetables into the evening meal most nights, and ensured that children ate at least some of them.
- Families/whānau that incorporated vegetables into some of their evening meals, and recognised their value, but might not have insisted that children eat them.
- Families/whānau that ate a relatively high proportion of takeaway and convenience food meals, did not emphasise vegetables in the meals that they cooked, and did not insist that their children eat them. However, some of these families deliberately opted for Chinese takeaways (such as chow mein) at least some of the time as a way of ensuring that their children ate some vegetables as part of their evening meal.

  "For years we had Chinese once a week because that was the only way to get the vegetables into us."

  Pakeha Female – Auckland

Routine Part of Evening Meal – Must be Eaten

Families/whānau that included vegetables in most evening meals tended to regard an evening meal without vegetables as unbalanced. The exception to this was when the family/whānau had takeaways, or a 'scratch' meal at the weekend, such as toasted sandwiches, eggs on toast or macaroni cheese.

In these households, evening meals typically included at least one vegetable (other than potato) and usually two or three (more if a salad or stir fry was on the menu). Some household cooks tried to include additional vegetables within other dishes, for example, adding grated vegetables to mince and other meat-based dishes. This behaviour was more typical of mothers than fathers.

Fathers who cooked in these households tended to be less inclined to cook and eat as many vegetables of their own accord, but incorporated them into family/whānau evening meals because the mother expected them to.

In these households children were expected to eat at least some, if not all, of the vegetables on their plate. Some parents allowed children to have one or two vegetables they did not eat, but meals were often planned to incorporate vegetables that were acceptable to the children. (One mother confessed that she herself does not eat vegetables, but ensured that her young sons did).

Households that routinely served and expected children to eat vegetables as part of the evening meal were more likely to offer children raw, cut-up vegetables as snacks.

Children in these households were most likely to be eating *'five plus'* servings of fruit and vegetables most days. Ironically, parents who were not habitual fruit eaters may not have been reaching this tally (except perhaps in the warmer months, when popular stone and berry fruits were cheap and plentiful).

Semi-routine Part of Evening Meal – May Not be Eaten

> *"Two or three nights [a week] we'd have some veges in the plan."*
>
> **Samoan/Tokelauan Male – Wellington**

Families/whānau that included vegetables in some evening meals often intended to include them more often than they actually did. This was because takeaways and quick and easy meals (e.g. instant noodles and chicken nuggets) were often resorted to when parents were busy, tired, not feeling well, or short of motivation to cook a 'proper' meal.

In these households, evening meals typically included at least one vegetable (other than potato) but were often quite meat-focused, with vegetables a relatively small component of the overall meal. Some parents restricted the range of vegetables they served to those they knew their children would eat, eschewing unfamiliar or exotic (and possibly expensive) options in favour of the familiar (such as carrots and peas).

These parents typically wanted their children to eat their vegetables, and encouraged them to do so. However, some were reluctant to force the issue because they did not want to upset the children, nor did they want to deal with the emotional fall-out (e.g. complaining children and a protracted, bad-tempered meal-time).

Children in these households were less likely to be eating *'five plus'* servings of fruit and vegetables most days. However, some of them would be reaching this target by eating a lot of fruit. Parents were also less likely to be reaching this target, because they typically ate less fruit than their children (except perhaps in summer – see earlier).

Vegetable-free Evening Meals were Commonplace

These families/whānau may have had vegetables only once or twice a week. Some of these parents were not brought up eating vegetables regularly themselves, and had limited understanding of how to prepare vegetables.

Children in these households were unlikely to be eating *'five plus'* servings of fruit and vegetables most days, as were their parents. It was this group who was most likely to include tomato sauce or fruit juice in their fruit and vegetable serves.

> *"I said, 'what about veges?', and she [our doctor] says, 'does he like tomato sauce?' I said, 'yeah', and she said, 'well, two dessertspoons of tomato sauce equals one serving of vegetables, so there you go'. I said, 'great'. So when I'm feeling really lazy we have fish and chips for dinner – I say 'here, don't forget your vegetables', and then, 'there's the sauce bottle'."*
>
> **Pakeha Female – Auckland**

Vegetable Practices

When vegetables were eaten by family/whānau in this study it was typically in one or more of the following contexts:

- As part of the evening meal when it was home-cooked (but some home-cooked meals also contained few or no vegetables).
- As part of takeaways that included a vegetable component (e.g. Chinese, Indian, some pizzas) – one of the reasons these options may have been chosen was to salve parents' conscience that they were not giving children a proper meal by opting for takeaways. (Note: Indian participants did not consider Indian takeaways to be particularly healthy, perhaps because they were more familiar with the ingredients).
- As an 'any-time' snack for children, e.g. some families/whānau encouraged children to eat raw vegetables such as carrot sticks or cucumber (as with fruit, in a few families/whānau this was the only option for children claiming to be hungry shortly before or after meals).
- As a component of some lunchbox food (e.g. carrot sticks or lettuce, tomato, sprouts or grated carrot in a sandwich or roll – this was more common in the summer months).
- As part of family/whānau weekend lunches – more typically in summer when salad vegetables were in season.

Vegetable Dynamics

- Some children would happily eat a relatively wide range of vegetables – others would not. A parent's willingness to insist – and 'wear' the emotional fall-out – was often pivotal to children developing the vegetable eating habit.

  "I've only just started doing their vegetable things … since I started cooking – to me that's not long enough. I'd rather they get taught when they are babies. The sad thing is I should have been a lot stronger when they were babies … I was aware of it, I just didn't do anything. If I did say something then I would get put in my place from the boss [my wife]."

  Samoan Male – Wellington

- Parents generally agreed that eating vegetables was a habit best got into when children were young. There was a role modelling issue with vegetable consumption. It was hard for parents to get their children to eat vegetables if the parents themselves did not eat them willingly. In this study, the issue was usually one of fathers not liking vegetables, however, at least one mother was a very reluctant vegetable eater.
- Women in this study tended to emphasise the importance of vegetables more than men, and often reported eating more vegetables than their male partners.
- Perhaps partly as a result of this, some men were not keen or confident vegetable cooks. They reported cooking fewer vegetables, in more traditional ways (e.g. boiled) than women – and some 'weekend cooks' did not cook vegetables at all if the children's mother was not at home.

  "I'm a meat and potatoes sort of person, but that's only in the weekends – it's not like I'm missing out because we're eating veges all during the week."

  Pakeha Male – Wairarapa

- Families/whānau with a vegetable garden had a plentiful, cheap supply of seasonal vegetables. In these households, adults and children typically ate more vegetables, and children were often involved in planting and harvesting. Households with vegetable gardens were often carrying on a family/whānau tradition, whereby vegetable consumption was a given.

- Parents who grew up in gardening households were also more likely to continue an emphasis on vegetable consumption in their own family/whānau, whether or not they had their own vegetable garden (and those who did not may have still harboured the ambition to have a garden one day).

Cultural Differences

Māori

Māori whānau living in small communities were generally related to the next door neighbour or whānau down the road. In these situations, food would be intentionally shared among whānau. For example, whānau may have grown a particular range of vegetables to share. Others may have had an orchard and would have shared fruit within their community. This reflected a collective rather than individual approach, which for these whānau was about being Māori.

Pacific Peoples

Some Pacific families commented that they had grown up with a more western-style of cooking, which included more vegetables than a traditional Pacific diet.

Other Pacific families who had been brought up with traditional Pacific foods felt that this was reflected in the relative lack of vegetables in their own family's diet. Some Pacific families were working hard to increase their vegetable consumption, partly as a result of being exposed to ideas about healthy eating through the media.

Asian Peoples

Asian participants generally tended to be using a wider variety of vegetables than many other participants reported, and tended to do most of their cooking 'from scratch'. Meals also tended to include a higher proportion of vegetables to meat.

> *"I think for the Chinese meal, it's always plenty of vegetables. Like stir fry – you cut meat in very little pieces with lots of vegetables stir fried together. I think that's a good thing about stir fry Chinese – a lot more vegetables than meat. Yeah. Compared to the Kiwi meal – like a big piece of steak, or a roast is a lot of meat too."*
>
> **Chinese Female – Christchurch**

Vegetables were a feature of most Indian participants' evening meals, and some Indian families were vegetarian. Some Indian mothers added vegetables to many dishes, and sometimes attempted to disguise them in dishes such as curries (this practice was also noted among Pakeha participants). Indian participants did not give their children raw vegetables as snacks or in their lunchboxes.

Chinese mothers in this study typically placed more emphasis on fresh vegetables as an integral part of meals, not just dinners, and encouraged raw vegetables as snacks.

4.3.4 Fruit

Highlights

- Most people believed fruit was good for you and encouraged their children to eat it.
- Fruit was popular with children – few parents had to enforce fruit eating.
- Some families were limiting children's consumption of fruit on cost grounds.
- Parents often ate a lot less fruit than their children. Children were often daily fruit eaters – their parents often were not.

> *"Oh, we eat quite a bit of fruit – at least the kids do, I don't … I don't really enjoy it … I'll eat a bit – not like the kids do where they'll eat two or three apples in a day. I won't. I'll eat one once in a while, but that's it."*
>
> **Pakeha Male – Wairarapa**

Attitudes to and the Role of Fruit

Overall, fruit was regarded by many, if not all, families/whānau as one of the key planks in healthy eating (along with vegetables). There was high awareness of the *'five plus a day'* message and, even if people were not achieving this tally on a daily basis, they were aware that fruit was an important part of a healthy diet.

Families/whānau in this study could be broadly grouped into those that encouraged their children to eat fruit and placed no limits on their fruit consumption, and those that placed limits on fruit consumption on cost grounds. (A minority said they restricted fruit consumption on health grounds as well as cost because of a belief that fruit was high in sugar).

Unrestricted Access to Fruit – Seen as the Best Snack

Some families/whānau gave their children unrestricted access to fruit, encouraging it as the first-choice snack (i.e. the first snack option parents provided when asked for snacks), and ensured it was included in their lunchbox every day. In these families/whānau, parents reported that children typically ate at least a couple of pieces of fruit a day. Parents reported that keeping their children supplied with this volume of fruit could be an expensive business, particularly in larger families/whānau.

Cost sometimes limited the types of fruit bought, with families sticking to seasonal fruit and the relatively inexpensive core fruits such as apples, bananas, oranges and pears. Some families/whānau bought tinned fruit to supplement fresh fruit because it worked out cheaper. Some families made a point of buying fruit in bulk from markets, roadside stalls, or orchards in order to keep costs down, while still encouraging unlimited fruit consumption. This was more likely to apply to families/whānau in provincial and rural areas.

Restricted Access to Fruit – On the Basis of Cost

Other families/whānau recognised the importance of fruit, but restricted their children's consumption on the grounds of cost. Some, but not all, of these families/whānau were lower income. In such families/whānau, children might have taken a piece of fruit in their lunchbox, but be restricted in how much fruit they were allowed to eat at other times (e.g. no more than two pieces of fruit a day per child).

Restricted Access to Fruit – Concerns over Sugar Content

A few families/whānau in this study reported restricting their children's consumption of fruit out of a belief that eating too much fruit equated with eating too much sugar. In one case, this idea had been gleaned from a television current affairs programme. There was also evidence in this study of some confusion arising from the 'made with real fruit' or 'natural fruit sugar' claims of the food industry.

Fruit Practices

Fruit was typically eaten by family/whānau in the following contexts:

- At kindergarten and pre-school.
- In children's lunchboxes – usually one or two pieces (many schools reportedly encouraged fruit consumption and some lower decile schools provided free fruit to pupils).
- As part of a packed lunch for working parents.
- As an after-school snack for children – the first-choice snack in some families/whānau.
- As an 'any-time' snack for children – some families/whānau made fruit the only option for children claiming to be hungry shortly before or after meals (some adults would also snack on fruit).
- As dessert for the family/whānau – e.g. fruit salad, cut-up fruit, or pieces of fruit. (Note: The practice of cutting-up fruit generally encouraged consumption by both adults and children, but people had to be sufficiently motivated to take the time to do this).

Fruit Dynamics

- Many parents stated that their children enjoyed fruit, and that encouraging them to eat it was not a problem.
- In some families/whānau eating fruit was seen as a way of excusing or ameliorating the effects of eating other less healthy foods. For example, a parent or caregiver might grant a child's request for a biscuit, provided they had a piece of fruit as well.
- Fruit was also seen as a vegetable substitute, whereby eating lots of fruit made up for not eating enough vegetables – on any given day, or on a regular basis. (Although fruit and vegetables were linked in many people's minds, there was little evidence of people substituting vegetables for fruit in the same way. The researchers note that this may be because fruit's inherent sweetness makes it more universally appealing to children than vegetables).
- Parents tended to stick to seasonal and the least expensive fruits in an attempt to keep costs down, meaning that families/whānau could get stuck in a fruit rut consisting of apples and bananas. This appeared to be more of a problem for adults (than it was for children), some of whom found these fruits relatively unappealing compared to more expensive, exotic fruits.

- Many parents in this study reported eating considerably less fruit than their children, despite knowing it was an important part of a healthy diet (this also applied to vegetables). It was not uncommon for parents to report that they ate only a couple of pieces of fruit a week, if that. Some fathers had very little regular fruit in their diets. This did not appear to influence their children's liking for fruit, and non-fruit eating parents still encouraged their children to eat fruit. However, the researchers note that parents who were not big fruit eaters themselves may have been inclined to devote less of the grocery budget to fruit, and to buy smaller quantities (thereby indirectly restricting their children's fruit consumption).
- Younger children were reportedly easily influenced by what others around them were doing. There was evidence that the ritual of shared fruit at pre-schools had turned some young children on to fruit, even when it was not frequently eaten at home.

> *"[My daughter] is at kindy and she is four, and they have morning sit-around with the fruit bowl. And I find she actually eats it because the other kids are, whereas at home if I put out a bowl of fruit she wouldn't eat it. No definitely not interested in fruit at all, but at kindy she'll eat it."*
>
> **Pakeha Female – Christchurch**

Cultural Differences

Māori

As discussed earlier, Māori whānau living in small communities often shared fruit and vegetables they grew within the community. This reflected a collective rather than individual approach, which for these whānau was about being Māori.

Pacific Peoples

As discussed already, some Pacific families were working hard to increase both their fruit and vegetable consumption. These families often found it easier to increase fruit consumption than vegetable consumption, by offering fruit as snacks and ensuring fruit was included in children's lunchboxes.

Asian Peoples

Many Asian participants regularly served a platter of cut-up fruit for the family dessert. Some Indian participants offered fruits to the gods during their "puja" religious prayer gatherings, or when they visited the temple. On these occasions, once the fruit had been blessed, it was cut-up and offered to everyone present.

4.3.5 Fizzy Drink

Highlights

- There was relatively high awareness of fizzy drink's high sugar content, and this was a key reason for families/whānau limiting or avoiding it.
- If parents consumed fizzy drink at home, their children were more likely to drink it too (or to want to).
- Consuming fizzy drink was often linked to eating takeaways.
- For fizzy drinking families/whānau, the relatively low cost of fizzy drink, especially compared to milk, reinforced its consumption.

Attitudes to and the Role of Fizzy Drink

Fizzy drink consumption varied widely in this study, from families/whānau consuming eight litres a day, to families/whānau who would not keep it in the house. Attitudes to fizzy drink differed from household to household, but family/whānau in this study could be grouped into three broad categories in terms of fizzy drink consumption:

- Families/whānau in which fizzy drink was the primary type of cold drink consumed at home by children and young people (and was also popular with some adults).
- Families/whānau in which fizzy drink was an occasional or infrequent treat and was more likely to be consumed on special occasions or away from home.
- Families/whānau who had been regular consumers of fizzy drink at home but who were actively trying to reduce their consumption, for health reasons.

Fizzy Drink as Primary Cold Drink

In these families/whānau, fizzy drink was regarded as a household staple because it was popular with the children. Parents in these households had often grown up in homes where consuming fizzy drink was usual, and enjoyed its taste and sweetness. These parents tended to prioritise fizzy drinks as a grocery purchase, and may have been quite proactive in seeking out specials on fizzy drink.

In fizzy drinking families/whānau, children often had a fizzy drink with their evening meal, as did some adults.

> *"They [the children] all have their glass of fizzy with their tea."*
>
> **Pakeha Male – Wellington**

Children also helped themselves to fizzy drink from the fridge during the day, and there was usually fizzy drink in the house. Some of these parents were aware that fizzy drink was not healthy, but used its relatively cheap cost as an excuse to continue buying it.

Fizzy Drink as Occasional Treat

In these families, the parents limited their children's consumption of fizzy drink because of concerns about its high sugar content. Parents' awareness of the link between consumption of sugary drinks and tooth decay reinforced their decision to limit it, and made it easier to justify to children (tooth decay and the resulting fillings were tangible evidence of a problem).

In these families, parents were more likely to allow fizzy drinks when they were away from home, e.g. on holiday or on a special outing, as a treat rather than a regular occurrence.

In these households, large bottles of fizzy drink may have been bought for special occasions or social gatherings, for example, as mixers for alcoholic drinks for adults. Children were then allowed to drink whatever fizzy drink remained in already opened bottles.

Some parents in these households quite enjoyed drinking fizzy drink themselves, but tended to do their fizzy drinking away from home (e.g. at work) in a bid to set a good example for children.

Cutting Down On Fizzy Drink

Families/whānau in this category had been regular consumers of fizzy drink at home, with both children and adults drinking it regularly. The parents had become aware of fizzy drink's high sugar content, and were trying to change the habits of their family/whānau so that fizzy drink became an occasional treat rather than a regular fixture in the daily diet.

Growing awareness of the high sugar content in fizzy drink appeared to have been hastened by schools – many of which have reportedly banned fizzy drinks. As a result of this, drinking water at school had become a norm that appeared to have flowed into many homes where water was the drink of choice.

However, parents in these households tended to have a taste for fizzy drink themselves. As a result, double standards around fizzy drink abounded. For example, in one family the parents purchased a soda stream to cut down the cost of the adults' daily fizzy drink fix, and restricted their children to a glass at the weekend.

> *"The children are not allowed fizzy drinks … oh, they have water, but [my husband] and I are really bad … ah! I love my fizzy drinks … actually, a couple of weeks ago I went out and bought a Soda Stream … and it actually worked wonders for restricting fizzy intake too because they make up a one litre bottle, so [my husband] will make up his one litre bottle and I'll make up my one litre bottle and that will be it until the next day … and the children are allowed them on the weekends."*
>
> **Pakeha Female – Wairarapa**

In another household, the parents had drastically reduced the number of bottles of fizzy drink they bought a week, but continued to keep a supply of fizzy drink in their bedroom that was effectively off-limits to the children.

Fizzy Drink versus Other Drinks

In regular fizzy drinking families/whānau, some parents reported that they and their children did not enjoy drinking water as an alternative. Such families/whānau may have developed a sweet tooth as a result of their drinking and eating habits, and their palates were not accustomed to the relatively bland taste of water. The researchers note that fizzy drink's packaging may have also served to make it more attractive than plain tap water.

> *"Probably we get fizzy drinks twice a week but not as much as we used to … we don't like drinking water."*
>
> **Tongan Female – Christchurch**

In households where fizzy drink was limited, raro, cordial or juice may have been substituted for fizzy drink, in the belief that these drinks were healthier and less sugary. In one family, the parents noted that their daughter had become addicted to her daily cordial drinks, and they had had some trouble *"weaning"* her off them.

For many families/whānau who restricted fizzy drink consumption, water (and milk) had considerable currency as healthy drinks for children to consume (aided by some schools promoting water consumption).

Cultural Differences

Pacific Peoples

Some Pacific peoples in this study were particularly heavy consumers of fizzy drinkers. A number of Pacific families were making efforts to reduce their fizzy drink consumption, in part because of new-found awareness of its high sugar content and link to child (and adult) obesity.

4.3.6 Alcohol

Highlights

- Many families/whānau reported that they drank alcohol sparingly or not at all in their home.
- Parents may have hidden their alcohol consumption (and its effects) from their children in a bid to be good role models.
- Coming to grips with alcohol was seen as a rite of passage for teenagers.
- Many families/whānau were uncertain about how to prepare their children to handle alcohol, and about the risks associated with alcohol consumption.

Attitudes to and the Role of Alcohol

Families/whānau in this study believed that alcohol was something that their children would be confronted with and would need to make decisions about simply as part of growing up. Alcohol was seen as something that teenagers may want to experiment with, and as something that children would need strategies for dealing with as they entered the teenage years.

Many parents were unsure whether and at what age to allow teenagers to drink alcohol at home (if the parents were drinkers), and at what age it should become an acceptable part of young people's socialising away from home.

It was common for participants in this study to report keeping little or no alcohol kept at home. Alcohol was bought as needed for specific occasions, such as a party or barbeque with friends.

A number of alcohol-dependent parents were aware that alcohol was a problem for them, and that their children may be susceptible to alcohol dependency. There were a number of recovering alcoholics, and people who had previously been heavy drinkers, in the study. Recovering alcoholics were often very sensitive to the prevalence of alcohol in their community, with one complaining to her local supermarket because she and her children had to negotiate aisles of alcohol every time they did their grocery shopping.

People who had previously been heavy drinkers reported that they had become more moderate drinkers with age. In some cases, this influenced their attitude toward their teenage children drinking alcohol. They were more likely to see experimentation with alcohol as part of growing up, and excessive drinking as something that their children were likely to grow out of.

Families/whānau in this study who had teenagers in the household recognised that alcohol was something their children must inevitably confront and learn to deal with. Some assumed that their teenagers were already drinking, but were not always sure how to prepare their children to handle alcohol and the risks associated with its consumption. Others were confident that their teenagers were not yet drinking regularly, but were still uncertain as to the best way to safely and responsibly introduce them to alcohol.

Some parents of younger children (i.e. under ten years) who drank little themselves, assumed that their children would eventually follow their example in drinking lightly or not at all. The researchers believe their position is a mix of optimism, complacency and naivety (and has not yet been tested).

Alcohol Practices

- Drinking toward the end of the week – linked to pay-day, the weekend, and work routines – in the company of friends and colleagues. Usually away from home.
- Sharing a drink when friends come over to the house – more likely to be at the weekend.
- At home in the evening – before, with or after the evening meal. Some middle to high income Pakeha and Māori participants reported regularly drinking wine with dinner or an evening snack. Some males also reported drinking beer with the evening meal.
- When going out socially (rather than at home) – this included socialising at venues that served alcohol (e.g. pubs, bars and cafes) and in other people's homes.
- At home on special occasions, such as birthdays or family/whānau 'get togethers' – this may have involved buying in alcohol specifically for the occasion.
- Some recovering alcoholics banned all alcohol from the house.
- Teenagers drinking with their mates at home (this was more likely to be encouraged or tacitly accepted by parents as preferable to teenagers drinking away from home) or at parties and gatherings.

Alcohol Dynamics

- Alcohol-dependent parents were aware that their children may be susceptible to alcohol dependency – as a result they may have been more vigilant and initiated discussion about alcohol with their children.
- Some regular social drinkers did all their drinking away from the house, i.e. not in front of the children (and also avoided the children seeing them drunk or worse for wear after drinking).
- Some parents of teenagers allowed their children to sample the alcoholic drinks that adults were drinking on special occasions, as a way of introducing their teenager to alcohol in a safe setting. However, parents may not have agreed on the age at which teenagers should be introduced to alcohol, which could result in mild parental conflict and a lack of clear rules for teenagers.

  "There is a little wine that their mother will let them have, not me … she will give them a little sip. I'm looking at her, like a stare … like, 'are you serious?' She will be like, 'it's alright, it's just a little sip'. I reply, 'I hope so.'"

  Samoan Male – Wellington

- Some parents of teenagers had agreements in place to minimise the risks associated with alcohol, e.g. that the child would call the parent at any time for a ride home from occasions involving alcohol.
- Some parents of teenagers provided their children with an agreed amount of alcohol so that the parents could control how much and what type of alcohol their teenagers were drinking. Some parents offered to host gatherings and parties for their teenager and their friends for the same reason. The general feeling was that they preferred to know their children were safe while they were drinking.
- Parents of teenagers were concerned about the risks associated with drinking (sexual safety and drink driving) as much as the risks associated with alcohol consumption itself.

Cultural Differences

Pacific Peoples

Some Pacific churches (in this study, churches with Samoan and Tongan congregations) proscribed drinking – church members generally adhered to this within the Pacific community, but may have drunk occasionally in palagi settings such as work social occasions.

One Pacific father commented that it was socially inappropriate for young girls to be intoxicated in public (as well as unsafe). This view was shared by some Asian participants. (It may also be shared by other cultures, but this was not noted in this study).

> *"I don't like them going out at all … because I've seen it myself when I go out. I see women, girls who are highly intoxicated. I see what they do and even though I'm drunk, I'm thinking, 'I don't want my daughter doing that'."*
>
> **Samoan Male – Wellington**

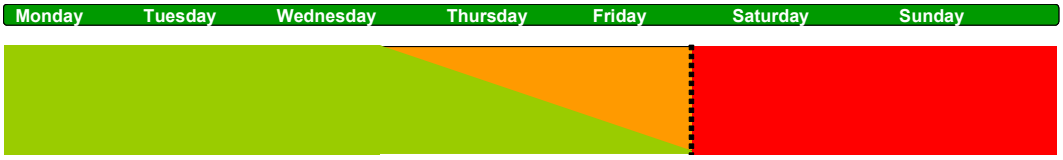
Asian Peoples

Some Chinese women reported that they were easily affected by alcohol, and were very careful to limit their consumption. There was some feeling that it was inappropriate – shameful and embarrassing – for a woman to be intoxicated in a social setting. From this point of view, alcohol was men's business.

4.4 Weekday Versus Weekend Eating Practices

4.4.1 Overview

The diagram below illustrates the overall differences noted in this study between what, and how, people were eating during the week, and at weekends.



Week end eating is different from week day eating – week day tends to be more routine

Gradual slide mid-week towards weekend eating which is typified by less healthy eating - fewer vegetables, less fruit and more quick, convenient options, e.g. takeaways, convenience foods (such as pizzas), McDonalds, Dad cooking

Less routine

Pressure of family/whanau commitments, e.g. sport

Time of relaxation = less scheduled escape from weekday routines – more spontaneous

More special occasion type eating

Family/whanau time

Visitors

Overall, this study found that weekday eating tended to be healthier than weekend eating, which has an element of relaxation, reward and enjoyment attached to it. Weekdays were associated with routines, and time pressure. Weekends for many family/whānau offered a chance to relax weekday routines – this often extended to eating routines and rules.

4.4.2 Weekday Eating Overall

- The weekday routine included simpler breakfasts (continental in style) rather than cooked.
- It was common for children to have fruit as part of a packed school lunch.
- Weekday evening meals were more likely (than weekend evening meals) to be home-cooked, and to include at least some vegetable component.
- As the weekend approached, weekday eating tended to slide in terms of healthy eating – with families/whānau eating fewer vegetables, less fruit, and more quick, convenient meals. Families/whānau were more likely to buy takeaways as the weekend approached.

4.4.3 Weekend Eating Overall

- Weekends tended to be less scheduled than weekdays for many families/whānau. Reflecting this, weekend eating was also more spontaneous, arising out of whatever weekend activities family/whānau members were involved in.
- Weekends often involved socialising with friends and family/whānau, as well as celebration of special occasions. Special foods and treats were typically associated with family/whānau get-togethers.
- Weekends also often involved family/whānau outings, e.g. for sports events, shopping, or just spending time together. Outings often involved meals and snacks bought and consumed away from home – the foods involved were often less healthy than meals and snacks consumed at home during the week.
- Weekends often involved large and high energy breakfasts and brunches, and less formal midday and evening meals than during the week. Vegetables may have been missing from the latter, particularly when fathers were cooking.

The differences between weekday and weekend eating did not apply in all families/whānau. This study found that the common distinctions between weekday and weekend eating were less marked, or non-existent for some family/whānau, because of one or more of the following factors:

- One or more parents did paid work at the weekend, e.g. shift workers and casual workers. For such families/whānau weekday and weekend routines tended to be less differentiated.
- Where there was a homemaker and very small children in the household. For these families, weekend eating routines often closely resembled weekday routines.
- The most committed healthy eaters tended to adhere to established eating routines and rules during weekends as well as during the week.
- The least healthy eaters also made little distinction between weekdays and weekends when it came to their eating practices. Generally, their weekday eating resembled weekend eating (fewer vegetables, more takeaways, more treats, and more use of packaged and convenience foods).

4.5 Food and Drink Preferences

4.5.1 Favourite Foods and Drinks

Within this study, a wide range of favourite foods was nominated by individuals. Providing a list of foods popular with all the people in this study would provide little insight into food tastes, because it would be very long and feature a diverse range of foods.

Instead, we have provided a list of food categories that were commonly nominated as favourite foods. As such, it is indicative of people's tastes, but does not capture the full variety of people's nominated favourite foods.

Children's Favourite Foods and Drinks

- Bakery items such as pies, muffins and croissants
- Biscuits
- Cereals both plainer (e.g. Ricies and Weetbix) and sweeter varieties (e.g. Nutrigrain and Coco Pops)
- Cheese
- Fizzy drink and juice
- Fruit
- Home-cooked meals, such as spaghetti bolognaise, roast chicken, and lasagne
- Instant noodles
- Lollies
- Packaged snacks such as chippies and muesli bars
- Popcorn (microwave packets and air popped with a machine)
- Sandwiches, crackers and rice crackers
- Takeaways such as McDonalds, KFC, fish and chips, pizza, butter chicken
- Water
- Yoghurt.

Children's requests for their parents to buy specific foods included *"fancy"* breakfast cereals and snack foods, such as chippies, chocolate, biscuits, muesli bars and lollies. Usually, children would have seen these products advertised on television. (Sometimes they had seen them in other children's lunchboxes). Children reportedly liked the sweetness of many of the above foods. Some packaged lunchbox snacks also had considerable social cachet.

Despite their focus on sweet foods and packaged snacks, children in this study showed evidence of diverse (and sometimes sophisticated) tastes in terms of the foods they enjoyed eating; and some of them liked their vegetables.

> *"My son loves the 'trees' – the broccoli and the cauli, he calls them 'trees'. He loves peas, I don't think he likes beans. I don't think any of my kids like beans, but everything else. That's why I like Chinese [food] – chow mein, how they have got the vegetables. I think he got hooked on it through the chow mein."*
>
> **Pacific Other Female – Auckland**

Adults' Favourite Foods and Drinks

- Bakery items such as pies, muffins and croissants
- Barbequed and roast meats
- Egg dishes
- Fizzy drinks and energy drinks – for some adults
- Fruit – for some adults
- Home-cooked meals – a wide variety
- Lollies
- Packaged snacks such as chippies
- Seafood
- Takeaways such as McDonalds, fish and chips, pizza, butter chicken and other ethnic dishes
- Vegetables – for some adults (more so for women).

As is evident from the list above, some parents had a taste for sweet and high fat foods, although some tried to keep this in check, or to hide it (because they were aware that they were eating role models for their children). Parents may also have hidden or downplayed their liking for fizzy drink for the same reason.

4.5.2 Less Popular Foods

Children's Unpopular Foods

- Vegetables – for some but not all children. Some children disliked some vegetables but liked others – there was no clear pattern to this (although parents reported that children often rejected 'new' vegetables on first tasting them). However, these foods may have become an acquired taste if parents had kept offering them (some made a point of doing so, others stuck to vegetables they knew their children would accept). Potatoes did not count as vegetables in this context
- Spicy or hot food.

Adults' Unpopular Foods

- Vegetables – some parents emphasised the importance of vegetables while eating relatively few vegetables themselves. Fathers in particular may have avoided or refused to eat certain vegetables, despite the children being expected to eat them. Parents often commented that a taste for vegetables was best acquired in childhood. Some adults who disliked vegetables grew up in families that did not cook many vegetables, or did not insist on children eating them. Again, potatoes did not count as vegetables in this context, with few adults rejecting them on taste grounds.

4.5.3 Foods and Drinks that were Encouraged

Parents and caregivers routinely encouraged children to eat certain foods or food groups by telling them that these foods were *"good for them"*. Chief among foods that were promoted to children as healthy were:

- Fruit and vegetables – some people emphasised the vitamins and minerals found in fruit and vegetables. Other people simply knew they were healthy foods, but were not sure exactly why, beyond that they were not fattening (with some exceptions, such as bananas and potatoes, which some people perceived as potentially fattening).
- Water, particularly in favour of sweetened drinks such as fizzy drink and cordial. Some people included juice in this sweet drinks category.
- Meat and dairy products, particularly milk. These were regarded as healthy for their protein content, and for the calcium found in milk.

However, despite many families/whānau considering these as healthy foods, some parents regarded dairy products as foods that could be potentially unhealthy if too much was eaten (because of their fat content). A few parents also considered fruit potentially unhealthy on account of their belief that it had a high sugar content. Fatty meats were also considered potentially unhealthy, but reactions were generally to visible rather than hidden fat.

Many parents and caregivers also encouraged foods that they perceive to be nutritious by virtue of having fibre (e.g. whole grain breads).

4.5.4 Foods and Drinks that were Limited

Many parents and caregivers limited certain foods because they perceived that eating them too often, or eating too much of them at a time, could be unhealthy. Chief among foods that were limited for these reasons were:

- Fatty foods, such as pies, fatty meat, hot chips, chippies, cakes and biscuits – because they were high in fat content and considered fattening. Note: Indian participants limited deep fried Indian foods, such as samosas, puris (small deep fried chappatis), tikkis (deep fried potato patties) and bhajjyas (onions or potatoes that were mixed in garam flour).
- Sweet fatty foods may have also been limited because of their sugar content.
- Fizzy drinks – because of their high sugar content.
- Lollies – because of their high sugar content.
- Sweet foods, such as biscuits, sweet cereals, sweet lunchbox snacks such as 'strings' because they had a high sugar content.
- Takeaways – which were widely regarded as being high in fat content and fattening.

Fat was linked to being overweight, and to a lesser extent with future health problems (such as heart disease). Sugar was linked to tooth decay, weight gain, and to children getting *"hyper".*

> *"My eldest mokopuna has tooth decay and my second one has tooth decay already – that comes from all the sugary food and junk."*
>
> **Māori Female – Gisborne**

However, some parents and caregivers considered sweet lunchbox snacks such as muesli bars and 'strings' to be healthy alternatives to other sweet foods (such as chocolate biscuits and lollies).

Some parents and caregivers also believed that, provided their children were not clearly overweight, there was little or no need to limit their consumption of high fat foods.

4.5.5 Cultural Differences

Māori

Many Māori parents and grandparents included boil-up among their favourite foods. Boil-up was usually boiled meat such as pork bones, brisket, meat flaps with puha, watercress or cabbage and potatoes.

However, consumption of boil-up was also often limited because of its fat content, with whānau reserving it for special occasions. Many Māori adults in this study said they enjoyed boil-up. For many it was food they had grown up with, and it was regarded as an economical way to feed a lot of people.

Some of the younger Māori parents were not so keen on boil-up, and did not prepare it for their own whānau.

Māori whānau were also likely to nominate seafood, e.g. shellfish, crayfish, paua, mussels and kina as among their favourite foods.

Pacific Peoples

Pacific peoples in this study also talked frequently about boil-up. As with Māori, there was something of a generational split among Pacific peoples regarding the popularity of boil-up. Many younger Pacific parents reported that they and their children did not particularly like boil-up, and that they did not cook it at home.

However, older Pacific peoples often included boil-up as a favourite dish. Many Pacific parents noted that their own parents enjoyed boil-up and it was therefore often on the menu for special occasions, as well as for regular shared Sunday lunches with grandparents, uncles, aunties and cousins.

5.0 Understanding and Achieving Healthy Eating

This section of the report explores the meaning of healthy eating, attitudes to healthy eating, including perceived benefits and drawbacks of healthy eating and levels of concern about healthy eating, and what factors were perceived to support and work against families/whānau eating healthily. It also outlines awareness of, and attitudes towards, the Government being involved in promoting healthy eating and addressing the issue of obesity among New Zealand families/whānau.

5.1 The Meaning of Healthy Eating

Participants were asked what healthy eating meant to them. Their responses covered perceived signifiers of healthy eating (i.e. what constituted healthy eating), indicators of healthy eating (i.e. how one could judge it), as well as the perceived benefits of healthy eating (i.e. the pay-offs).

Signifiers of healthy eating were foods and eating practices, as identified by participants, whose inclusion (or exclusion) signalled that a diet was generally healthy, or not. For example, the inclusion of fruit and vegetables was widely regarded as a signifier of healthy eating.

Indicators of healthy eating were visible or tangible effects of having a healthy diet, as identified by participants, such as having plenty of energy or not being overweight. The benefits of healthy eating included both tangible effects (e.g. not being overweight) and also less tangible, future-focused effects (e.g. being less likely to get cancer).

5.1.1 Signifiers

Signifiers of healthy eating centred mainly on the type of food eaten, having a balanced diet, eating in moderation and, in a minority of cases, how food was cooked.

This study found that two key signifiers of healthy eating from participants' perspective were the inclusion of fruit and vegetables in one's diet. As mentioned earlier in this report (see Section 4.3.3 – Vegetables and Section 4.3.4 – Fruit) there was high awareness of the *'five plus a day'* message. Even if this tally was not achieved on a daily basis, many people felt that members of their family/whānau were eating healthily if fruit and vegetables featured in their diet for at least part of the week (even if just on a few days).

While fruit and vegetable consumption was usually the first response to the questions about what constituted healthy eating, participants also identified other signifiers of healthy eating. Limiting the consumption of (obvious) sugar (e.g. biscuits, lollies and fizzy drink) and (obvious) fat, e.g. fatty meats, fried foods, takeaways (excluding healthier varieties such as Subway) were also common signifiers of healthy eating. Over-indulging in sugar or fat was associated with contributing to poor physical health for the following reasons:

- Sugar consumption was associated with tooth decay, especially in children, and weight gain in both adults and children. A couple of families/whānau in this study had children aged under seven years who had had at least one tooth removed because of decay, and had been advised by their dentist to eliminate fizzy drinks from their diet to protect their children's teeth.
- In participants' minds, a higher fat intake was linked to potentially becoming overweight (or obese), having an elevated cholesterol level and running the risk of developing a heart problem.

Note: Participants were typically less conscious of hidden sugar and fat when considering what constituted healthy eating. For example, fruit juices may have been considered healthy because of their fruit content, and the added sweeteners (sugar) in them may have gone overlooked.

The inclusion of meat and dairy products (particularly milk for children) in a diet were also seen as signifiers of healthy eating because of their protein content and the calcium content of dairy products. However, to qualify as being 'really' healthy, these foods also needed to be of a lower fat nature. For example, to avoid unhealthy eating, there was a perception that fatty meat (e.g. sausages) should be eaten occasionally rather than regularly, meat should have little visible fat, and tasty morsels such as the skin on roast chicken and crackling on roast pork should be relegated to the waste-bin instead of being savoured on the dinner plate (although this was difficult, if not impossible, for some people to do). Similarly, many participants recognised that low-fat dairy products were healthier than their fuller-fat counterparts.

Consuming foods made from less processed products signified healthy eating for many people. For example, breads made from wholemeal or rye flour and containing whole grains or seeds equated with healthy eating. In contrast, white bread with its base of highly processed flour was seen as more nutrient-depleted and therefore a less healthy option (although it was the bread of choice for some people who preferred its taste over that of *"brown bread"*).

Organic food was associated with healthy eating by some people because the food was seen to be uncontaminated by chemical fertilisers and sprays. For example, one Tongan family regularly consumed taro imported 'from the islands' on the basis that it had been grown without chemical aids. They perceived this to be healthier than eating commercially grown New Zealand produce, which was assumed to be grown with the aid of chemicals and was therefore less healthy.

Sufficient daily water intake was seen by many participants as part and parcel of a healthy diet. The 'eight glasses of water a day' mantra was frequently cited as important for flushing toxins out of the body and preventing dehydration.

Having a balanced diet was commonly associated with healthy eating, however it was a poorly understood concept. It appeared that the traditional meaning of 'balance' at the overall diet level, and particularly at the individual meal level, had been eroded. (For example, some participants appeared to have little awareness of protein, starch and vegetables as constituent parts of a balanced meal).

A common view of 'balance' in this study was that, as long as some healthy foods were eaten some days of the week, it was acceptable to eat less healthily on the other days. For example, some families/whānau ate vegetables from Sunday to Wednesday and perceived that this level of intake was sufficient to carry them through the week (i.e. their attitude could be summed up with the phrase 'it balances out overall'). The researchers suggest it is possible that the weight of diet information, food industry marketing, and contradictory health messages in the media have contributed to eroding the traditional meaning of a balanced diet. Note: Women were more likely to consider the balance of individual meals than men. When they did so they talked about balance in terms of the mix of protein, carbohydrate (e.g. potatoes, rice and pasta) and vegetables on the plate.

While eating in moderation was frequently cited as part of healthy eating, many people were unable to explain what it meant. In the absence of such knowledge, people created their own meanings, e.g. relating to portion size and/or frequency of consumption.

Choice of cooking method also played a role for some participants in determining whether food was considered healthy or otherwise. Cooking methods that excluded the use of fat or oils, e.g. steaming, boiling, grilling and baking, were perceived to make for healthier eating, whereas those that used fat and oils, e.g. roasting and frying, were not. Some people were aware of fat substitution as a means of healthier eating, e.g. substituting olive oil for butter.

Consuming food that was not over-cooked, primarily vegetables, was part of healthy eating for some people because the nutritional value of the food was retained. Over-cooked vegetables, on the other hand, were seen as having less nutritional value because the goodness was leached out of them during the cooking process.

Cooking from scratch was synonymous with healthy eating for some people, their rationale being that they 'knew what went into' their food, and it was free of additives and preservatives – other than the ingredients they themselves used.

5.1.2 Indicators of Healthy Eating

A number of indicators of healthy eating were identified by participants in this study, as outlined below. Note: There was some overlap between the perceived benefits of healthy eating – outlined in Section 5.2 – and indicators of healthy eating. As mentioned earlier, indicators were seen as the visible or external effects of healthy eating, whereas benefits were associated with tangible and less tangible pay-offs of healthy eating, e.g. avoiding heart disease. Indicators of healthy eating noted by participants included:

- Family/whānau members appeared to be physically healthy, i.e. they did not exhibit any obvious or known signs of being physically unwell.
- Family/whānau members did not easily succumb to sickness and/or recovered quickly if they did become unwell – this was often attributed to having a *"good"* immune system.
- Family/whānau members were not overweight or obese. People's definition of what constituted a weight problem varied, with some adult participants being quite tolerant of carrying a bit of extra weight themselves (i.e. while they may not have seen their weight as ideal, they would not have classified themselves as being in poor health because of it).
- Family/whānau members had sufficient energy. Parents in this study often cited their children having plenty of energy as evidence that the children were sufficiently healthy, regardless of the quality of their diet.

5.2 Benefits and Drawbacks of Healthy Eating

Participants were asked about the perceived benefits and drawbacks (or 'costs') of healthy eating for their family/whānau.

5.2.1 Perceived Benefits of Healthy Eating

Some of the benefits of healthy eating identified by participants were also noted as indicators of healthy eating (see earlier), i.e. tangible, visible effects such as not getting sick often. Note: Because some perceived benefits of healthy eating were not immediately tangible (or visible) to participants, they may have been given less importance than indicators that participants could point to as evidence that their diet was 'healthy enough'. For example, some participants placed little importance on future-focused concerns such as a reduced risk of developing cancer, and more importance on the fact that family/whānau members were not overweight and appeared to have plenty of energy.

Health-related Benefits of Healthy Eating

The benefits of healthy eating noted by participants were primarily health-related. These included:

- Enjoying good physical health, i.e. not having any obvious or known signs of being physically unwell.
- Not easily succumbing to sickness, and being able to recover quickly from any illness.

> *"We [the whānau] are pretty active and healthy. It means that we don't get sick or if we do we can bounce back pretty quickly."*
>
> **Māori Male – Gisborne**

- Being able to improve, or effectively manage a health condition. For example, one Tongan mother in this study (who was overweight and whose family had followed a traditional Pacific diet) had changed the family's diet on medical advice after she suffered a major heart attack. As a result of these changes she had lost a substantial amount of weight and was now considered a low health risk by her doctor.
- Providing protection against potential future health problems (as yet unseen and undiagnosed), e.g. reducing the likelihood of developing life threatening conditions such as cancers or heart problems.

- Not being overweight or obese (as noted earlier, people's ideas about weight varied, with some adults quite tolerant of carrying a few extra pounds and not seeing this as a health problem per se). Adults did tend to be more concerned about children carrying extra weight, but again notions of what was normal and what was too heavy varied. (As noted already, some cultural differences were evident in this matter, with Pacific peoples more inclined to regard well-covered children as healthy).
- Helping to achieve and maintain weight loss, where this was deemed desirable or necessary (e.g. based on a doctor's advice).
- Having plentiful, or at least sufficient, energy. It was common for parents in this study to cite their children's high energy levels as evidence that they were sufficiently healthy, regardless of the quality of their diet.

  "Better health, better energy to do what you need to do. I think the fatty stuff and the sugary stuff tends to slow you down."

  Pakeha Female – Auckland

- Helping keep 'hyper' children calm. Some participants perceived that eliminating (or at least limiting) the consumption of preservatives and food colourings helped to keep hyper children on a calmer, more even keel. Some parents had come to this belief through a process of trial and error in an attempt to control a child with attention or behaviour problems. Some adults also simply liked the idea of their family/whānau eating food that was closer to its natural state.
- Feeling virtuous. Some parents reported the mental benefit of feeling virtuous as a result of providing their family/whānau with healthy food. It reinforced their own belief, and signalled to others, that they were *'a good parent'.*
- Feeling 'cleaner on the inside'. Some participants reported feeling *'cleaner'* on the inside through treating their body well, i.e. with healthy (as opposed to unhealthy) food.

  "Your insides are clean and you don't get sick. You are never in pain or something. If you are sick you heal faster."

  Pacific Other Female – Auckland

Cost-related Benefits of Healthy Eating

A minority of participants also identified some cost-related benefits of healthy eating.

Eating healthily was a cost saving in the minds of some people, not necessarily because healthy food was cheaper,[16] but because it reduced the amount of money spent on doctors' bills, and the amount of time off work on sick leave.

Others believed that a healthy diet generally worked out cheaper than an unhealthy diet, because the latter included highly processed and heavily marketed snack foods and convenience foods that were not necessary as part of a healthy diet.

Providers, in particular, believed it was cheaper to eat healthily than to eat unhealthily, by accessing fruit and vegetables close to source (e.g. from orchards and markets) or growing their own, and by avoiding often expensive packaged and processed convenience foods.

> *"I think we're probably in the top twenty percent [of healthy eaters] I'd say … Probably [because we] can't afford the crap! … If you go to South Auckland they blame poverty as being a reason people don't eat healthily, which seems a bit weird to me."*
>
> **Pakeha Male – Wairarapa**

Apart from the cost savings to individual households, some participants held the view that New Zealand was better served as a country on the economic front if production levels were maintained through reduced sickness levels.

No Perceived Benefits

A small number of participants reported that they saw no benefits in eating healthily. These participants tended to fall into the Avoider or Inert segments (see Section 8.0 – Audience Segmentation in this report).

> *"[Benefits of healthy eating?] I have no idea. We sort of take what we get and we don't really make a conscious effort. Well apparently it makes you feel better but so does exercise apparently. I don't do that either."*
>
> **Pakeha Female – Auckland**

[16] There was evidence in this study of lower socio-economic status participants eating healthily and cheaply.

"The biggest thing is not so much what people are eating these days, it's the fact they are sitting in front there [television] and not getting the exercise to go with what they are eating."

Pakeha Male – Auckland

5.2.2 Perceived Drawbacks of Healthy Eating

Participants were also asked whether they saw any drawbacks to healthy eating. Drawbacks identified by participants included perceived financial cost, as well as perceived 'costs' associated with time, effort and enforcement of healthy eating practices.

Cost-related

Some families/whānau perceived healthy eating to be expensive in terms of the cost of food. This was a key barrier to some families/whānau who were on tight budgets (who were often more concerned with filling stomachs than the quality of food) adopting healthier eating behaviours. Healthy food appears to have gained a reputation as being expensive because of its association with, for example, lean cuts of meat and fresh fruit and vegetables.

In some cases the association with organic food had fuelled ideas about healthy eating being an expensive business. For others, the calculation of price per calorie or per full stomach came out with fruit and vegetables costing much more than a spread of fish and chips or other takeaway foods.

"It is more expensive to make your kids healthier [i.e. have them eat more healthily] and you get smaller quantities as well. Junk food – you get big bags of chips, and you get healthier food and its smaller quantities and it's more expensive."

Pakeha Female – Auckland

Time and Effort-related

Another drawback identified with healthy eating was that it was seen to require time, effort, planning, commitment and persistence to implement and maintain. More thought had to go into planning meals and even at the snack level, food was more time consuming to administer – for some it was quicker and easier to hand out a pre-packaged snack than to peel fruit. In the time-scarce world that many people lived in, these factors worked against their family/whānau eating more healthily.

Lack of Taste

A further drawback for some participants was that they perceived healthy food as synonymous with food that tasted 'boring and bland'. For these people, incorporating more healthy food into the family/whānau diet would have meant sacrificing the 'yummy' tastes of less healthy foods, e.g. those with a higher fat, salt and sugar content.

Potential Disruption to Household Harmony

A significant drawback of healthy eating identified by many participants was the emotional conflict that trying to instil healthier eating habits in the family/whānau could create. Resistance to adopting healthy eating habits, either by a partner (referred to by the researchers as *partner drag*) or children in a household, could take an emotional toll on the person responsible for feeding the family/whānau. From this perspective, the perceived benefits gained from healthy eating were often outweighed by the desire to avoid conflict and achieve harmony in the family/whānau.

5.3 Level of Concern About Healthy Eating

5.3.1 Overall Level of Concern

This study found that levels of concern about healthy eating ranged widely from family to family, with no clear coalescence of feeling at one or other end of the spectrum. Overall, a greater number of families/whānau reported low or moderate levels of concern, rather than high levels of concern, about healthy eating as an issue for their family/whānau.

However, attitudes toward healthy eating varied widely. Participants in this study could be broadly grouped into six segments on the basis of their eating attitudes and behaviours about healthy eating. These segments are based on the in-depth interviews carried out with individual family members, and are outlined in Section 8.0 – Audience Segmentation.

Briefly, the six segments, and their relative levels of concern around healthy eating, were:

- **True Believers** – these individuals expressed relatively high levels of concern around healthy eating because they saw diet as central to the health and well-being of their family/whānau, and one means of enabling their children to maximise their potential. Their children were among the healthiest eaters in this study. True Believers were active information seekers and kept themselves abreast of new information about what did and did not constitute a healthy diet.
- **Providers** – these individuals tended to be only moderately concerned (or relatively unconcerned) about healthy eating, despite their children being among the healthiest eaters in this study. Providers kept the diet of their family/whānau simple, with a focus on home-cooked (and often home-grown) foods, and limited use of takeaways and convenience foods. Their focus was on using the food resources they had around them, e.g. produce from their garden, fruit from the local orchard, freshly caught fish, or meat from a neighbouring farmer. They experienced considerable pride in being able to provide for their family/whānau (and, importantly for some Providers, being able to keep their food budget down).

- **Convertees** – these individuals had a new-found concern about healthy eating because they were trying to improve the diet of their family/whānau and to eliminate or reduce old bad habits. In some cases, this involved distancing themselves from less healthy eating patterns they had grown up with. Convertees were eating more healthily than in the past, and had become active information seekers in their quest for a better diet.
- **Complacents** – these individuals were relatively unconcerned about healthy eating, because they believed that they and their family/whānau was doing okay and had a 'healthy enough' diet. Their children were not among the healthier eaters in this study, but their parents might be surprised to learn this. When they examined their eating practices in this study, they were sometimes surprised at the amount of less than healthy food that had crept into the diet of their family/whānau.
- **Avoiders** – these individuals may be moderately concerned about healthy eating (although some would deny it), but were resistant to healthy eating messages because they were not convinced that healthy eating really made a difference, and they were loathe to give up the less than healthy foods they enjoyed. They may have cited their good health and lack of weight issues as evidence that their diet was fine.
- **Inerts** – these individuals were unconcerned about healthy eating because it was not on their radar. Getting their children to eat something, and having enough food to put on the table, were higher priorities than the nutritional quality of the foods they were eating. These individuals were not active information seekers, and they found it hard to sort through the many conflicting messages about food in the media. Most simply did not try to do this.

5.3.2 High Concern – Influencing Factors

Families/whānau in this study who expressed high levels of concern around healthy eating recognised that healthy eating plays a role in maintaining good health. Parents in these families/whānau perceived that eating a healthy diet was one way of helping family/whānau members, and particularly children, to maximise their potential. The segments most concerned about healthy eating were True Believers and Convertees.

The most concerned and conscious healthy eaters in this study saw healthy eating as one of the building blocks contributing to the overall quality of life for their family/whānau. From this perspective, the healthy eating equation went thus: if family/whānau members ate well they were less likely to succumb to illness and disease, and more able to bounce back quickly from any illnesses; they would have more energy, and would be better able to tackle life's challenges and to reach their potential.

Parents in such families/whānau emphasised the importance of their children eating well in terms of them fulfilling their potential – getting the best possible start in life. Adults, although often less careful with their own diets, may have regarded their own diet as important to the extent to which it enabled them to be around for their children, and grandchildren.

Some of these families/whānau had a new-found interest in healthy eating as a result of struggles with ill-health or chronic health conditions. They had come to the realisation – sometimes with prompting from their doctor – that they needed to eat more healthily as part of overcoming or managing their health issues.

Many Māori participants talked about the health concerns that had been prevalent in their whānau through many generations. Diabetes, heart conditions, and high blood pressure were all mentioned. For some, these were talked about as part of the whānau history – where older members of the whānau were sick with one or more of these conditions.

Recognising that these conditions were 'in the whānau' provoked different reactions. Some Māori were actively becoming fitter and eating more healthily so that they did not get sick in the future. For example, the grandparents in one whānau had high blood pressure and cholesterol levels and had done a stock-take of their eating habits, stopped smoking and started exercising regularly. Apart from personal health benefits, the underlying driver for these behavioural changes was the strong desire to be around for mokopuna and for each other.

5.3.3 Low Concern – Influencing Factors

The segments least concerned about healthy eating were Complacents and Inerts. Providers were moderately concerned about healthy eating but it was not their main focus, while Avoiders may be moderately concerned but were generally resistant to healthy eating messages.

Some families/whānau who were relatively unconcerned about healthy eating focused on weight as an indicator of whether the eating habits of their family/whānau were healthy or not. Some relatively unconcerned participants believed that. provided family/whānau members were not obviously overweight, their diet must be healthy enough.

These parents judged the nutritional value of their physically active children's diets on the basis of whether they were expending the energy they were taking in, rather than on the nutritional value of what the children were eating and drinking. These parents also reasoned that as long as their children had plenty of energy, their diet must be adequate.

Some participants who were relatively less healthy eaters saw physical activity as more central to good health than eating habits. This perspective was in part a rationalisation that allowed them to continue some of their less healthy eating habits, but it also harked back to the notion that in their grandparents' day, people ate many of the things now considered unhealthy without putting on weight because they were more active.

Some family/whānau had relatively low levels of concern about healthy eating because the parents were replicating the eating practices and behaviours they had grown up with, and perceived that these were relatively healthy (Complacents). In some cases, the diet of the family/whānau may actually have been less healthy than it appeared, as convenience foods and treat foods that were not available when the parents were young had established themselves as regular features in the diet of their family/whānau.

In some relatively unconcerned families/whānau, their diet was focused on simple, traditional, home-cooked (and sometimes home-grown) food, which they presumed to be healthy because takeaways and convenience foods did not play a large part in the mix (Providers).

Other relatively unconcerned families/whānau simply did not give healthy eating much thought (Inerts). In their scheme of things, eating healthily was less important than finding food that was affordable and acceptable to them and their children. Some Māori and Indian families fell into this group.

In some cases with Māori participants, there was a whānau history of health conditions which they acknowledged but were taking a wait-and-see approach toward. Māori whānau in this group tended to be in lower socio-economic groups, where the cost of food rather than its quality was the key factor.

5.3.4 Cultural Differences

Some cultural differences in attitudes toward healthy eating were noted in Pacific and Asian families in this study (as compared with the sample as a whole). Few differences were found between Māori and Pakeha families/whānau and the rest of the sample.

The researchers note that differences in attitudes toward healthy eating often appeared to relate to upbringing, education, and socio-economic status (as opposed to cultural factors).

Pacific Peoples

Some Pacific families in this study expressed high levels of concern about healthy eating, fitting into the Convertees segment. These families were working on improving their diet, and were sometimes consciously moving away from what they saw as unhealthy, traditional Pacific eating practices (such as boil-ups, corned beef, and little emphasis on vegetables other than taro).

One Pacific father noted that he had been exposed to healthier eating practices through his Pakeha work colleagues. His daughter reported that it was typically the *"white"* girls at her college who had vegetables and hummus for lunch, but that they were also more likely to be exhibiting disordered eating behaviour, such as taking laxatives or vomiting to control their weight. (She noted that this behaviour was starting to influence the attitudes and behaviour of some Pacific girls at her school, who were self-conscious about their larger, heavier bodies).

Pacific families were also found in the Complacents, Avoiders, and Inert segments. Some Pacific peoples in the latter two categories felt trapped in unhealthy eating practices influenced by both culture and genetics – they believed that Pacific peoples were predisposed to like unhealthy, fatty food. They may have made attempts to eat more fruit and vegetables, or to reduce their intake of food they knew was not so healthy, but at some level they appeared to believe that any change was going to be temporary, and that they were fighting their genes and culture, i.e. they had a fatalistic attitude to their future health in general. As a generalisation, these Pacific families tended to be less well informed about health matters and questioned the credibility of some health messages.

There was a tendency among Pacific families to expect healthy children to be well covered, with a couple of Pacific mothers expressing concern that their children did not have enough 'meat on their bones'. Some Pacific peoples were rethinking this traditional Pacific belief and, as a result, were encouraging portion control (as well as involvement in sport) to combat a tendency to be overweight. However, attempts to restrict a larger child's food intake could create conflicts between parents, or between parents and grandparents. (The researchers note that willingness to redefine notions of healthy body size may be linked to education, and was more prevalent among younger, New Zealand-born or raised Pacific adults).

Asian Peoples

Asian people were found in the True Believers, Complacents and Inert segments.

Chinese

Chinese families in particular expressed high levels of concern regarding healthy eating because they believed it was central to having a healthier life. The Chinese women in this study (True Believers) incorporated western-style foods into their diets, but their diets emphasised traditional Chinese cooking. They typically placed more emphasis on fresh vegetables as an integral part of meals, not just dinners, and were using a wider variety of vegetables than many other participants. They did much of their cooking 'from scratch' because this was part of Chinese culture.

Some Chinese women mentioned that traditional Chinese ways of cooking were high in salt, and that exposure to western food had highlighted this and influenced them to attempt to cut down on salt in their cooking.

Indians

Indian families ranged from expressing high to low levels of concern about healthy eating. Those with a high level of concern were working on improving their eating habits and *unlearning* unhealthy Indian eating practices (e.g. reducing their intake of deep fried snacks and curries, and substituting saturated fats with healthier options). Migrants had typically had their awareness of 'healthier eating options' raised since arriving in New Zealand.

Some Indian mothers reported that they made a conscious effort to cook their traditional dishes in more healthy ways, for example, using less ghee or oil than a traditional recipe might call for, and grilling or baking food such as samosas in preference to deep frying.

In contrast, Indian participants with low levels of concern about healthy eating were replicating the eating practices and behaviours they grew up with, and perceived that these were relatively healthy. In some cases, a family's diet may be less healthy than they perceived it to be, e.g. because of the inclusion of convenience foods like deep fried snacks such as samosas and bhajyas.

5.4 Achieving Healthy Eating

This section of the report explores factors perceived by families/whānau to support and work against healthy eating occurring in their families/whānau. It also explores parents and caregivers' self-efficacy in ensuring healthy eating in their families/whānau.

5.4.1 Factors that Support Healthy Eating Within Families/whānau

In this study a number of factors, internal and external to families/whānau, were identified as supporting healthy eating. The extent to which any of these factors (discussed below) was not present in a household reduced the likelihood of healthy eating occurring in that household.

Factors Internal to Families/whānau

- Where parents had a strong belief in the benefits of healthy eating (e.g. because of the perceived short and long term health benefits it provided for their family/whānau), they were typically committed to ensuring that their family/whānau ate healthily, if not all the time, then certainly most of the time (some relaxation in healthy eating was considered permissible for special occasions such as birthdays). These parents made the time to plan and prepare healthy food, and implemented and consistently enforced healthy eating rules. Having one parent (or two parents) in the household who 'took a stand' for healthy eating and who consistently followed their words with actions, not only provided a powerful role model for healthy eating to other members of the family/whānau, but signalled to them that the situation regarding healthy eating was 'not negotiable'. The researchers note that, where healthy eating rules were consistently applied, children tended to become self-regulating in terms of healthy eating.

  However, having a personal belief in healthy eating was necessary, but not sufficient, to ensure healthy eating in families/whānau. A critical element was having a parenting style that set goals and rules generally, and particularly in relation to healthy eating. Parents in this study who operated as outlined above could be found in the True Believer and Convertee segments.

- A parent who was promoting healthy eating and who had a partner who 'backed' him/her, was operating in a supportive environment. Such parents approached eating for their family/whānau from a positive mindset because they knew that they could count on the support of their partner to uphold the ideals of healthy eating if the going got tough, e.g. if children became tricky about eating certain types of food. Receiving such support from a partner reinforced healthy eating beliefs and behaviour and made it easier to continue with a healthy eating approach than would have been the case if there was little or no partner support. Teamwork between partners was, therefore, important in supporting healthy eating in households. Partner support enhanced the self-efficacy of the partner promoting healthy eating.
- Parents needed to have knowledge about healthy (and unhealthy) eating in order to feel confident about making the right, i.e. healthy, choices when selecting food for their family/whānau. Participants in this study who felt particularly knowledgeable about healthy eating were True Believers, and to a lesser extent, Convertees (as mentioned these participants were relatively new to healthy eating and were still building their knowledge about it). Where parents had knowledge about healthy eating, and the skills to successfully apply healthy cooking methods, e.g. steaming, boiling, grilling and baking, they were able to serve a variety of healthy, tasty meals to their family/whānau. Such meals were typically prepared with minimum fat, sugar and salt and other additives and preservatives.
- Having easy access to fresh produce made it easier for some families/whānau to incorporate fruit and vegetables into their diets because the time and effort required to do so was not too onerous. Rural dwellers in the Provider segment typically accessed home-grown produce either from their own garden or that of another family/whānau member. While some urban Providers grew their own vegetables, others took advantage of being able to access fresh produce from nearby produce markets, farmers' markets or market gardens. 'Easy access' (to fresh produce) therefore was a factor that supported healthy eating in some families/whānau in this study. Some participants commented that produce purchased from market-type sources was more competitively priced than that available from retail outlets such as supermarkets and fruit and vegetable shops. Having easy access to competitively priced produce also helped some families/whānau to eat more healthily, while also managing their food budget.

- For a minority of participants in this study, being able to understand and accurately interpret nutritional information on food packages was seen as a crucial part of making healthy food choices for their family/whānau. By understanding what levels of fat, salt and sugar in food items were generally regarded as acceptable in terms of being healthy, they felt they had the confidence to make more informed and healthy foods choices for their family/whānau.

Factors External to Families/whānau

- Healthy eating messages such as *'five plus a day'*, and those coming home from schools (and in a few instances from pre-schools) had played an important role in supporting some families/whānau to eat healthily. These messages provided an ongoing reminder of the need to eat healthily. For those whose family/whānau typically ate healthily, these messages reinforced that they were 'doing the right things' and this, in turn, contributed to continuation of healthy eating. For those whose family/whānau may not have been eating so healthily, such messages had raised awareness of the need to eat more healthily and, in some instances, had been a call to take action on this front. The researchers comment that while (some) healthy eating messages could 'make a difference', many may not have because of the sheer volume and often conflicting messages they gave. For example, Inerts found it hard to sort through the many messages about food in the media (some of which they perceived to be conflicting), and most simply did not try.
- School rules about what must be excluded from lunchboxes (e.g. chocolate, lollies and any drinks except for water) were an ongoing reminder that kept parents and caregivers focused on providing healthy items in lunchboxes. Some parents and caregivers (especially those from households that ate at the healthier end of the scale) valued schools having rules about lunchbox content because it created a 'home – school' partnership that supported families/whānau to eat healthily.
- The marked increase in the range of pre-prepared healthier food options over the last few years was empowering for some parents and caregivers, especially those working under tight time constraints. With the advent of healthier options such as Subway, ready-made sushi, pre-prepared fruit salads (in containers) and washed and peeled baby carrots, parents and caregivers no longer had to rely on less healthy meal and snack options, and this helped to support them with ensuring their family/whānau ate healthily.
- Easy access to cheap fruit and vegetables – discussed above under internal factors.

- A number of instances were noted in this study where advice from a general practitioner had led to positive dietary changes being made in families/whānau. While a general practitioner's advice may have been directed at one family/whānau member (e.g. a Convertee following a health scare), dietary changes that were made applied for the whole family/whānau. This occurred because general practitioners had successfully communicated the link between having a healthy diet and being able to enjoy better health, and recipients of the information saw the benefits of this for their whole family/whānau, not just themselves.
- Print communications in women's magazines, health and diet magazines and various pamphlets in doctors' waiting rooms provided some parents and caregivers with information about healthy eating. While they may have gained additional knowledge about healthy eating and tried some healthier eating recipes for family/whānau meals, participants indicated that print communications tended to be less effective in supporting their families/whānau to eat healthy (e.g. than advice from a general practitioner or schools having rules about lunchbox content) because of the often conflicting messages they gave.
- As mentioned later (see Section 7.2.2 – Messages that Supported Healthy Eating), friends and work colleagues were also considered a useful source of information on healthy foods, healthy eating options, and recipe and meal ideas. One male in this study reported that, his ideas about healthy eating and exposure to unfamiliar, healthy foods, had been expanded by listening in on his female colleagues' regular discussions. This had resulted in him implementing some healthier eating options in his family.
- While breakfast being provided by some schools was cited by some participants as supporting children from less affluent families/whānau to potentially eat more healthily, there was no evidence in this study of participants' children receiving breakfasts provided by schools.

5.4.2 Factors that Work Against Healthy Eating Within Families/whānau

In this study a number of factors, internal and external to families/whānau, were identified as working against healthy eating in families/whānau. The extent to which any of the factors (discussed below) was present in a household reduced the likelihood of healthy eating occurring in that household.

Factors Internal to Families/whānau

- Habits learned in childhood were influential in terms of the type of eating that occurred in adulthood. Where unhealthy eating habits learned in childhood were not broken in adulthood, families/whānau tended to continue with them. This occurred through wanting to stick with what was familiar (because the food tasted good) or not having an appreciation of what constitutes healthy eating and what benefits it provides. In this study unhealthy eating habits carried over from childhood included consumption of fattier types of meat (e.g. sausages), takeaways, fizzy drinks and lollies, and – in some instances – a low intake of vegetables.
- Many participants felt they lived in a time-scarce world and were constantly juggling a number of commitments, e.g. running a home, working, and getting children to their various out-of-school activities. Lack of time meant that some people opted for convenience foods (including takeaways) and quick meal options (e.g. assembling meals through combining mince or chicken with sauce out of jars) because they helped to free-up time. Some participants had the perception that healthy food was time consuming to prepare because of its association with cooking 'from scratch' and avoided it for this reason.

  "Half the week we're lucky to get home by seven … anything that takes too long is just out. It's just not going to happen."

  Pakeha Female – Auckland

- In some families/whānau parents were reluctant to enforce healthy eating behaviours because of the potential (and in many cases real) conflict this caused in the household. The goal of many parents and caregivers was to have a happy, harmonious atmosphere in the home, and anything that threatened this was weighed up carefully to consider whether the pay-off was worthwhile. While some parents were willing to 'tough it out' and enforce healthy eating in their family/whānau (e.g. True Believers), others (e.g. Complacents) prioritised peace and harmony and were not prepared to 'take on the battle' to make healthy eating happen because the perceived cost – sacrifice of family/whānau harmony – was not worth it. For example, some folded to requests from children for treats and unhealthy snacks to buy and keep peace. Retention of family/whānau harmony was particularly important in households where parents were living time-scarce lives. Having to deal with conflict that could arise from insisting on healthy eating was seen as something that would eat into time – already a scarce commodity.
- Where children had exposure to a household that had laxer eating rules than those which applied at their home (e.g. at the home of a separated parent or a grandparent), parents sometimes had to deal with demands for less healthy food that had been experienced when away from home. If parents resisted this pressure it did not impact on the eating of the family/whānau. However, where parents did not have the resolve to resist such pressure, some less than healthy eating could occur among their children. The researchers suggest that having consistent healthy eating rules in homes that children spend time at would be one solution to addressing this issue.
- A parent who was promoting healthy eating but who was not 'backed' in this endeavour by his/her partner was operating in a challenging environment. The researchers have coined the phrase *partner drag* to describe this situation. In some families/whānau *partner drag* was a source of conflict between partners and within the household. It undermined good intentions or efforts to eat healthily, either by active or passive means. Active undermining occurred through the *dragging partner* complaining in front of the family/whānau about the type of healthy food offered, or offering unhealthy foods to the family/whānau if having to provide a meal or snacks. Passive undermining occurred through the *dragging partner* not stepping into the cooking role when the partner was not available. The researchers comment that *partner drag* could work in reverse – in some instances, a strong partner who promoted healthy eating had been able to draw a *dragging partner* into more healthy eating behaviour.

- Parents in this study were powerful eating role models for their children. This study found examples of role modelling of both healthy and not so healthy eating practices. Parents with a sweet tooth could influence their children's consumption of sweet foods by ensuring that there was a supply of sweet foods (such as biscuits, sugary cereal, lollies, and chocolate) for their own consumption. More often than not, the children ended up eating this food too.
- Lack of knowledge about food and having limited skills in terms of being able to prepare food (regardless of whether it was healthy or not) worked against families/whānau engaging in healthy eating. For example, healthy eating was not on the radar of Inerts. They had a limited understanding of the relationship between healthy eating and good health. At the best they may have been aware of more serious eating-related conditions, e.g. obesity, but considered these would be distant events and not something to worry about now. Inerts found it hard to sort through the many conflicting messages about food in the media and most did not bother to try because of lack of interest in food.
- Lack of money meant that some families/whānau were focused on filling stomachs as cheaply as possible, rather than concerning themselves with the nutritional quality of food that was consumed. For example, less healthy food options, such as fish and chips and other takeaway foods were perceived as representing better value for money than fruit and vegetables.
- The desire to continue with a traditional (often less healthy) diet to uphold cultural values meant that some Asian and Pacific families ate food that was less healthy. For example, in one Indian family a couple was at loggerheads because the wife wanted to pursue healthier eating for their family, while the husband wanted to continue with the traditional (unhealthier) Indian diet.
- Some parents confessed to having a tendency to eat impulsively (and unhealthily) if feeling stressed. Foods that provided instant gratification were usually of a more indulgent nature, e.g. chocolate, biscuits, lollies and chippies. While parents may have tried to avoid consuming such foods in front of children, this was not always avoidable.

- Most families/whānau in this study had experienced stressors at some point that had affected how their family/whānau functioned (in the shorter term at least). Stressors placed demands on parents that prevented or limited their ability to give full attention to their family/whānau, including to the food they consumed. When dealing with stress, parents tended to go for quick and convenient meals (including takeaways) to feed their family. The focus was usually on providing fuel as opposed to being concerned about the nutritional quality of food being consumed by the family/whānau. Stressors that were identified in this study were:
  - Sickness (either in the household or in the wider family/whānau)
  - Pregnancy and morning sickness
  - The birth of a baby
  - A death in the family/whānau
  - Work-related, e.g. working long hours or shift work
  - Moving house.

Factors External to Families/whānau

- Confusion caused by multiple and often conflicting health messages led to some people being resistant to healthy eating messages – this applied particularly to Avoiders. They perceived that no definitive evidence was being presented that said healthy eating made a real (i.e. positive) difference to health. Avoiders were loath to give up the less than healthy foods they enjoyed. They justified their unhealthy eating approach by citing their good health and lack of weight issues as evidence that their diet (and that of their family/whānau) was fine.
- Food industry advertising targeting children generally and, as part of this, food industry marketing aimed at children, worked to undermine healthy eating efforts in some families/whānau. In this study McDonalds was particularly singled out as an example of unhelpful messages that undermined healthy eating. Parents reported that children were particularly influenced by television advertising. It took effort on the part of parents to resist children's pressure to get the latest burger, breakfast cereal or snack bar that they had seen advertised on television. Those prioritising household harmony often found it easier to acquiesce to children's pressure for the sake of household harmony.

- Dairies, service stations and takeaway bars were perceived to stock a range of unhealthy foods and drinks. Comment was made that because these types of outlets were fairly liberally dotted on the landscape, they provided easy access to unhealthy foods. Older children (e.g. eleven years plus) who purchased their school lunch generally made their own decisions regarding what they bought. Purchases from dairies, service stations and takeaway outlets featured (in addition to purchases from school canteens). Note: Vending machines, although perceived as being less dense 'on the ground' were also associated with providing unhealthy foods and drinks. In this study there was little evidence of children using vending machines to access food and drink. This is possibly because they were typically located in more adult-populated locations, e.g. workplaces, hotels and clubs.
- The perceived high cost of fruit and vegetables prevented some families/whānau with little money including much in the way of fresh produce in their diet. Such families/whānau tended to focus on cheap, filling (and often unhealthy) foods because their focus was on filling stomachs, not the nutritional quality of food consumed. As mentioned earlier, fish and chips and other takeaway foods were perceived by such families as representing better value for money than fruit and vegetables.
- Pressure from children wanting to have similar (unhealthy) food in their lunchbox to that of peers led to some parents providing less healthy food, e.g. 'strings' and chippies in their children's lunchboxes. Parents did not want their children feeling left out or potentially being ostracised at school. They justified giving into their children's pressure on the basis that lunch was a less important meal nutritionally than breakfast and dinner, and perceived that lunch was more about energy than nutrition.
- Pacific families found it hard to say 'no' to unhealthy food offered by non-Pacific hosts because this went against cultural beliefs to reject offers of hospitality expressed through food.

5.4.3 Self-efficacy in Relation to Achieving Healthy Eating in Families/Whānau

In the context of this study, self-efficacy referred to the extent to which a person felt he/she had the knowledge, confidence and ability (i.e. the power) to implement healthy eating in his/her family/whānau.

Section 8.0 – Audience Segmentation discusses each of the segments in terms of how people in a particular segment lived their lives and their general approach to eating (see the sub-heading – As People), their eating knowledge, their level of concern about healthy eating and their eating behaviour. Section 8.0 is useful in terms of understanding the varying levels of self-efficacy across the segments in relation to healthy eating. For example:

- True Believers were knowledgeable about healthy eating and skilled in being able to provide their family/whānau with a wide range of healthy, appealing food. Such was their belief in, and commitment to, healthy eating that nothing stopped them from having their family/whānau eat in this way. They went in to 'battle' with their family/whānau as necessary to have members eat healthily and did not make concessions to their healthy eating rules (except for special occasions such as birthdays when some less healthy food options were allowed). True Believers' belief in healthy eating and high level of self-efficacy were central to their family/whānau achieving healthy eating.
- At the other end of the spectrum was Inerts, who did not have healthy eating on their radar. Inerts were not necessarily aware of their own unhealthy eating status or if they were, it was not a concern to them. They had little or no understanding of the link between healthy eating and good health, and most of them were not concerned about healthy eating. Inerts found food messages difficult to sort through and as a result, did not give healthy eating messages to their family/whānau. Inerts could be perceived to have limited self-efficacy in relation to their ability to achieve healthy eating in their family/whānau.

The following are factors that can undermine a parent or caregivers' self-efficacy in relation to achieving healthy eating in their family/whānau:

- *Partner drag* (as discussed earlier) could reduce the self-efficacy of the partner promoting healthy eating in the family/whānau. Rather than create conflict in the household, it was often easier to fall in with the wishes of the *dragging partner* and go with less healthy choices than would be the person's natural choice.

- *Family/whānau desire to avoid conflict*. As mentioned, some families did not eat vegetables on a daily basis. Not all those who did make a point of serving vegetables were willing to insist that children ate them, because of the emotional toll this could take on the parent. Similarly pressure from children to have treats and unhealthy snack options were often given into in order to buy and keep peace in the household.
- *Time scarcity and pressure.* Consistent application of healthy eating rules could depend on how busy or otherwise a parent or caregiver was. When not busy or pressured for time, it was easy for some to enforce healthy eating rules. However, when feeling under pressure, some found it easier to take the line of least resistance and, for example, allow takeaways more often than would normally occur or give into the demands of children for unhealthy snacks. Some recognised that their inconsistent application of healthy eating rules undermined their ability to uphold healthy eating ideals in the family/whānau. Children often knew if they nagged enough a parent would fold and give into their 'demands' for unhealthy peace.

5.5 Role of Government and Regulation

There was some awareness among participants in this study of the Government being involved with addressing issues of healthy eating and obesity among New Zealand families/whānau. Pakeha participants tended to have greater awareness of this involvement than Māori or Asian participants. The most frequently cited initiative was the *'five plus a day'* campaign.

As noted earlier, some Pacific families were aware that the Pacific community was a target for public education about obesity. This had influenced attitudes to physical activity and eating among some Pacific families. These families accepted the Pacific community being targeted on the issue of obesity, and recognised there was a link between obesity, eating and physical activity.

Schools were strongly associated with giving healthy eating messages. While these messages were often supported in the homes, they were not always associated with coming from the Government.

There were mixed views among participants about the involvement of Government in addressing issues of healthy eating and obesity.

One commonly expressed view was that the Government should be involved with addressing these issues because some people do not have the know-how or skills to address issues of healthy eating and obesity, and were therefore reliant on external support and guidance to do so. From this perspective, given the Government was responsible for the welfare of the country, it was seen as a logical agent to provide such support and guidance.

A further rationale given for Government involvement was the belief that having a nation of unhealthy eaters and obese people worked against New Zealand achieving greater economic wealth. Some participants reasoned that the healthier people were, the more likely they were to be in work, and the less likely they were to be a drain on the health and social welfare systems. From this perspective, having a productive workforce was associated with achieving greater economic wealth and, in turn, making New Zealand a better place for families/whānau to live in.

The opposing and minority view was that the Government should *"butt out"* of this area of life because people were entitled to have freedom of choice about what they did and did not eat.

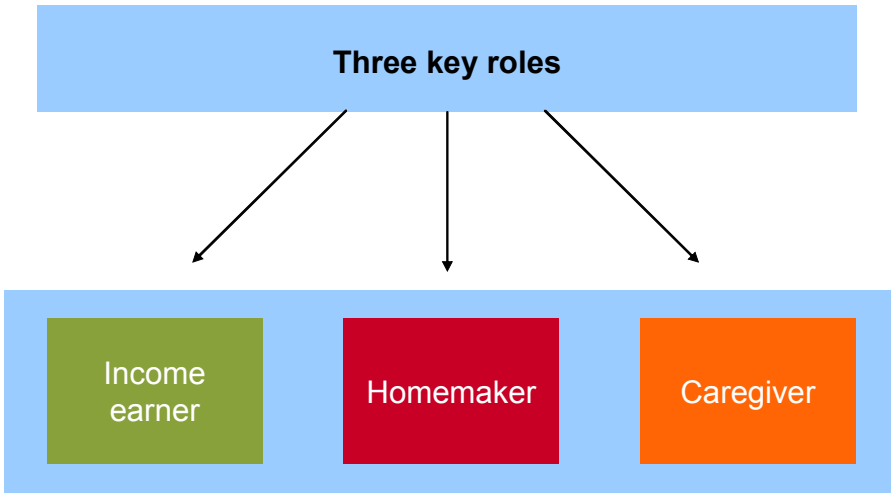
6.0 Eating in the Context of Family/Whānau Functioning

This section of the report explores key adult roles and responsibilities that existed within families/whānau in this study, particularly in relation to food planning and preparation. It also discusses household decision-making dynamics in relation to meals and snacks: who decided what would be eaten, when, and by whom. Finally, it examines the specific rules that existed in relation to breakfast, lunch, dinner and snacks across families/whānau in this study.

6.1 Roles and Responsibilities Relating to Family/ Whānau Eating

6.1.1 Key Roles

Three key adult roles existed within families/whānau in this study – across all cultural groups – as shown in the diagram below.



The income earner, homemaker and caregiver roles were not mutually exclusive. Some income earners acted as a main caregiver, for example a mother working part-time to fit in with school and pre-school hours. Similarly, a homemaker almost always took on the role of primary caregiver for children in the household, with most homemakers (usually women) seeing caring for children as implicit in the homemaking role. There were few exceptions to this.

However, the homemaker role did not intersect with the income earner role. People who described themselves as homemakers in this study (usually women) were not in paid employment.

The income earner and caregiver roles could be jointly shared by the adults in a family/whānau, or could be the province of one adult. In the case of single parent households, the parent fulfilled all three roles, but may have derived support from adults outside the household, e.g. with grandparents providing caregiving.

In the context of family/whānau eating practices, decision-making and enforcing, in terms of what was and was not eaten by the children in the family/whānau, could be the preserve of any or all of the above roles. However, the adults who occupied the homemaker and caregiver roles (which may be one and the same role where there was a full-time homemaker) tended to have the most direct influence over what families/whānau, especially children, ate and drank and when. This was because these adults tended to take responsibility for grocery shopping and food preparation, and were 'on the spot' making moment-to-moment decisions when children were asking for food and drinks.

6.1.2 The Income Earner Role

Two-parent Households with a Single Income Earner

In two-parent households with a single income earner, there was usually a male in full-time employment, with the female partner in a full-time caregiver role for children (usually including pre-schoolers). By virtue of being absent from the home more of the time, sole income earners had a limited role (and limited influence) in relation to eating matters for their family/whānau. While they may have held ideas about what children should be eating, this was often left to the adults in the caregiving or homemaking roles because of their greater availability.

Full-time income earners in two-parent households may have shared food preparation and cooking at the weekends and, in a few cases, on weekdays as well. However, it was less common for them to be involved with food planning - although this did occur in some instances, either as a planned activity before doing the regular supermarket shop, or in an ad hoc way while doing the shopping.

Two-parent Households with Dual Income Earners

In households where both parents were working, responsibilities relating to eating were often shared, albeit with mothers typically taking responsibility for the majority of food planning, preparation and cooking (and enforcing eating rules). Lack of confidence – usually based on experience – in a partner's knowledge, experience and judgment in relation to food and eating was sometimes a motivator for taking on more eating-related responsibilities for the family/whānau. In short, mothers often perceived they could 'do better' for their family/whānau, in terms of eating, than fathers could.

The eating-related tasks listed under 'the homemaker role' (see later) were those undertaken by most working mothers.

Note: In some dual income households, the father had taken on the bulk of responsibility for food planning, cooking and/or shopping. In one case this was motivated by a desire to improve the family's diet (a concern not shared by his wife to the same degree).

Working and running a family/whānau placed high demands on parents' time. The impact of time scarcity in relation to eating, especially preparing dinners, was that parents could find themselves reaching for less healthy options in the name of convenience.

Single-parent Households

In single parent households the income earner, by necessity, typically had near sole responsibility for all aspects of eating for his/her family/whānau. Some support may have been given by other family/whānau members, e.g. grandparents or adult siblings providing children with meals when acting as caregivers or helping out with supermarket shopping (to a pre-determined list rather than making purchasing decisions).

Like two-parent households with dual income earners, single parents who were working were pressured for time and sometimes opted for less healthy eating options for convenience.

6.1.3 The Homemaker Role

In this study, the homemaker role was usually occupied by the mother, although a couple of two-parent households had a father in this role, with the mother in paid employment.

The homemaker was responsible for the day-to-day running of the household. Preparing and cooking meals for the family/whānau were two of the key responsibilities and defining characteristics of the homemaker role. (In some households, the homemaker was responsible for providing virtually all meals consumed by the family/whānau. In others, the food preparation and cooking were shared with the father at weekends and, in a few cases, on weekdays as well).

Even where homemakers were sharing the food preparation and cooking roles, they were likely to be making key decisions around what types of foods to buy, which brands to choose, and how much to spend on different food items.

Tasks encompassed by the homemaker role included:

- Providing food for household members, whether cooking or assembling meals (there may have been a requirement to fill stomachs as cheaply as possible where money was tight).
- Shopping for groceries (often within a budget).
- Keeping a mental inventory of what was in the cupboards, and what needed to be stocked up on during the next supermarket shop.
- Planning ahead to ensure there was adequate food to provide meals and snacks for the family/whānau.
- Some homemakers saw it as part of their role to educate their family/whānau about healthy eating, and to model healthy eating behaviour to them.

Where there was no full-time homemaker, the above tasks were shared by the adults involved with paid work outside the home. Time scarcity could lead to healthy eating ideals becoming rapidly eroded in the name of convenience.

Because homemakers were physically present in the home more of the time, they tended to have their 'finger on the pulse' in terms of what the family/whānau was eating and when. Emotionally, homemakers tended to see the physical nourishment of their family as a key part of their role in the home. For these reasons, homemakers had the greatest direct influence over the household's eating, and their own beliefs, practices and learned behaviour were likely to be most influential on the children's eating.

It is important to note that while males sometimes occupied the homemaker role, they did so in a different way from females. Males in the homemaker role tended to be less detail-oriented than females, which meant that some homemaking responsibilities still fell back on to mothers, regardless of how many hours they were working in paid employment. As a by-product, mothers who were not in the homemaker role were often still making key decisions around what food got purchased and eaten by the family/whānau.

6.1.4 The Caregiver Role

The caregiver role could be occupied by one or more people within a family/whānau. Who occupied this role could be quite fluid, and could be shaped by who was available at the time of need. In most households in this study, one parent – usually the mother – occupied the caregiver role most of the time (when she was at home full-time this morphed into the homemaker role). However, grandparents (usually grandmothers) or adult siblings could also occupy the caregiver role some of the time - this was noted in a number of Māori whānau, and in some Pacific and Asian families.

When the main caregiver was the mother, the responsibilities that went with this role were the same as those for the homemaker role (see above). When a caregiver was a person other than a parent, e.g. a grandparent or adult sibling, they may have been charged with applying the parents' rules around eating. However, this study found that non-parent caregivers may have chosen to follow their own preferences and household norms regarding what to feed the children in their care. This could result in grandparents treating their grandchildren with sweet foods or treats, such as McDonalds, without the parents' knowledge or against their wishes.

While parents may have tried to stipulate what caregivers fed to their children when they were not around, it was an awkward arena, clouded by parental gratitude towards the caregiver, as well as some parental guilt at their own absence. Parents typically felt grateful to caregivers for their support – whether paid or otherwise – and may have been reluctant to dictate or enforce their household's rules around what the children ate.

6.1.5 Food Planning

Adult Roles

Where both parents were in paid work, food planning more often tended to fall to the mother. It was more common for mothers in this study to be the parent who kept a mental inventory of the fridge and cupboards, and to devise a shopping list (whether this existed on paper or merely in her head).

However, in some dual income households, the father or another male caregiver had taken on this role. One Pacific father reported taking responsibility for both food planning and cooking for his household because of his desire to improve his family's diet (a concern that his wife did not share to the same degree). In another household, a Māori grandfather took care of all the food planning and shopping.

In other households, the parents shared the food planning, whether this occurred in an ad hoc fashion as they cruised the supermarket aisles together, or as a planned activity that took place before the regular grocery shop was done.

Where there was a homemaker in the household, this person was more likely to make the key decisions around what types of foods were bought, and how much was spent on different food items. In households without a full-time homemaker, the mother tended to dominate decisions about which foods made their way into the grocery trolley. Some males deferred to their female partners on key decisions, such as which meat or bread to buy, but made sure that their preferred foods in categories such as snack foods were included in the shopping.

Where there was no full time homemaker, food planning and grocery shopping had to be shared somehow or other by the adults in paid work outside the home. Mothers re-entering the workforce could be a trigger to fathers getting more involved in both food planning and cooking, to relieve the pressure on their partner.

> *"Well, I wouldn't say nothing would get done. Things would get done, but it'll either get done with – not so much a screaming match – but done out of pure stress. It was like, 'oh God, why can't someone else do this?' type of thing."*
>
> **Pacific Other Male – Wellington**

As a generalisation, many 'homemaking' responsibilities fell back on to mothers, regardless of how many hours they worked in paid employment. Mothers who were not in the homemaker role were often still making key decisions around what food got purchased and eaten by the family/whānau.

Children and Young People's Roles

Children's involvement in food planning tended to be largely limited to asking their parents to buy certain kinds of products, typically cereals and snack foods they had seen advertised on television (or in other children's lunchboxes).

While children were not often directly involved in food planning, parents did know their food preferences, and took these into account when planning meals, writing shopping lists, or working out what to buy at the supermarket.

Children were often involved with food shopping – particularly preschoolers. While many parents preferred to do grocery shopping without their children present – because it is quicker and there are no spontaneous requests for treats to deal with – sometimes it was inevitable that children went along to the supermarket.

> *"They're always trying to shove stuff into my trolley. Then when I get to the checkout I just tell the checkout [staff] 'take that bar of chocolate [out], take that, take that."*
>
> **Pakeha Female – Christchurch**

Parents with more than a couple of children may have been particularly reluctant to do the supermarket shopping with the children in tow, in order to avoid conflicting requests, e.g. for different types of cereals or biscuits.

Children's requests for specific foods – whether or not they accompanied their parents to the supermarket – tended to revolve around *"fancy"* breakfast cereals and snack foods, such as chippies, chocolate, biscuits, muesli bars and lollies. Usually, children would have seen these products advertised on television.

Parents often took children's requests into account when deciding what foods to buy – particularly in relation to lunchbox snacks – by giving them some say in terms of what brand, variety or flavour of a particular product was bought. In some families/whānau the children took turns to be the one whose preference dictated what kind of snacks got bought.

The mokopuna in one whānau carried out her own inventory of lunchbox snacks prior to the grandparents going shopping.

> *"She knows what she needs or what she wants to have in her lunches – she'll count how many [packs of] chippies are left. She likes to get snacky things for her lunchbox."*
>
> **Māori Female – Gisborne**

When confronted with children's requests to buy products the family/whānau had not bought before – i.e. that were new or unfamiliar – parents often attempted to work out whether the product was the kind of thing they normally allowed, for example, by checking for sugar or fat content on the packaging.

> *"We have the same view. I'll say, 'the kids want this', and she'll say, 'oh, that's really sugar coated' …. sometimes it has 'sugar-coated' [laughs]. That's a clue. 'Syrup coated' and all that .... If it's something we want to get and haven't tried before then we will definitely read the label. You don't need to read the labels on those coated ones because we all know they're full of sugar."*
>
> **Pacific Other Male – Wellington**

Some parents went by the product category, and the appearance of packaging as a guide to whether it was the kind of food they would normally allow, without going into the detail of exactly what its nutritional value was. Price was also influential.

Some parents had bought their children a new product they were asking for only to see it go uneaten because the children did not like it once they tried it. This tended to make such parents less likely to say 'yes' to similar future requests.

Some older children also asked for specific convenience foods, such as instant cake mixes or 'heat and eat' meals, which they prepared for themselves when they missed the family evening meal because of sporting or other activities.

> *"You know those little square lasagne things? I sometimes have one for dinner because I'm so tired. I just warm it up and eat it before I go to bed … or they [parents] put away a pan [of dinner] for me and I have to warm it up. So sometimes I have the lasagne."*
>
> **Samoan/Niuean Female Teen – Wellington**

When having takeaways the children may have got to choose what type of takeaways they had. They could also influence the decision to get takeaways.

6.1.6 Food Preparation

Adult Roles

In some households in this study, the homemaker (who was in most instances a female) was responsible for virtually all meals consumed by the family. In others, the father shared in the cooking and food preparation at weekends and, in a few cases, on weekdays as well.

In households without a full time homemaker, cooking the evening meal was shared by the income earners, or fell to one or other of them. The person in the primary caregiver role – whether or not they lived in the household – prepared and dispensed snacks and meals when the children were in their care.

When a caregiver such as a grandparent or family friend cared for children in their own home, they may have followed their own food preferences and household norms regarding what was fed to the children. This sometimes resulted in grandparents regularly treating their grandchildren with sweet foods or treats such as McDonalds.

Children and Young People's Roles

Children's involvement with food preparation and cooking was age-related, and tended to start around the age of five years. At this age, many children started to get involved in baking and preparing very simple child-orientated foods such as jellies. They may have initiated or simply participated at this age. Children's motivation to get involved with baking in particular was linked to the *"yummy"* results, which they were keen to eat.

This study suggests that girls were particularly curious and interested in getting involved in baking and simple food preparation – they were often also keen to help their mother. The focus of these activities was on the children enjoying the activity and its results, with the skills involved in baking (measuring, reading the recipe) a welcome by-product rather than the purpose of the activity.

At this age some children were also involved in simple tasks such as preparing vegetables (i.e. peeling and chopping) for the evening meal. Some parents limited their children's involvement to tasks that avoided hot water, sharp knives and use of the stove. The focus of this activity was on learning to participate in routine household tasks and reducing the workload on the cook.

While children in this age group may have been keen to get into the kitchen and help, some parents limited their involvement because it was easier – quicker and less messy – to do it themselves. Particularly when younger siblings also wanted to get involved, parents may have discouraged baking, or saved it for an occasional activity as a treat.

> *[Mum] "We haven't got a very big kitchen …"*
>
> *[Dad] "… they'd drive you nuts …"*
>
> *[Mum] "And they get messy … nanny lets [the four year old] bake … she'll get out the flour and [there's] flour everywhere."*
>
> **Pakeha Family Focus Group – Gisborne**

From around the age of eight years children were often involved in other tasks associated with family/whānau meals, particularly weekday dinners. These included setting the table (if a table was used), clearing away plates at the end of a meal, and washing and drying dishes or loading and unloading the dishwasher. These tasks may have been assigned to children on a permanent basis. The focus of these activities was on sharing in routine household tasks and reducing the workload on parents.

While parents of children in this age group may have been keen to foster their children's growing interest in cooking, and saw it as ultimately desirable that they learnt to cook and participate in family cooking, it could be hard to integrate this into a busy week night routine.

> *"[The eight year old's] getting there slowly. But it depends – if I'm trying to cook a meal for the family, I really don't want any distractions and [to] try to teach her at that time of day isn't great. So sometimes, on the weekends, if it's good timing she can help make pancakes or will butter a sandwich … she's starting to take more of an interest but it's pressure for time."*
>
> **Pakeha Female – Gisborne**

Children of this age were often involved in making their own snacks, and school lunches, although they may have required guidance and supervision. Where there were younger siblings in the household, some children made simple snacks for them (e.g. sandwiches) or got their cereal in the weekends while their parents had a lie in.

By the teenage years, children in this study were often involved in preparing simple meals and snacks, particularly at the weekend, for themselves and their younger siblings or for the entire family/whānau. The focus of these activities may have been on the teenager acquiring cooking skills, or simply on reducing the workload on parents, either occasionally or regularly.

> *"If the kids cook for themselves it's spaghetti and baked beans. Sometimes I leave them to sort themselves out if older ones [teenagers] are here."*
>
> **Pakeha Male – Wairarapa**

Some teenagers also prepared meals for themselves when their after-school activities meant that they were not home for the evening meal with the family/whānau. In some cases, convenience foods such as 'heat and eat' meals were bought specifically for this purpose.

6.2 Decision-making Dynamics Relating to Meals and Snacks

6.2.1 Breakfast Decision-making

Cereal was a breakfast staple in many households. Decisions about what kinds of cereals the family/whānau ate were typically made by the main shopper(s), with input from the children in terms of their likes and dislikes. Children often pestered their parents to buy particular kinds of cereals, and were influenced by television advertising for new cereals.

Parents tended to categorise breakfast cereals according to their perceived healthiness (related primarily to sugar content, and use of colourings) as outlined below:

- Healthy (and usually cheapest): traditional cereals, e.g. Ricies, Cornflakes, Weetbix, porridge, muesli (not cheap, may be bought for adults in household).
- Okay (not particularly unhealthy): more fancy (i.e. sweet and expensive) cereals e.g. Honey Puffs, Nutrigrain (for some);
- Unhealthy (and usually most expensive): the fanciest, often newer types of cereal, e.g. Nutrigrain (for some), Coco Pops, Fruit Loops and other highly sugared and coloured cereals.

> *"… they want those particular breakfast things like Fruit Loop' or whatever they are called. They want those and they're all sugar-coated, and that's what we're fighting – the TV adverts."*
>
> **Pacific Other Male – Wellington**

Children in this study often started to get their own breakfast from the age of seven or eight years. However, they were usually choosing from an agreed range of breakfast foods which parents had deemed acceptable – typically cereals and/or toast and spreads. Most food eaten at breakfast-time was part of a habitual routine, with children sticking to a fairly narrow range of cereals, and toast spreads.

The kind of bread eaten as toast was influenced by the children's tastes as well as the parents' preferences. In some families/whānau the mother's preference dictated what kind of bread the family/whānau ate.

> *"… generally the whole house runs on what I want to eat, and I don't like wholegrain bread. I like white bread – so we stick with the white bread."*
>
> **Pakeha Female – Gisborne**

In other families/whānau, the preferences of the children and/or father were more influential.

> *"[My wife] tries to encourage as much brown bread as possible, but they're [the brown loaves] always the last ones left in the freezer aren't they?"*
>
> **Pakeha Male – Wairarapa**

Some older children in this study were given money to buy breakfast on their way to school. In these cases, the children were ultimately determining where and how they spent their money.

6.2.2 Lunch Decision-making

The mother (or other primary caregiver) was usually the key decision-maker in terms of what went into younger children's lunchboxes (e.g. up to around ten or eleven years of age). Even where young children were making their own lunches, they did so from a range of pre-determined foods (e.g. sandwiches, a piece of fruit, a lunchbox snack, a yoghurt).

Children were often allowed to choose among the range of lunchbox snacks that the family/whānau purchased on a regular basis – once the main shopper had deemed these acceptable (e.g. in terms of sugar and fat content, and price).

Weekend lunches tended to be determined by what was in the fridge, with the food preparer the key decision-maker. However, when the family/whānau was away from home around lunchtime, children often influenced what types of foods were consumed for lunch, e.g. choosing what kinds of takeaways were bought.

6.2.3 Dinner Decision-making

Decisions about what was eaten at dinner-time took place on two levels:

- When the grocery shopping was done, and purchase decisions were made regarding foods and ingredients that constituted main meals (e.g. meat, potatoes, rice, pasta, convenience foods, and frozen or fresh vegetables).
- When whoever was responsibility for cooking dinner considered what they would cook for the evening meal. Their decisions could be influenced by mood, available time and energy levels.

In some households, evening meals were planned some days in advance, so that the supermarket shopping incorporated the required food items. In other households, supermarket shopping regularly included dinner staples, such as potatoes, vegetables and meat, as well as convenience foods such as tinned food, and packaged meals and sauces, so that some kind of meal could be assembled, whether this was planned in advance or decided by the cook on the day.

Dinner decisions were often influenced by what else was going on in the household. When work or after-school commitments ate into potential cooking time, families/whānau may have resorted to convenience foods or takeaways, despite knowing these options were less healthy.

The parents' energy levels also significantly influenced what kinds of meals got cooked, with parents opting for easier (typically less healthy) options when they were tired or unwell.

> *"I've got to make sure I've got something planned and I remember to take something out of the freezer. It might end up being quarter past five and I think, 'there's no way I've got time to cook anything'."*
>
> **Pakeha Female – Gisborne**

6.2.4 Snack Decision-making

In some families/whānau, children were allowed to help themselves to snacks between meals, with few rules around what was consumed. However, when parents observed children snacking, they may have put a limit on what was eaten, or how much was eaten, particularly if it was close to the evening meal.

In other families/whānau, children had to ask before they helped themselves to snacks. This may have been because of the children's ages (e.g. in the pre-school and early primary school years), or down to the family/whānau parenting style (e.g. more hands-on in terms of eating).

Children asked for specific snack foods (often treats such as lollies or packaged snacks) when they knew these were in the house. Parents tended to have rules (firm or loose) around when such snacks may be consumed, and generally adhered to these. Parents' decisions whether or not to grant children's requests were influenced by what else had already been consumed by the child (e.g. in the last hour or that day) and how close it was to a meal-time. Their decisions were also influenced by their mood, e.g. how harassed or tired they were feeling, and whether they felt able to withstand the child's pestering. Some decisions to grant treat snacks were made to 'buy peace' and 'time-out' from children's demands.

> *"I don't give them as much snacks as [my wife] does. Because [she] is there 24/7 and she needs a bit more of a break, so she's more tolerant to give snacks so they will go away and just be quiet and leave her alone."*
>
> **Samoan/Tokelauan Male – Wellington**

6.3 Eating Rules and Guidelines (and Enforcement)

This study found a large number of rules in relation to healthy and unhealthy eating. However, these rules were far from universal, and were sometimes randomly enforced.

> *"No. No rules at all. As far as food goes, no. If it tastes good and they are going to eat it, eat it."*
>
> **Pakeha Female – Auckland**

Specific rules applied in relation to each meal-time and in relation to snacking. These meal and snack-specific rules are outlined below.

6.3.1 Breakfast Rules

There were relatively few explicit breakfast rules in families/whānau. This was because the foods consumed at breakfast tended to fall into habitual patterns, with little variance day-to-day beyond a small range of foods. The following breakfast rules were identified in this study:

- Many families/whānau had a general rule that children ate breakfast, however, there was less routine supervision of older children (e.g. ten years plus).
- Most families/whānau also had an understanding that children may not eat packaged snack foods such as chippies for breakfast.

Enforcement of breakfast rules depended to a large extent on what else parents were trying to get done while children were eating breakfast. However, some rules were not negotiable and appeared to be adhered to by children regardless of whether parents were watching them (e.g. not eating packaged snack foods for breakfast).

6.3.2 Lunch Rules

There were several lunch rules in families/whānau as outlined below. These were linked to the fact that during the week, many children were eating lunch at school.

- In some families/whānau, children were encouraged to eat any uneaten food in their lunchbox before they were allowed to eat other after-school snacks. However, while some parents instigated this rule, it was not always enforced because they recognised that uneaten lunch was often distinctly unappetising by the time it reached home.

- Some families/whānau also stipulated that children had to bring home any lunch not eaten at school, so that the parent or caregiver knew what was and was not being consumed (and this gave a guide as to what not to buy or make in future, or what to leave out of that child's lunchbox).
- Some families/whānau, who included packaged lunchbox snacks in their children's lunches, had rules about the number of packaged snacks allowed as part of school lunch. This number could range from one to as many as five or six, depending on the individual family/whānau. (The researchers note that children who were allowed a greater number of packaged lunchbox snacks tended to be in lower socio-economic families/whānau).
- Some families/whānau only allowed water as a lunch-time drink for children, e.g. taken from home in a sipper bottle.
- Many families/whānau had rules relating to how often their children could buy their lunch on school days. This was not always motivated by health concerns, but was often budget-driven. When lunch was bought infrequently, it was seen as a treat for the child (and in some cases, also for the parent whose task it was to make the lunches).
- Where children were routinely given money to buy their lunch, some families/whānau had rules around what they may buy with that money. However, parents were unlikely to check whether this rule was being adhered to. Primary schools may get around this problem by providing a lunch order sheet for bought lunches (organised through the school) that the child can fill in with parental supervision.

> *"It's not so bad for [the six year old] – because I can fill out a lunch order and I know what he's getting – but with the older two, they take the money and they go to the canteen and goodness knows what they buy. They could spend it all on – I don't even know what."*
>
> **Pakeha Female – Wairarapa**

Enforcement of lunch rules got harder as children got older. Some families/whānau gave older children lunch money on a regular basis and assumed it was actually spent on lunch, but did not ask.

Enforcement of rules around lunch was often aided by schools, many of which had their own rule ensuring that children took uneaten food home in their lunchboxes. Some schools also prohibited chocolate and lollies being taken as part of lunches, and drinks other than water.

6.3.3 Dinner Rules

Many families/whānau had some rules around dinner. At least one, if not both, parents were also likely to be eating dinner with their children (compared to breakfast and lunch, which were often eaten separately), and thus able to monitor what their children were eating. The following dinner rules were identified in this study:

- Some families/whānau emphasised the importance of vegetables and had a rule that children must eat some or all of their vegetables.
- Some families/whānau encouraged their children to eat everything on their plates. Parents often commented that they were brought up this way.
- Other families/whānau allowed some leeway in terms of what got eaten. Their rules may have allowed the child to leave some of a disliked food, provided they had eaten at least some of it.
- Some families/whānau emphasised the nutritional importance of protein and dairy foods, and would allow children to leave their vegetables provided the former were eaten.
- In other families/whānau, the protein and vegetable components of the meal had to be eaten, but children may have been able to leave some of the starch component (e.g. potatoes or rice).
- It was quite common for families/whānau to encourage their children to broaden their tastes by stipulating that the children must try a little bit of unfamiliar foods. In this way, parents hoped that their children would acquire a taste for foods the parents were keen for them to eat (because they were deemed healthy and/or because the parents enjoyed eating them).
- Some parents allowed their children to not eat certain, agreed upon foods that the child did not like. The child may have been able to either leave the food on their plate, or the parent did not dish up the offending food to the child who did not like it.
- It was fairly common practice for parents to use pudding or some sweet food as a bargaining tool in encouraging children to finish their dinner.
- In some families/whānau, children who did not finish their dinner were not allowed post-dinner snacks. In other families/whānau, in this situation any post-dinner snacks were limited to acceptable food groups (e.g. fruit).
- Some families/whānau had a rule that there was one evening meal that everyone must eat at the same time.

Parents described trying to find a balance between enforcing family/whānau dinner rules and accommodating the preferences, and sometimes fluctuating appetites, of individual children. They may have done this by not giving one child a food they knew they did not like, and by adjusting portion sizes according to what they expected that child to eat.

> *"I'll put more on his plate than what I think he needs to eat and I'll say, 'you can eat half of that'. I have to do that because he thinks he's getting a deal that way!"*
>
> **Pakeha Female – Wairarapa**

Enforcing dinner rules could be complicated by the parents' own eating habits. When children observed one or other parent not eating things that the children were supposed to eat, it became difficult to enforce that particular rule. Some mothers reported that the father in the family/whānau was a poor role model in terms of eating vegetables, making it hard to encourage the children to eat theirs.

6.3.4 Snack Rules

Snacks were an accepted part of family/whānau eating routines. Rules around snacks tended to focus on limiting snacks deemed to be less healthy, and ensuring that children did not fill up on snacks at the expense of proper meals. The following snack rules were identified in this study:

- Many families/whānau limited snacks given before meals, for example not allowing any snacks in the hour (or two) leading up to dinner-time.
- Some families/whānau allowed snacking closer to dinner-time, but limited this snacking to pieces of fruit (or, less commonly, raw veges).
- Some families/whānau encouraged fruit as the household snack of choice, and would offer this before any other options. In these households, children were typically allowed to eat as much fruit as was available.
- However, some families/whānau limited the number of pieces of fruit their children ate in a day, for cost reasons.
- A common rule was for treat snacks (such as lollies and chippies) to be banned before a certain time of day – typically mid-morning.

- Parents also typically limited the quantities of treat snacks their children may consume, in a sitting. For example, in one family the parents had a 'one for each hand' rule for the number of biscuits a child could take at any one time. In a couple of families/whānau, the parents encouraged portion control, for example, by instructing children to put a handful of chippies in a bowl, rather than eating them straight out of the family-size bag.

  "I say to them, 'you don't have to eat the whole packet of chips in one time or one day, leave enough for the next day or another time'."

  Tongan Female – Christchurch

Enforcement of snack rules required vigilance and motivation on the part of parents and caregivers. Snack rules tended to be less defined than other eating rules, and were more open to fluctuation according to the mood and stress levels of the parent or caregiver who was being asked for snacks. Sometimes parents and caregivers granted treat snacks to 'buy peace' and 'time-out' from children's demands, or to create household harmony.

7.0 Healthy Eating Messages and Communications

This section of the report explores the eating messages that parents and other caregivers passed on to children, as well as the eating messages that come from sources outside the family/whānau.

It also explores common messages that undermined healthy eating, and where these messages come from, and details influential communication channels for adults and for children.

7.1 Eating Messages Given to Children/Young People by Parents and Caregivers

Parents and caregivers transmitted messages about eating – healthy and otherwise – to children both verbally and non-verbally (i.e. through their own eating behaviours). Parents who tended to eat less healthily may have downplayed – or been unaware of – the impact of their own eating behaviour on that of their children.

7.1.1 Verbal Messages About Eating

Parents and caregivers routinely encouraged children to eat certain foods or food groups by telling them these foods were *"good for them"*. Chief among foods that were promoted to children as healthy were fruit and vegetables and, to a lesser extent, meat and dairy products, particularly milk.

Some parents considered dairy products as potentially unhealthy if too much was consumed, because of their high fat content. A small number of participants also believed that fruit should be limited because of its supposedly high sugar content.

Other foods and drinks associated with being unhealthy by participants were:

- Takeaways (because they were fatty and fattening)
- Fizzy drink (because it was full of sugar)
- Lollies (because they were full of sugar)
- Fatty foods, e.g. pies, fatty meat, hot chips, chippies, and cakes (because they were fatty and fattening)
- Sweet foods, e.g. biscuits, sweet cereals, sweet lunchbox snacks such as 'strings' (because they were full of sugar).

In messages given to children, fatty foods were linked with being overweight, and, to a lesser extent, with future health problems (such as heart disease).

Sugar was strongly linked to tooth decay and, in some cases, to children getting *"hyper".*

However, some parents considered sweet lunchbox snacks such as muesli bars and 'strings' to be healthier alternatives to sweet foods such as biscuits and lollies – and communicated this to their children by encouraging these foods in preference to other sweet alternatives. The researchers note that this reflected the food industry's marketing of such products, i.e. as healthy options for children.

Some parents also believed, that provided their children were not clearly overweight, there was less or no need to monitor consumption of high fat foods. As a result, these parents did not communicate messages about the need to limit high fat foods to their children because they did not see that there was a need to do so.

> *"Like there's a whole lot of it about childhood obesity and everything – well my kid's not fat, he's [a] skinny little runt."*
>
> **Pakeha Female – Auckland**

7.1.2 Non-verbal Messages About Eating

As mentioned earlier, children picked up eating messages from their parents by observing what they themselves ate. Non-verbal messages about healthy eating from within the family/whānau were transmitted by children observing adult family/whānau members who ate healthy food (and who were fit and active), including grandparents who looked after themselves in these ways and were in good health.

However, non-verbal messages from family/whānau members could also undermine healthy eating. In terms of leading by example, some parents provided mixed messages around the following foods, in particular, by saying one thing, and doing something else:

- Vegetables – some parents emphasised the importance of vegetables while eating relatively few vegetables themselves. Fathers in particular may have avoided or refused to eat certain vegetables, despite the children being expected to eat them. This dynamic made it difficult for mothers to encourage the children to eat their vegetables (as discussed in this report – see Section 4.3.3 – Vegetables).

- Fruit – some parents only occasionally or seldom ate fruit themselves, despite encouraging their children to eat fruit daily (as discussed earlier in this report - see Section 4.3.4 – Fruit). These parents often said they had never acquired a taste for fruit as a child, but that this did not influence their children's fruit consumption. The researchers note that such parents may have indirectly limited their children's fruit consumption by purchasing less fruit than parents who themselves liked and ate fruit regularly.
- Fizzy drinks – parents may have limited their children's fizzy drink intake on the basis that it was not healthy for them to drink, but be regular fizzy drinkers themselves (as discussed earlier in this report – see Section 4.3.5 – Fizzy Drink).
- Biscuits and lollies – as above, parents may have limited their children's intake of biscuits and lollies on the basis that they were not healthy foods, but snacked on these foods themselves while around their children, or after the children were in bed. In such households, the children knew that these foods were in the house, and the parents routinely bought them for their own consumption, as well as that of the children. Once children knew such foods were in the house, they tended to make them the focus of repeated requests for snacks.
- Snack foods – the same dynamic applied to snacks as reported above for biscuits and lollies. Some parents bought snacks foods such as chippies as much for their own consumption as for that of their children. Children may have also witnessed their parents having a 'snack attack', e.g. eating chippies from the bag in front of television, thereby undermining any messages about the desirability of avoiding or limiting such snack foods.
- Takeaways – parents may have told children that takeaways were not healthy because they were fatty and fattening, but continued to buy them as regular family meals and as treats because they were convenient and the parents also enjoyed eating them.

> *"You have to be really careful because if we let her [daughter – she] will eat junk. If I didn't watch what she ate, and that is really up to me … what I do think really is I should actually stop buying that."*
>
> **Pakeha Female – Auckland**

7.1.3 Cultural Differences

Pacific Peoples

As discussed earlier, Pacific peoples were aware that Pacific communities were a target for health campaigns relating to obesity. Partly as a result of this, some Pacific parents were conscious of their own weight, as well as that of their children. Some Pacific peoples reported their own tendency to put on weight, and watched for this in their children. One weight conscious mother often alerted her teenage daughter to foods that would be *"fattening"* for her (despite enjoying some of these foods herself).

> *"They don't like me eating chippies, that's why I stay away from them when I can. Muffins, sometimes, because I like chocolate croissants as well. Mum tells me not to eat a lot of these … she says it's fattening."*
>
> **Samoan/Niuean Female Teen – Wellington**

In another family, the father sought to restrict the quantities of food his more heavily built four year old son was eating. However the mother wanted the boy to be left in peace and allowed to eat like his more lightly built siblings.

7.2 Eating Messages From External Sources

7.2.1 Overview

Participants reported gleaning healthy eating messages and information from a number of sources external to the family/whānau, including schools and pre-schools, the media, doctors, colleagues, and peers.

Messages from external sources also worked to undermine healthy eating efforts by family/whānau. Participants noted the negative impact of food marketing, especially television advertising aimed at children, and discounting of unhealthy foods such as chippies and fizzy drink, on their efforts to encourage healthy eating in their family/whānau.

7.2.2 Messages that Supported Healthy Eating

Messages via Schools and Pre-schools

Parents in this study reported that their children brought healthy eating messages home from school and pre-school. In some cases, the messages children brought home and imparted to their parents were 'news' to the parents. For example, one Pacific family in this study reported that they had recently learned that fizzy drink was not healthy as a result of their child bringing this information home from primary school.

In this study, schools and pre-schools were identified with imparting the following messages in particular:

- That drinking water was good for you – and better than sweet alternatives such as fizzy drink, cordial and juice.
- That fruit and vegetables were good for you (this message was strongly linked to the *'five plus a day'* campaign).

  > *"School programmes really drum it into the kids and the kids come home and they say, 'mum, make sure I've got five plus a day'."*
  >
  > **Māori Female – Gisborne**

- That sweet foods should not be eaten too often, and that sugar was bad for teeth. Many schools reportedly banned or discouraged lollies and chocolate coming to school as part of a packed lunch. Some schools and pre-schools also provided healthy lunchbox suggestions to parents and children.
- That the Heart Foundation tick denoted healthier food options.

Messages via the Media

Parents noted that women's magazines and health and diet-focused magazines were an important source of information on nutrition, and that they often had a focus on reducing fat consumption, and achieving weight loss.

Messages in the print and electronic media also reportedly had a focus on reducing fat consumption and weight loss, and included:

- Cutting down on fat consumption as a key means of promoting weight loss (and also of promoting wider health benefits such as protecting against heart disease).
- Fatty foods should be eaten in moderation (for the above reasons).
- Some fats were healthier than others, e.g. oils rather than animal fats. (Here the focus was on the wider health benefits above and beyond weight loss).
- Substituting higher fat foods for low(er) fat foods as a means of promoting weight loss (and also of promoting wider health benefits such as protecting against heart disease).
- Limiting or avoiding consumption of *"junk food"* such as takeaways and packaged snacks (e.g. chippies) as a key means of reducing fat intake.

Television programmes such as *Down Size Me* and *The Biggest Loser* also focused on ways of achieving weight loss.

> *"'Downsize Me', with the big fella … when I was looking at that programme, the New Zealand one, and they get out all the junk food and stuff that they eat, and I look at it and that's what my family eats."*
>
> **Tongan Female – Wellington**

Television also exposed families/whānau to inspiring, healthy role models such as sports people. Some sports people (e.g. the Evers-Swindell twins promoting beef and lamb) were reported to be a source of healthy eating messages (e.g. endorsing consumption of specific foods on the basis of their health-giving properties). Note: In this study no specific mention was made of sports people endorsing McDonalds, or the potential influence of this.

Television cooking shows were another source of messages on healthy eating options, for example, providing healthy eating messages and suggestions (e.g. olive oil was a healthier option than butter and other saturated fats).

Messages via General Practitioners and Other Health Professionals

General practitioners were another important source of messages regarding weight loss and the impact of diet on overall health. For one whānau, their general practitioner was their most influential source of information. Health scares had led them to the belief that their doctor knew best and it was wise to follow his advice.

However, other participants reported finding their doctor's direct questioning about their diet a little threatening, and potentially shaming. In one case, a Pacific mother had been careful not to describe her real diet (which she perceived to be unhealthy) to her general practitioner when questioned about it.

> *"I lied [laughs]. Because I used to work up there and so he's been my doctor for ages, and I didn't want him to lecture me about food."*
>
> *[Interviewer] SO WHAT DID YOU LIE ABOUT?*
>
> *"That I was eating three meals a day, fruit and veges – you know – what doctors want to hear."*
>
> **Niuean Female – Wellington**

It is worth noting that the same woman took notice of a poster in a chemist shop illustrating how many teaspoons of sugar there were in a glass of fizzy drink. This medium had more impact for her because she digested the message and reflected on her own fizzy drinking habits without feeling the shame that the doctor's more direct questioning provoked.

Other health professionals and allied organisations such as Plunket and Māori health providers were also sources of messages supporting healthy eating. For some gym-going participants, gym instructors had been a useful source of information on the role of nutrition in relation to physical (and mental) energy.

> *"It wasn't until I went to the gym and told them what I was eating, they said, 'oh, there you go'. I thought, 'if I'm eating that, my kids are eating that. What are they doing at school?' My second eldest daughter, she fell asleep a couple of times at school."*
>
> **Samoan Male – Wellington**

Messages via Colleagues and Peers

Friends and work colleagues were also considered a useful source of information on healthy foods, healthy eating options, and recipe and meal ideas. One Pacific father in this study reported that his ideas about healthy eating and exposure to unfamiliar, healthy foods had been expanded by listening in on his female colleagues' regular discussions.

Peers, particularly for teenage girls, could be an influential source of information on healthy and unhealthy eating. One teenage girl in this study reported that discussion of food, and evidence of disordered eating (including induced vomiting) were both commonplace at her single sex college.

> *"I've seen girls vomiting and stuff -… they take excess laxative pills and stuff … some girls, when I first started out in college, some girls were talking about how big they were and how they wanted to lose so much weight. Then they started to talk about laxative pills and I don't get why they do that to their bodies … they were white girls. Sometimes Pacific girls can't admit that they're overweight … there are more Pacific girls who are getting much skinnier, but some of them are just obese."*
>
> **Samoan/Niuean Female Teen – Wellington**

7.2.3 Messages that Undermined Healthy Eating

Participants in this study readily identified messages from external sources that effectively undermined their attempts to promote healthy eating (and role models) in their family/whānau. Parents noted the effect of television advertising in prompting their children to ask for specific foods, particularly snack foods, less healthy breakfast cereals, and takeaways. They also noted the role that price promotions on products such as chippies and fizzy drink played in undermining parents' resolve to cut down on or avoid these foods and drinks.

> *"When you see stuff in the papers like chocolate that are on special, you know, that makes you want to buy it. That's unhealthy."*
>
> **Pacific Samoan Female – Wellington**

The following high level messages were identified in this study as undermining healthy eating by families/whānau:

- The general promotion of sweet foods and packaged snack foods as healthy alternatives because they were made from "fruit" or had "natural sugars" in them. The researchers note that these same foods may also have been high in fat but that some participants were not aware of this.
- The general importance placed on females (in particular) being slim. There was evidence in this study of the impact of teenage peers (usually girls) becoming focused on weight loss at the expense of nutrition, e.g. with one teenage participant reporting the excessive dieting and bulimic behaviour modelled by girls at her college.
- The idea that takeaways were part of a balanced diet. As discussed already, for many people the concept of a balanced diet was hazy and extremely accommodating of unhealthy eating. Many people appeared to have adopted the view that a balanced diet was one in which there was a mix of healthy and less healthy foods, without having given much thought as to what the proportions of each should ideally be. In this context, messages about takeaways being part of a balanced diet were embraced as an excuse to eat takeaways without guilt, without much clarity as to how often was too often.
- Food industry advertising that targeted children generally and, as part of this, food industry marketing aimed at children. (McDonald's involvement in children's sport was specifically singled out by at least one participant as an example of unhelpful messages that undermined healthy eating).

> *"Get McDonalds out of soccer and rugby. Get rid of the vouchers of McDonalds doing well in sport – it is just ridiculous. It costs the government a little bit [but] the way McDonalds survive, they just get in and spend all their money that way, the kids get indoctrinated with it. Get rid of all the unhealthy advertising – if it is not healthy then don't advertise it while kids are watching – let's face it, at three or four o'clock in the afternoon they are not advertising to me or you – they are advertising to children."*
>
> **Pakeha Male – Christchurch**

7.3 Influential Communication Channels

7.3.1 Adults

The following communication channels were frequently cited as influencing adult participants' ideas about healthy eating, and/or providing messages in support of healthy eating:

- Women's magazines and other health and lifestyle publications that included sections on cooking, nutrition and weight loss.
- Television programmes with a focus on weight loss and nutrition.
- General practitioners and other health practitioners, local health organisations affiliated with Māori organisations and rununga.
- Gyms.
- Colleagues and friends.
- Products in supermarkets that carried the Heart Foundation tick.

The following communication channels were cited as providing mixed or confusing messages about healthy eating, which could then work to effectively undermine messages from other sources.

- The diet industry – diet industry advice and information tended to take a primary focus on weight loss in the context of healthy eating. As a result, people reported receiving confusing or conflicting messages about what they should or should not be eating. The researchers note that this may have also been because diet industry notions of healthy eating may have placed energy content ahead of other nutritional considerations.
- The food industry, via marketing and promotion of foods, often made health-related claims for its product that were in conflict with messages from other channels.

- Media coverage of the latest report on this or that food (e.g. coffee was a common example) often highlighted conflicting findings about what foods were considered to be healthy or otherwise. Some people used the regular emergence of new, and different opinions, as to whether a particular food was healthy or not as an excuse to ignore healthy eating messages as a whole, and to continue eating as their tastes dictated. This was a common response for Avoiders in particular (see Section 8.0 – Audience Segmentation in this report).

  "To be honest, I only know about the sugar content in apples and oranges and stuff because I was watching something on TV about it the other night, which is why I will sit here and argue with you – because I know. I think it was '20/20' or '60 Minutes'."

  Pakeha Male – Auckland

7.3.2 Children

The following communication channels were cited by children and parents as influencing children's ideas about healthy eating, and providing messages in support of (and in some cases, undermining) healthy eating.

- Parents and caregivers – both verbally and by providing healthy eating role models (in some cases). As discussed already, some parents provided mixed messages by saying one thing regarding healthy eating, while doing something different themselves.
- Schools and pre-schools (as outlined earlier) were a significant source of healthy eating messages.
- Television programmes with a focus on weight loss and nutrition – more so for older children and teenagers – were an influential source of eating messages.
- Television advertising aimed at children, promoting cereals, packaged snack foods, and takeaways in particular (as outlined earlier) were reportedly a significant influence in undermining healthy eating in the family/whānau.

  "Probably the TV ads more than anything, and the really irritating thing is, right on dinner-time, you start getting all the KFC ads and the McDonalds ads and the Pizza Hut ads and the kids look and go, 'oh, oh, can we have takeaways?'… but then you get the good ads – you get the 'five plus a day' – they haven't been on for a while, have they? ... the children see that and they realise that they should be eating [vegetables] … TV's telling them, and if the TV is telling them, well it must be true! So that was helpful."

  Pakeha Female – Wairarapa

- Media coverage of healthy role models such as sports people.
- Television and print campaigns that promoted healthy eating such as the *'five* plus *a day'* campaign. (As discussed already, schools were an important means of promulgating these messages).
- Peers (as children got older and the impact of peer influence increased) were an influential source of eating messages. In this study, this was more relevant to girls than boys. The findings relating to peer influence indicated that while peers could be a source of healthy eating messages, they were also a powerful potential role model for unhealthy eating behaviours and disordered eating (e.g. excessive dieting and vomiting as a means of weight control).

> *"They don't really talk about food but even though they're not talking about it, you can like kind of see it in their faces when we're eating like a sausage roll. They are always harping on like 'do you know what's in sausage rolls?', so they can feel a bit better about themselves."*
>
> **Samoan/Niuean Female Teen – Wellington**

8.0 Audience Segmentation

8.1 Introduction

As part of its study into Healthy Eating in New Zealand Families/Whānau, HSC wished to understand what segments existed in relation to eating, so that targeted social marketing messages could be developed to support healthy eating. A segment is a sub-group of people who share one or more characteristics, e.g. attitudes and behaviours that differentiate them from other members of a given audience.

This section of the report discusses the segmentation that was developed to explain the composition of the audience in relation to eating. It outlines the basis of the segmentation, shows the relative positioning of the six segments that were identified in the study (on a segmentation map), and gives a detailed profile of each segment. A summary of the segment profiles appears at the end of the section.

8.2 Basis of the Audience Segmentation

8.2.1 Use of In-depth Interviews

The eating audience segmentation was developed from data generated from the 48 individual in-depth interviews with parents and caregivers (18 of these interviews were conducted with people who had previously participated in a family focus group in Phase One of the SMAR project, and 30 were conducted with people who had not taken part in a family focus group).

The rationale for using an in-depth interview method was that the development of any audience segmentation required an in-depth understanding of people as individuals, e.g. their attitudes, behaviours, practices, motivations and barriers. Obtaining such understanding is best achieved in the privacy and security of in-depth interviews[17] because they enable frank disclosure by the participant.

8.2.2 A Knowledge – Behavioural Segmentation

Prior to fieldwork commencing, it was agreed with HSC that the basis of the audience segmentation would be determined by the research findings, rather than on a pre-determined basis. In other words, the segmentation would emerge from the data, rather than the researchers testing previously generated hypotheses as to what the segments might be based on.

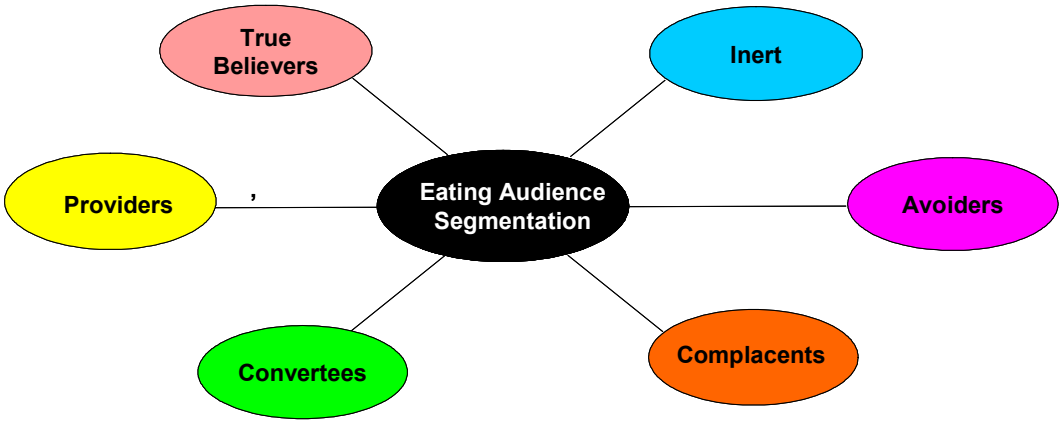
[17] In-depth interviews are a dialogue between one participant and one researcher.

The segmentation that emerged from the research was knowledge-behavioural in nature. The distinctions between different segments were driven both by eating behaviours, and also by knowledge about healthy eating (and an active interest in pursuing such information).

TNS's analysis showed that the two defining characteristics of the audience were the extent to which the participants were or were not informed about healthy eating (see knowledge below) and were or were not practising healthy eating behaviours (see behavioural below).

- **Knowledge** – were (or were not) informed about healthy eating – this refers to the level of knowledge people had about healthy eating. It includes the extent to which they were active information seekers regarding healthy eating. An understanding of participants' knowledge about healthy eating assisted with gaining insight into their attitudes to healthy eating.
- **Behavioural** – were (or were not) practising healthy eating behaviours – this refers to the nature of eating behaviours displayed by participants. Participants' eating behaviours were underpinned by their attitudes to eating.

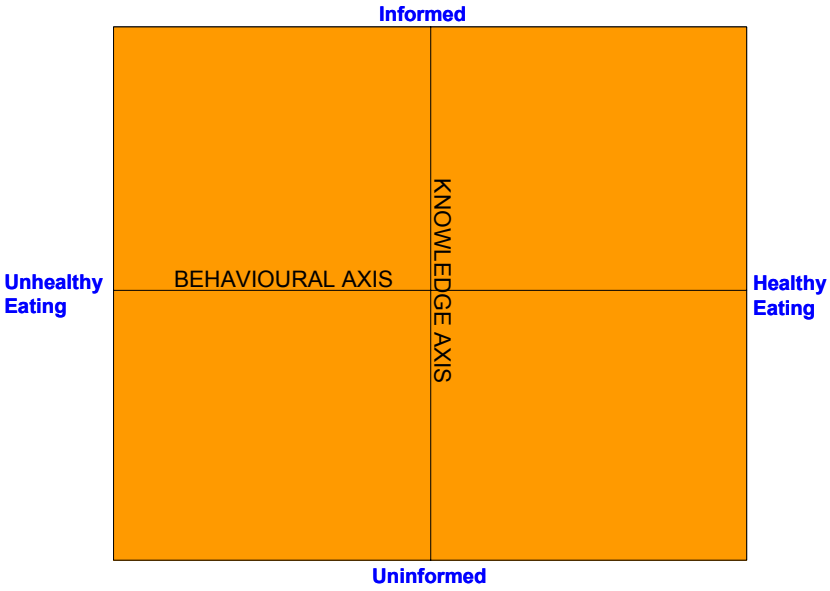
Six distinct groups (referred to here as 'eating segments'), were identified in this study as shown in the diagram below. The segment names (except for the Provider segment) were developed by the researchers to reflect the essence of the respective segments in relation to healthy eating.



8.3 Segmentation Map

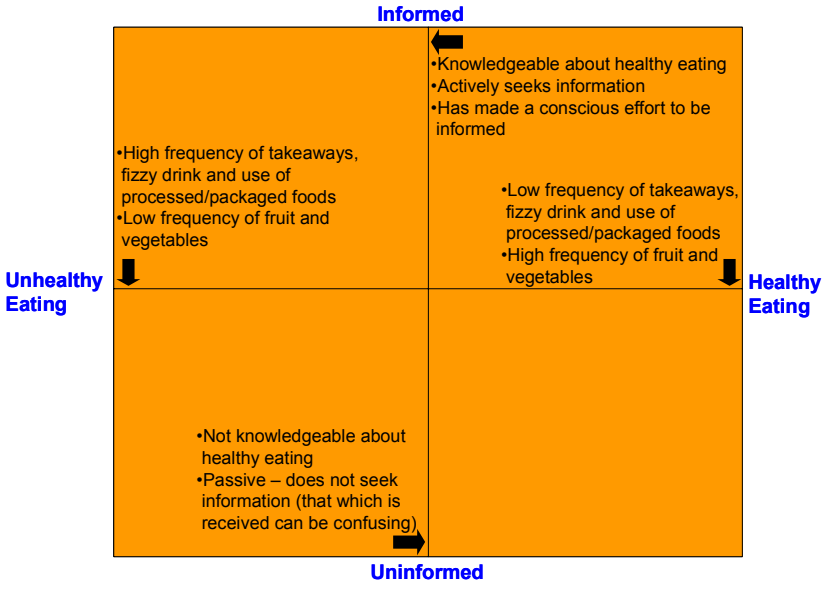
8.3.1 The Axes

A segmentation map has been developed to help the reader conceptualise the audience – see below. The two axes used in the map are *informed – uninformed* (refers to level of knowledge about healthy eating) on the vertical axis, and *healthy eating – unhealthy eating (*refers to behaviours) on the horizontal axis.



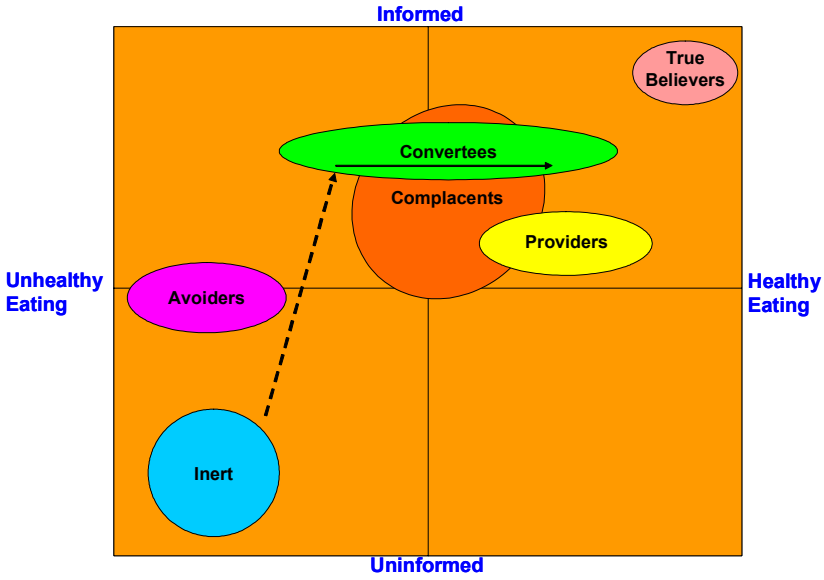
8.3.2 Meaning of Axes

The diagram below describes the meaning of each axis.



8.3.3 Positioning of the Segments

The following diagram shows the six eating segments identified in this study, and their relative positioning on the knowledge and behaviour axes. Note: The information in the diagram is based on qualitative data so is indicative only.

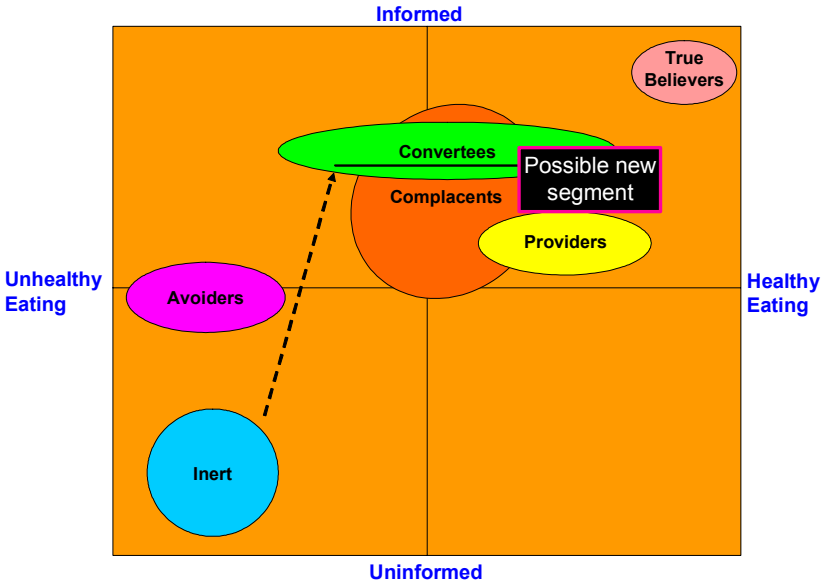


The meaning of the arrow on the Convertees segment is defined in that segment's profile (see later).

Key points to be made in relation to the audience segmentation follow:

- While True Believers were very knowledgeable about healthy eating and some bordered on the fanatical in practicing healthy eating, this positioning (as shown in the segmentation map above) is not likely to be attainable by the majority of people, and nor is it necessarily desirable for them to achieve it. Adhering to such a disciplined approach to healthy eating would be demanding and difficult for other segments to sustain over time.

- HSC may wish to consider 'creating' a possible new segment, i.e. promoting a space on the above segmentation map that represents a sustainable balance between being reasonably well informed about healthy eating and operating on the healthy side of the ledger in terms of eating behaviour (although not in the fanatical way of True Believers). The diagram below shows the positioning of a possible new segment. Note: Some Convertees were on the move to this space already, and simply required encouragement and reinforcement of their newly acquired healthy eating behaviours. Some Complacents had occupied this space in the past, and needed gentle reminders of the desirability of maintaining previous healthy eating behaviours in the face of numerous opportunities to let their eating habits slide. Providers also shared many of the behaviours associated with this space, and needed reinforcement that many of their existing eating habits were desirable from a healthy eating point of view.



8.4 Segmentation Profiles

Given the segment profiles below were developed from qualitative data, they do not indicate the proportion of the population that fits into each segment. A measurement of segment size could be obtained using quantitative research.

8.4.1 True Believers – 'zealously practice healthy eating'

'You are what you eat'

As People

- True Believers were very knowledgeable about healthy eating and zealously ensured that their family/whānau engaged in healthy eating behaviour with few exceptions, e.g. special occasions such as birthdays.
- Individuals in this segment were passionate about their family/whānau and were driven to ensure their partner and children were looked after in the best possible way. They personally felt highly responsible for all aspects of their partner's and their children's well-being and had perfectionist, unyielding views about what should and should not happen to ensure that their family/whānau was looked after in the best possible way. This controlling approach to managing one's family/whānau was driven by love. True Believers were typically brought up in this type of environment and were simply acting out in adulthood, what they had experienced during their childhood.
- True Believers comprised a mix of stay-at-home mothers[18] and those in full-time employment (in one case, a father). Those in full-time employment typically received considerable support from other family/whānau members (often their own mother), to ensure that the household ticked over efficiently and effectively while they were at work. Those providing support were required to adhere to the True Believer's eating rules, regardless of whether they were in the True Believer's home or their own home.

[18] Who may have chosen to be a stay-at-home parent to reinforce the values they grew up with.

Eating Knowledge

- True Believers were the key decision-makers regarding what would and would not be eaten in their household. They were very well informed about healthy eating, and tended to pass this information on to their children. They actively sought information to keep themselves abreast of new information about what did and did not constitute a healthy diet, and made dietary changes to reflect current thinking. They were typically well versed in interpreting nutritional information on products at supermarkets, purchasing only those that met known criteria for healthy food (e.g. less than three percent fat).
- The discerning nature of True Believers meant they considered and weighed up things carefully when it came to what their family/whānau would and would not be given to eat. While they would try new foods, these were well researched (through a variety of means including the Internet, promotional material, women's magazines, talking to sales assistants at health food and organic stores, and reading labels). Marketing hype for food and eating carried little weight with True Believers, rather, they sought their own evidence to back up claims.

Concern about Healthy Eating

- True Believers expressed relatively high levels of concern around healthy eating because they saw diet as central to the health and well-being of their family/whānau both now and in the future. It was perceived as one means of helping their children to maximise their potential. They reasoned that a child who ate healthily was more alert and performed better at school, and therefore had a better opportunity of maximising his/her potential in life, e.g. having better career and incoming earning prospects.
- This segment had an almost exclusive health-focus when it came to eating, with the nutritional benefits of food emphasised for health reasons. The adage, 'we are what we eat' was the mantra of the True Believer, with the physical body often likened to being a temple – something to be respected – and not to be abused by eating unhealthy foods or over eating. The nature of food and the size of portions consumed were both important to True Believers.

- The True Believers in this study comprised a mix of low to high socio-economic status people. Overall, True Believers were not cost conscious when it came to healthy eating. Even those in the low socio-economic group were prepared to invest money into healthy eating, reasoning that failure to do this would cost the family/whānau more in other ways, e.g. doctors' bills and time off work. However, True Believers also believed that eating healthily was more affordable than the costs associated with eating unhealthily. There was evidence in this study that it was possible to eat healthily and cheaply.

Eating Behaviours

- True Believers' commitment to their family/whānau (as described earlier) and their zealous belief in the benefits of healthy eating meant they willingly 'invested' time, effort, planning, commitment and persistence to ensuring healthy eating occurred. Being naturally good time managers helped to make it easier for True Believers to make such an 'investment'.
- True Believers had strategies and practices that reinforced healthy eating, as well as healthy eating rules that were strongly and consistently enforced. Unlike segments that prioritised household harmony over healthy eating (e.g. Complacents and Avoiders), True Believers were prepared to (and did) 'go into battle' as necessary to enforce healthy eating behaviour in their family/whānau.

  "They have no choice, but to eat what's put in front of them. If they say, 'I don't like this or whatever', we never force them to eat it, but there's no alternative."

  Māori Female – Auckland

- True Believer strategies that reinforced healthy eating included: planning meals, always shopping with the plan in mind, sticking to a shopping list, maintaining control of all snacks and meals purchased when away from home, banning unhealthy options such as fizzy drink and lollies from the home, and ensuring there were healthy alternatives on hand. Where children were given choices, mothers (and in one case a father in this study) retained final say over what the children ate. True Believers' children may not have been allowed to spend pocket money on food.
- Rules tended to be more numerous than for other segments, and were enforced. Eating rules included: eat what you are given, everybody eats the same dinner, no snacks after or as an alternative to dinner, dinner is eaten at the table with no television on, no dessert until the main course is eaten, no bread or drinks until vegetables are eaten, no one leaves the table while the family/whānau is eating. Some families/whānau also discouraged children talking while eating dinner.

- In this segment, emphasis was placed on cooking 'from scratch' because True Believers wanted to know what was in the food prepared for their family/whānau (this reflected the controlling – but loving – approach mentioned earlier). Limited use was made of processed foods, and takeaways featured rarely – both types of foods were strongly regarded as *'unhealthy'.*
- True Believers' diets were characterised by a low frequency of takeaways, fizzy drinks and use of processed and packaged foods, and a high frequency of healthy, tasty foods, with emphasis on fruit and vegetables.
- True Believers' children were among the healthiest eaters in this study and appeared to eat this way from choice. They were exposed to a wide range of healthy, tasty foods at home and appeared to reject unhealthy foods when offered them away from home.

True Believer Demographics

The demographic data of participants in this study who were identified as True Believers appear in the table below:

Ethnicity	Socio-economic Status[19]	Number of Children	Age of Children	Location
Pakeha Māori Chinese Malaysian Singaporean	Low to high	2 to 3	3 to 12 years	South Auckland Wellington Christchurch

8.4.2 Providers – 'pride in using your resources'

'Keeping it close to home, and (for some) keeping costs down'

As People

- Individuals in this segment had been brought up being close to nature, i.e. 'living off the land' and had continued this lifestyle in adulthood because it felt natural to do so (and in some instances this approach was also used to help contain food costs – see below).
- Some Providers were cost-conscious and strongly motivated to keep their food budget down and in support of this, to use the food resources they had around them (e.g. produce from their garden, fruit from the local orchard, freshly caught fish, or meat from a neighbouring farmer). In small rural communities this approach to life was often the norm, as was sharing foods with others nearby.

[19] As defined by HSC for the purpose of the SMAR project.

- Some urban Providers in this study grew their own vegetables and took pride in being self-sufficient on this front for at least part of the year. Those not growing their own vegetables took advantage of being able to access fresh produce from nearby produce markets, farmers' markets or market gardens. Urban Providers were less likely than their rural counterparts to be involved with fishing or have access to meat from a farm.
- For Māori Providers, using their own food resources was also motivated by desire to and pride in being able to provide for their whānau (i.e. not just keeping food costs down). Māori Providers reported that their whānau had always gardened/fished/farmed, so it was natural for them to carry on this tradition and they took considerable pride in being self-sufficient in these areas. They had the ability to do this, because they had land to support growing food, and access to other fresh food sources (e.g. fish and meat).
- Māori Providers were generally related to the next door neighbour or whānau down the road, and there was an emphasis on community. In these situations, food would be intentionally shared among whānau, and there may have been shared decision-making as to who would grow what. For example, whānau may have grown a particular range of vegetables to share. Others may have had an orchard and would share fruit within their community. Often, diving or hunting excursions would also provide fresh food for the community rather than for one whānau.

Eating Knowledge

- Providers had an average level of knowledge in terms of healthy eating. They were not especially proactive in seeking information about healthy eating but were reasonably receptive to information that found them, e.g. by way of magazines, television and radio. Providers who lived in small rural communities typically shared such information within their community, with neighbours or whānau members.

Concern about Healthy Eating

- Providers enjoyed food but were not deliberately focused on healthy eating – although this occurred as a by-product of them accessing food resources around them (as outlined above). They tended to be only moderately concerned (or relatively unconcerned) about healthy eating, despite their children being among the healthiest eaters in this study. Providers saw healthy eating as desirable, but it was not the overwhelming focus that it was for True Believers. Rather it was a welcome by-product of their 'do-it-yourself' approach to feeding their families/whānau.

Eating Behaviours

- Providers were replicating the eating behaviours they grew up with in childhood. The old *"tried and trusted"* ways from their past, e.g. reliance on home-grown food and natural, unprocessed foods and avoidance of processed foods, had continued to serve them well (and helped to contain food costs). This reinforced the view that such foods were 'the best'.
- They kept the diet of their family/whānau simple, with a focus on home-cooked (and often home-grown) foods, limited use of takeaways and convenience. As indicated above, Providers' focus was on providing for family/whānau using the food resources they had around them. Keeping costs down was also a significant motivator for some. Providers typically cooked their food from 'scratch' because it was readily accessible (and more cost effective). As time-rich individuals, Providers had the time, (as well as the energy and motivation) to cook in this way. (These households were likely to have a full-time homemaker or at least one parent working flexible part-time hours).
- The ethos of not wasting food meant Providers were resourceful in making use of food they had produced themselves or had had given to them. They composted so that their gardens continued to produce well. Seasonal surpluses of produce were not wasted, rather they were stored by means of preserving, freezing or turned into accompaniments such as chutneys and pickles. In keeping with the 'no waste' ethos, the nature of food available at a given time tended to determine the diet of the Provider and his/her family/whānau. This meant that occasionally some less healthy foods, e.g. mutton flaps, were eaten.

> *"Whatever hits my table I'll create something out of it. So if somebody dumps a load of venison on the table or fish or whatever … it's to do with what comes in; that's exactly how it goes … whatever comes in the door is what I'm making the meals out of really … like the boys shot a duck a few weeks ago and I sort of said, 'right, it has to be plucked and gutted – so we will be having duck' … it is interesting the different sorts of foods that hit this table and I've had to learn how to cook [them] – like wild venison and wild pork, and how to fillet a fish and those sorts of things – because if people come in and say, 'do you want some fish?' they mean a whole fish – they don't mean organised and ready to cook."*
>
> **Pakeha Female – Wairarapa**

- Relatively few unhealthy foods made their way into the homes of Providers and, as a result, few healthy eating rules existed in such families/whānau because there was not the necessity for them. Providers in this study lived mainly in rural areas, which meant that their children had less ready access to takeaways and other junk foods (such as lollies, chippies and fizzy drinks) that children in some other segments – living in urban areas – routinely bought from dairies.

Provider Demographics

The demographic data of participants in this study who were identified as Providers appear in the table below:

Ethnicity	Socio-economic Status[20]	Number of Children	Age of Children	Location
Pakeha Māori	Medium to high	2 to 5	3 to 17 years	Gisborne Wairarapa Christchurch

8.4.3 Convertees – 'health scare had motivated healthier eating'

'I want to be around for my family/whānau, especially grandchildren'

As People

- Convertees had a new-found concern about healthy eating, because they were trying to improve the diet of their family/whānau through eliminating or reducing less healthy eating habits. This may have involved distancing themselves from *'bad'* eating habits they grew up with. For example, some Pacific Convertees were moving away from what they now saw were unhealthy traditional Pacific eating practices (such as boil-ups, corned beef, and little emphasis on vegetables other than taro).

[20] As defined by HSC for the purpose of the SMAR project.

- The catalyst for improving the diet of the family/whānau typically came from Convertees personally having a health scare, e.g. a heart attack or being overweight and being told by their general practitioner to make dietary changes to eliminate or manage the situation (or the death of parent, e.g. through a heart attack). Those in this situation had been motivated to make recommended changes to the diet of their family/whānau in order to enjoy better personal health, and to protect the health of their family/whānau. Importantly, Convertees expressed an overwhelming desire to have a future – to be there for their family/whānau (and in the case of grandparents, to be there for their grandchildren).

  "I learn to eat healthy food because I was sick the last three years and the doctor said I had [a] heart problem and [was] diabetic and [had] high blood pressure. I woke up … After that I collapsed ... so I decided I'm not going to [eat unhealthy food] … I'm going to eat vegetables and watch what I'm eating."

  Tongan Female – Wellington

- Convertees comprised a mix of stay-at-home parents and those in part and full-time employment.

Eating Knowledge

- Convertees were knowledgeable about healthy eating (although less so than True Believers). They were often characterised by the desire to become better informed, and as such were active information seekers regarding healthy eating and ways of achieving this.
- Many Convertees were previously Inerts and had had limited knowledge in relation to healthy eating. However, as Convertees they avidly sought out information on healthy eating to get themselves up to speed and put new learnings into practice.

Concern about Healthy Eating

- Convertees had a high level of concern about healthy eating, often triggered by a personal health scare or that of a close family/whānau member, e.g. a parent.
- Growing awareness of obesity among Māori whānau and Pacific families had been a driver of increased concern about healthy eating among some Māori and Pacific Convertees.

- Convertees may also have been alerted to the need to change their eating habits by steady weight gain, lethargy, or advice from their general practitioner. Television programmes such as *Downsize Me,* gym instructors, and work colleagues may have also functioned as prompts to look at their eating habits, and were also important sources of information on healthy eating.

Eating Behaviours

- Although the eating behaviours of individuals in this segment ranged from moderately unhealthy to moderately healthy, on becoming a Convertee it was common for these individuals to increasingly adopt healthier eating behaviours *over time* (see arrow on the Convertee segment in the segmentation map earlier), as opposed to switching instantly from very unhealthy eating behaviours (as was the norm for Inerts) to healthier eating behaviours. Change occurred over time as Convertees gained experience and confidence with eating more healthily.
- Convertees in the infancy of transitioning their family/whānau to healthier eating, were committed to the journey they were taking to healthy eating but recognised there was still a way to go to fully achieve this.
- Convertees understood the relationship between healthy eating and achieving healthier outcomes for their family/whānau. In some instances, individuals had made health gains since adopting healthier eating behaviours, e.g. weight loss, feeling more mentally and physically energetic and enjoying enhanced self-esteem, and this had reinforced the benefits of healthy eating.
- Some Convertees recognised that healthy eating required planning and were trying to become better planners to facilitate this. Convertees who were already some way down the road toward healthy eating set aside time to plan what their family/whānau would eat over the coming week or so, and factored in time to shop for healthy food and prepare and cook this.
- Some Convertees in part-time or full-time employment were time-poor. When pressured time-wise, it could be easier to reach for convenience foods than to spend time preparing and cooking food. Guilt about doing this was sometimes reduced by choosing healthier bought food such as Subway or chicken and bread rolls from the supermarket.

- Convertees (especially those who were further down the healthy eating track) were limiting unhealthy foods that were previously eaten without concern. For example, some Pacific peoples had sacrificed some cultural traditions around food to protect the health of their family, e.g. reduced or eliminated foods such as taro and dishes with coconut cream. It was typical for Convertees to also limit fizzy drink, junk food and takeaways, items that may have previously been a routine part of their family/whānau diet.
- Some Pacific Convertees 'walked the talk' about healthy eating beyond their family, i.e. in their wider cultural community, despite resistance from some quarters. For example, they took healthy food options to church and social functions and good naturedly accepted the less than positive comments about their food contributions. They accepted that it would take time to gain traction with healthy eating ideas, especially among older Pacific peoples, who it was felt could interpret the introduction of non-traditional Pacific food as a rejection of cultural values. 'Walking the talk' in their wider cultural community was motivated by wanting to help with bettering the health of 'their people'.
- Those individuals who were more evolved in adopting healthy eating behaviours, had rules about which foods could and could not be eaten, and enforced these consistently. They were also prepared to go 'in to battle' with family/whānau members who did not support their approach to healthy eating.
- The cooking methods and food repertoires of Convertees were not expansive, although there appeared to be willingness to expand these (e.g. through education).
- In a few instances Convertees had become 'new' (small-scale) vegetable gardeners, in an effort to gain control over the quality of vegetables consumed (and to help manage food costs).

Convertee Demographics

The demographic data of participants in this study who were identified as Convertees appear in the table below:

Ethnicity	Socio-economic Status[21]	Number of Children	Age of Children	Location
Pakeha Māori Samoan Niuean Tokelauan Tongan Cook Islander Fijian	Low to high	1 to 5	1 to 16 years	Wellington Gisborne Wairarapa Christchurch Timaru

8.4.4 Complacents – 'there's others worse than us'

'We're doing okay'

As People

- Complacents lived very time-scarce lives and emphasised that they were trying to 'do their best' for their family/whānau within the time available. They claimed that managing a family/whānau and being in full or part-time employment limited the amount of time available to prepare food. In terms of eating, Complacents' priority was on getting the family/whānau fed as quickly and as easily as possible. This meant food needed to be simple, fast and convenient – these criteria made it easy to opt for less healthy foods. Variety was not seen as especially important because it took time to factor this into the family/whānau diet.

> *"You know there's days where tea is veges and chicken nuggets … I might be a little bit under a misconception, but I think that because we're eating veges I don't worry too much about what else we eat – because we probably do have chicken nuggets a bit too often … I mean they had meat pies just last night with other veges and broccoli … probably we shouldn't be giving them meat pies for dinner but they like them, and it's not like we're having meat pies seven days a week. I think as long as you balance it all out."*
>
> **Pakeha Female – Wairarapa**

[21] As defined by HSC for the purpose of the SMAR project.

"[It] takes a lot longer to cook – to boil potatoes and to prepare vegetables and to cook ordinary average plain food. It's a lot easier to chuck in some fish cakes, fry some chips and nuke some chicken nibbles and mixed vegetables … they're vegetables but they're microwaved and they're frozen. They're not fresh. So it takes a lot longer to cook plain food than it does fancier stuff these days."

Pakeha Female – Gisborne

Eating Knowledge

- Complacents ranged from average to reasonably high in terms of being informed about healthy eating, however, their eating behaviours were fluid and included a mix of healthy and unhealthy behaviours within individual families/whānau.

Concern about Healthy Eating

- Complacents were relatively unconcerned about healthy eating, because they believed that their family/whānau was 'doing okay' and had a 'healthy enough' diet.
- Their children were not among the healthier eaters in this study but their parents might be surprised to learn this. When they examined their eating practices in this study, they were sometimes surprised at the amount of less than healthy food that had crept into their diets.
- Information collection tended to be passive rather than active. For example, they may have seen advertisements or programmes on television (such as the cooking channel or *Downsize Me*), read something in a magazine, or had a conversation with a friend that touched on healthy eating issues.
- Complacents may have more actively sought information about healthy eating when there was a specific problem to be addressed, but tended to take a targeted rather than global approach to solutions. For example, one mother avoided fatty foods because of a problem with digesting fat – but the rest of the family ate less healthily because it was *her* problem. Another family limited sugar for one child who got *"hyper"*. When the child got unmanageable, sugar was severely limited – but the rules were relaxed when the problem appeared less acute – and there was no attempt to cut the whole family's sugar consumption.

Eating Behaviours

- Complacents were typically aware that they were a 'bit naughty' in terms of the unhealthy foods eaten but reasoned that because fruit and vegetables were included in the family/whānau diet, that this signified they had their health at heart. Having family/whānau members who were healthy (i.e. not sick), and children who were not overweight and who had plenty of energy, reinforced that their current diet (of a mix of healthy and unhealthy foods) was not a problem.
- Complacents emphasised the importance of having a harmonious family/whānau. They aimed to avoid conflicts because these took time to resolve. With eating being an area that could cause conflict within the family/whānau, it was sometimes easier to allow consumption of unhealthy foods to 'buy peace', than go 'into battle' on the healthy food front.
- Overall, Complacents were happy to settle for being 'average' in terms of their quality of eating, reasoning that *"there are [were] others worse than us".* Their current approach to eating appeared to work, so there was no perceived reason to make any changes.
- Individuals in this segment may have eaten more healthily earlier in life, e.g. in childhood or in adulthood prior to having a partner and managing the demands of running a family/whānau (in conjunction with full-time or part-time work for some). Complacents had typically moved away from healthier eating for any of the following reasons:
    - Lack of time combined with easy access to unhealthier (more convenient) foods made it easy for Complacents to choose such food because it freed up time in their lives. Marketing of such foods alerted Complacents to quick, easy food options and got them into their consideration set.
    - The influence of a less healthy eating partner, i.e. *partner drag* (as discussed earlier).
    - Prioritising having a harmonious family (as discussed earlier).
- Healthy eating rules may have existed in Complacent families/whānau. However, Complacents tended to have a less stringent, more flexible approach than did more committed healthy eaters. Rules tended to be ad hoc and not thought through, making it difficult for parents to make 'on the spot' decisions, e.g. how many biscuits were okay as a snack? What rules they did have were not consistently applied, because sometimes Complacents took the line of least resistance in order to avoid getting off-side with their children.

- The erosion of healthy eating typically started with the consumption of unhealthy snacks and treats rather than meals. Once set in motion, the unhealthy 'trend' spread to meals. Pay-offs such as better management of time pressures and less conflict over foods eaten by the family/whānau reinforced this approach and ensured its continuation.
- Some Complacents' own taste for unhealthy foods and drinks contributed to their children picking up unhealthy eating habits. Parents may have included items such as fizzy drink, chocolate cereals, chocolate biscuits and lollies in the shopping trolley because they enjoyed them. For example, one Complacent mother reported that she bought chocolate cereal not because the children insisted on it, but because she enjoyed eating it whenever *"mummy's muesli"* ran out.
- In a few cases, Complacents' children were putting pressure on their parents to improve their eating habits. This had been motivated by learning healthy eating messages at school and wanting their family/whānau to have the benefits of such eating.

Complacent Demographics

The demographic data of participants in this study who were identified as Complacents appear in the table below:

Ethnicity	Socio-economic Status[22]	Number of Children	Age of Children	Location
Pakeha Māori Samoan Tongan Indian	Low to high	1 to 5	0 to 15 years	Gisborne Wairarapa Wellington

[22] As defined by HSC for the purpose of the SMAR project.

8.4.5 Avoiders – 'our diet isn't healthy but it's enjoyable'

'Where's the evidence that healthy eating makes a difference?'

As People

- Avoiders may have been Inerts who had transitioned to Avoiders as they had became more knowledgeable about healthy eating.
- Avoiders valued family harmony and were keen to avoid conflicts. In terms of healthy eating, apart from not wanting to implement this for personal reasons (discussed later), they were not prepared to implement it because of the discord it would cause among family/whānau members (especially children).

Eating Knowledge

- Avoiders had an average level of knowledge in relation to healthy eating. Much of their knowledge had been picked up from the food marketing and diet industries, and was therefore conflicting.

Concern about Healthy Eating

- Individuals in this segment may be moderately concerned about healthy eating (although some would have denied this). Avoiders' increased knowledge about healthy eating (e.g. through healthy eating messages) had raised the idea of a potential connection between healthy eating and good health. However, Avoiders were resistant to healthy eating messages because of the conflicting information about what was and was not healthy eating, and no perceived definitive evidence being presented that healthy eating made a real difference to health. The researchers suggest that Avoiders' resistance to healthy eating messages was possibly a 'strategy' to make them feel less guilty about actively choosing to eat unhealthily.
- Some Avoiders picked up much of their information from food marketers and the diet industry. Overall, Avoiders were not active information seekers. For some families/whānau this appeared to be a tactic that enabled them to remain in denial (e.g. thinking along the lines of: 'if I don't know, I don't need to do anything differently' or 'if I don't know, then it can't hurt me').

Eating Behaviours

- Avoiders were loath to give up the less than healthy foods they enjoyed. T hey justified their unhealthy eating approach by citing their good health and lack of weight issues as evidence that their diet was fine.
- Avoiders enjoyed tasty (but often unhealthy) food and in some cases, large portions of it. By resisting healthy eating messages, Avoiders could live out their engrained eating habits without needing to feel guilty. Further, allowing consumption of unhealthy foods made them popular with their children, and this in turn helped to maintain family harmony – a quality much desired by Avoiders.
- Avoiders typically did not have eating rules in their families/whānau. Rather, they believed that if people stayed active and did not smoke or consume alcohol excessively, that they could largely eat what they wanted to and remain in good health.
- Some Avoiders claimed that healthy eating was too expensive and cited this as a reason for not taking it up. However, the researchers suggest that cost was less likely to be the real reason for these Avoiders not eating more healthily, rather it was a further justification for not doing so.

Avoider Demographics

The demographic data of participants in this study who were identified as Avoiders appear in the table below:

Ethnicity	Socio-economic Status[23]	Number of Children	Age of Children	Location
Pakeha Māori Pacific	Low to high	2 to 3	1 to 15 years	Auckland Wairarapa

[23] As defined by HSC for the purpose of the SMAR project.

8.4.6 Inerts – 'healthy eating isn't on the radar'

'The kids are very active'

As People

- Like Complacents, Inerts described very time-scarce lives and tried to 'do their best' for their family/whānau within the time available.
- Inerts may not have been aware of their own unhealthy eating status or if they were, it was not a concern to them. They had always eaten the (unhealthy) food they currently ate and because it had not caused any perceived health problems to date, they saw no reason to make changes. Diet-related illnesses in the wider family/whānau had not acted as trigger points to change (as was the case with some Convertees).
- Individuals in this segment were time-poor and cash-strapped – both factors influenced the eating behaviours that occurred in their family/whānau. Lack of money meant Inerts worried about having enough money to put food on the table for their family/whānau. Concern about filling stomachs was a priority.
- Individuals in this segment comprised a mix of full-time and part-time workers. Shift work and low paid work were common.

Eating Knowledge

- Inerts had a limited understanding of the relationship between healthy eating and good health. At the best they may have been aware of more serious eating-related conditions, e.g. obesity, but considered these would be distant events and not something to worry about now. Generally the perceived benefit of healthy eating was not becoming overweight. However, given Inerts may have been inactive or overweight and were not strongly motivated by aesthetic concerns, neither condition was a trigger to change their eating behaviour.
- These individuals were not active information seekers, and found it hard to sort through the many conflicting messages about food in the media. Most Inerts simply did not try to do this because they were not sufficiently interested in food and, in many cases, did not have the skills to critically assess messages. In a few cases (females), Inerts perceived that the diet industry was a reliable source of information about what food was healthier. Overall though, Inerts found it too difficult to sort through food messages and, as a result, did not give healthy eating messages to their family/whānau. However, there was evidence that some Inerts may have been receptive to healthy eating information if the instructions seemed achievable and affordable.

Concern about Healthy Eating

- Most Inerts were not concerned about healthy eating because it was not on their radar (discussed below). However, a few had a very minor interest in it.

Eating Behaviours

- Inerts had a low level of interest in food as reflected in their limited cooking and food repertoires, and their perception of food as fuel and the preparation and cooking of meals as chores. In terms of food, emphasis was on having foods that were fast, convenient and filling and that provided the most volume for money (the latter reflected that Inerts were typically cash-strapped).
- Like Complacents and Avoiders, Inerts valued family harmony and were keen to avoid conflicts. The researchers suggest that implementing healthier eating in the families/whānau of Inerts would almost certainly result in discord in the family/whānau and this could be a barrier to moving in this direction.
- Unhealthy eating was the norm, with Inerts consuming a high level of processed and convenience foods, takeaways and fizzy drinks. Fruit and vegetables were not a usual part of their diet (a deliberate effort had to be made for their inclusion) and dinners tended to be based on meat and carbohydrates.
- Little or no eating rules existed in Inerts' families/whānau, and those which did exist were rarely enforced.
- Inerts were primarily assemblers of food as opposed to cooking 'from scratch'.

Inert Demographics

The demographic data of participants in this study who were identified as Inerts appear in the table below:

Ethnicity	Socio-economic Status[24]	Number of Children	Age of Children	Location
Pakeha Māori Samoan Fijian Indian	Low to medium	1 to 4	1 to 16 years	Auckland Gisborne Wellington Christchurch

[24] As defined by HSC for the purpose of the SMAR project.

8.5 Summary of Segment Profiles

A summary of demographic data by segment is provided in the table below for comparison purposes.

Variable	True Believers	Providers	Convertees	Complacents	Avoiders	Inerts
Essence as people in relation to eating	'You are what you eat'	'Keeping it close to home, and (for some) keeping costs down'	'I want to be around for my family/whānau and grandchildren'	'We're doing okay'	'Where's the evidence that healthy eating is good for you?'	'The kids are very active'
Knowledge about healthy eating	High	Moderate	Moderate and increasing	Moderate but may be out of date	Varies - may reject information received	Low
Concern about healthy eating	High	Moderate to low	High	Moderate to low	Varies – may be in denial	Low
Eating behaviours	Fanatically healthy and very disciplined.	Healthy as a result of DIY approach.	More healthy than in past. Making gains in some areas (e.g. fizzy & takeaways).	Less healthy than in past. Subtle erosion of healthy eating habits (e.g. through convenience foods and snacks).	Unhealthy is the norm.	Unhealthy is the norm.
Ethnicity	Pakeha Māori Chinese Malaysian Singaporean	Pakeha Māori	Pakeha Māori Samoan Niuean Tokelauan Tongan Cook Islander Fijian	Pakeha Māori Samoan Tongan Indian	Pakeha Māori Pacific	Pakeha Māori Samoan Fijian Indian
Socio-economic status	Low to high	Medium to high	Low to high	Low to high	Low to high	Low to medium
Number of children	2 to 3	2 to 5	1 to 5	1 to 5	2 to 3	1 to 4
Age of Children	3 to 12 years	3 to 17 years	1 to 16 years	0 to 15 years[25]	1 to 15 years	1 to 16 years
Geographic location	South Auckland Wellington Christchurch	Gisborne Wairarapa Christchurch	Gisborne Wellington Wairarapa Christchurch Timaru	Gisborne Wairarapa Wellington	Auckland Wairarapa	Auckland Gisborne Wellington Christchurch

[25] 'Prevalence' of babies and pre-school aged children noted in the Complacent segment.

Discussion and Interview Guides

Smoking Focus Group Discussion Guide

Duration of group: up to 3 hours

Key Terms Used in the Discussion Guide

The following is a list of key terms used in the discussion guide. Each is supported with explanations as to how HSC is conceptualising them.

- **Internal factors:** characteristics of family/whānau functioning; includes factors such as family make-up, roles and responsibilities, norms, rules, cultural practices, and communication styles.
- **External factors:** includes factors such as socio-economic status, geography, and community.
- **Practices:** includes behaviours, decision-making, rules, roles and responsibilities, routines and rituals, communication styles, parenting styles etc.
- **Messages:** includes messages from a range of sources – television, radio, print media, health professionals, friends and family, marketing, etc.

Important Messages for Facilitators

- **Expanding on questions as appropriate** – the questions in the discussion guide are indicative and should be expanded on (where appropriate) during discussion groups for greater understanding.
- **If in doubt about the line of questioning you are using** – always bring it back to children. Do not get weighted down with discussion on adults at the expense of understanding what is happening for children (and the family/whānau that shapes what is happening for children).
- **Participant break/s** – please take a break (or breaks) at appropriate time/s in the group to help participants to stay energised.
- **Helpline numbers and relevant website details** – this information has been included in the participant incentive envelopes.

Introduction

15 minutes

Facilitator to introduce him/herself.

Participants to introduce themselves.

- Facilitator to explain nature of the discussion.
- The discussion will take up to three hours.
- Outline topic matter – we are interested in finding out about New Zealand parents and caregivers' attitudes to some topics such as families, health, eating and smoking.
- Explain that there are no right or wrong answers and no need to reach a consensus.
- Importance of expressing own views (and not being swayed by other participants' views).
- Respect for others' views (even if these are at odds with one's own views).
- Emphasise confidentiality of responses (i.e. these will be pooled for reporting purposes).
- Confirm consent to audio record group (all focus groups).
- Confirm consent to video record group (Auckland and Wellington groups only).
- Confirm consent for client viewing (where applicable).

Facilitator to ask if participants have any queries about the discussion group or participating in it (and to address any queries before proceeding).

1.0 Context Setting

25 minutes (total time 40 minutes)

Objectives of this section of the discussion guide:

- To explore who participants identify as being part of their family/whānau (especially who the parents and caregivers are).
- To explore key roles of identified family/whānau.
- To explore key issues and challenges facing families/whānau and where health and well-being issues fit within this context.

1a. Family/Whānau Make-up and Key Roles

10 minutes

We'll start off by finding out something about your family/whānau. We're going to do this by getting you to fill in a short questionnaire about your family/whānau.

1. **Please list the names of everyone you think of as being your family/ whānau in the spaces below.**

1.	**9.**
2.	**10.**
3.	**11.**
4.	**12.**
5.	**13.**
6	**14.**
7	**15.**
8	**16. (and so on)**

2. Beside each person above, please list your relationship to him/her e.g. mother, father, sister, uncle, close friend.

FACILITATOR NOTE

- Give each participant a questionnaire and pen.
- After questionnaire completion, participants to briefly share information on relationships.

Probe nature of what constitutes family/whānau and reasons.

Thinking about roles and responsibilities in your family/whānau ...

- What are the bigger roles that people in your family/whānau have?

Probe nature of key (i.e. bigger) roles and who occupies such roles.

FACILITATOR NOTE:

- By 'bigger roles' we are meaning roles such as income earner, caregiver, other (participants to specify).
- We are not interested in 'smaller type roles', e.g. story-teller to children at night, supermarket shopper.

1b. Key issues and Challenges Facing Family/Whānau

15 minutes

We're going to move on now and talk about what 'big things' if any, you feel your family/whānau has to deal with on a day-by-day basis.

'Big things' will likely mean different things for different people. If something feels like a 'big thing' for your family/whānau, we're interested in hearing about it …

- What, if anything, are the 'big things' facing your family/whānau on a day-to-day basis?

Seek spontaneous responses and explore as necessary for understanding.

FACILITATOR NOTE:

- Check whether health and well-being features on the list of 'big things' (i.e. challenges and concerns) family/whānau feel they are facing.
- If health and well-being mentioned, probe reasons.
- If health and well-being not mentioned, probe reasons.
- Where non-health and well-being issues are mentioned, explore for understanding but without going into too much depth. For example, if money is mentioned as a challenge, explore 'in what way money is a challenge?' e.g. 'is it a challenge in terms of not having enough money to buy food or is it a challenge in terms of not having enough to save?'

2.0 Health and Well-being

40 minutes (total time 80 minutes)

Objectives of this section of the discussion guide:

- To explore the meaning of *health* and *well-being* (and gauge the extent to which these are perceived as similar or different concepts).
- To explore what value parents/caregivers place on family/whānau health and well-being relative to other key challenges and concerns.
- To explore the importance of specific health considerations: smoking, healthy eating, gambling, alcohol consumption, physical activity.

2a. Meaning of 'Health' and 'Well-being'

5 minutes

We'll move on now and talk about health and well-being …

Thinking about *health* …

- What comes to mind when you think of *good health*?

  Probe for understanding and basis for this.

- What comes to mind when you think of *poor health*?

  Probe for understanding and basis for this.

Thinking about *well-being* …

- What comes to mind when you think about *well-being*?

  Probe for understanding and basis for this.

FACILITATOR NOTE:

- Note extent to which similar or different interpretations are given for the concepts of health and well-being.
- If there is considerable difference in how these concepts are interpreted, this will affect how questioning in the rest of this section of the guide is handled.

2b. Importance of Health Considerations Compared with Other Issues/Concerns for New Zealand Families/Whānau

10 minutes

We're going to talk now about where you see the health and well being of your family/whānau fitting compared with the 'big things' your family/whānau has to deal with on a day-to-day basis. Take a moment and think back to what you said were the 'big things' your family/whānau has to deal with on a day-to-day basis …

- How important is the health and well-being of your family/whānau compared with the 'big things' you mentioned earlier?

  Probe for importance of family/whānau health and well-being compared with 'big things' and reasons why it is more or less important.

2c. Importance of Particular Health Considerations

25 minutes

FACILITATOR NOTE:

- The purpose of the question below (i.e. 'how concerned are you about the following for family/whānau?) is to find out how much of a concern each of the health considerations (i.e. smoking, healthy eating, gambling, alcohol consumption and physical activity) is for parents/caregivers in terms of their family/whānau (including adults and children/young people).

We're going to talk now about five areas of health – smoking, healthy eating, gambling, alcohol consumption and physical activity.

We're interested in hearing what level of concern, if any, you have about each of the five areas of health when it comes to your family/whānau.

We're going to get you to fill in a short questionnaire to give us the information. Once you've filled in the questionnaire, we'll talk about what you've had to say in it.

FACILITATOR NOTE:

- Give a questionnaire to each participant and explain instructions for completion.

Please complete the questionnaire by putting a cross (X) on the line that best describes how concerned you are about a particular area of health for your family/whānau.

Q1. How concerned are you about **SMOKING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q2. How concerned are you about **HEALTHY EATING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q3. How concerned are you about **GAMBLING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q4. How concerned are you about **ALCOHOL CONSUMPTION** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q5. How concerned are you about **PHYSICAL ACTIVITY** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

FACILITATOR NOTE:

- When participants have completed their questionnaire, ask the (top level) questions below.
- If participants reveal why the various health considerations are an issue for them, explore this – otherwise do not probe for this information because it will be covered in the family groups.

We are interested in hearing briefly about some of the answers that you gave in the questionnaire …

- Which of the five areas of health did you say you were MOST concerned about in relation to your family/whānau?

SEEK SPONTANEOUS RESPONSES.

- Which of the five areas of health did you say you were LEAST concerned about in relation to your family/whānau?

SEEK SPONTANEOUS RESPONSES.

FACILITATOR NOTE:

- Collect questionnaires from participants (and staple together).

3.0 Eating

50 Minutes (total time 130 minutes)

Objectives of this section of the discussion guide:

- To explore family/whānau eating behaviours and attitudes.
- To explore messages about eating (given by parents and caregivers and received from external sources).
- To identify communication channels through which participants receive messages about eating (and identify the most influential communication channel/s).

3a. Eating Behaviour

20 minutes

FACILITATOR NOTE:

- The purpose of this section of the discussion guide is to provide HSC with an understanding of what types of meals/diets participants' family/whānau have. However, please do not spend too much time on Section 3a of the discussion guide.
- 'Eating behaviour' to include discussion on food and drinks (i.e. water, juice, milk, fizzy drinks and alcohol).
- Do not probe as to WHY participants' family/whānau do certain eating/drinking behaviours.

Individual Exercise

We're going to talk now about what your family/whānau eats and drinks …

- We want you to think about a typical kind of day and tell us what your family/whānau eats and drinks – we want to hear about this for a typical day in the week and a typical day at the weekend.
- You're going to do this by individually writing the information down on a sheet I'm going to give you. Once you've finished writing things down, we'll hear from each of you about what happens in your family/whānau in terms of eating and drinking.

WEEK DAY	WEEKEND
On a typical day in the week my family/ whānau eats and drinks the following things. Participants to list below: • • • •	On a typical day in the weekend my family/whānau eats and drinks the following things. Participants to list below: • • • •

Now that you've finished your lists, let's hear about the food and drink your family/whānau has on a typical day in the week and at the weekend.

Participants to share as above.

If not mentioned, probe the extent to which the following feature on a typical day during the week and at the weekend:

- Takeaways
- Fizzy drinks
- Fruit
- Vegetables
- Snacks
- Alcohol

Probe for any differences between participants' own eating and drinking behaviour and that of their family/whānau.

Thinking about what your family/whānau eats and drinks on a typical week day and a typical day at the weekend …

- Which of these foods and drinks would you say are really favourite foods and drinks for your family/whānau?

  Probe what makes particular foods favourites.

- Which of these foods and drinks are not particularly popular among your family/whānau?

  Probe what makes particular foods not particularly popular.

- What food and drinks do you make a real effort to get your family/whānau to have?

  Probe reasons for making a real effort re consumption of certain foods and drinks.

- What food and drinks do you try and limit the consumption of in your family/whānau?

  Probe reasons for limiting consumption of certain foods and drinks.

FACILITATOR NOTE:

- 'Limiting' food can be done for two reasons – 1) because of health-related reasons, e.g. allergy, weight and 2) other, e.g. disliked, not acceptable.

3b. Eating Attitudes

10 minutes

Still thinking about eating …

- What do you consider to be healthy eating?

  Probe participants' definition of healthy eating and basis for this.

- What do you consider to be eating that is not healthy?

  Probe participants' definition of eating that is not healthy and basis for this.

3c. Eating Messages and Communication Channels

10 minutes

Messages

- What sorts of things do you say to your children and other family/whānau members about eating?

  Probe messages and reasons for giving them.

- What do you and your family/whānau see and hear (from outside the family) about eating?

  Probe messages about healthy eating and sources.

  Probe messages that encourage eating that is not healthy, and sources.

FACILITATOR NOTE:

- 'Sources' could be tv, radio, parents, good friends, GP, children and so on.

Communication Channels

Thinking about where you get messages about healthy eating from …

- Which channel(s) work best in terms of getting the message across to you (and your family/whānau)?

  Probe most influential source and reasons.

3d. Role of Government and Regulation

10 minutes

Thinking about the role of government in addressing issues of healthy eating and obesity …

- What, if anything, are you aware of that the government does to encourage healthy eating and address obesity among New Zealand families/whānau?

  Seek spontaneous responses.

  Probe for views on initiatives mentioned, particularly whether government should have a role in these initiatives.

If not mentioned, probe for views on government regulating to encourage healthy eating (an example of this are the recent rules around food and drinks to be available in school tuck-shops).

4.0 Smoking

50 minutes (total time 180 minutes)

Objectives of this section of the discussion guide:

- To briefly explore family/whānau smoking behaviours.
- To explore attitudes and beliefs about influences on children/young people taking up smoking.
- To explore family/whānau practices that influence the likelihood of children/young people taking up smoking.
- To identify communication channels through which participants receive messages about smoking (and identify most influential communication channel/s).

4a. Family/Whānau Smoking Behaviour

10 minutes

We're now going to talk about smoking …

- What happens in your family/whānau in relation to smoking?

  Probe who smokes, when, why and where.

4b. Attitudes and Beliefs About Influences on Children/Young People Taking up Smoking

15 minutes

We're going to talk about smoking in relation to your child/children …

- Does your child/children currently smoke?
- To what extent, if any, are you concerned at the moment that your child/children may start smoking?

  Participants to rate their concern on a scale of 1 to 100, where 1= extremely unconcerned and 100 = extremely concerned.

  Probe reason for rating.

- To what extent, if any, are you concerned that your child/children may start smoking in the future?

  Participants to rate their concern on a scale of 1 to 100, where 1= extremely unconcerned and 100 = extremely concerned.

  Probe reason for rating.

Thinking about what does/could influence children/young people to start smoking …

- What things do you believe might increase the likelihood of a child/young person starting smoking?

  Probe influential factors and reasons.

  If not mentioned probe extent to which participants are aware that seeing smoking take place around them can influence the uptake of it.

Thinking about the different things that can influence children/young people to start smoking …

- What influence, if any, do you feel parents/caregivers have on the likelihood of children/young people taking up smoking?

  Probe nature and extent of parents as influential factors and reasons.

- What influence, if any, do you feel peers have on the likelihood of children/young people taking up smoking?

  Probe nature and extent of peers as influential factors and reasons.

- What influence, if any, do you feel showing smoking in the media (e.g. tv programmes, films, magazines) have on the likelihood of children/young people taking up smoking?

  Probe nature and extent of media portrayals as influential factors and reasons.

4c. Family/Whānau Practices that Influence Children/Young People taking up Smoking

15 minutes

Thinking about your child/children and the possibility of them taking up smoking …

- What, if anything, is your family/whānau doing to reduce the likelihood of your child/children taking up smoking (or increase the likelihood of them stopping smoking if they already smoke)?

  Seek spontaneous responses and explore for understanding and reasons.

Probe factors such as:

- ***having rules about smoking (where, when, who)***
- ***allowing access to cigarettes***
- ***talking to child/young person about smoking (what is said?)***
- ***FACILITATOR: This is a priority probe – please explore thoroughly.***
- ***not allowing smoking in front of children/young people.***

4d. Communication Channels

10 minutes

Messages

- What do you and your family/whānau see and hear (from outside the family) about smoking?

  Probe messages about not smoking and sources.

  Probe messages that encourage smoking and sources.

FACILITATOR NOTE:

- 'Sources' could be TV, radio, parents, good friends, GP, children and so on.

Communication Channels

Thinking about where you get anti-smoking messages from …

- Which channel(s) works best in terms of getting the message across to you and your family/whānau?

  Probe most influential source and reasons.

Before we close the group, what final comments, if any, would you like to make about anything we've been talking about in the group.

THANK AND CLOSE

Gambling Focus Group Discussion Guide

Duration of group: up to 3 hours

Key Terms Used in the Discussion Guide

The following is a list of key terms used in the discussion guide. Each is supported with explanations as to how HSC is conceptualising them.

- **Internal factors:** characteristics of family/whānau functioning; includes factors such as family make-up, roles and responsibilities, norms, rules, cultural practices, and communication styles.
- **External factors:** includes factors such as socio-economic status, geography, and community.
- **Practices:** includes behaviours, decision-making, rules, roles and responsibilities, routines and rituals, communication styles, parenting styles etc.
- **Messages:** includes messages from a range of sources – television, radio, print media, health professionals, friends and family, marketing, etc.

Important Messages for Facilitators

- **Expanding on questions as appropriate** – the questions in the discussion guide are indicative and should be expanded on (where appropriate) during discussion groups for greater understanding.
- **If in doubt about the line of questioning you are using** – always bring it back to children. Do not get weighted down with discussion on adults at the expense of understanding what is happening for children (and the family/whānau that shapes what is happening for children).
- **Participant break/s** – please take a break (or breaks) at appropriate time/s in the group to help participants to stay energised.
- **Helpline numbers and relevant website details** – this information has been included in the participant incentive envelopes.

Introduction

15 minutes

Facilitator to introduce him/herself.

Participants to introduce themselves.

- Facilitator to explain nature of the discussion.
- The discussion will take up to three hours.
- Outline topic matter - we are interested in finding out about New Zealand parents and caregivers' attitudes to some topics such as families, health, eating and smoking.
- Explain that there are no right or wrong answers and no need to reach a consensus.
- Importance of expressing own views (and not being swayed by other participants' views).
- Respect for others' views (even if these are at odds with one's own views).
- Emphasise confidentiality of responses (i.e. these will be pooled for reporting purposes).
- Confirm consent to audio record group (all focus groups).
- Confirm consent to video record group (Auckland and Wellington groups only).
- Confirm consent for client viewing (where applicable).

Facilitator to ask if participants have any queries about the discussion group or participating in it (and to address any queries before proceeding).

1.0 Context Setting

25 minutes (total time 40 minutes)

Objectives of this section of the discussion guide:

- To explore who participants identify as being part of their family/whānau (especially who the parents and caregivers are).
- To explore key roles of identified family/whānau.
- To explore key issues and challenges facing families/whānau and where health and well-being issues fit within this context.

1a. Family/Whānau Make-up and Key Roles

10 minutes

We'll start off by finding out something about your family/whānau. We're going to do this by getting you to fill in a short questionnaire about your family/whānau.

1. **Please list the names of everyone you think of as being your family/whānau in the spaces below.**

1.	**9.**
2.	**10.**
3.	**11.**
4.	**12.**
5.	**13.**
6	**14.**
7	**15.**
8	**16. (and so on)**

2. Beside each person above, please list your relationship to him/her e.g. mother, father, sister, uncle, close friend.

FACILITATOR NOTE

- Give each participant a questionnaire and pen.
- After questionnaire completion, participants to briefly share information on relationships.

Probe nature of what constitutes family/whānau and reasons.

Thinking about roles and responsibilities in your family/whānau ...

- What are the bigger roles that people in your family/whānau have?

Probe nature of key (i.e. bigger) roles and who occupies such roles.

FACILITATOR NOTE:

- By 'bigger roles' we are meaning roles such as income earner, caregiver, other (participants to specify).
- We are not interested in 'smaller type roles', e.g. story-teller to children at night, supermarket shopper.

1b. Key Issues and Challenges Facing Family/whānau

15 minutes

We're going to move on now and talk about what 'big things' if any, you feel your family/whānau has to deal with on a day-by-day basis.

'Big things' will likely mean different things for different people. If something feels like a 'big thing' for your family/whānau, we're interested in hearing about it …

- What, if anything, are the 'big things' facing your family/whānau on a day-to-day basis?

Seek spontaneous responses and explore as necessary for understanding.

FACILITATOR NOTE:

- Check whether health and well-being features on the list of 'big things' (i.e. challenges and concerns) family/whānau feel they are facing.
- If health and well-being mentioned, probe reasons.
- If health and well-being not mentioned, probe reasons.
- Where non-health and well-being issues are mentioned, explore for understanding but without going into too much depth. For example, if money is mentioned as a challenge, explore 'in what way money is a challenge?' e.g. 'is it a challenge in terms of not having enough money to buy food or is it a challenge in terms of not having enough to save?'

2.0 Health and Well-being

40 minutes (total time 80 minutes)

Objectives of this section of the discussion guide:

- To explore the meaning of *health* and *well-being* (and gauge the extent to which these are perceived as similar or different concepts).
- To explore what value parents/caregivers place on family/whānau health and well-being relative to other key challenges and concerns.
- To explore the importance of specific health considerations: smoking, healthy eating, gambling, alcohol consumption, physical activity.

2a. Meaning of 'Health' and 'Well-being'

5 minutes

We'll move on now and talk about health and well-being …

Thinking about *health* …

- What comes to mind when you think of *good health*?

  Probe for understanding and basis for this.

- What comes to mind when you think of *poor health*?

  Probe for understanding and basis for this.

Thinking about *well-being* …

- What comes to mind when you think about *well-being*?

  Probe for understanding and basis for this.

FACILITATOR NOTE:

- Note extent to which similar or different interpretations are given for the concepts of health and well-being.
- If there is considerable difference in how these concepts are interpreted, this will affect how questioning in the rest of this section of the guide is handled.

2b. Importance of Health Considerations Compared with Other Issues/Concerns for New Zealand Families/whānau

10 minutes

We're going to talk now about where you see the health and well being of your family/whānau fitting compared with the 'big things' your family/whānau has to deal with on a day-to-day basis. Take a moment and think back to what you said were the 'big things' your family/whānau has to deal with on a day-to-day basis …

- How important is the health and well-being of your family/whānau compared with the 'big things' you mentioned earlier?

  Probe for importance of family/whānau health and well-being compared with 'big things' and reasons why it is more or less important.

2c. Importance of Particular Health Considerations

25 minutes

FACILITATOR NOTE:

- The purpose of the question below (i.e. 'how concerned are you about the following for family/whānau?) is to find out how much of a concern each of the health considerations (i.e. smoking, healthy eating, gambling, alcohol consumption and physical activity) is for parents/caregivers in terms of their family/whānau (including adults and children/young people).

We're going to talk now about five areas of health – smoking, healthy eating, gambling, alcohol consumption and physical activity.

We're interested in hearing what level of concern, if any, you have about each of the five areas of health when it comes to your family/whānau.

We're going to get you to fill in a short questionnaire to give us the information. Once you've filled in the questionnaire, we'll talk about what you've had to say in it.

FACILITATOR NOTE:

- Give a questionnaire to each participant and explain instructions for completion.

Please complete the questionnaire by putting a cross (X) on the line that best describes how concerned you are about a particular area of health for your family/whānau.

Q1. How concerned are you about **SMOKING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q2. How concerned are you about **HEALTHY EATING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q3. How concerned are you about **GAMBLING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q4. How concerned are you about **ALCOHOL CONSUMPTION** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q5. How concerned are you about **PHYSICAL ACTIVITY** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

FACILITATOR NOTE:

- When participants have completed their questionnaire, ask the (top level) questions below.
- If participants reveal why the various health considerations are an issue for them, explore this – otherwise do not probe for this information because it will be covered in the family groups.

We are interested in hearing briefly about some of the answers that you gave in the questionnaire …

- Which of the five areas of health did you say you were MOST concerned about in relation to your family/whānau?

SEEK SPONTANEOUS RESPONSES.

- Which of the five areas of health did you say you were LEAST concerned about in relation to your family/whānau?

SEEK SPONTANEOUS RESPONSES.

FACILITATOR NOTE:

- Collect questionnaires from participants (and staple together).

3.0 Eating

50 Minutes (total time 130 minutes)

Objectives of this section of the discussion guide:

- To explore family/whānau eating behaviours and attitudes.
- To explore messages about eating (given by parents and caregivers and received from external sources).
- To identify communication channels through which participants receive messages about eating (and identify the most influential communication channel/s).

3a. Eating Behaviour

20 minutes

FACILITATOR NOTE:

- The purpose of this section of the discussion guide is to provide HSC with an understanding of what types of meals/diets participants' family/whānau have. However, please do not spend too much time on Section 3a of the discussion guide.
- 'Eating behaviour' to include discussion on food and drinks (i.e. water, juice, milk, fizzy drinks and alcohol).
- Do not probe as to WHY participants' family/whānau do certain eating/drinking behaviours.

Individual Exercise

We're going to talk now about what your family/whānau eats and drinks …

- We want you to think about a typical kind of day and tell us what your family/whānau eats and drinks – we want to hear about this for a typical day in the week and a typical day at the weekend.
- You're going to do this by individually writing the information down on a sheet I'm going to give you. Once you've finished writing things down, we'll hear from each of you about what happens in your family/whānau in terms of eating and drinking.

WEEK DAY	WEEKEND
On a typical day in the week my family/ whānau eats and drinks the following things. Participants to list below: • • • •	On a typical day in the weekend my family/whānau eats and drinks the following things. Participants to list below: • • • •

Now that you've finished your lists, let's hear about the food and drink your family/whānau has on a typical day in the week and at the weekend.

Participants to share as above.

If not mentioned, probe the extent to which the following feature on a typical day during the week and at the weekend:

- Takeaways
- Fizzy drinks
- Fruit
- Vegetables
- Snacks
- Alcohol

Probe for any differences between participants' own eating and drinking behaviour and that of their family/whānau.

Thinking about what your family/whānau eats and drinks on a typical week day and a typical day at the weekend …

- Which of these foods and drinks would you say are really favourite foods and drinks for your family/whānau?

  Probe what makes particular foods favourites.

- Which of these foods and drinks are not particularly popular among your family/whānau?

  Probe what makes particular foods not particularly popular.

- What food and drinks do you make a real effort to get your family/whānau to have?

  Probe reasons for making a real effort re consumption of certain foods and drinks.

- What food and drinks do you try and limit the consumption of in your family/whānau?

  Probe reasons for limiting consumption of certain foods and drinks.

FACILITATOR NOTE:

- 'Limiting' food can be done for two reasons – 1) because of health-related reasons, e.g. allergy, weight and 2) other, e.g. disliked, not acceptable.

3b. Eating Attitudes

10 minutes

Still thinking about eating …

- What do you consider to be healthy eating?

  Probe participants' definition of healthy eating and basis for this.

- What do you consider to be eating that is not healthy?

  Probe participants' definition of eating that is not healthy and basis for this.

3c. Eating Messages and Communication Channels

10 minutes

Messages

- What sorts of things do you say to your children and other family/whānau members about eating?

  Probe messages and reasons for giving them.

- What do you and your family/whānau see and hear (from outside the family) about eating?

  Probe messages about healthy eating and sources.

  Probe messages that encourage eating that is not healthy, and sources.

FACILITATOR NOTE:

- 'Sources' could be tv, radio, parents, good friends, GP, children and so on.

Communication Channels

Thinking about where you get messages about healthy eating from …

- Which channel(s) work best in terms of getting the message across to you (and your family/whānau)?

  Probe most influential source and reasons.

3d. Role of Government and Regulation

10 minutes

Thinking about the role of government in addressing issues of healthy eating and obesity …

- What, if anything, are you aware of that the government does to encourage healthy eating and address obesity among New Zealand families/whānau?

  Seek spontaneous responses.

  Probe for views on initiatives mentioned, particularly whether government should have a role in these initiatives.

If not mentioned, probe for views on government regulating to encourage healthy eating (an example of this are the recent rules around food and drinks to be available in school tuck-shops).

4.0 Gambling

50 minutes (total time 190 minutes)

Objectives of this section of the discussion guide:

- To explore perceptions and experiences of gambling.
- To explore perceptions and experiences of problem gambling.
- To explore views on initiatives to make gambling safer.
- To identify communication channels through which participants receive messages about gambling (and identify the most influential communication channel/s).

4a. Perceptions and Experiences of Gambling

10 minutes

We're going to talk now about gambling …

- What would you say is gambling?

  Probe types of gambling activities and behaviours

- What, if anything, do you associate with being good about gambling?
- What, if anything, do you associate with being bad about gambling?
- What happens in your family in relation to gambling?

  Probe who, if anyone, gambles, what type of gambling activity, when and why

  Probe whether children/young people take part in any gambling activities

4b. Perceptions and Experiences of Problem Gambling

25 minutes

Thinking about problem gambling …

- Have you heard of problem gambling before?

  Just a YES or NO answer is required here.

- What do you understand problem gambling to be?

  SEEK SPONTANEOUS RESPONSES.

FACILITATOR NOTE:

- Provide participants with the definition of problem gambling if necessary i.e.

Problem gambling exists when people experience trouble as a result of gambling, for example, they do not have enough time and/or money to pay their bills, or do not spend (enough) time with their family/whānau or do not spend (enough) time at their job.

- What experience, if any, have you had in relation to problem gambling?

  Probe in participants' community, family and friendship networks.

- What impact, if any, has this problem gambling behaviour had?

  Seek spontaneous responses.

  Probe on participants themselves (i.e. as an individual), and their families and communities.

We're going to talk now about how the situation of problem gambling arose …

- Looking back, what sorts of things happened that led to someone ending up in a situation where his/her gambling was a problem?

  Probe factors perceived to influence problem gambling behaviours – both their initial onset and maintenance e.g. financial issues; stress; habit; enjoyment, other (participants to specify).

- What sort of support, if any, has been used in terms of addressing problem gambling?

  Probe type of support sought/used (including at the individual participant level and the family/whānau levels) and reasons.

  Probe perceived efficacy of any support received and reasons.

Thinking about stopping people getting into situations where gambling causes problems …

- What sorts of thing do you feel might (help) stop people ending up in situations where gambling causes problems?

  Probe factors internal and external to the family/whānau and reasons.

4c. Views on Initiatives to Make Gambling Safer

15 minutes

Thinking now about making gambling safer …

- What sorts of things do you feel can be done to make gambling safer?

  EXPLORE: at the national, community and family/whānau levels.

  PROBE: who (at the three levels above) is perceived as being responsible for making these things happen and reasons.

Thinking now about initiatives currently used for making gambling safer …

FACILITATOR NOTE:

- Provide each participant with a list of the examples of current initiatives used to make gambling safer (see examples below).

- We're interested in hearing how acceptable you feel the current initiatives being undertaken are in terms of making gambling safer …
- How acceptable do you feel the current initiatives are?
  - Examples of current initiatives:
    - councils are required to consult with their community about the number and location of TABs and venues with pokie machines
    - communities have the opportunity to make submissions to their local council
    - councils are required to develop policies on where pokie machines can be located and how many machines each bar and club can have
    - casinos and bars and clubs have to follow 'host responsibility' rules relating to gambling (make information available to players; have signage encouraging players to gamble at affordable levels; provide information and assistance to people they have reason to believe may have a gambling problem).
    - the government is funding a social marketing campaign to strengthen society's understanding and awareness of, and response to, gambling-related harms

  Probe initiatives that are perceived as acceptable and reasons.

  Probe initiatives that are not perceived as acceptable and reasons.

  Probe alternative initiatives and reasons.

4d. Communication Channels

10 minutes

Messages

- What do you and your family/whānau see and hear (from outside the family) about gambling?

  Probe messages that encourage gambling and sources.

  Probe messages that discourage gambling and sources.

FACILITATOR NOTE:

- 'Sources' could be tv, radio, parents, good friends, GP, children and so on.

Communication Channels

Thinking about where you get messages about safe gambling from …

- Which channel(s) works best in terms of getting the message across to you and your family/whānau?

  Probe most influential source and reasons.

Before we close the group, what final comments, if any, would you like to make about anything we've been talking about in the group.

THANK AND CLOSE

Family Focus Group Discussion Guide

Duration of group: up to 3 hours

Key Terms Used in the Discussion Guide

The following is a list of key terms used in the discussion guide. Each is supported with explanations as to how HSC is conceptualising them.

- **Internal factors:** characteristics of family/whānau functioning; includes factors such as family make-up, roles and responsibilities, norms, rules, cultural practices, decision-making processes, communication styles, parenting styles.
- **External factors:** includes factors such as socio-economic status, geography, community.
- **Practices:** includes behaviours, attitudes, rules, decision-making, roles and responsibilities, routines and rituals etc.
- **Messages:** includes messages from range of sources – television, radio, print media, health professionals, friends and family, marketing, etc.

Important Messages for Researchers

- **Expanding on questions as appropriate** - the questions in the discussion guide are indicative and should be expanded on (where appropriate) during family groups for greater understanding.
- **If in doubt about the line of questioning you are using** - always bring it back to children. Do not get weighted down with discussion on adults at the expense of understanding what is happening for children (and the family/whānau that shapes what is happening for children).

Introduction

15 minutes

Researcher to introduce him/herself

Participants to introduce themselves to researcher.

Researcher to explain nature of the discussion.

- The discussion will take up to three hours.
- Outline topic matter - we are interested in finding out about your family/whānau in terms of attitudes and behaviours relating to topics such as families, health, smoking eating and gambling.
- Explain that there are no right or wrong answers and no need to reach a consensus.
- Importance of expressing own views (and not being swayed by other family/whānau members' views).
- Respect for others' views (even if these are at odds with one's own views).
- Emphasise confidentiality of responses (i.e. these will be pooled for reporting purposes).
- Confirm consent to audio record group (all family groups).

Researcher to ask if participants have any queries about the discussion group or participating in it (and to address any queries before proceeding).

1.0 Context Setting

40 minutes (total time 55 minutes)

Objectives of this section of the discussion guide:

- To explore who participants identify as being part of their family/whānau (especially who the parents and caregivers are).
- To explore key roles and responsibilities of identified family/whānau and internal and external factors (as defined earlier in Key Terms) that shape these roles and responsibilities.
- To explore key issues and challenges facing families/whānau and where health and well-being issues fit within this context.

1a. Family/Whānau Make-up

We'll start off by finding out something about your family/whānau. We're going to do this by getting you to fill in a short questionnaire about your family/whānau. You'll each fill in a questionnaire and once you've done that, we'll talk about what you see makes up your family/whānau.

1. **Please list the names of everyone you think of as being your family/whānau in the spaces below.**

1.	**9.**
2.	**10.**
3.	**11.**
4.	**12.**
5.	**13.**
6	**14.**
7	**15.**
8	**16. (and so on)**

2. Beside each person above, please list your relationship to him/her e.g. mother, father, sister, uncle, close friend.

FACILITATOR NOTE:

- Give each participant a questionnaire and pen.
- After questionnaire completion, participants to briefly share information on relationships.

Probe nature of what constitutes family/whānau for each participant and reasons.

1b. Key Family/Whānau Roles and Responsibilities

Thinking about roles and responsibilities in your family/whānau, we're interested in hearing about the roles and responsibilities of various members …

- What are the "bigger roles" that people in your family/whānau have?

  Probe nature of key (i.e. bigger) roles (and responsibilities that go with them) and who occupies such roles and reasons.

- Who acts as caregivers to children in your family/whānau?

  Probe the nature of the relationship of caregivers to children in the family/whānau (e.g. parent, grandparent, aunt, uncle, sibling, other [participants to specify]).

  Probe reasons why certain members act as caregivers (and not others).

Stepping back and having a look at your family/whānau …

- What do you think has influenced why certain family members have certain roles and responsibilities?

  Probe internal and external factors (as defined under Key Terms) that have shaped key roles and responsibilities.

  If not mentioned, probe historical factors, social norms, logistics, other (participants to specify).

1c. Key Issues and Challenges Facing Family/Whānau

We're going to move on now and talk about what 'big things' if any, you feel your family/whānau has to deal with on a day-to-day basis.

'Big things' may mean different things for each of you. If something feels like a 'big thing' to you for your family/whānau, we're interested in hearing about it …

- What, if anything, are the 'big things' facing your family/whānau on a day-to-day basis?

  Seek spontaneous responses and explore as necessary for understanding.

FACILITATOR NOTE:

- Check whether health and well-being features on the list of 'big things' (i.e. challenges and concerns) family/whānau feel they are facing.
- If health and well-being mentioned, probe reasons.
- If health and well-being not mentioned, probe reasons.
- Where non-health and well-being issues are mentioned, explore for understanding but without going into too much depth. For example, if money is mentioned as a challenge, explore 'in what way money is a challenge?' e.g. 'is it a challenge in terms of not having enough money to buy food or is it a challenge in terms of not having enough to save?'

2.0 Health and Well-being

30 minutes (total time 85 minutes)

Objectives of this section of the discussion guide:

- To explore the meaning of *health* and *well-being* (and gauge the extent to which these are perceived as similar or different concepts).
- To explore the value family members place on family/whānau health and well-being relative to other key challenges and concerns, and specific health and well-being concerns.
- To explore the importance of specific health considerations; smoking, healthy eating, gambling, alcohol consumption, physical activity.

2a. Meaning of 'Health' and 'Well-being'

We'll move on now and talk about health and well-being …

Thinking about *health* …

- What comes to mind when you think of *good health*?

  Probe for understanding and basis for this.

- What comes to mind when you think of *poor health*?

  Probe for understanding and basis for this.

Thinking about *well-being* …

- What comes to mind when you think about *well-being*?

  Probe for understanding and basis for this.

FACILITATOR NOTE:

- Note extent to which similar or different interpretations are given for the concepts of health and well-being.
- If there is considerable difference in how these concepts are interpreted, this will affect how questioning in the rest of this section of the guide is handled.

2b. Importance of Health and Well-being and Specific Health Considerations for Individual Families/Whānau

We're going to talk now about where you see health and well-being of your family/whānau in relation to the 'big things' your family/whānau has to deal with on a day-to-day basis. Take a moment and think back to what you said were the 'big things' your family/whānau has to deal with on a day-to-day basis …

- How important is the health and well-being of your family/whānau compared with the 'big things' you mentioned earlier?

  Probe for importance of family/whānau health and well-being compared with 'big things' and reasons why it is more or less important.

- What specific health and well-being issues/concerns (considerations), if any, exist for your family/whānau?

  Facilitator to jot these down and probe reasons why these are issues/concerns.

2c. Importance of Particular Health Considerations

FACILITATOR NOTE:

- The purpose of the question below (i.e. 'how concerned are you about the following for family/whānau?) is to find out how much of a concern each of the health considerations (i.e. smoking, healthy eating, gambling, alcohol consumption and physical activity) is for individual family/whānau.

We're going to talk now about five areas of health – smoking, healthy eating, gambling, alcohol consumption and physical activity.

We're interested in hearing what level of concern, if any, you have about each of the five areas of health when it comes to your family/whānau.

We're going to get you to fill in a short questionnaire to give us the information. Once you've filled in the questionnaire, we'll talk about what you've had to say in it.

FACILITATOR NOTE:

- Give questionnaire to family/whānau group and explain instructions for completion.

Questionnaire

Please complete the questionnaire by putting a cross (X) on the line that best describes how concerned you are about a particular area of health for your family/whānau.

Q1. How concerned are you about **SMOKING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q2. How concerned are you about **HEALTHY EATING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q3. How concerned are you about **GAMBLING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q4. How concerned are you about **ALCOHOL CONSUMPTION** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q5. How concerned are you about **PHYSICAL ACTIVITY** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

FACILITATOR NOTE:

- When the family/whānau group has completed their questionnaire, ask the (top level) questions below.

We are interested in hearing briefly about some of the answers that you gave in the questionnaire …

- Which of the five areas of health did you say you were MOST concerned about in relation to your family/whānau?

  SEEK SPONTANEOUS RESPONSES.

  Probe why.

- Which of the five areas of health did you say you were LEAST concerned about in relation to your family/whānau?

  SEEK SPONTANEOUS RESPONSES.

  Probe why.

FACILITATOR NOTE:

- Collect questionnaire from group.

Facilitator to explore where previously identified health and well-being concerns sit in relation to the above health considerations talked about: smoking, healthy eating, gambling, alcohol consumption and physical activity.

3.0 Eating

60 minutes (total time 145 minutes)

Objectives of this section of the discussion guide:

- To explore family/whānau eating behaviours.
- To explore family/whānau eating attitudes.
- To explore family/whānau eating practices.
- To identify through what communication channels participants receive messages about eating (and identify most influential communication channel/s).

3a. Family/Whānau Eating Behaviours

We're going to talk about eating now. We're interested in hearing about what your family/whānau eats on a typical day in the week and on a typical day in the weekend.

FACILITATOR NOTE:

- The purpose of this section of the discussion guide is to provide HSC with an understanding of what types of meals/diets family/whānau have.
- 'Eating behaviour' to include discussion on food and drinks (i.e. water, juice, milk, fizzy drinks and alcohol).

We're going to talk now about what your family/whānau eats and drinks …

We want you to think about a typical kind of day and tell us what your family/whānau eats and drinks – we want to hear about this for a typical day in the week and a typical day at the weekend.

Facilitator to jot down participants' responses on the form below.

WEEK DAY	WEEKEND
On a typical day in the week my family/ whānau eats and drinks the following things. Participants to list below: • • • •	On a typical day in the weekend my family/whānau eats and drinks the following things. Participants to list below: • • • •

If not mentioned, probe the extent to which the following feature on a typical day during the week and at the weekend:

- Takeaways
- Fizzy drinks
- Fruit
- Vegetables
- Snacks
- Alcohol

Probe for any differences between parents' own eating and drinking behaviours and that of other family/whānau members (especially children).

Thinking about what your family/whānau eats and drinks on a typical week day and a typical day at the weekend …

- Which of these foods and drinks would you say are really favourite foods and drinks for your family/whānau?

  Probe what makes particular foods favourites.

- Which of these foods and drinks are not particularly popular among your family/whānau?

  Probe what makes particular foods not particularly popular.

- What food and drinks is there a real effort made to eat/drink in your family/whānau?

  Probe who decides to make a real effort re consumption of certain foods and drinks and reasons.

- What food and drinks is there an effort to try and limit consumption of in your family/whānau?

  Probe who decides to limit consumption of certain foods and drinks and reasons.

FACILITATOR NOTE:

- 'Limiting' food can be done for two reasons – 1) because of health-related reasons, e.g. allergy, weight and 2) other, e.g. disliked, not acceptable.

3b. Attitudes

Still thinking about eating …

- What do you consider to be healthy eating?

  Probe participants' definition of healthy eating and basis for this.

- What do you consider to be eating that is not healthy?

  Probe participants' definition of eating that is not healthy and basis for this.

3c. Practices

Thinking about eating within your family/whānau …

- What happens in your family/whānau in terms of eating meals?

  Probe which meals are shared/not shared.

  Probe whether adults eat the same as children

When meals are shared, how does this happen?

Probe whether family/whānau sits down at a table together (or sits around in lounge chairs [watching television? not watching television?]).

- What happens in your family/whānau in terms of having special occasion meals/feasts?

  Probe eating practices for special occasion meals/feasts

- What happens in your family/whānau in terms of having snacks?

  Probe when and what.

  Probe differences for adults and children.

Thinking about rules in relation to eating for your family/whānau …

- What rules, if any, does your family/whānau have about eating? (you may have already mentioned some)

  Probe rules relating to healthy eating and not healthy eating

  Probe rules relating to takeaways, fizzy drinks, fruit, vegetables and alcohol.

Thinking about decision-making around eating …

- How are decisions made in your family/whānau about what and how food and drinks are consumed?

  Probe nature of decision-making, e.g. who is involved (including kids).

Thinking about the children in your family/whānau …

- In what way, if any, are children in your family/whānau involved with food preparation?

  Probe when and how children are involved.

- In what way, if any, are children in your family/whānau involved with ***shopping for food***?

  Probe when and how children are involved.

- What sorts of things do you say to your children and other family/whānau members about eating?

  Probe messages.

3d. Communication Channels

Messages

- What do you see and hear (from outside the family) about eating?

  Probe messages about healthy eating and sources.

  Probe messages that encourage eating that is not healthy and sources.

FACILITATOR NOTE:

- 'Sources' could be TV, radio, parents, good friends, GP, children and so on.

Communication Channels

Thinking about where you get messages about healthy eating from…

- Which one(s) works best in terms of getting the message across to you (and your family/whānau)?

  Probe most influential source and reasons.

4.0 Smoking

20 minutes (total time 165 minutes)

Objectives of this section of the discussion guide:

- To briefly explore family/whānau smoking behaviours.
- To explore attitudes and beliefs about smoking and influences on the likelihood of young people taking up smoking.
- To explore family/whānau practices that influence the likelihood of young people taking up smoking.

4a. Family/Whānau Smoking Behaviour

We're now going to talk about smoking …

- What happens in your family/whānau in relation to smoking?

  Probe who smokes, when, why and where.

4b. Attitudes/Beliefs

Thinking about smoking …

- How acceptable is smoking among your family/whānau?

Thinking about what does/could influence children/young people to start smoking …

- What things do you believe might increase the likelihood of a child/young person starting smoking?

  Probe influential factors, e.g. parents, peers, media (e.g. TV programmes, films, magazines showing smoking), smoking in the home environment.

- How concerned are you by the possibility of your child/children taking up smoking?

4c. Practices

- What, if anything, is your family/whānau doing to reduce the likelihood of your child/children taking up smoking?

  Seek spontaneous responses and explore for understanding.

  Probe factors such as:

  - having rules about smoking (where, when, who)
  - allowing access to cigarettes
  - talking to child/young person about smoking (what is said?)
  - not allowing smoking in front of children.

5.0 Gambling

15 minutes (total time 180 minutes)

Objectives of this section of the discussion guide:

- To briefly explore family/whānau gambling behaviours.
- To explore family/whānau understanding and perceptions of gambling and problem gambling.
- To explore awareness and practices relating to protecting family/whānau, children and young people in particular, from gambling harm.

5a. Family/Whānau Gambling Behaviour

We're going to talk now about gambling …

- What would you say is gambling?

  Probe types of gambling activities and behaviours.

- What happens in your family in relation to gambling?

  Probe who, if anyone, gambles, what type of gambling activity, when and why?

  Probe whether children/young people take part in any gambling activities.

5b. Understanding and Perceptions

- What, if anything, do you associate with being good about gambling?

  Probe: Generally, and specifically for family/whānau (e.g. funding for community events and organisations, social connectedness, additional ways of making money (e.g. to relieve financial pressure, meet cultural obligations).

- What, if anything, do you associate with being bad about gambling?

  Probe: Generally, and specifically for family/whānau (e.g. any type of cost to the family/whānau (e.g. financial, emotional) and social costs).

Thinking about problem gambling …

- Have you heard of problem gambling before?

  Just a YES or NO answer is required here.

- What do you understand problem gambling to be?

  Seek spontaneous responses.

5c. Protection from Gambling Harm

We're going to talk now about gambling in relation to children and young people …

- What things do you believe make it more likely children/young people might start gambling?
- What things do you believe make it more likely children/young people might grow up to have a problem with gambling?

  Probe influential factors, e.g. exposure to gambling (through observation or participation).

- How concerned are you by the possibility that your child might start gambling, or develop a gambling problem, later in life?
- What, if anything, are you doing to help make your child/children and family/whānau safe from gambling harm?

  Seek spontaneous responses and explore for understanding and reasons.

  Probe factors such as:

  - ***having rules about gambling***
  - ***whether children are allowed to take part in gambling activities***
  - ***talking to child/young person about gambling and its potential for harm (what is said?).***

Before we close the group, what final comments, if any, would you like to make about anything we've been talking about in the group.

THANK AND CLOSE

Adult In-depth Interview Guide

Duration of Interview: up to 2 hours

Key Terms Used in the Interview Guide

The following is a list of key terms used in the interviewon guide. Each is supported with explanations as to how HSC is conceptualising them.

- **Internal factors:** characteristics of family/whānau functioning; includes factors such as family make-up, roles and responsibilities, norms, rules, cultural practices, decision-making processes, communication styles, parenting styles.
- **External factors:** includes factors such as socio-economic status, geography, community.
- **Practices:** includes behaviours, attitudes, rules, decision-making, roles and responsibilities, routines and rituals etc.
- **Messages:** includes messages from range of sources – television, radio, print media, health professionals, friends and family, marketing, etc.

Important Messages for Researchers

- **Expanding on questions as appropriate** – the questions in the discussion guide are indicative and should be expanded on (where appropriate) during discussion groups/interviews for greater understanding.
- Information gleaned from the adult in-depth interviews will form the basis of the audience segmentation that is a requirement of the research.

Introduction

5 minutes

Researcher to introduce him/herself to participant.

Researcher to explain nature of the interview.

- The interview will take up to 2 hours.
- Outline topic matter - we are interested in finding out about you as an individual in relation to topics such as family, health, eating, smoking and gambling. We will also be asking you some questions about your family/whānau relating to these topics.
- Explain that there are no right or wrong answers.
- Importance of honest responses.
- Emphasise confidentiality of responses (i.e. these will be pooled for reporting purposes).
- Confirm consent to audio record interview.

Researcher to ask if participant has any queries about the in-depth interview or participating in it (and to address any queries before proceeding).

1.0 Context Setting

15 minutes (total time 20 minutes)

Objectives of this section of the interview guide:

- To explore who the participant is as an individual, i.e. what makes him/her tick.
- To explore key roles and responsibilities within families/whānau and internal and external factors (as defined earlier in Key Terms) perceived to shape these roles and responsibilities.
- To explore key issues and challenges facing parents/caregivers.

1a. Warm-up Exercise for Participants who have not Taken Part in a Family Focus Group

FACILITATOR NOTE:

- Start at Section 1b. if participant has taken part in a family focus group.

We'll start off by talking about you as a person …

- What kind of things are important/not important to you in life generally?

  Seek spontaneous responses only.

- What goals, hopes, dreams, aspirations do you have for your future?

  Seek spontaneous responses only.

- What things will help/hinder you from achieving your goals, hopes, dreams and aspirations?

  Seek spontaneous responses only.

1b. Key Family/Whānau Roles and Responsibilities

Thinking about roles and responsibilities in your family/whānau, we're interested in hearing about the roles and responsibilities of various members …

- What are the "bigger roles" that people in your family/whānau have?

  Probe nature of key (i.e. bigger) roles (and responsibilities that go with them) and who occupies such roles and reasons.

- Who acts as caregivers to children in your family/whānau?

  Probe the nature of the relationship of caregivers to children in the family/whānau (e.g. parent, grandparent, aunt, uncle, sibling, other [participants to specify]).

  Probe reasons why certain members act as caregivers (and not others).

Stepping back and having a look at your family/whānau …

- What do you think has influenced why certain family members have certain roles and responsibilities in your family/whānau?

  Probe internal and external factors (as defined under Key Terms) that have shaped assignment of key roles and responsibilities to certain family members.

  If not mentioned, probe historical factors, social norms, logistics, other (participants to specify).

1c. Key Issues and Challenges Facing Family/Whānau

We're going to talk now about what 'big things' if any, you feel your family/whānau faces on a day-to-day basis. If something feels like a 'big thing' for your family/whānau, I'm interested in hearing about it …

- What, if anything, are the 'big things' facing your family/whānau on a day-to-day basis?

  Seek spontaneous responses and explore as necessary for understanding.

FACILITATOR NOTE:

- Check whether health and well-being features on the list of 'big things' (i.e. challenges and concerns) for the family/whānau on a day-to-day basis.
- If health and well-being mentioned, probe reasons.
- If health and well-being not mentioned, probe reasons.
- Where non-health and well-being issues are mentioned, explore for understanding but without going into too much depth. For example, if money is mentioned as a challenge, explore 'in what way money is a challenge?' e.g. 'is it a challenge in terms of not having enough money to buy food or is it a challenge in terms of not having enough to save?'

2.0 Health and Well-being

30 minutes (total time 50 minutes)

Objectives of this section of the interview guide:

- To explore the meaning of *health* and *well-being* (and gauge the extent to which these are perceived as similar or different concepts).
- To explore the value parents/caregivers place on family/whānau health and well-being relative to other key challenges and concerns, and specific health and well-being concerns for the family/whānau.
- To explore the importance of specific health considerations: smoking, healthy eating, gambling, alcohol consumption, physical activity.

2a. Meaning of 'Health' and 'Well-being'

We'll move on now and talk about health and well-being …

Thinking about *health …*

- What comes to mind when you think of *good health*?

  Probe for understanding and basis for this.

- What comes to mind when you think of *poor health*?

  Probe for understanding and basis for this.

Thinking about *well-being*…

- What comes to mind when you think about *well-being*?

  Probe for understanding and basis for this.

FACILITATOR NOTE:

- Note extent to which similar or different interpretations are given for the concepts of health and well-being.
- If there is considerable difference in how these concepts are interpreted, this will affect how questioning in the rest of this section of the guide is handled.

2b. Importance of Health and Well-being and Specific Health Considerations for Individual Families/Whānau

We're going to talk now about where you see health and well-being fits in your family/whānau with the 'big things' it has to deal with on a day-to-day basis. Take a moment and think back to what you said were the 'big things' your family/whānau has to deal with on a day-to-day basis …

- How important is the health and well-being of your family/whānau compared with the 'big things' you mentioned?

  Probe for importance of family/whānau health and well-being compared with 'big things' and reasons why it is more or less important.

- How important is your own health and well-being compared with the 'big things' you mentioned?

  Probe for importance of personal health and well-being compared with 'big things' and reasons why it is more or less important.

- What specific health and well-being issues/concerns (considerations), if any, exist for your family/whānau?

  Facilitator to jot these down and probe reasons why these are issues/concerns.

2c. Importance of Particular Health Considerations

FACILITATOR NOTE:

- The purpose of the question below (i.e. 'how concerned are you about the following for family/whānau?) is to find out how much of a concern each of the health considerations (i.e. smoking, healthy eating, gambling, alcohol consumption and physical activity) is for parents/caregivers in terms of their family/whānau.

We're going to talk now about five areas of health – smoking, healthy eating, gambling, alcohol consumption and physical activity.

We're interested in hearing what level of concern, if any, you have about each of the five areas of health when it comes to your family/whānau.

We're going to get you to fill in a short questionnaire to give us the information. Once you've filled in the questionnaire, we'll talk about what you've had to say in it.

FACILITATOR NOTE:

- Give a questionnaire to participant and explain instructions for completion.
- If participant has taken part in a family group, he/she will have already completed the questionnaire and does not need to do another one (but have his/her questionnaire with you at the interview to discuss).

Questionnaire

Please complete the questionnaire by putting a cross (X) on the line that best describes how concerned you are about a particular area of health for your family/whānau.

Q1. How concerned are you about **SMOKING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q2. How concerned are you about **HEALTHY EATING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q3. How concerned are you about **GAMBLING** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q4. How concerned are you about **ALCOHOL CONSUMPTION** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

Q5. How concerned are you about **PHYSICAL ACTIVITY** in relation to your family/whānau?

Very Unconcerned — **Very Concerned**

FACILITATOR NOTE:

- When participants have completed their questionnaire, ask the (top level) questions below.
- If participants reveal why the various health considerations are an issue for them, explore this – otherwise do not probe for this information because it will be covered in the family groups.

We are interested in hearing briefly about some of the answers that you gave in the questionnaire …

- Which of the five areas of health did you say you were MOST concerned about in relation to your family/whānau?

  SEEK SPONTANEOUS RESPONSES.

  Probe why.

- Which of the five areas of health did you say you were LEAST concerned about in relation to your family/whānau?

  SEEK SPONTANEOUS RESPONSES.

  Probe why.

  PROBE ALSO THE RANKINGS OF THE OTHER THREE HEALTH CONSIDERATIONS AND REASONS

FACILITATOR NOTE:

- Collect questionnaire from participant.

Facilitator to explore where previously identified health and well-being concerns sit in relation to the above health considerations talked about; smoking, healthy eating, gambling, alcohol consumption and physical activity.

3.0 Eating

40 minutes (total time 90 minutes)

Objectives of this section of the interview guide:

- To briefly explore family/whānau eating behaviours.
- To explore parent/caregiver eating attitudes.
- To explore family/whānau eating practices and influences on these practices.
- To explore parent/caregiver efficacy in ensuring healthy eating for their family/whānau and internal and external factors perceived to influence their ability to ensure healthy eating for their family/whānau.
- To identify through what communication channels participants receive messages about eating (and identify most influential communication channel/s).

3a. Family/Whānau Eating Behaviours

We're going to talk about eating now.

If not mentioned, probe the extent to which the following feature on a typical day during the week and at the weekend:

- Takeaways
- Fizzy drinks
- Fruit
- Vegetables
- Snacks
- Alcohol

Probe for any differences between parents' own eating and drinking behaviours and that of other family/whānau members (especially children).

Thinking about what your family/whānau eats and drinks on a typical week day and a typical day at the weekend …

- Which of these foods and drinks would you say are really favourite foods and drinks for your family/whānau?

  Probe what makes particular foods favourites.

- Which of these foods and drinks are not particularly popular among your family/whānau?

  Probe what makes particular foods not particularly popular.

- What food and drinks is there a real effort made to eat/drink in your family/whānau?

  Probe who decides to make a real effort re consumption of certain foods and drinks and reasons.

- What food and drinks is there an effort to try and limit consumption of in your family/whānau?

  Probe who decides to limit consumption of certain foods and drinks and reasons.

FACILITATOR NOTE:

- 'Limiting' food can be done for two reasons – 1) because of health-related reasons, e.g. allergy, weight and 2) other, e.g. disliked, not acceptable.

3b. Attitudes

Still thinking about eating …

- What do you consider to be healthy eating?

  Probe participants' definition of healthy eating and basis for this.

  Probe perceived benefits and costs of healthy eating.

  Probe interest in and commitment to healthy eating.

- What do you consider to be eating that is not healthy?

  Probe participants' definition of eating that is not healthy and basis for this.

  Probe perceived benefits and costs of eating that is not healthy.

3c. Family/Whānau Eating Practices and Influences

Thinking about eating within your family/whānau …

- How are decisions made in your family/whānau about what and how food and drinks are consumed in your family/whānau?

  Probe nature of decision-making, e.g. who is involved (including children).

- What happens in your family/whānau in terms of eating meals?

  Probe which meals are shared/not shared and why.

  Probe whether adults eat the same as children.

- When meals are shared, how does this happen?

  Probe whether family/whānau sits down at a table together (or sits around in lounge chairs [watching television? not watching television?]) and why.

- What happens in your family/whānau in terms of breakfast?

  Probe context of breakfast e.g. whether consumed (at home or away from home), not consumed, types of food and drinks consumed and reasons.

  Probe who/what factors influence decision-making about how breakfast occurs in/for your family/whānau.

  Probe any differences between weekday and weekend breakfasts and reasons.

- What happens in your family/whānau in terms of lunches?

  Probe context of lunches, e.g. whether consumed (at home or away from home), not consumed, bought versus home-made food (if home-made is food prepared, e.g. sandwiches, salads, or convenience food, e.g. yoghurt, noodles, tinned soup).

  Probe who/what factors influence decision-making about how lunches occur in/for your family.

  Probe any differences between weekday and weekend lunches and reasons.

- What happens in your family/whānau in terms of having special occasion meals/feasts?

  Probe context of special occasion meals/feast e.g. what types food and drink are consumed (and in what way, if any, do these differ from food/drink consumed at other times), are food/drinks planned versus pot-luck style (e.g. other family/whānau members contribute what they want to).

  Probe who/what factors influence decision-making about what is eaten and drunk on these occasions.

- What happens in your family/whānau in terms of having snacks?

  Probe context of snacks, e.g. what types of food and drink are consumed (and in what way, if any, do these differ from food/drink consumed at other times), are snacks available to children in a controlled or uncontrolled way.

  Probe also who/what factors influence decision-making about what snacks are eaten and when snacking can occur.

  Probe any differences between weekday and weekend snacks and reasons.

Thinking about rules in relation to eating (you may have already mentioned some) …

- What rules, if any, does your family/whānau have about eating food that is healthy?
- What rules, if any, does your family/whānau have about eating food that is not healthy?

  Probe nature and reason for any rules (including who determine rules).

  Probe rules relating to takeaways, fizzy drinks, fruit, vegetables and alcohol if not already mentioned.

Thinking about the children in your family/whānau …

- In what way, if any, are children in your family/whānau involved with food preparation?

  Probe when, how and why children are involved.

- In what way, if any, are children in your family/whānau involved with shopping for food?

  Probe when, how and why children are involved.

- What sorts of things do you say to your children and other family/whānau members about eating?

  Probe messages and reasons for giving messages.

3d. Efficacy and Factors Influencing Achievement of Family/whānau Healthy Eating

HSC is interested in participants' perceived efficacy in terms of achieving healthy eating for their family/whānau.

Definition of Efficacy:

Efficacy = confidence and a sense of having the resources to successfully implement change (e.g. a person has got the skills, tools, time, money and power to make change happen, i.e. a person feels that the ability to implement change is within his/her control).

Thinking about achieving healthy eating for your family/whānau …

- How well do you feel your family/whānau is achieving healthy eating?
- What factors **inside** the family/whānau **help** your family/whānau achieve healthy eating (e.g. family make-up, roles and responsibilities, norms, rules, cultural practices, decision-making processes, communication styles, parenting styles)?

  Probe responses for understanding.

- What factors **inside** the family/whānau **hinder** your family from achieving healthy eating (e.g. family make-up, roles and responsibilities, norms, rules, cultural practices, decision-making processes, communication styles, parenting styles). **Probe responses for understanding.**
- What factors **outside** the family/whānau **help** this (e.g. socio-economic status, geography, community)? **Probe responses for understanding.**
- What factors **outside** the family/whānau **hinder** this (e.g. socio-economic status, geography, community)? **Probe responses for understanding.**

3e. Communication Channels

Messages

- What do you see and hear (from outside the family) about eating?

  Probe messages about healthy eating and sources.

  Probe messages that encourage eating that is not healthy and sources.

FACILITATOR NOTE:

- 'Sources' could be tv, radio, parents, good friends, GP, children and so on.

Communication Channels

Thinking about where you get messages about healthy eating from …

- Which one(s) works best in terms of getting the message across to you (and your family/whānau)?

  Probe most influential source and reasons.

4.0 Smoking

15 minutes (total time 105 minutes)

Objectives of this section of the interview guide:

- To briefly explore family/whānau smoking behaviours.
- To explore beliefs about influences on young people taking up smoking.
- To explore family/whānau practices that influence the likelihood of young people taking up smoking.
- To identify through what communication channels participants receive messages about smoking (and identify most influential communication channel/s for anti-smoking messages).

4a. Family/Whānau Smoking Behaviour

We're now going to talk about smoking …

- What happens in your family/whānau in relation to smoking?

Probe who smokes, when, why and where.

4b. Influences on Young People Taking Up Smoking

Thinking about what does/could influence children/young people to start smoking …

- What things do you believe might increase the likelihood of a child/young person starting smoking?

  Probe influential factors, e.g. parents, peers, media (e.g. tv programmes, films, magazines showing smoking), smoking in the home environment.

- What, if anything, is your family/whānau doing to reduce the likelihood of your child/children taking up smoking (or increase the likelihood of them stopping smoking if they already smoke)?

  Seek spontaneous responses and explore for understanding.

  Probe factors such as:

  - having rules about smoking (where, when, who)
  - allowing access to cigarettes
  - talking to child/young person about smoking (what is said?)
  - not allowing smoking in front of children

4c. Communication Channels

Messages

- What do you see and hear (from outside the family) about smoking?

  Probe anti-smoking messages and sources.

  Probe messages that encourage smoking and sources.

FACILITATOR NOTE:

- 'Sources' could be tv, radio, parents, good friends, GP, children and so on.

Communication Channels

Thinking about where you get anti-smoking messages from …

- Which one(s) works best in terms of getting the message across to you (and your family/whānau)?

  Probe most influential source and reasons.

5. Gambling

15 minutes (total time 120 minutes)

Objectives of this section of the interview guide:

- To briefly explore family/whānau gambling behaviours.
- To explore awareness and practices relating to protecting family/whānau, children and young people in particular, from gambling harm.
- To identify through what communication channels participants receive messages about gambling (and identify most influential communication channel/s for gambling messages).

5a. Family/Whānau Gambling Behaviour

We're going to talk now about gambling …

- What would you say is gambling?

  Probe types of gambling activities and behaviours.

- What happens in your family in relation to gambling?

  Probe who, if anyone, gambles, what type of gambling activity, when and why?

  Probe whether children/young people take part in any gambling activities.

5b. Protection from Gambling Harm

We're going to talk now about gambling in relation to children and young people …

- What things do you believe make it more likely children/young people might start gambling?
- What things do you believe make it more likely children/young people might grow up to have a problem with gambling?

  Probe influential factors, e.g. exposure to gambling (through observation or participation).

- What, if anything, are you doing to help make your child/children and family/whānau safe from gambling harm?

  Seek spontaneous responses and explore for understanding and reasons.

Probe factors such as:

- having rules about gambling
- whether children are allowed to take part in gambling activities
- talking to child/young person about gambling and its potential for harm (what is said?)

5c. Communication Channels

Messages

- What do you see and hear (from outside the family) about gambling?

  Probe messages and sources.

FACILITATOR NOTE:

- 'Sources' could be tv, radio, parents, good friends, GP, children and so on.

Communication Channels

Thinking about where you get messages about gambling from …

- Which one(s) works best in terms of getting the message across to you (and your family/whānau)?

Probe most influential source and reasons.

Before we close the interview, what final comments, if any, would you like to make about anything we've been talking about in the interview.

PROBE as necessary.

THANK AND CLOSE

Child Interview Guide

Duration of group: up to 30 mins

Important Message for Researchers

- **Expanding on questions as appropriate** – the questions in the interview guide are indicative and should be expanded on (where appropriate) during interview for greater understanding.
- **Adapting questions for children of different ages** – the questions in the interview guide should be adapted to use language appropriate to the age of the child being interviewed.

Introduction

5 mins

Researcher to introduce self

- Explain the nature of the discussion – we are interested in finding out about you/your family in terms of eating.
- The discussion will take up to 30mins.
- Confirm that the interview is going to be recorded
- Emphasise the importance of giving honest answers.
- Emphasise that there are no right or wrong answers.

Researcher to ask if participant has any queries about the in-depth interview or participating in it (and to address any queries before proceeding).

Objectives of the interview guide

- To explore children's attitudes about healthy and not healthy eating and drinking.
- To explore children's eating practices and views on these practices.
- To explore messages about eating given by parents and caregivers.
- To identify through what communication channels participants receive messages about eating.

1.0 Attitudes

5 minutes (total time 10 minutes)

- What food and drinks do you see as being healthy and how come?
- What food and drinks do you see as not being healthy and how come?

2.0 Practices

15 minutes (total time 25 minutes)

- Which meals do you eat together as a family/whānau?

  Probe where meals are eaten.

  Probe who decides what and where meals are eaten.

  Probe if there are any rules around meal times and who makes these rules.

  Probe opinions on above.

- What snacks do you have?

  Probe when snacks are eaten.

  Probe who decides what and when snacks are eaten.

  Probe if there are any rules around snacks and who makes these rules.

  Probe opinions on above.

- Are you involved in preparing food?

  Probe when and how.

  Probe opinions on above.

- Are you involved in shopping for food?

  Probe when and how.

  Probe opinions on above.

3.0 Messages and Communications

5 minutes (total time 30 minutes)

- What sort of things, if any, do your Mum/Dad or other family members tell you about eating?

  Probe messages about what is eaten.

  Probe messages about how things are eaten.

  Probe messages about healthy eating.

  Probe messages that encourage eating that is not healthy.

- What sort of things, if any, do you hear about eating, other than what Mum/Dad or family members may tell you about it? I'm thinking of things you may hear from outside your family/whānau, e.g. through tv, radio, friends, school.

  Probe source of message.

Thank participant and close interview

Give incentive

Appendix

Appendix One

Suburbs/locations of Mid-to-High Deprivation at the Research Locations

Auckland	Wellington	Christchurch	Wairarapa	Gisborne	Timaru
Avondale Beach Haven Blockhouse Bay East Tamaki Glen Eden Glendene Glenfield Central Glen Innes Henderson Kelston Mangere Manukau East Manurewa Mount Wellington Mount Roskill New Lynn Onehunga North West Orakei Otahuhu Otara Panmure Papatoetoe Ranui Heights Ranui North Te Atatu Central	Ascot Park Brentwood Cannons Creek Elsdon Porirua Central Naenae Newtown Taita Takapuwahia Timberlea Titahi Bay Trentham North Wainuiomata Waitangirua	Addington Avon Loop Avonside Barrington North Belfast Bexley Bromley Broomfield Casebrook Cathedral Square Chisnall East Linwood Edgeware Ensors Ferrymead Hagley Park Hillmorton Hornby North Hornby South Islington Jellie Park Linwood Middelton New Brighton North Beach North Linwood Northcote Phillipstown Rawhiti Riccarton Riccarton South Riccarton West Richmond Shirley East Shirley West Sockburn South Richmond Spreydon St Albans East St Albans West Sydenham Upper Riccarton Waltham Wharenui Wigram Woolston South Woolston West	**Provincial areas** Masterton Carterton Featherston Martinborough **Rural Areas in Wairarapa:** Gladstone Tinui Mauriceville Hinakura Pirinoa	**Gisborne City suburbs** *All suburbs eligible* **Rural Areas in Gisborne Region:** Wharekaka Tarndale-Rakauroa Manutuke	*All suburbs eligible*