SOCIAL MARKETING AUDIENCE RESEARCH

Health and Well-Being and Family/Whānau Functioning: An Interim Report






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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.

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 and caregivers and 10 interviews with children. The research sample comprised a mix of Pakeha, Māori, Pacific and Asian participants – see Section 3.0 for information about the research method, sample and procedure.

This document, *Health and Well-being and Family/Whānau Functioning: An Interim Report*, reports on Phase One findings on health and well-being and family/whānau functioning. Phase One findings that relate to eating are the subject of a companion report, *Healthy Eating in New Zealand Families and Whānau (December 2007)*.

[1] www.hsc.org.nz

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).

Throughout this report reference is made to eating because this was the health area explored in-depth in Phase One of the SMAR project. While the companion report – *Healthy Eating in New Zealand Families/Whānau (December 2007)* – contains detailed findings on eating (e.g. attitudes, behaviours and practices), reference is also made to eating as it relates to family/whānau functioning in this report.

1.2 Key Findings

1.2.1 What Constitutes Family/Whānau

Participants were asked to define what constitutes family/whānau for them, in particular, they were asked who they included (and excluded) as family/whānau members and why certain people were included (or excluded).

Family/whānau was perceived as comprising people who were connected through blood and marriage/partner relationships. It may also have included people who were not related in these ways, but who were considered 'adopted' family because of their close emotional ties with family/whānau members.

Blood and marriage/partner relationships – in this study four types of arrangements emerged within this category of family/whānau, as outlined below:

- People who lived in the same household (or nearby) – such family/whānau typically consisted of one or two parents and children, with the adults taking responsibility for the well-being of children in the household. Usually a sense of emotional closeness existed in such families/whānau.
- Māori grandparents bringing up mokopuna (grandchildren) in their own home, or living with the mokopuna and their parents (and playing a significant part in ensuring the well-being of the household). A sense of emotional closeness existed in such family/whānau arrangements.
- Some family/whānau had members who were emotionally estranged and had little contact with other members, whether or not they lived geographically close (this phenomena was evident across all cultural groups).
- Biological parents who were living apart from their children (Note: adults who were in the day-to-day parenting roles may not have regarded these absent parents as family/whānau, but children typically did).

'**Adopted' family** were, in some cases, included as family/whānau – these were usually adults who were not legally adopted, but who were considered part of a family/whānau by virtue of their long-standing and emotionally close relationship with family/whānau members. 'Adopted' family included close family friends and neighbours. 'Adoptees' usually lived nearby, rather than in the household.

Cultural differences[2] were noted in terms of how the participants in this study defined family/whānau, as outlined below.

Pakeha participants were more likely to interpret family/whānau as blood relations and relationships arising from marriage or de facto partnerships, with a focus on those living in the immediate household. (Note: Some Māori and Pacific participants shared a similar view of family/whānau, subscribing to the western concept of the nuclear family[3]).

The Māori concept of whānau was understood by many Māori to be fundamentally different from family. Whānau was generally described in one of two ways:

- Whakapapa whānau – this was a collective of people connected through blood/kinship (whakapapa) to a common ancestor.
- Kaupapa whānau – this was a collective of people who were connected through a common purpose, mission or interest (kaupapa) that was not usually based on kinship, e.g. religious affiliations kapa haka and sports groups.

Pacific participants, like Māori, had definitions of family/whānau that often extended beyond their immediate household to include family members living nearby, such as elderly parents, adult siblings and their children. For some Pacific participants family/whānau also encompassed social groups such as sports, youth and church groups.

It was common for Asian participants in this study to include blood and marriage relations in their country of origin (or elsewhere overseas) as family. Some Asian participants also included friends, neighbours and, in a few cases, colleagues, as part of their family. Where Asian migrants were socially and emotionally isolated in New Zealand, these ties took on greater importance. For example, a divorced Indian woman considered her New Zealand friend to be family, because her friend had supported her emotionally through her divorce which had left her estranged from her ex-husband's family.

[2] Note: A requirement of the SMAR project was identification of any cultural differences that existed in relation to the areas explored in the research.
[3] Note: The nuclear family is typically seen as comprising two parents and a small number of children living in the same household.

1.2.2 Family/Whānau Roles and Responsibilities

Participants were asked to identify what key adult roles and responsibilities existed within their family/whānau.

Three broad roles were identified in this study - income earners, homemakers and caregivers. These roles were found among Pakeha, Māori, Pacific and Asian families/whānau. A summary of how these roles related to family/whānau eating practices follows:

- **Income earners** – working in full or part-time employment – income earners had less direct influence on the family/whānau diet because they were absent from the home during working hours. Although income earners may have held ideas about what children should be eating and drinking, it was often left to the adults in the homemaking and caregiving roles to plan for, implement, model and enforce healthy eating, because of their more direct involvement with the children throughout the day.
- **Homemakers** – parents (usually mothers) who were based in the home full-time – homemakers were in a key position to influence the family/whānau diet, because they tended to do much of the shopping and food preparation and were present in the home to influence and monitor what was eaten. Even where the homemaker was sharing the cooking (e.g. with an income earner) they were likely to be making key decisions about what types of foods got bought, and how much was spent on different food items.
- **Caregivers** were family/whānau members who regularly cared for children in the household. (The homemaker role sometimes incorporated the caregiver role). Caregivers were sometimes people such as grandparents, living within or outside the household. The caregiver role was influential when it came to the family/whānau diet, because caregivers were on the spot when children got hungry. Addressing hunger and keeping children happy was sometimes a greater priority than considering whether or not food was healthy.

In single parent households, the parent fulfilled all three roles outlined above, but may have derived support from adults outside the household, e.g. with grandparents providing caregiving.

Mothers in this study were often the main caregivers in families/whānau. This role was also filled by some fathers, and by grandparents – especially in Māori, Pacific and Asian families/whānau. Grandparents in the caregiver role may not have adhered to household rules around eating – allowing sweet foods and other treats without parents' knowledge (or even against their wishes). Parents were generally reluctant to tackle 'indulgent' caregivers out of an over-riding sense of gratitude for their support.

1.2.3 Key Issues/Challenges Facing Family/Whānau

Participants were asked what kinds of issues/challenges (if any) their family/whānau faced in daily living, i.e. issues/challenges that were 'top of mind' and occupied their thoughts or influenced the way they lived. The purpose of this line of questioning was to find out whether, and to what extent, health and well-being issues/challenges impacted on families/whānau in daily life.

A number of key issues/challenges common to many families/whānau emerged in this study, as shown below:

- Money worries
- Blended family/whānau
- Time scarcity
- Parenting
- Culture clash
- Life's surprises.

Money Worries

Many families/whānau reported money worries. These ranged from struggling to survive from pay-day to pay-day, to worrying about getting ahead financially, e.g. saving for one's own home, for children's education, or for retirement.

Socio-economic status and disposable income both influenced the nature of food and drinks consumed by families/whānau. The most financially constrained or budget conscious families/whānau fell into two groups in terms of healthy eating: those that said they could not afford more healthy food (such as fruit and vegetables and lean cuts of meat); and those that said they could not afford not to eat healthily because the overall cost was higher.

Blended Family/Whānau

Some parents in blended families/whānau struggled with the children's emotional reactions to loss and change resulting from parents breaking-up and re-partnering. They may also have had to work harder at creating and maintaining emotional bonds within the blended family/whānau, and avoiding differential treatment of step-children and biological children.

Children in blended families have sometimes had to re-learn eating habits (such as eating vegetables), or to adapt to living in two households with different eating rules and practices. Conflicts around food may have been heightened when step-parents were in the enforcing role in relation to eating.

Time Scarcity

Lack of time was a common issue for families/whānau, although it was felt less keenly in families/whānau with a full-time homemaker. Parents in paid work often struggled to fit 'quality' family/whānau time into long working weeks. Some parents worried that, in not spending enough time with their children, they were failing as parents. They also worried that they were not spending enough time with their partner, placing strain on relationships and making the task of parenting harder.

In the context of healthy eating, lack of time had a significant influence on food choices. Lack of time for meal planning and considered food shopping sometimes drove people in the direction of takeaways and packaged convenience foods. While the regular use of such foods helped to free up time spent on cooking (and cleaning up), their use sometimes induced feelings of guilt, especially when they became diet staples.

Parenting

Parents of babies, toddlers, pre-adolescents and adolescents seemed to particularly feel the strain of daily parenting. As their children moved through the various developmental phases, parents often felt under-prepared to cope (particularly if they were dealing with a phase for the first time). Parents of very little children may have felt sleep deprived and worn down by the demands of parenting this age group. Parents of older children often struggled with how to prepare and handle their teenagers in relation to risk-taking behaviours such as drug and alcohol consumption and involvement with fast cars. Any parental focus on healthy eating could take a back seat if offspring were engaging in risk-taking behaviour (e.g. alcohol consumption or unplanned sexual activity).

Culture Conflict

Asian parents in this study were often dealing with the perceived threat to their traditional values as their children adopted New Zealand attitudes and values. Asian parents placed great value on education and academic excellence. Some Asian parents were concerned that their children were becoming less motivated as they assimilated into New Zealand society. Having the mother in a full-time homemaker role had been a way for some Asian families to address this perceived challenge to their traditional values.

Life's Surprises

Inevitably, families/whānau were often dealing with unexpected events that changed the fabric of their lives, for a while or perhaps for good. In this study, life's surprises included: unplanned pregnancy, the death of a partner or parent, the breakdown of a relationship resulting in mokopuna moving in with grandparents, redundancy resulting in a change of traditional family roles (e.g. the female as the income earner) and the onset of dementia leading to full-time caregiving for an elderly parent.

Health and Well-being in Relation to Key Issues/Challenges

Most families/whānau did not include health and well-being issues among the key issues/challenges they were facing on a day-to-day basis. Rather, health and well-being issues were found to be 'sleeper issues', which percolated along in the background until a problem arose, at which point they became a significant (and often dominant) issue.

Families/whānau tended to take health and well-being for granted, until a problem arose which could not be overlooked. Even where a significant health issue existed, such as a chronic condition, this tended to become part of the background unless a significant worsening occurred, at which point it took centre-stage.

1.2.4 Health and Well-being

Participants were asked to describe their understanding of good health (and poor health) and well-being, with a view to finding out whether health and well-being were seen in the same way, or whether they were regarded as different.

Good Health

Good health was understood in two ways, namely as good physical health or as a superset of good physical, emotional and spiritual health (this reflected a holistic view of health).

Good Health as Physical Health

One common view of good health translated as good physical health. This was viewed from either a medical or physical activity point of view, as outlined below:

- From the medical point of view, the indicators of good physical health were: no obvious or known signs of being physically unwell, not being overweight or obese, not easily succumbing to sickness, and recovering quickly from illness.
- From the physical activity point of view, participating in physically demanding sports (e.g. netball or tennis as opposed to bowls) or exercise (e.g. running, cycling or going to the gym) were perceived as indicators of good physical health.

Factors perceived to contribute to good physical health included eating healthily (including eating 'correct' sized portions), getting enough exercise, drinking alcohol in moderation (or not at all), not smoking (or cutting down), getting plenty of sleep, and minimising stress (which was associated with potentially life threatening conditions such as cancer and hearts attacks).

Note: Poor health was typically understood as the opposite of good physical health.

Good Health as Holistic Health

An alternative and also common view of good health took a more holistic perspective, with good health being seen as a combination of physical, spiritual and emotional health.

The holistic view of good health incorporated feeling physically fit and well, being able to live life according to one's beliefs (spiritual health) and feeling positively engaged with life on an emotional level. Spiritual and emotional health were associated with having a supportive network (e.g. within the family/whānau, or among friends and work colleagues) and having balance across priority areas in life, particularly in relation to family/whānau relationships.

Well-being

Two views existed on the meaning of well-being. One view was that well-being only related to spiritual and emotional matters, while the other view was that it embraced physical, spiritual and emotional health. Note: The latter view of well-being equated with the holistic view of good health (see above).

Cultural Context of Health and Well-being

Pakeha

Pakeha participants typically associated good health with good physical health, and understood well-being as relating to spiritual and emotional well-being. Only a minority of Pakeha participants perceived good health from a holistic perspective (as described above).

Māori

Māori participants in this study could be divided into two broad groups in terms of how they perceived health and well-being.

Some Māori viewed health and well-being from a western perspective, where health typically related to physical health, and well-being related to spiritual and emotional well-being.

Other Māori had a more holistic view of health and well-being which embraced physical, spiritual and emotional matters (i.e. equated with the holistic view of good health discussed earlier).

Māori in this study had typically had contact (directly or through whānau members) with a range of health conditions common amongst Māori, e.g. diabetes, heart-related diseases, being overweight and smoking-related illnesses. While these conditions are not solely Māori conditions, some Māori viewed them as such because they had become part of their whānau – often affecting many whānau members over generations. Some Māori participants accepted there was an inevitability that they would be similarly affected, while others actively worked to avoid this happening.

The mokopuna-grandparent relationship resonated with many Māori. This had motivated some Māori grandparents to take (better) care of their health to ensure they were around to participate in the lives of their mokopuna.

Pacific Peoples

Pacific participants were similar to Māori in that some had a western perspective of health (as physical health) and well-being (as spiritual and emotional health), while others had a holistic view of health and well-being as embracing physical, spiritual and emotional health.

Some Pacific participants recognised the link between healthy eating and better health and well-being. This had typically stemmed from having a health scare and making dietary changes (on medical advice) to eliminate or manage the situation. There was increasing recognition among some younger Pacific participants of the need to move away from less healthy traditional Pacific foods to introduce healthier eating behaviour and enjoy better health.

However, some Pacific participants did not make the connection between diet and health. Rather they relied on medical solutions for health problems and did not see they had a role to play in achieving better health and well-being for themselves and their family, e.g. by eating more healthily.

Asian Peoples

While most Asian participants in this study had a holistic view of health and well-being, some participants (e.g. Indian people) had a western perspective of good health as physical health.

Health and well-being were often considered (more so by Chinese people) in financial terms. Enjoying good health and well-being meant less time off work sick and less money spent on medical bills. This meant effort was put into staying healthy – part of which was eating healthily.

Some migrant Indian participants had become more conscious of their physical health, especially their weight, after arriving in New Zealand. As part of the commitment to be more healthy, some Indian people were opting to eat more healthily (e.g. through substituting saturated fats with healthier alternatives and reducing the amount of fried foods consumed) and engaging in more physical activity.

Impact of Health and Well-being on Family/Whānau Functioning

Discussion took place with participants on how health and well-being impacted on the way their family/whānau functioned.

The study showed that health and well-being impacted on family/whānau functioning in any one or more of the following ways:

- Parents' ability to earn an income to support their family/whānau.
- Parents' ability to physically care for their children. This was particularly relevant in relation to babies and very young children, who required a great deal of physical care. Mothers reported that when their health suffered, the whole household was affected.
- Parents' energy and motivation to consistently attend to the physical and emotional tasks of parenting. This included giving time and energy to meeting children's nutritional needs by providing healthy foods and drinks, and avoiding or limiting less healthy ones. When parents were lacking in energy and motivation, their consistency and quality of their attention could slide.
- Parents' energy and motivation to model physical activity to their children, by participating in physical activity with them (e.g. bike riding, walking, swimming) and supporting their participation in organised sports (e.g. school teams). Parents who felt unfit and overweight were typically less ready to get involved in physical activity with their children.
- Parents' use of alcohol could impact on family/whānau functioning. A small number of parents in this study were recovering alcoholics, or had ex-partners with drinking problems. These families/whānau had experienced the physical and emotional neglect associated with a heavy drinker whose focus was on drinking at the expense of the family/whānau.
- Problem gambling also impacted on family/whānau functioning. A small number of parents in this study were children of problem gamblers. As children, they had experienced family conflict as well as physical and emotional neglect on the part of the gambling parent.

1.2.5 Health Issues

This study explored five health issues of interest to HSC: smoking, gambling, alcohol consumption, physical activity and healthy eating, and their impact on family/whānau functioning (discussed below).

Smoking

Smoking and its potential for harm was of high concern to many parents and caregivers. Smokers and non-smokers alike recognised that their children would be confronted with smoking as part of growing up, and hoped they would avoid taking up smoking.

Many households had rules about smoking outside, or not smoking around children, but these were not always consistently enforced. Some smoking parents (and caregivers) were in denial about their influence as role models in relation to their children taking up smoking, and elevated the relative influence of peers.

Gambling

Potential harm from gambling was seen as a distant threat by most families/whānau. Most people associated problem gambling with pokies and casinos, and saw this as ghetto-ised behaviour that did not concern their family/whānau. Many families/whānau saw no need to talk to their children about the potential risks of gambling, and indicated they would not know where to start in doing so.

Few people made a connection between playing Instant Kiwi and Lotto and potentially developing problems with gambling later in life. Many children were part of adults' Instant Kiwi and Lotto routines, with Instant Kiwi regarded as a harmless treat, and Lotto as the potential 'way out' of financial difficulties for some families/whānau (especially some Pacific families).

The exception to this generally low concern around gambling was among some Pacific peoples, who were aware that their community was vulnerable to gambling harm. Despite this, problem gambling tended to be associated with casinos and pokies, rather than other forms of social gambling that Pacific families routinely participated in, such as Housie.

Alcohol Consumption

Alcohol consumption was of high concern to many parents and caregivers. As with smoking, parents and caregivers recognised that their children would be confronted with alcohol as part of growing up, and that prohibition was not an enduring solution. However, many parents were not sure how to normalise alcohol consumption and how to teach their children to manage the risks associated with alcohol consumption.

Physical Activity

Physical activity was of low concern for most Pakeha and Asian participants and some Māori. However, it rated as a greater concern among Pacific peoples and some Māori.

There was generally a low level of concern among participants about physical activity. It was strongly linked with weight in the public mind: many parents cited lack of weight problems as tangible evidence that family/whānau members were sufficiently active. Other, less immediately apparent benefits of physical activity – such as cardiovascular health and having more energy – were less 'top of mind' than weight issues (and seemed less relevant in relation to children, who appeared to have plenty of energy regardless).

Despite the links made between physical activity and weight, some relatively inactive, overweight parents saw no pay-off for increasing their fitness levels.

Some Pacific and Māori participants were placing greater emphasis on physical activity, partly as a result of health scares or warnings from doctors. Some Pacific participants were aware that the Pacific community was being targeted in relation to obesity, and the messages about the benefits of physical activity in preventing and reducing obesity were starting to gain traction with this audience (as evidenced by some Pacific families incorporating physical activity into their daily routines).

Healthy Eating

Healthy eating was of low to moderate concern for most families/whānau. Not all participants 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.

Unlike the other health concerns covered in this report, eating is a fact of everyday life and continual decisions around eating (such as what to eat and how much to eat) are unavoidable. This study found that 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) with less commitment to healthy eating can undermine these intentions.

1.3 Conclusions

1.3.1 The Meaning of Family/Whānau

Family/whānau has different meanings to different people, with Māori and Pacific participants, in particular, typically having a broader understanding of family/whānau that includes people not resident in their household.

Given that wider family/whānau members can influence attitudes and behaviours in relation to the five health issues of interest to HSC, the HSC may need to be aware of these different understandings of family/whānau when developing strategies and communications for its social marketing programmes.

1.3.2 Key Issues/Challenges Facing Family/Whānau

Health and well-being did not feature among the key issues/challenges facing families/whānau on a day-to-day, only coming to the fore when a problem arose.

Rather than health and well-being only taking centre-stage in a negative context (i.e. when there is a problem), HSC may wish to explore how health and well-being could be celebrated as part of the foundation of a happy family/whānau. This could include encouraging parents and caregivers to take a proactive approach to health and well-being, and spelling out the links between health and well-being and having a happy family/whānau.

1.3.3 Health and Well-being

Good health did not have a universal meaning, with some people narrowly focused on physical health, and others taking a more holistic view (incorporating physical, emotional and spiritual health). This should be considered when developing communications.

Similarly, well-being did not have a universally understood meaning and nor was it a commonly used term. Should HSC wish to use the term ‘well-being’ in communications, it would ideally define the term. Well-being as a superset of physical, emotional and spiritual health would have currency with HSC’s social marketing audiences.

1.3.4 Health Issues

Smoking

While smoking was of high concern for many families/whānau, some smokers remained in denial about their relative influence as a role model to children in the family/whānau. There is scope for HSC to emphasise the potency of parental and caregiver role modelling in relation to smoking. A compelling message for smoking parents and caregivers would communicate that giving up smoking may prevent the children they love from falling into the smoking trap. HSC may wish to consider communications that acknowledge the short-term challenges inherent in quitting smoking (grumpiness and household tension), while emphasising the longer term gains (a healthy, happy family/whānau).

Parents who were unconcerned about their children taking up smoking would benefit from being moved from a position of complacency, to one of active prevention. HSC may have a role to play in communicating preventative messages to such parents.

Gambling

Many people in this study assumed that children who were not brought up around gambling activities would effectively be inoculated from its harm. People generally discriminated between gambling that was perceived as harmless fun (Lotto, Instant Kiwi, Housie, an occasional flutter on the horses) and what they saw as problem gambling activities (casinos, pokies, regular TAB betting).

Parents would benefit from communications that provided guidance on how (and at what age) to raise and talk about the issue of gambling with children.

HSC may also want to consider developing communications that gently challenge the normalisation of gambling in the Pacific community.

Alcohol Consumption

Alcohol consumption was an issue of high concern to many parents. They 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 may have a role 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 could potentially have a role to play in communicating preventative messages to such parents.

Physical Activity

The health benefits of physical activity, beyond weight control, had a relatively low profile in participants' minds. There is scope for HSC to promote physical activity as having health benefits above and beyond weight control, and to spell out these benefits. In particular, there is scope to emphasise the connection between physical activity and increased energy levels and holistic good health, whatever one's weight.

Healthy Eating

Some people were unaware of, or downplayed, the importance of healthy eating to good health. There is scope for HSC to communicate the role of diet in relation to good health.

Healthy eating does not happen by chance – it takes time, effort, planning, commitment and persistence on the part of parents and other significant caregivers. Good intentions with regard to healthy eating can be undermined by the lack of buy-in by the wider family/whānau. HSC may wish to consider promoting healthy eating as a family/whānau concern. There is also scope for HSC to consider reinforcing the attitudes and practices of healthy eating families/whānau, as well as to raise the profile and rationale for healthy eating among less healthy eating families/whānau.

1.3.5 Summary

In this study, health and well-being were not a great focus of day-to-day attention in families/whānau, until something went wrong. Despite agreeing that health and well-being were important, most families/whānau were consciously focused on more pressing issues such as money worries or lack of time. However, these issues often impacted on family/whānau health and well-being in negative ways.

The health and well-being of the adults in a family/whānau had both direct and indirect consequences for the children in their care. The health and well-being of the main caregiver in a household – usually the mother – was particularly influential.

Parents were powerful role models for their children in all the areas of health identified by HSC: smoking, gambling, alcohol consumption, physical activity, and healthy eating. Despite some awareness of their position as role models, parents and caregivers often provided mixed messages to their children, in effect instructing them to 'do as I say, not as I do'. Parents and other adults in the household sometimes also undermined each other by providing conflicting messages to children in their care – mainly through their actions.

The health and well-being impacts of smoking and alcohol consumption were generally widely understood. However, people needed reminders of the potential harm posed to their children by smoking and alcohol. They also required strategies for tackling these subjects with their children.

The potential threat to health and well-being posed by gambling was less well understood. People needed convincing that the issue of problem gambling was of potential relevance to their family/whānau. They also required strategies for introducing and discussing gambling with their children.

While healthy eating and physical activity were seen to contribute to health and well-being, understanding of their importance was patchy. Habits learned in childhood were influential, and it often took a health scare to prompt changes to diet or levels of physical activity. People needed reminding that healthy eating and physical activity are the building blocks of good health, and that good health is the foundation of happy families/whānau.

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 (final 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 an interim report on the health and well-being and family/whānau functioning findings drawn from Phase One of the SMAR project. These findings will be added to on completion of Phases Two and Three of the 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 this report. 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 the companion 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.

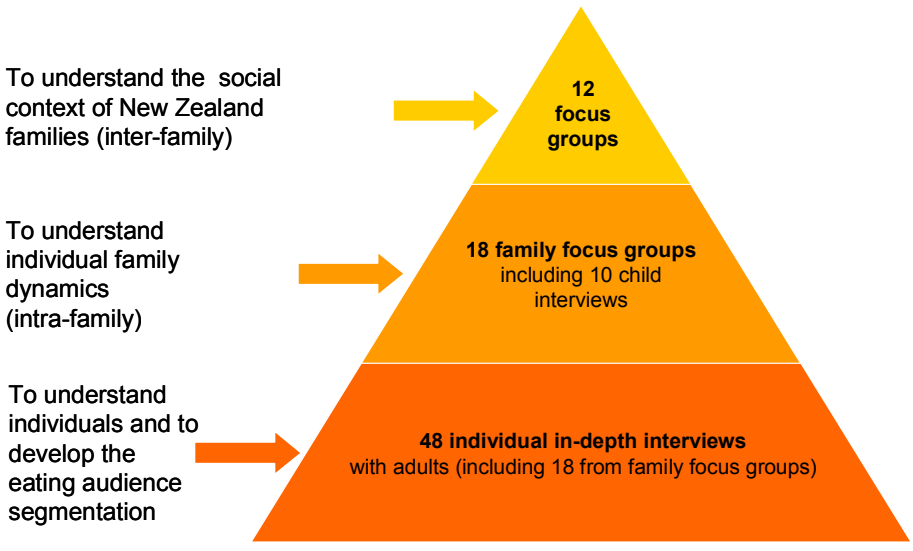
- An in-depth interview is a face-to-face dialogue between one participant and one researcher. This is the method of choice when discussing personal, sensitive or complex topics or when we want to understand people as individuals (e.g. their attitudes, behaviours, motivations and barriers) and when we 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 this report (i.e. *Health and Well-Being and Family/Whānau Functioning: An Interim Report; December 2007*). Findings that relate to eating have been incorporated into the companion 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 this report, and findings that relate to eating have been incorporated into the companion report *Healthy Eating in New Zealand Families and Whānau (December 2007).*

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 P58eoples	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.

Throughout this report reference is made to eating because this was the health area explored in-depth in Phase One of the SMAR project. While the companion report – *Healthy Eating in New Zealand Families/Whānau (December 2007)* – contains detailed findings on eating (e.g. attitudes, behaviours and practices), reference is also made to eating as it relates to family/whānau functioning in this report.

Research Findings

4.0 Family/Whānau Functioning

This section of the report discusses participants' definitions of family/whānau and roles and responsibilities within participants' family/whānau, particularly in relation to eating. It also considers the key issues/challenges faced by families/whānau on a day-to-day basis and where health and well-being is positioned in relation to these.

4.1 What Constitutes Family/Whānau

4.1.1 Interpretations of Family/Whānau

Participants were asked to define what constitutes family/whānau for them. In particular, they were asked who they included (and excluded) as family/whānau members and why certain people were included (or excluded).

This study found that, at an overview level, family/whānau was not determined by emotional closeness, although this was often a characteristic of relationships with people considered to be family/whānau.

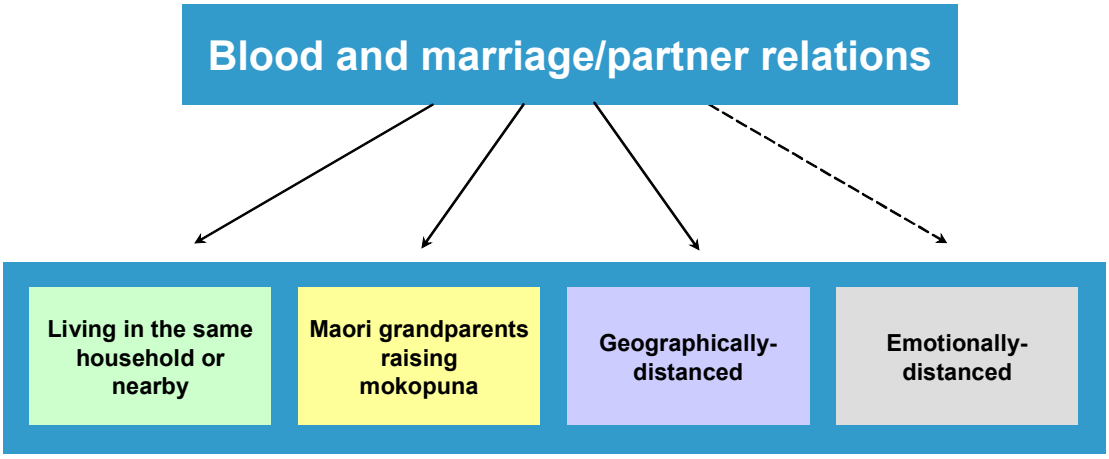
The participants in this study interpreted family/whānau in two broad ways, namely **blood and marriage/partner relations** and **'adopted' family.**

Blood and Marriage/Partner Relations[16]

This category refers to people who were regarded as family because they were related by blood, or through marriage or comparable partnerships (such as de facto relationships). The researchers note that same-sex partnerships and Civil Unions would also fit into this category, although examples of these relationships were not evident in the research sample.

[16] Included legally adopted family members (as distinct from 'adopted' family, i.e. people who were not related by blood or marriage but who were treated as if they were family – discussed later).

In this study four types of arrangements emerged in relation to the **blood and marriage/partner relations** category, as outlined below.



Living in the same household or nearby - blood and marriage/partner relations tended to live in the same household, or nearby. This grouping of family/whānau typically consisted of one or two parents and children living in the same household, with the adults taking primary responsibility for the well-being of the children. Family/whānau who lived nearby tended to be the participants' parent/s and/or adult siblings.

Māori grandparents raising mokopuna (grandchildren) - in some Māori whānau, grandparents were bringing up their mokopuna in their homes or living with the mokopuna and his/her whānau, and played a significant role in contributing to the well-being of the household. Even when they did not live together, the grandparents still had a key role and influence on the well-being of the mokopuna and the family/whānau as a whole.

Geographically-distanced – people included in the blood and marriage/partner relation category did not need to be geographically close to be considered part of the family. Most Asian migrants in this study included family members in their country of origin (or elsewhere in the world) in this category.

Emotionally-distanced – people included in the blood and marriage/partner relation category did not need to be emotionally close to be considered part of the family/whānau.

Participants often included family/whānau members from whom they were emotionally estranged or distant in this category. These were people they chose not to have much to do with, creating distance from them as a way of managing differences (e.g. in lifestyle and values). This phenomena was evident across all cultural groups that participated in the research (i.e. Pakeha, Māori, Pacific and Asian).

Biological parents who were living apart from their children were typically considered part of the family/whānau by the children. However, adults living in the same household as these children did not regard an 'absent' parent as part of their family/whānau.

'Adopted' Family

Emotional and geographic closeness – 'adopted' family members (usually adults) had not been legally adopted, but were regarded as part of the family/whānau by virtue of their emotional ties to the family/whānau, the mutual emotional (and sometimes financial) support provided, and the long-term nature of the relationship. This grouping included people such as close family friends and neighbours who had forged close emotional bonds with the family/whānau. Such 'adopted' family/whānau members tended to be both emotionally and geographically close, but did not typically live in the household.

> *"Yeah I would consider them [referring to a close friend] almost like family … just because of the closeness of the relationship, and I suppose circumstance. She and my wife were pregnant with our first children at the same time, and then she went through a marriage split, and we sort of helped look after her at the time."*
>
> **Māori Male – Auckland**

4.1.2 Cultural Considerations

Pakeha

Pakeha participants were more likely to interpret family as blood relations, and relationships arising from marriage or de facto partnerships. They were more likely to list their family members as the members of their immediate household, and to regard their other biological family members (such as their own parents and adult siblings) loosely as family, but not part of their family's innermost circle (i.e. their nuclear family).

> *"In my family, first we distinguish between what we call the nuclear family, and the wider family. So we have this sense of a split. There is the four of us – two children, my wife and I and that is the nuclear family to us, and then we have my wife's sister [she is] in Wellington, [and] my parents and we conceive of them as the wider family. It is not a matter of caring less about them but there is a sense of difference between them and the four of us … and they [our children] are the first concern to us before my wife's parents or mine or before my wife's sister. So there is that centre but then it flows out from there."*
>
> **Pakeha Male – Wellington**

There was wide variation in interpretation of family/whānau however, as some Pakeha families had close connections with 'aunties' and 'uncles' who may or may not have been related by blood or marriage. They lived close by and reciprocally shared family responsibilities such as child-minding, food preparation and general concern for each others' well-being.

Absent parents may have been regarded as family by their biological children, but were not regarded as part of the blended family in the household the children lived in. This was noted in two Pakeha families in this study.

Māori

The Māori concept of whānau was understood by many Māori to be fundamentally different from family. Whānau was linked to the concept of whānaungatanga (relationships) and the nature of the relationships and interactions that arise out of whakapapa (blood/kinship).

Whānau was generally described in one of two ways:

- Whakapapa whānau – this was a collective of people who were connected through whakapapa to a common ancestor
- Kaupapa whānau – this was a collective of people who shared in or were connected through a common purpose, mission or interest.

Marae were the centrepoint for whakapapa whānau, especially when they lived within their own rohe (geographic area). With the whakapapa links, whānau were also able to describe hapū (a grouping of whānau) and iwi (a grouping of hapū), and these terms were frequently used interchangeably to refer to larger or smaller groups of whakapapa whānau. Close relationships and the experience of whānaungatanga – involvement in whānau, hapū, iwi and marae activities – all contributed to what it meant to be whānau.

Kaupapa whānau were groups of people who shared a common purpose, mission or interest, and were usually not based on kinship. It comprised a group of individuals who came together as whānau for a specific purpose and generally for a certain period of time. Examples of kaupapa whānau cited by participants in this study were Te Kohanga Reo[17], religious and church affiliations, and kapa haka and sports groups. At times, kaupapa whānau took precedence over iwi affiliations.

Similar to the concept of 'adopted' family noted previously, whānau membership could also be conferred or granted to people through a range of means such as whangai[18], marriage, being brought up together, and long-standing friendships. Living within the prescribed whānau rohe, having had a long association, and having made a significant contribution, e.g. to the local marae, could also result in people being recognised as whānau.

> *"My sisters. My husband, children. I go to church, so my church family, my in-laws, even extended family, cousins, aunties, uncles, mum, dad, and close friends [they are included], probably because we have been raised together, like from primary [school]. My kids know them as uncle, aunty."*
>
> **Māori Female – Auckland**

In this study, some Māori participants had a similar view of family to many Pakeha participants, subscribing to the western concept of the nuclear family (as described earlier).

[17] Te Kohanga Reo is a total immersion te reo Māori whānau (family) programme for young children aged from birth to six years of age. Children participating in the programme are raised within its whānau Māori, where the language of communication is te reo Māori. www.kohanga.ac.nz

[18] A whangai is a child adopted in accordance with tikanga Māori. The child is likely to be brought up by blood relations who are not his/her biological parents. In many cases, whangai know their parents, and often have contact with them.

Pacific Peoples

Like Māori, Pacific participants' definitions of family often extended beyond their immediate household to include family members living nearby, such as elderly parents, and adult siblings. Such family members often spend large amounts of time in each others' homes, and meals and caregiving for children may be regularly shared.

> *"I regard my family as open, whether they are in the [Pacific] Islands or overseas, up the road – I still consider them my family."*
>
> **Tongan Female – Wellington**

Some Pacific participants' definitions of family also encompassed social groups such as church, sports and youth groups. Typically, these groups comprised mainly Pacific peoples of diverse ethnic mix.

> *"My personal perspective of family is definitely mum and dad and my siblings, and then mum's family and their families and as you say– the layers – there is a church family and league family and netball family. I guess who ever I am in contact with I consider family and [my family in] the [Pacific] Islands."*
>
> ***Tongan Female – Wellington***

The researchers comment that for Pacific peoples, family was traditionally and intrinsically linked to one's identity. Family helped Pacific peoples to understand their place and role in society as well as providing others within Pacific society with an idea of where one belonged in terms of genealogy and family links. This study indicates that in the New Zealand context, this definition was changing as younger generations formed and maintained strong relationships with individuals and groups with whom they did not have familial ties. While genealogy and family links remained important and strong, ties with groups, e.g. churches, had strengthened because such groups upheld many traditional social and cultural values.

In this study, some Pacific participants had a similar view of family to many Pakeha and some Māori participants, subscribing to the western concept of the nuclear family (as described earlier).

Asian Peoples

Similar to Māori and Pacific participants, Asian participants' definitions of family often extended beyond their immediate household to include family members living nearby and overseas, such as elderly parents, and adult siblings and their children.

> *"My brothers, and my sisters, my wife, my kids, the extended family as well."*
>
> **South Asian Male – Wellington**
>
> *"… my husband's brothers and there's his sister, and her husband, their two children. There is my sister and her husband and their three children."*
>
> **Indian Female – Wellington**

While embracing the immediate and extended family, some Chinese families focused attention on those living in the household (e.g. a spouse and children) because of having primary responsibility to provide for them.

> *"Immediate [family] – [my] husband, myself, my three children and [my] mother … [my extended family] would be my in-laws and my brother and sister … Well when you marry and you do have children, you've got a family unit and [a] cluster of, shall we say little cells and those little cells would be [my] immediate responsibility."*
>
> **Chinese Female – Auckland**

Some Asian families did not include relations living overseas as family. This was because they were not immediately able to provide support to the family in New Zealand if required.

> *"For me, because my parents live away [in China], my family are my wife and kids."*
>
> **Chinese Male – Auckland**

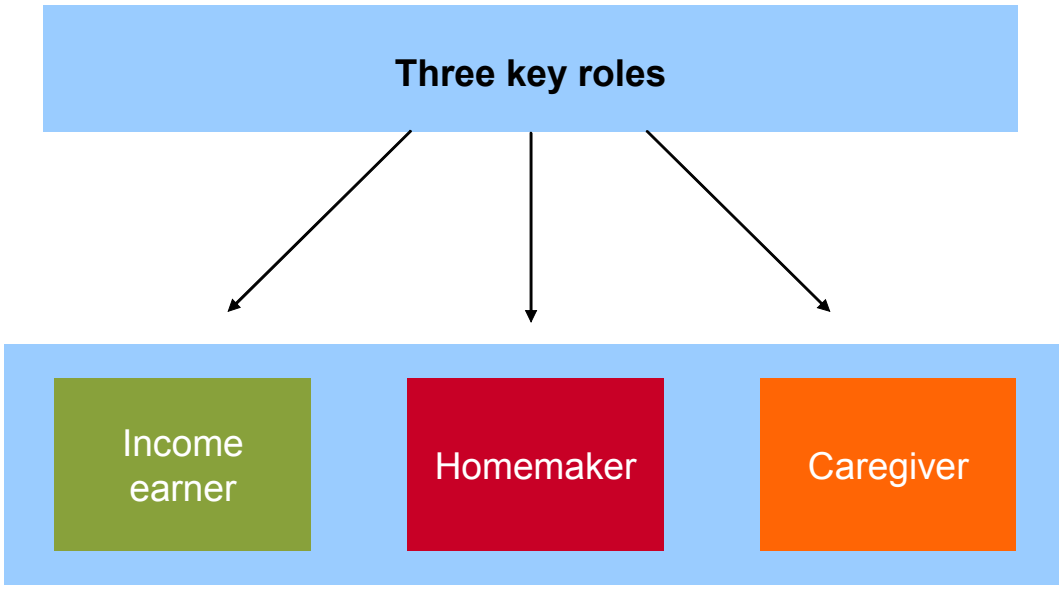
Some Asian participants included friends, neighbours and, in a few cases, colleagues, as part of their family. Where Asian migrants were socially and emotionally isolated these ties took on greater importance. For example, a divorced Indian woman considered her New Zealand friend to be family, because her friend had supported her emotionally through her divorce which had left her estranged from her ex-husband's family.

4.2 Family/Whānau Roles and Responsibilities

Participants were asked to talk about roles and responsibilities within their family/whānau, and to explain what factors (internal and external to the family/whānau) had determined role allocation.

4.2.1 Key Roles

This study identified three key adult roles that existed within families/whānau and applied across all cultural groups, as shown in the diagram below.



The income earner, homemaker and caregiver roles were not always mutually exclusive. Some income earners acted as a main caregiver, for example, a mother working part-time to fit in with the 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 these roles, and undertook the tasks of homemaker (although would not refer to themselves as a homemaker). Single parent households may also 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 most the 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.

The Income Earner Role

The income earner role could be jointly or singly occupied by adults in the household.

Single income earner households in this study adhered to one of the following patterns:

- A two-parent household where the traditional role of income earner was held by the male – in these cases, the female partner tended to be a full-time caregiver for small children (usually including pre-schoolers) and had chosen to take up this role rather than being part of the paid workforce.

  "We're a bit old-fashioned. It's hard work raising children properly. It needs your one hundred percent attention."

  Pakeha Female – Gisborne

- A two-parent household where the partner with the higher earning capacity, or greater ability to get and keep a job. was the income earner, whether they were male or female – in these households, the partner who was not working took on greater responsibility for caregiving for children, however they may have also received support from outside the household for this function (e.g. from grandparents). If the income earner was female, she also tended to take responsibility for caregiving when she was not at work.

- A one-parent household where the parent, typically the mother, took on the role of income earner – in such families/whānau the parent typically relied on childcare or support from family/whānau such as grandparents or adult siblings, and in one case a neighbour.

Dual income earner households in the research fell into three categories:

- Households where there was a main income earner – in such households the main income earner was more likely to be a male, who was working longer hours for more pay, with an augmenting income earner, who was more likely to be female, who was typically working part-time to fit in with school and pre-school hours so that she was available as a caregiver.
- Households where both parents were working full-time – such households relied heavily on paid childcare and/or family members such as grandparents to pick up much of the caregiving role.
- Households where an adult child in paid employment was contributing to the household income.

In these dual income households, the second income may have been considered essential to ease the strain on the household finances, or as a way of getting ahead financially. In terms of the latter, a second income was often used to save for a home, or for providing for non-essential but nice extras (e.g. holidays, home renovations, trips 'home' to one's country of origin), or for covering the cost of equipment and activities that supported their children's development (e.g. a computer, a school trip overseas) or allowed participation in sporting and cultural activities.

In terms of healthy eating, adults who were in the main or dual income earner role had less scope to influence healthy eating decisions by virtue of being absent from the home more of the time. While they may have held ideas about what children should be eating, it was often left to the adults in the caregiving or homemaking roles to plan for, implement, model and enforce healthy eating.

Note: In some families/whānau neither parent was in the income earner role, with the family dependent on a government benefit for income. In one whānau, the father was on a sickness benefit. While he and his partner shared the grocery shopping, the mother continued to fill the homemaking and caregiving roles, as she had when her husband was in paid work.

The Homemaker Role

Unlike the income earner role, which could be jointly or singly occupied by adults in the household, the homemaker role was occupied by just one person. 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. This included the physical and emotional care of the children, and imparting the values and behaviours that the parents wished the children to adopt.

In terms of family/whānau eating practices, 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 was 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.
- Shopping for groceries (often within a budget, where there may have been a requirement to fill stomachs as cheaply as possible where money was tight).
- 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 had to be shared by the adults involved with paid work outside the home. Time scarcity on the part of these people sometimes led to healthy eating ideals becoming rapidly eroded in the name of convenience.

> *"To me health and well-being is obviously eating the right foods. Staying healthy, making sure you've got a well balanced diet. Totally opposite to the way we eat [laughter]. We try, we try, but busy lives …"*
>
> **Samoan Male – Wellington**

Because homemakers were physically present in the home, they tended to have their 'finger on the pulse' in terms of what the family/whānau was eating and when, and were in a position to dispense snacks and monitor what the children were eating. Emotionally, homemakers tended to see the physical nourishment of their family/whānau 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.

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. Someone may have temporarily stepped into a caregiving role in times of family ill-health or crisis, or offered to fill the role on a temporary basis which then became a long-term solution.

In most households, 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). The other parent may also have regarded themselves as a caregiver, but this tended to be in a supporting capacity, e.g. a dad in full-time work taking the children off mum's hands at the weekend. This pattern of the mother in the main caregiving role was common across all cultural groups in this study.

In a number of Māori and Pacific families, a grandparent – usually a grandmother – occupied the caregiving role at least some of the time, whether or not the grandparent lived in the household. Grandparents who took on the caregiving role freed up mothers to enter the workforce, as the main or secondary income earner. Grandparents were typically seen as a trusted and more economical alternative to paid child-care. In the case of some Pacific families, where grandparents had their own home, they often provided daily care for several grandchildren who belonged to more than one set of parents.

In Asian families, it was common for a grandmother to come from overseas to stay with the family for an extended period to provide support, e.g. before and after the birth of a child.

Note: Grandparents also occupy caregiving roles in Pakeha families, however, this arrangement was not found among the Pakeha families in this study.

Taking on a caregiving role also allowed grandparents to love and lavish attention on their grandchildren, and to impart knowledge and values they considered important. For example:

- In some Indian families, even if the mother was at home, the grandparents played an important role in imparting cultural values and teaching the children prayers and how to speak and read their mother tongue, e.g. Hindi.
- Similar to the above also applied in many Māori and Pacific families.

Providing caregiving to grandchildren fulfilled an emotional need for grandparents as well as providing practical support to the family.

> *"She's [my mother] a back-up I think. If I need her to help out with my daughter or anything, she's there. She's like her [my daughter's] second mum, my mum is. When my dad was alive, they used to spoil her … then my dad died, so for her [my mum] it was sort of empty, so she wanted my daughter. She couldn't sleep without her. So her and my daughter have become really close. She's a really good companion for my daughter, or my daughter's a really good companion for her.*
>
> **Māori Female – Auckland**

Other family members may have also stepped into the caregiving role to free up parents to enter paid work, or to fulfil other roles within the family (e.g. caring for an elderly/fragile parent). In one such case, when the mother got a well-paid job out of town, her male partner assumed the role of caregiver to their three children, with help from grandparents, and adult siblings. When the mother secured a position in their home town, she and her partner agreed that he would continue in the caregiver role.

Other examples of how caregiving was provided in families included:

- In some Pacific families an adult sibling – typically the mother's sister – took on a caregiving role.
- Older children in a household may also have sometimes acted as caregivers, as was found in a number of Māori whānau in this study[19].

[19] In one Māori family/whānau, the teenage daughter was placed into a caregiving role as a 'strategy' intended to prevent and discourage her from entering into early, unplanned motherhood herself.

- In some cases, family/whānau members shared caregiving within the family because they wanted to, were able to (because they lived in proximity to one another), or because it was simply how the family/whānau functioned.

  "Our family homestead is about five minutes away from all my brothers and sisters. We're all in the vicinity, in the area. So that's pretty much the focal point for our family. So I'm really lucky that my Mum's there, my older sister and her husband and their family are there, and I can take my daughter there as well, and they can help me out."

  Māori Female – Auckland

The caregiver role was characterised by both physical care (e.g. feeding, changing nappies, and ensuring children were rested, safe and secure) and emotional care. Mothers in particular described themselves as taking the emotional temperature of individual family/whānau members and trying to keep the household on an emotional 'even keel'. They did this by trying to meet the emotional needs of both children and partners, through solving problems and looking for solutions. (Where fathers were involved in physical caregiving, the mother often still assumed much of the emotional caregiving for the family).

The caregiver was in an influential role in relation to healthy eating. The main caregiver in the household – in this study more often the mother – was most influential in terms of what got bought and cooked. Caregivers were also on the spot when children got hungry, and needed to anticipate and respond to requests for food. In this context, addressing hunger and keeping children emotionally happy and physically content sometimes took greater priority than worrying about whether or not food was healthy. Caregivers may have used treats as a way to buy peace from children and create harmony.

When the caregiver was also the parent, household rules tended to apply when making decisions about what the children ate. However, when a caregiver such as a grandparent or family friend was caring for children in their own home, they may have followed their own preferences and household norms regarding what to feed the children. This sometimes resulted in grandparents treating their grandchildren with sweet foods or treats such as McDonalds, without the parents' knowledge or even against their wishes.

> *"They can have fruit [after school] but usually they're at their nana's [place], so sometimes she takes them to McDonalds without me knowing … I say to my Mum, 'don't give them too much before they come home' … and she gives them junk food … lollies, chippies, maybe takeaways – like she'll take them to the fish shop and gets hot chips but when she picks them up from school, they can go to the shop and they can choose."*
>
> **Niuean Female – Wellington**

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. Typically, parents 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.

There was also evidence among some parents and grandparents of a general acceptance of grandparents' right to indulge their grandchildren with treats as part and parcel of grandparenthood. When a caregiver was standing in for a parent in times of ill-health or emergency, there may have been even greater relaxation of normal eating rules, with parents placing children's emotional security and happiness ahead of nutritional concerns.

> *"So he [grandad] moved up here and he was the wife! [laughter]. The cooking consisted of cooking up lots of stuff – like fish fingers, chicken nuggets and sausages for tea – all in one night – and eggs … [the kids] thought it was fantastic … so, you know, the children were fed and they were happy – that was the most important thing."*
>
> **Pakeha Female – Wairarapa**

4.2.2 Factors Determining Role Allocation

Participants were asked what factors (internal and external to their families/whānau) had determined the allocation of key roles in their family/whānau. A summary of internal and external factors appears in the table below, with discussion on each factor appearing after the table.

Internal Factors	External Factors
▪ Focus on parenting (e.g. desire to have a 'stay at home' parent) ▪ Costs of working exceeds pay-offs ▪ Specific family needs (e.g. having a special needs child) ▪ Self-worth and identity issues	▪ Tradition ▪ Social norms ▪ Earning capacity and marketability of skills ▪ Financial pressures ▪ Cultural expectations

Internal Factors

Focus on Parenting

In this study, some couples made a joint decision to forgo a second income in order for one parent (usually the mother) to have a greater presence in their pre-school and school-aged children's daily lives. Couples who had made an active choice for one partner not to enter into paid work, often wanted to have more involvement with their children than they perceived working outside the home would allow.

> *"I don't think that values really have a price tag on them. I think that both of our girls are getting, especially with me being a 'stay at home' Mum, great values and just consistent messages."*
>
> **Māori Female – Auckland**

In some cases, homemakers were seeking to ensure the emotional (rather than financial) security of their family/whānau, and particularly their children. In this way, a mother may have chosen not to take on paid work during periods when she perceived her children were particularly reliant on her emotional presence (e.g. during the teenage years).

Some homemakers perceived that their role in the home enhanced the quality of life of their family/whānau. They reasoned that they had the time to do things with and for their family that time-stretched workers did not, such as becoming involved with their children's schools.

Asian families reported that having a mother in the homemaker role helped in passing on the cultural values and practices of their country of origin. For example, teaching children to respect their elders was a key value for Asian families.

Costs of Working Exceeds Pay-offs

Having a large family/whānau, e.g. three or more children, reinforced the decision to be a full-time homemaker in some families/whānau. This was because the cost of childcare and the logistics of managing different arrangements for different children, started to erode the financial gains of paid work. It was also because larger families took more time because there were more physical and emotional needs to attend to.

Specific Family Needs

In some families, having a child with special needs may have precipitated the decision to remain at home, as did the desire or need to home-school children in families in remote rural locations.

> *"She has some fairly mild special needs. It is not noticeable if you look at her but beyond that it actually goes into social and emotional well-being, and some social situations can almost cause [her] anxiety attacks … so, you know – being an advocate for a child with special needs is almost a full-time job really. So, if I had a full-time job or even a part-time job, I would not have much sanity left."*
>
> **Māori Female – Auckland**

Self-worth and Identity Issues

There was evidence that taking on paid work provided an important sense of self-worth for many men, in that they were providing for their family materially. In the same way, the homemaker role brought self-worth for some women because they were providing for their family emotionally and practically with their labour.

It should be noted that some women entered paid work not for financial reasons alone, but for the same psychological reasons that men did. In some cases, women whose mental health had suffered in a full-time homemaking role, had found new confidence and happiness in the paid workforce.

> *"After our youngest child was born, it really took a toll on her [my wife] … I saw her pretty much go downhill from there. When I came back [from a trip] she got an offer to go work part-time, where she is now. I said, 'oh, awesome'. To me it was like an answer to get her out of this, and yeah it helped out for about a year or two …"*
>
> **Samoan Male – Wellington**

External Factors

Tradition

Beliefs about traditional roles appeared to be enduring. Some traditional role occupation – in which the male partner was the sole income earner and the female partner stayed home to care for children – still existed across all cultural groups in this study. This pattern was more likely to be seen in households with pre-school children, and in households where there were three or more children. In such families/whānau childcare would have been expensive and eroded the financial gains made by the second income earner.

In families/whānau where the female partner was also in paid work, her earning role tended to be regarded as secondary to the male's income earning role, and often accommodated caring for children before and after school.

Where a woman with young children entered into a new relationship, this traditional role division was reinforced. Because the male was more likely to already have been in paid employment, he remained in the central income earning role. The arrival of subsequent children cemented these roles – the male as income earner and the female as the caregiver – during the children's preschool years.

> *"I had two children to a previous marriage. Two of the children are biologically [my husband's]. But at that stage I was a full-time parent and when I met [my current husband] – it was natural [that I was the caregiver]."*
>
> **Pakeha Female – Gisborne**

Social Norms

Social norms were a powerful influencer in determining role division in families/whānau. Males in this study still tended to identify with the breadwinning role. However, changing social norms were also encouraging women to pursue careers, as this became the norm among their peer group.

Earning Capacity and Marketability of Skills

The earning capacity of the adults in the household sometimes influenced whether both partners worked or which partner took up work or full-time work.

> *"… at this point in time I can bring the most money in. As I said to X, she wanted to swap roles, but it is the money thing at the moment. She is looking at training to be a teacher, so once the youngest one is at school things might change a little bit."*
>
> **Pakeha Male – Christchurch**

In addition to earning capacity, the availability of jobs that matched each adult's skills may have also influenced which partner took up the main income earner role. In some families/whānau, males who had been made redundant, who had casual work or whose employment was less stable, had been replaced as the income earner by female partners with more marketable skills.

> *"So we went to [a] one worker [household]. When the kids were little, one worker and one of us at home. Financially it was more ideal for [the wife] to go back to [her] full-time job than for me to stay on a contract that was going to end in a couple of months anyway."*
>
> ***Māori Male – Auckland***

Financial Pressures

Financial drivers had a large influence on how families/whānau divided the income earning and homemaking roles. Financial pressures – making ends meet, saving for a home, paying off the mortgage, saving for children's education, saving for retirement – were a reality for most families in this study, and had often influenced the mother's entry into the paid workforce, whether full-time or part-time.

Financial drivers were influencing changes in family/whānau roles across all cultural groups. However, there was anecdotal evidence from a number of families/whānau in this study that the Working For Families package had made a difference to them by reducing the pressure to work longer hours outside the home.

> *"My dad used to spend a lot more time at work [than I do]. Whereas now, what is it? – Working For Families – like, I've done a lot of over time [in the past …."*
>
> *"If we had to make up the same amount of money, he would need so many 'over- times' …. but [with Working For Families] we've got a guaranteed amount coming in …."*
>
> **Pakeha Couple – Gisborne**

Examples of the difference that the Working for Families package had made included shift workers feeling financially able to choose to work fewer shifts and to spend more time with their family/whānau, and mothers choosing to remain out of the workforce longer with their babies. Some also reported that the Working for Families package had enabled them to contemplate having another child, where once this would not have felt financially viable.

Cultural Influences

Pacific participants typically viewed being in paid employment as a means of financially sustaining their family and fulfilling any obligations to extended family members and church affiliations (as opposed to having a career and following career aspirations). Dual incomes had become necessary for some Pacific families, in order for them to financially sustain themselves and meet any obligations. Where females could earn more money, some were acting as the main income earner for their household. Having females in this role was acceptable to Pacific families, provided both parents felt they had a viable solution in terms of child-care and were able to maintain home and family life. In one instance, one Pacific female earned more than her husband, so it was acceptable for her to be the main income earner while the husband focused more on looking after the children and home.

4.2.3 Cultural Differences

Pakeha

Pakeha families in this study tended to adhere to traditional role division, with males tending to take the main income earner role, and women working part-time or caring full-time for children.

Māori

There was evidence of greater role fluidity among Māori whānau, with redundancy in one instance having changed traditional gender roles.

Which partner was able to get paid employment, and who was able to earn the most money, both influenced which partner took on the main income earning role. In a number of Māori whānau this role was taken by women. For example, in one Māori whānau, the mother was the main income earner and the father was the primary caregiver – who also worked in part-time employment with flexible, family friendly hours and school holidays off.

> *"I work long hours. I'm normally working 7:30 [am] till 5:30 [pm] and then I get home at around 6:30 [pm]. So [my husband] is the main caregiver. So all through the kids growing up X was a 'stay at home' dad while I went back to work. … he can work at home, and he's got a good boss, who lets him. He can say, 'I've got kids. I need to work at home, or I need to work shorter hours'. So it works [for us]."*
>
> **Māori Female – Auckland**

Māori grandparents were often involved in caregiving within the whānau, for practical reasons and also in order to impart their values to their mokopuna. One grandmother in this study had moved in with her daughter and grandson, so that the daughter could come off the Domestic Purposes Benefit and move into paid employment. Both the grandmother and mother secured shift work, enabling both to work and care for the boy at different times. In other whānau, mokopuna lived with grandparents, or were cared for by grandparents in their home after school and during school holidays.

Pacific Peoples

There was also role fluidity among Pacific families. In a number of Pacific families, both partners were working, or the female partner had moved in and out of the main income earner role at different stages.

> *"For me, I'm not egotistical enough to think that a woman can't go out to work … we both have a goal which is looking after our kids."*
>
> *"… with [paid] childcare you never get to see your children …"*
>
> **Samoan/Tokelauan-Pakeha Couple – Wellington**

In facilitating this movement, Pacific families had received considerable caregiving support from grandparents. In some cases, grandparents provided caregiving support because the family could not afford to pay for childcare. In other cases, the parents paid the grandparents to care for their children. In either case, there was a clear, mutual expectation that grandparents would be involved with caregiving, and that this was desirable for all concerned (parents, grandparents and children).

This greater role fluidity may reflect changing cultural expectations among younger, often New Zealand-born or raised Pacific peoples. One young Pacific father described his relationship with his wife as a partnership of equals, in contrast to his own parents' traditional marriage in which he believed his mother was the '*docile*' Pacific wife.

> *"My Mum was very docile and like a typical Pacific Island wife who listened and obeyed one's husband and she wouldn't ever step out or argue against her man."*
>
> **Samoan/Tokelauan Male – Wellington**

Asian Peoples

Asian families in this study tended to adhere to traditional role division, with fathers in the income earner role, and mothers working part-time or staying at home to care for children. A number of migrant Chinese families chose to have the mother in a full-time homemaking role so that she was available to their school age children as they adjusted to New Zealand society.

Some Asian families described an abdication of responsibility on the part of the father – an attitude supported by tradition and cultural norms. For example, Indian participants reported that the typical Indian male felt it was his wife's role to take care of the house and all the responsibilities that went with it, including attending to the children's needs.

However, there was evidence in this study of traditional roles changing in a few Asian families, for example, where the male had been made redundant and his wife had taken on the income earner role.

4.3 Key Issues/Challenges Facing Families/Whānau

4.3.1 Overview

Participants were asked what kinds of issues/challenges (if any) their family/whānau faced in daily living, i.e. issues/challenges that were 'top of mind' and occupied their thoughts or influenced the way they lived. The purpose of this line of questioning was to find out whether, and to what extent, health and well-being issues/challenges impacted on families/whānau in daily life.

A number of issues/challenges common to many families emerged in this study, as shown below:

- Money worries
- Blended family/whānau
- Time scarcity
- Parenting
- Culture clash
- Life's surprises

The above issues/challenges had become daily concerns because they caused ongoing problems for families/whānau, i.e. they were problems that could not be ignored and over which families/whānau may have felt they had little or no control.

4.3.2 Key Issues/Challenges

Money Worries

Money worries were common to many families/whānau in this study. However, the nature and severity of their financial issues varied. Some families/whānau were having difficulty just surviving from pay-day to pay-day. They struggled to pay regular bills – choosing to pay only those most urgent – and needed to budget carefully to put sufficient food on the table on a daily basis.

> *"Bills. If something is overdue or if I have missed a payment I think, 'how am I going to catch up that payment and what am I not going to pay this week in order for me to catch up for last week?' I think a lot about that."*
>
> **Pacific Female – Auckland**

For these families/whānau, skimping on the family food budget was an achievable way of making ends meet when big bills came in. In this context, food was a 'squeezable' item, where the mortgage or the power bill was not.

Other families/whānau felt they had enough money for their daily needs, but worried about money regardless. Their concerns were to do with getting ahead financially. Issues such as being able to buy their own home, help their children pay for tertiary education, and saving enough for retirement were in the forefront of their minds.

> *"Like financially – that is the main thing. Trying to work for today and tomorrow … [so] that there is enough or something there for them [our children] in the future. Yeah, I think that is the main [thing]. Wanting, hoping to own a house. Education. I think that is one of the big challenges for ourselves – the children's future and also their education and also financially …"*
>
> **Tongan Female – Christchurch**

Money worries often underpinned and intensified the other worries a family/whānau may have faced, because they increased feelings of vulnerability and inadequacy in providing for one's family/whānau. For families/whānau struggling to make ends meet, money worries could feel overwhelming because they were ongoing, and surfaced in times of crisis such as ill-health and job loss. For example, an unplanned pregnancy had intensified one family's ongoing low-level worries about making ends meet financially.

Within the context of family/whānau eating practices, money worries could influence the amount and nature of food available to the family/whānau. This study found that the families/whānau who were most budget conscious fell into two groups on the question of healthy eating: those that said they could not afford more healthy food (such as fruit and vegetables and lean cuts of meat); and those that said they could not afford not to eat healthily (saving money by avoiding processed and packaged foods, treat items and takeaways).

Blended Families/Whānau

A number of families/whānau in which the parents had children from previous relationships expressed concerns about how children in the household were coping within the blended family/whānau. In a couple of cases, children's emotional well-being was affected, with young children feeling keenly the loss of contact with an absent parent due to the breakdown of the parents' relationship.

> *"The girls' father … he's up north somewhere. He doesn't contact them. I notice that she [step-daughter] has his cell phone number – little things like that. I spoke to her about it. She just started crying. So that's kind of hard, trying to explain to them – little things like that. I explain that, 'he does love you but he's just not good at keeping in touch' ... I sort of wonder whether the problems we have with X [the other step-daughter] are partly because of that, or is it just the age she's at?"*
>
> **Pakeha Male – Gisborne**

Parents in blended families may have been struggling with the children's emotional reaction to loss and change (such as anger, fear, sadness, and emotional outbursts). Parents may also have had to work harder at creating and maintaining emotional bonds within the blended family, and at accepting step-children and avoiding differential treatment (in relation to how they treated their biological children).

> *"That was a bit of a deal and getting through to [my step-daughter] that I wasn't trying to replace her father … to be honest, I'm probably a bit quick tempered with them – which I don't like … I have a bit more patience with [my daughter]. I'm not sure whether it's because of her [younger] age or … because they're not biologically mine – I'm not sure. I have to watch myself."*
>
> **Pakeha Male – Gisborne**

Children who had come to live in a new home as a result of a relationship breakdown may have generated parental conflict over rules and discipline, including what foods and eating behaviours were encouraged and discouraged. In one family, the step-mother described trying to instil new eating habits in a child who had been brought up in a home with different eating norms.

> *"[With my step-daughter] we really had to work on it because she came from a house where they ate, I think, takeaways most nights and even when her mum cooked, there wasn't veges. So we really had to work on the whole vege thing … we did have a stage where she was being a bit sneaky and she was hiding broccoli under shelves and under the table … we had shelving in the dining room and I pulled it out one day so I could sweep under it, and there were ants and there was [were] these huge piles of broccoli underneath."*
>
> **Pakeha Female – Wairarapa**

Time Scarcity

Lack of time was a common issue for families/whānau in this study, although it was felt less keenly in families/whānau with a full-time homemaker. Many parents felt the pressure of having too much to do, and too little time to do it in. This was particularly strongly felt in single-parent households, and in dual income households where both parents worked full-time or hours that were not family-friendly (including shift workers and weekend workers).

Some parents felt guilty that, in not spending enough time with their children, they were failing as parents. Parents also worried that they were not spending adequate time with their partner, and felt this placed a strain on relationships and made the tasks of parenting harder. Working parents were often required to prioritise paid work over time with their children, effectively fitting 'quality' family time into after-hours.

> *"I did pinpoint this to my wife, about the fact we spend more time at work than we do with our kids. If you take away the time that you are at work and the time you have on your own, you spend more time doing that than you do with your kids."*
>
> **Samoan/Tokelauan Male – Wellington**

The very real feeling of time scarcity diminished quality of life for a significant number of families/whānau in this study and, in the context of healthy eating, had a significant influence on food choices. Takeaways and packaged convenience foods were the preserve of the time-poor. Use of such foods elicited feelings of guilt, particularly when they became family diet staples. Rushed grocery shopping and lack of time for meal planning had also led to convenient food choices taking precedence over healthy ones in some instances.

> *"We'll buy takeaways probably three or four times a week. It's usually my wife who will ring me before I finish work. It's only because she's spent the whole day nursing the little one and looking after the other two and she'll ask me just to pick some takeaways up on the way home from work. Before we had our last one [child] she used to be able to do everything but now she's got her hands full with all three of them."*
>
> **Samoan Male – Auckland**

Parenting

The task of parenting was an ongoing issue for a number of families/whānau in this study. As parents in this study described it, parenting was not a 'state of being' but a process – as babies became children and children became adolescents, the stages and phases they went through were ever-changing, and parents often felt they were running to keep up with their growing children in terms of knowing how to best manage each ensuing phase of development.

Parents of adolescents, pre-adolescents, babies and toddlers may have particularly felt the strain of parenting day-to-day. As the need to keep children physically safe receded, and as they approached adolescence and gained in independence, the need to keep children sexually safe and out of trouble (e.g. from drugs, alcohol, and fast cars) arose. In addition to all the physical and emotional tasks of parenting, parents were aware of the need to instill their growing children with values and guidelines for how to live successfully.

For parents coping with their children's emotional, physical and developmental changes, the issue of healthy eating could become more, or less, of a concern according to what else was going on in their children's lives.

Healthy eating could become the focus of attention when children, particularly teenagers, were eating very little at home, or not at all. Concerns over the adequacy of their children's' diet, both the amount and what was being eaten and, in some cases, concerns about possible eating disorders, added to the challenges of parenting.

Healthy eating became less of a focus if children were engaged in risk-taking behaviour (e.g. drugs, binge drinking and fast cars). Where this was the case, keeping them safe, having them home and getting them to eat anything – let alone whether the food was healthy – were the priorities.

Cultural Compromise

Asian Peoples

The loss of traditional cultural values was a concern to some Asian families. In general, these parents were concerned that their New Zealand-raised children were picking up New Zealand culture and values, thereby diluting or threatening the parents' traditional (Asian) values. Respect towards elders, and not answering back, in particular, were values parents felt were being eroded by living in New Zealand.

Asian families may have also struggled when their teenage children started to adopt elements of the New Zealand lifestyle that were alien to their own culture. For example, the parents of one teenager were concerned her New Zealand friends were influencing her to talk of leaving their home to go flatting, something they were trying to dissuade her from.

In terms of education, Asian parents highly valued education and excelling in studies. Migrant parents particularly were concerned that their children were becoming less motivated in relation to education as they assimilated into New Zealand society.

Some Asian families responded to the perceived challenge to their cultural values by having the mother in a homemaker role, keeping a close eye on their children, monitoring their friends and activities, and imposing curfews. The families also participated in religious and other activities of their community so that the children were given a sense of their roots and culture. Some parents also put a lot of effort into teaching their children their native language.

Pacific Peoples

First generation Pacificans,[20] who were now starting their own families, had similar concerns to some Asian participants regarding erosion of values, particularly around respect and etiquette when engaging with people on social occasions.

> *"… they've changed I reckon. I've noticed it. I mean things like sitting down to eat together as a family, saying the prayer before we eat, and family time too because we all work different shifts, me, my wife and my oldest daughter. Things like that … we don't do that stuff as much anymore. Like saying 'tulou' [excuse me] if someone is in the way … Maybe because my wife and I are really busy but we notice our kids don't do it, unless we tell them to sit down and eat [instead of standing up to eat] or tell them to say 'thank you', or Mum and Dad are here. That's why we like the kids to spend time with their grandparents, because we know they'll teach them."*
>
> **Samoan Male – Auckland**

Life's Surprises

In this study, life's surprises included:

- the unplanned pregnancy that had created a financial strain and was the catalyst for renovating or moving to a larger house
- the death of a partner or parent
- the breakdown of a relationship that resulted in mokopuna moving in with their grandparents
- redundancy that resulted in a change of traditional roles in the family (e.g. a female partner taking on the role of income earner)
- the onset of dementia in an elderly parent had led one mother to giving up her full-time job in order to care full-time for her mother (while also caring for her own children)

These events were key challenges for participants who experienced them because they were stressors that required significant adjustments to be made to the way that families/whānau lived their lives.

[20] New Zealand-born Pacific Peoples or those Pacific Peoples who move between Pacific and New Zealand cultures relatively easily.

4.3.3 The Place of Health and Well-being

While few people in this study questioned the theoretical importance of health and well-being per se, in practice, these issues were seldom uppermost in people's minds on a daily basis.

Generally speaking, health and well-being issues were seen as 'sleeper issues' – they tended to be taken for granted until something went wrong, at which point they became a significant and dominant issue for the family and could not be overlooked. Even where a family was dealing with chronic health problems, their ongoing nature meant that at some point their existence merged into the fabric of daily life, so that they ceased to dominate until the person's condition worsened or a fresh health crisis erupted.

The following were examples of how ongoing health and well-being issues transformed from 'sleeper issues' to being centre-stage:

- The Pakeha mother of a young baby had a back problem, in that she occasionally put her back 'out'. When she read the warning signs (the twinges) in advance, a quick trip to the chiropractor usually sorted things out. However, when she missed the warning signs, or was too busy to act on them, her back 'went out' and she was unable to physically care for her baby or manage her usual homemaker roles. When this happened, her health 'problem' took centre-stage, and the family needed to call on grandparents to take on caregiving and cooking roles.
- Some Pacific families were aware of health problems but did not prioritise them as requiring medical attention until a health problem became acute.
- Other examples included families with chronic illnesses such as asthma. It was only when there was a severe asthma attack, or an increased reliance on medication brought about by a change in weather or stress, that increased concerns about health and well-being came to the fore.
- Similarly, people awaiting minor surgery were 'just getting on with it' in the meantime, providing for their family/whānau as best they could and accepting the limitations of their condition.

In the case of emotional well-being, issues and concerns may have been pushed to the background of daily life because families did not know how to proceed or resolve them.

A few families were exceptions to this rule, with at least one parent actively concerned for their family's well-being and thinking about ways to promote and safeguard this. Where this was the case, typically a crisis or peak experience of some kind had led to a new emphasis on health and well-being. To illustrate:

- For one Pacific family, the mother's brush with post-natal depression had led to a re-evaluation of family roles, with the mother re-entering the paid workforce and the father taking on more responsibility for caregiving and cooking.
- For one Māori whānau, the death of the father had left the mother with small children to raise. This mother was very focused on her sons' health and well-being, as a means of ensuring they were able adjust to their loss and to work things through day-by-day.

A family history of chronic illness related to diet and lifestyle resulted in an emphasis on health and well-being for some families.

> *"Obesity. My biggest worry is kidney failure. Dialysis. That'd be my hugest. My Dad died of it ... I sort of worry about that every day."*
>
> **Māori Female – Auckland**

As discussed in the *Healthy Eating in New Zealand Families and Whānau* Report (see Section 8.0 – Audience Segmentation), some individuals were focused on health and well-being as the foundation for building a happy, resilient family/whānau and nurturing happy, healthy and successful children into adulthood.

These people had a strong sense of personal responsibility to be a good parent. Importantly, a healthy lifestyle was part of what it meant to be a good parent. They prioritised the family/whānau and children's well-being ahead of all other commitments.

> *"Because of guilt. I'd feel so bad as a parent if I couldn't do that for my kids, you know. If I couldn't give them a healthy life."*
>
> **Māori Female – Auckland**

> *"… I think we've just made some good decisions for our family and we just make sure we keep our family in mind first, before other distracting things in life. Like outside our family, like my family that would come and I don't want something to take our focus off our family and [my husband] would like say, 'come on now, our family, our family, y'know, we come first'. Yeah, and we just both commit to it. You know [my husband] doesn't have any outside life commitments. We both don't drink. We don't smoke. Everything's pretty much about the kids for now."*
>
> **Māori Female – Auckland**

The specific health and well-being concerns faced by families/whānau in this study are outlined later in this report (Section 5.2 – Health and Well-being Concerns for Families/Whānau).

5.0 Health and Well-being

This section of the report explores participants' understanding of good and poor health, and well-being, and what indicators they associated with each. It also outlines the health and well-being concerns that families/whānau in this study had, considers the cultural context of health and well-being, and the impact of health and well-being on family/whānau functioning.

5.1 The Meaning of Health and Well-being

Participants were asked to outline how they perceived good health, poor health and well-being. The purpose of this was to explore what overlap, if any, participants perceived existed between 'health' and 'well-being'.

5.1.1 Good Health

Opinion was divided among participants on the meaning of good health. One view of good health related solely to good physical health, while the other view reflected a holistic perspective in which good health was perceived as a superset of good physical, spiritual and emotional health.

Good Health as Good Physical Health

While it was mainly Pakeha who associated good health with good physical health, some Māori, Pacific and Indian people also held this view.

> *"Good health is eating properly, being physically fit and active. Yeah. Looking after yourself probably."*
>
> **Pakeha Female – Wairarapa**
>
> *"Good health is about physical health, as well as your appearance."*
>
> **Māori Female – Auckland**
>
> *"I think things like [have] high blood pressure and have the cholesterol sewn up – that's the thing."*
>
> **Samoan Male – Auckland**

Good health as good physical health was viewed by participants from either a medical or physical activity point of view.

From the medical point of view, any one or more of the following was perceived as an indicator of good physical health:

- Not having any obvious or known signs of being physically unwell (e.g. not having an acute or chronic condition)
- Not being overweight or obese
- Not easily succumbing to sickness or being able to recover quickly if so afflicted through having a *"good"* immune system.

From the physical activity point of view, indicators of good health included:

- Participating in more physically demanding sports (e.g. netball or tennis as opposed to bowls) and/or exercise, e.g. running, cycling or going to the gym
- Having the energy to do things that needed to be done, e.g. in terms of running a home, maintaining a property and going to work and taking part in activities with one's children.

Most participants reasoned that if people were not in good physical health they would not be able to function in the ways outlined above.

> *"Yeah, but we both are pretty active. We play a lot of sport like touch and basketball so we are okay I reckon."*
>
> **Tongan Female – Auckland**

There was general agreement that any one or more of the following factors could contribute to good physical health:

- Having a diet that included fruit and vegetables and avoided or only had a moderate intake of fatty and sugar-laden foods was seen as essential to enjoying good physical health, and preventing the onset of medical conditions (or at least reducing the likelihood of these occurring).

> *"Probably just making sure you're just eating right and just not constantly sick."*
>
> **Māori Female – Christchurch**
>
> *"If you get up and feel energetic, no headaches, you just don't feel any pain, then you'll know you're eating sensibly."*
>
> **Samoan Female – Auckland**

- Eating appropriately-sized portions (combined with a suitable amount of exercise – for some people) was seen as key to avoiding becoming overweight or obese and potentially getting a health condition stemming from these, e.g. diabetes and heart-related issues.

  "Just [eating] good foods and the right amounts and stuff."

  Māori Male – Auckland

- Getting an appropriate amount of exercise was perceived as keeping the body in good physical shape, and this translated to it being less susceptible to sickness and diseases.

  "Good health [is about] fit people, fruit and vegetables, active lifestyle, medium slim build, not [being] tired [or having] drowsiness during the day time."

  Māori Female – Auckland

- Being physically active was strongly associated with not being overweight, which was taken as evidence that the person was eating healthily. This was about appearances rather than less tangible, nutritional benefits.
- Excluding alcohol, or drinking it in moderation, to avoid the damaging effects of excess alcohol intake, e.g. to the liver.
- Not smoking or reducing the number of cigarettes smoked (if unable to give up) to reduce the risk of cancer and respiratory conditions.

  "Good habits too – like no smoking and no drinking too much."

  Chinese Female – Christchurch

- Getting plenty of sleep to ensure that the body was well rested and therefore able to restore itself.
- Minimising stress because of its association with potentially life threatening conditions such as cancer and heart attacks.

Good Health as Holistic Health

Good health as holistic health was a perspective embraced more by Māori, Pacific peoples and Chinese and Malaysian people, and to a considerably lesser extent by Pakeha.

Holistic health was a super-set of good physical, spiritual and emotional health. It was perceived as being achieved through feeling physically fit and well, being able to live life according to one's beliefs (spiritual health) and feeling positively engaged with life emotionally. The latter two were achieved through being supported by appropriate networks, e.g. within the family/whānau or the wider context of friends and work colleagues, and having balance across priority areas in life, especially family/whānau.

> *"I think I should say both mentally healthy and physically healthy."*
>
> **Chinese Female – Christchurch**
>
> *"To get up in the morning, enjoying yourself and not feeling like crap when you get up in the morning. To me that is healthy. I like to get out and enjoy life with the kids. Play squash a couple of nights a week, like I do. Going to the track like I do. Go for a walk and bike. Go out and attack life really."*
>
> **Pakeha Male – Christchurch**

Many Māori in this study provided a holistic view of what they considered to be good health. In doing so they talked about health in the context of their whānau (both in and outside the household), including members' physical, emotional and spiritual health. It was reasoned that if these aspects of health were in place, then the whānau was healthy, happy and well. This was described in a number of ways as reflected in the following quotes:

> *"Health and well-being go hand in hand. We can't have one without the other. It's a ladder effect."*
>
> **Māori Female – Wairarapa**
>
> *"We think of a good mind and body and soul – just don't look at one because one can't be balanced without the others."*
>
> **Māori Female – Gisborne**

5.1.2 Poor Health

Poor health was largely seen as the opposite of good physical health. Indicators of poor (physical) health were having a medical condition, being overweight or obese, being run down, lacking energy, readily succumbing to illness and not being able to bounce back quickly if taken ill, and not being physical fit.

> *"Poor health covers poor eating, you're not exercising, not looking after yourself, your teeth are bad and your general hygiene [is poor]."*
>
> **Pakeha Male – Wellington**
>
> *"You're [physically] sick all the time."*
>
> **Samoan Female – Auckland**

There was general agreement that any of the following factors could contribute to poor physical health:

- Eating unhealthily, in particular, having a diet that included lots of takeaways, and fatty, starchy and sugary foods, and lacked nutrient-giving foods such as fruit and vegetables. By virtue of not receiving appropriate nutrients from food, the body was seen as being more susceptible to illness.

> *"Having a poor immune system due to unhealthy eating – eating cheap food like pies, fried chips."*
>
> **Indian Female – Wellington**
>
> *"Too much junk food, too much sugar. So for me it is diet and yeah that's pretty much [it]."*
>
> **Māori Female – Auckland**
>
> *"Obesity. Large people like myself. Bad skin. Fast food. Fizzy drink – high in sugar products."*
>
> **Māori Female – Auckland**
>
> *"Bad food, not eating the right stuff or staying on top of things. I have island food occasionally – like taro … I love it. All summer I can eat it every weekend."*
>
> **Samoan Male – Auckland**

- Irregular eating patterns – skipping meals and failure to have three well-spaced meals daily (regardless of the quality of food consumed) were associated with placing stress on the physical body and reducing its ability to function effectively. While isolated incidents of such behaviour may have been perceived as relatively harmless, it was felt that repetition over time could result in people experiencing poor health.
- A history of chronic conditions in the family/whānau – in this study some Māori participants believed they were more likely to be susceptible to getting a chronic condition because their family/whānau had a history of, for example, diabetes, heart-related conditions, being overweight or smoking-related illnesses. These participants had a fatalistic approach to health in that they expected that such conditions may well appear (if they had not already) in the present generation, and believed there was little or nothing they could do to prevent disease on-set.

  "You can't stop the illness because it's genetic."

  Māori Female – Gisborne

- Smoking – this was seen by some as a factor that contributed to poor health, not only of the person who was the smoker but also those they smoked in the presence of. It was associated with promoting cancer and various respiratory conditions.
- Alcohol consumption – because of the damaging effects of excess alcohol intake had on the body, e.g. to the liver.
- Lack of exercise – there was a perception that lack of exercise, especially when combined with unhealthy eating, led to being overweight or obese (and increased the likelihood of getting health problems associated with these conditions, e.g. diabetes and heart problems).

  "Unfit. Yeah – eating bad stuff or maybe the wrong stuff or too much of it, and no exercise. Yeah – just things like that."

  Tongan Male – Auckland

- Lack of money – this had left some families/whānau reliant on cheap and filling but unhealthy food[21] and/or having to cut back on, or go without, home heating in order to makes ends meet financially.

[21] Note: Some lower socio-economic status families/whānau did eat healthily and cheaply through buying the cheapest fruit and vegetables available, and focusing on staples such as rice and pasta and avoiding convenience foods and takeaways.

- Sleep deprivation – some parents cited sleep deprivation, e.g. through attending to babies or to unwell or unsettled children during the night, as the key cause of them having temporary periods of feeling run-down and being unable to effectively manage the family/whānau or function well at work.
- Overcrowding – having a number of people living in overcrowded conditions created an environment that made it more likely for sickness and diseases to spread quickly (noted more in relation to some Pacific peoples).
- Mental element – for some people, poor health also included a mental element, e.g. feeling unhappy, depressed and generally not having the coping skills to handle what was occurring in life.

> *"Being a sloth really I guess. A state of mind as well I guess. Probably not doing as much as you can with your day, unfit and can't be bothered."*
>
> **Tongan Male – Auckland**

5.1.3 Well-being

Well-being was not a commonly used term and nor did it have a universal meaning. One view of well-being equated with that used to define good health in a holistic sense, i.e. as a superset of physical, spiritual and emotional health (see details earlier).

> *"Good health is physical, mental, it's spiritual. It's a combination of the two. Just try to form well-being … [an] overall glow … well-being, and health would be part of it … well-being would be the centre of health, and well-being would spring from that …"*
>
> **Samoan/Tokelauan Male – Wellington**

> *"Well-being is the whole model, the whole mind and soul. I think with health, just our physical looks and appearance. But well-being is the whole. The inside of the mind, as well as your health. The physical, emotional, mental and spiritual."*
>
> **Māori Female – Auckland**

> *"Yeah a healthy balance. Trying to be in a place where you're able to be shoulder to shoulder, being able to better handle things that come as a surprise."*
>
> **Tongan Male – Auckland**

An alternative view was that well-being involved spiritual and/or emotional health, i.e. that it related to people's state of mind and did not involve their physical body.

> *"Well the thing [well-being] is mental and spiritual and your soul sort of thing … I feed my mind every day. I feed my mind and look at scriptures and meditation. It is like cleaning my waste paper basket [out]. Mental health for me. I make sure during the day, I make sure that I forgive people and just move on. That's the mental well-being, which I regard as very important."*
>
> **Samoan Male – Auckland**

However, most people regarded good physical health as the foundation on which well-being rested. Without good physical health, it was not possible to enjoy positive well-being.

> *"I think that well-being is being happy, and being happy as to where you are at that time. Yeah and in order to be there you have to have good [physical] health.*
>
> **Māori Female – Auckland**

> *"I suppose health affords you the ability to do the things that you need to do to be able to achieve a high level of well-being, doesn't it? So basically it gives you the wherewithal, otherwise if you don't have your health, then you're reliant on other people and that loses your independence."*
>
> **Pakeha Male – Wairarapa**

Some people recognised that environmental factors, such as adequate housing and income impacted on well-being. For parents, the well-being of their children was central to their own well-being.

> *"Probably spirituality [is part of well-being] … well-being's like when you're well-rounded isn't it? … actually, well-being's probably environmental as well … if your environment is not conducive … [where there is] violence and abuse I suppose – as well as having a cold, damp house I suppose, or nowhere to live."*
>
> **Pakeha Female – Gisborne**

5.2 Health and Well-being Concerns for Families/Whānau

Participants were asked what health and well-being concerns (if any) their families/whānau faced on a day-by-day basis. A list of concerns appears below, according to the frequency identified across the sample. Given the information is based on qualitative research findings, it is indicative only.

The researchers have split the concerns listed below into *health* and *well-being* concerns, with *health* concerns reflecting physical health and *well-being* concerns reflecting emotional and spiritual concerns.

Frequency	Health	Well-being
High	Diabetes (adults) Heart problems (adults) High cholesterol (adults) Overweight (children, young people and adults)	Blended family/whānau issues (discussed earlier) Dealing with the various developmental phases of childhood and teenage years (discussed earlier)
Medium	Asthma (children and adults) Cancer (adults) Eczema (children and adults)	
Low Note: health and well-being concerns marked with an asterisk (*) were reported by one participant only	Arthritis (adult) Autism (child)* Emphysema (adults) Lupus (adult)* Stroke (adult)*	Acne (young people) - emotional impact Anorexia (young person)* Bipolar depression (adults) Bulimia (young person)* Difficult pregnancies Stress (reported by some Indian parents who were dual income earners and needed to juggle home and work life without extended family support)

5.3 Cultural Context of Health and Well-being

5.3.1 Pakeha

Pakeha participants typically associated good health with good physical health, and understood well-being as relating to spiritual and emotional well-being. Only a minority of Pakeha participants perceived good health from a holistic perspective (as described above).

5.3.2 Māori

The following passage outlines the cultural factors shaping perceptions of health and well-being, as identified by Māori who took part in this study.

Māori who participated in this study could be divided into two broad groups, in terms of how they perceived health and well-being.

Some Māori viewed health and well-being from a western perspective, where health typically related to physical health, and well-being related to spiritual and emotional well-being.

Other Māori had a more holistic view of health and well-being which embraced physical, spiritual and emotional matters. This view equated with the holistic view of good health discussed earlier. Those with a holistic view of health and well-being considered it in the context of their whānau, both in and outside the household (as opposed to taking an individual approach).

> *"We need to look at the whole picture which includes wairua [spirituality] and whānau."*
>
> **Māori Female – Gisborne**

Other factors identified by Māori participants as defining the cultural context of health and well-being for Māori are outlined below:

- The mokopuna-grandparent relationship resonated with many Māori. There was a strong desire among grandparents to 'be around' for their mokopuna, to see them grow up and to be influential in terms of instilling Māori values, e.g. manakitanga (looking after people) so that mokopuna understood how to perform their roles within the whānau and on the marae. This had motivated some Māori grandparents to take (better) care of their health to ensure they would be around to participate in the lives of their mokopuna.

- Some Māori in the study had had contact, either directly or through a whānau member, with a range of health conditions common amongst Māori, e.g. diabetes, heart-related diseases, being overweight, smoking-related illnesses. As mentioned earlier, while these conditions were not solely Māori conditions, some Māori participants viewed them as 'Māori conditions', because they had become part of their whānau – often affecting many whānau members over generations. This had resulted in some Māori participants having a fatalistic approach to health. However, other Māori participants had made lifestyle changes, e.g. were eating more healthily and taking more exercise, to avoid the abovementioned health conditions.

  "Well my Mum was an obese person … I am one of eight [children]. So when my Dad was out working, drinking and he wasn't working, she would find comfort in us kids, and then find comfort in food. So the whole package of health – I don't want my kids to have that as a comfort for them. … I am certainly trying to break that cycle."

  Māori Female – Wellington

5.3.3 Pacific Peoples

The following passage outlines the cultural factors shaping perceptions of health and well-being, as identified by Pacific peoples who took part in this study.

Pacific participants were similar to Māori in that some people had a western perspective of health (as physical health) and well-being (as spiritual and emotional health), while others had a holistic view of health and well-being as embracing physical, spiritual and emotional health.

Some Pacific families who were strongly religious viewed well-being from a spiritual perspective and saw it as the foundation upon which all things were derived, including good health. Those with this perspective saw God as the centre of their universe and 'providing all things', including good health and well-being.

Some Pacific participants recognised the link between healthy eating and better health and well-being. Typically this had stemmed from having a health scare and making dietary changes (on medical advice) to eliminate or manage the situation. Those in this situation had been motivated to enjoy better health on a personal level (including so they could be there for their family in the longer term) and to have their family enjoy better health.

However, some Pacific participants did not make the connection between diet and health. Rather they relied on medical solutions for health problems and did not see that they had a role to play in achieving better health and well-being for themselves and their family, e.g. by eating more healthily.

There was increasing recognition among some younger Pacific peoples of the need to move away from less healthy traditional Pacific foods to introduce healthier eating behaviour. Some were trying to disseminate this view in the wider Pacific community, even in the face of adversity, e.g. treading on the toes of older Pacific peoples, who may have felt that this move was tantamount to younger Pacific peoples rejecting their culture.

5.3.4 Asian Peoples

The following passage outlines the cultural factors shaping perceptions of health and well-being, as identified by Asian peoples who took part in this study.

While most Asian participants in this study had a holistic view of health and well-being, some participants – Indian people – had a western perspective.

Those with a holistic view of health and well-being did not tend to see health and well-being issues as 'sleeper issues' (i.e. only coming to the fore in times of crisis), rather they saw them as central to having a good life both now and in the future.

Health and well-being were often considered (more so by Chinese people) in financial terms. Enjoying good health and well-being meant less time off work sick and less money spent on medical bills. This meant effort was placed on staying healthy – with healthy eating being seen as central to achieving this.

Many migrant Indian people had become more conscious of their physical health, especially their weight, since arriving in New Zealand. This had followed exposure to messages received from general practitioners, friends, work colleagues and various television programmes about the importance of *'staying healthy'*. As part of the commitment to be more healthy, some Indian people were opting to eat more healthily (e.g. through substituting saturated fats with healthier alternatives and reducing the amount of fried foods consumed) and engage in more physical activity.

Some Chinese families who were strongly religious viewed well-being from a spiritual perspective, and saw it as the foundation upon which all things were derived, including good health. Considerable emotional strength was derived from attending church.

Indian families relied heavily on prayer for emotional strength and peace, particularly during times of stress.

5.4 Impact of Health and Well-being on Family/Whānau Functioning

Smoking, gambling, alcohol consumption, physical activity and healthy eating were health issues identified by HSC for exploration in the SMAR project. The impact of each of these health concerns on family/whānau functioning is discussed in detail later in the report – see:

- Smoking – Section 6.2.5
- Gambling – Section 6.3.5
- Alcohol consumption – Section 6.4.5
- Physical activity – Section 6.5.5
- Healthy eating – Section 6.6.5

Discussion also took place with participants on how other aspects of health and well-being (identified by participants) impacted on the way their family/whānau functioned. Sections 5.4.1 to 5.4.8 below outline how different aspects of health and well-being impacted on the families/whānau that took part in this study.

5.4.1 Focus on Negative Impact

The impact of health and well-being on family/whānau functioning was more likely to be considered by participants from a negative than a positive perspective. Because (good) health and well-being tended to be taken for granted (and only became an issue when a problem arose – as discussed earlier) it was more difficult for people to conceptualise the impact of good health and well-being on family/whānau functioning.

When a health or well-being issue occurred this typically resulted in families/whānau experiencing stress and conflict (to varying extents). As a generalisation, families/whānau that were close-knit and well supported were likely to manage more effectively when health and well-being issues arose, than those that were less close and less supported.

Some Pakeha families of high socio-economic status were aware that they were not struggling with some of the social issues that impacted on family well-being (e.g. inadequate income or poor housing) that less affluent families had to deal with.

5.4.2 'Ripple Effect'

In some cases, families/whānau drew on past experiences of poor health to reflect on the impact that on-going poor health had on the functioning of their family/whānau. The poor health of one family/whānau member was perceived as being able to affect parents' ability to care for their children, disrupting routines and creating anxiety and other emotional difficulties.

> *"It would be very stressful if we had unhealthy [children] – like if one of the children was very ill … I mean, even when [the baby] was born, she was in and out of hospital for the first two weeks and it was hugely stressful on the family."*
>
> **Pakeha Female – Wairarapa**

5.4.3 Behavioural Changes

Some families/whānau had experienced a health scare or been told by their doctor to adopt a healthier lifestyle (e.g. lose weight and do more exercise) to overcome or manage their health issues. As a result of such triggers, some families/whānau had engaged in more healthy eating and drinking behaviours, and increased their levels of physical activity. This was noted particularly in relation to some Māori and Pacific families/whānau.

Moving to a more healthy diet was sometimes a source of conflict within families/whānau, until there was acceptance of the 'new way of being' (which typically took time).

5.4.4 Elderly Parents

Providing caregiving to an elderly parent (or parents) who needed physical and/or emotional support (whether they lived in the household or away from it) had the potential to place a strain on families/whānau, particularly where there was a long history of caregiving (especially on a day-to-day basis). Simply having to be *on call* for an elderly parent was an ongoing stressor for the caregiver, and this often limited how engaged he/she was with close family/whānau members, e.g. a partner or children.

> *"Probably a day-to-day thing for me is my Dad … Yeah, he's a big issue .... He had a pretty bad stroke. I mean I do his pills for him. He has like 17 pills a day and I do all that … that's like my biggest thing – because I like to think that my family runs relatively smoothly … my biggest thing is [my] Dad because I know one day I'm going to ring him and he's not going to answer the phone. I mean we've had that several times … [It's a] worry. I mean we've had phone calls from the hospital [they tell us] 'he's in here and he's got heart problems'. He's probably my biggest issue, worry, problem – however you want to put it."*
>
> **Paheka Female – Wellington**

Having to tend to the needs of elderly parents was a source of conflict in some families/whānau. Partners and children had times when they felt resentful of being deprived of the caregiver's time, love and attention (even for a short time). This created additional pressure on the caregiver because he/she was typically striving to maintain a high level of harmony within the family/whānau.

5.4.5 Babies and Children

As mentioned earlier, parents suffering from sleep deprivation through tending to babies or to unwell or unsettled children during the night were likely to have temporary periods of feeling run-down, stressed and unable to effectively manage the family/whānau or function well at work.

> *"Yes. In my case I have [a] younger one who is nearly three years. He wasn't well last night for example and we couldn't sleep. I think their health causes tension in our lives. He was born premature, so [we] had some health problems. That was very stressful."*
>
> **Chinese Male – Auckland**

5.4.6 Acute Illness

As discussed earlier, chronic but stable health conditions typically got accommodated into day-to-day life without too much concern. However, when a condition elevated to a crisis situation it had the potential to significantly impact on family/whānau functioning. Family members (often grandparents) were sometimes called on at short notice to provide assistance, e.g. caring for children and helping with running the household (especially cooking meals).

5.4.7 Blended Families/Whānau

Blended family/whānau issues also impacted on family/whānau functioning – see Section 4.3.2 Key Issues/Challenges – Blended Family/Whānau.

5.4.8 Pre-adolescent Years

Some parents and caregivers of pre-adolescents reported feeling the strain of dealing with their pre-adolescent children's developmental changes, especially those which manifested themselves on the emotional front.

> *"X started getting her period now and started developing, and being such a young age [11 years old] as well as getting into her teenage years and having mood swings and how kids think and talk about men at times. [She often says] 'but you said you were going to do it – but you said you were going to do this!' … Like Y [my wife–X's grandmother] we try to talk more sternly to her [X]. If you raise your voice she'll [X] say, 'don't yell at me!"*
>
> **Pakeha Male – Wellington**

Dealing with children's unpredictable mood changes and (in some cases) demanding ways, took its toll on family/whānau relationships, either between parents or between parents and caregivers and children. While the goal of most parents was to have a happy, harmonious family/whānau, this was sometimes difficult to achieve during the turbulent pre-adolescent years unless effective *strategies* were put in place to manage the situation, e.g. listening effectively to children, allowing them to have their say and parents responding to get their views across but without making the children wrong (this approach had worked successfully in one Pakeha family).

6.0 Health Issues

This section of the report explores the level of concern parents and caregivers in this study had towards five specific health issues of interest to HSC, as they related to their family/whānau (especially children).

The five health issues presented to participants for discussion were:

- Smoking
- Gambling
- Alcohol consumption
- Physical activity
- Healthy eating.

Participants were asked how concerned they were about each of the specified health issues, and about the nature of their concerns, particularly in relation to their children. They were also asked what, if anything, they were doing to act on their concerns, e.g. what, if anything, were parents who were highly concerned about smoking doing to discourage their children from taking up smoking?

6.1 Smoking

6.1.1 Overall Level of Concern

Overall, there was a high level of concern about cigarette smoking among families/whānau in this study (the adult sample comprised smokers, non-smokers, ex-smokers and people who had never smoked). Smokers and non-smokers recognised that smoking had a strong profile for ill-health.

Many families/whānau were fearful that their children would experiment with smoking because of peer pressure and the relative ease of access to cigarettes. Smokers and reformed smokers did not want their children to repeat their mistake of taking up smoking. Non-smokers did not want their children to start smoking.

However, within the overall sample, levels of concern about smoking varied widely, with some participants expressing relatively low levels of concern. The reasons for these variations are outlined below, along with an explanation of what was driving people's concern or lack of concern about smoking.

Overall participants perceived that smoking had lost its glamorous image, and was fast losing the social acceptability it once had. Smokers and non-smokers commented that smokers were becoming increasingly marginalised in society, with smoking being seen as a broadly anti-social behaviour. The researchers suggest that the recent changes to the Smoke-free Environments legislation (which does not allow smoking indoors in public settings) may have contributed to this perception.

However, participants also perceived that the addictive qualities of smoking, and the potency of peer pressure to encourage experimentation and rebellion against authority, remained powerful lures to take up, and continue, smoking. Although the marginalisation of smoking could make it easier for parents to communicate their desire that their children did not take up smoking, it also increased the appeal of smoking as a way for teenagers to 'act out' in a socially inappropriate manner.

6.1.2 High Concern About Smoking – Influencing Factors

Overview

The group of participants who said they were highly concerned about smoking included smokers, ex-smokers and non-smokers (including the non-smoking partners of smokers).

Part of what was driving their concern was their belief that smoking was something that their children would be confronted with at some point, regardless of whether there were smokers in the household. Parents saw the pre-adolescent years (around 11 and 12 years of age) as a particularly vulnerable time because children were starting to seek greater independence from parents, and were looking to peers for validation of their identity and self-worth.

Acceptance into peer groups that were *'cool'* because they smoked was a perceived motivating factor in taking up smoking. Parents often expressed concern that one or other of their children was likely to be vulnerable to peer pressure to smoke, because of their personality, e.g. because they had low self-esteem or engaged in risk-taking behaviours.

Smoking and non-smoking parents were fearful that their children would be tempted to take up smoking because of peer pressure. A number of smokers (and reformed smokers) downplayed their own influence on whether or not their child would take up smoking in the future, citing peer pressure as a key reason why they themselves had taken up smoking (typically in their early teens).

> *"I got peer pressured, that's why I took up smoking. …. also I was pressured by my brother. I knew it was wrong, I just thought it was cool."*
>
> **Māori Female – Christchurch**

Some smoking parents said that they only smoked when their children were not around. This made them feel less guilty about modeling harmful behaviour because they were confident their child was not aware that they smoked (or was at least not witnessing them in the act).

Smokers

Smokers who were highly concerned at the thought of their children taking up smoking were anxious that their children did not repeat their own mistake. They tended to regard their habit with regret, as expensive and unhealthy.

> *"I realise the cost and the sort of psychological attachment to smoking as well – not just the cost money-wise, but the cost to your health …"*
>
> **Pakeha Female – Wairarapa**

> *"I know that does sound hypocritical, but I wish I never started – you probably hear every smoker say that – as I am standing here with a cigarette in my hand, I know what it is doing to me."*
>
> **Pakeha Male – Auckland**

At the same time, smokers often felt they were in thrall to their nicotine addiction, and that it was simply too hard or too late for them to quit (some had tried a number of times without lasting success). A number of smokers in this study rationalised their smoking, for example, stating that 'roll-your-own' cigarettes were less harmful to smokers (and passive smokers), and less polluting than tailor-made cigarettes.

> *"… they keep pushing those ads on telly … I don't see how it's as relevant because they seem to be targeting on tailor-mades. I don't know that kids get the same effect from rollies. They don't let off as much smoke …"*
>
> **Pakeha Female – Gisborne**

Some smoking parents made a link between their smoking and the increased likelihood of their children taking up smoking. They often instigated rules that attempted to minimise the children's exposure to the act (in the hope it would discourage their uptake of smoking) and by-products of smoking.

> *"My son smokes and that worries me, and my daughter started smoking. I'm a smoker and I know it's bad because you're a role model, but I do smoke outside."*
>
> **Pakeha Female – Christchurch**

The parents in one Māori whānau (both smokers) recognised that their smoking had been a key influence on both their teenagers taking up smoking. Even though all the people in this whānau now smoked, they had rules about where to smoke within the house, in an effort to keep some rooms smoke-free for family/whānau and visitors.

Smokers in this study tended to smoke outside, or in rooms where there were no children. In some cases, children were also banished from places where adults were smoking.

> *"My sister smokes, I smoke, my older brother smokes. We have a rule, if you want to smoke you go outside. We don't smoke inside."*
>
> **Samoan Female – Auckland**

However, as parents told it, children were often curious about the smoking behaviour, and tried to make sense of it. In some instances, smoking adults' body language and tone of voice, e.g. humour and embarrassed laughter, provided mixed messages to children about the desirability of smoking (i.e. it may not be healthy, but it sure looked fun, and was perhaps a bit naughty). This was a case of actions speaking louder than words.

> *"Like I said, my sister does say, 'oh, smoking's no good', and the kids sit there laughing … she smokes outside by the back door and if the kids come round she's [saying], 'no, no, don't come outside, aunty's smoking' … [my daughter] has asked me once, 'why does aunty smoke?' I just say, 'I don't know'. I'd say, 'smoking is no good for you', and she'd say, 'why?' [I just say] 'it's just no good'."*
>
> **Samoan/Tokelauan Male – Wellington**

While smokers did not want their children to smoke, they often felt highly hypocritical in giving anti-smoking messages to them. They were aware of the incongruence between what they said and what they did. While smokers often emphasised the unhealthy and addictive nature of smoking to their children, they were often ambivalent about taking a strong anti-smoking line because they realised their continued smoking undermined their authority. Their perceived lack of credibility on the smoking issue made it hard for them to give consistent, strong anti-smoking messages to their children.

Instead, these parents tried to give guidance to their children, along the lines of 'it was not a good idea to smoke' and then to 'hope for the best' (i.e. that their children would not become smokers). Smoking parents (and some ex-smokers) tended to abdicate responsibility for whether or not their children took up smoking, by emphasising the child's own choice and the power of peer pressure. Underneath this lay a belief that they did not have the moral authority to assert their parental role vis-a-vis not smoking, as well as helplessness about their ability to exert control.

> *"I don't know how I'd feel about it [my children smoking]. I wouldn't feel very good about it … I can't stop them anyway … I probably couldn't say anything really … I'd be a hypocrite and I couldn't stop them anyway, y'know. Parents can't stop the kids doing things."*
>
> **Pakeha Male – Wairarapa**

In some cases, smoking parents gave their older children money that they knew would be used for cigarettes to keep the peace in the family/whānau, and to keep the household stress levels down. One smoking participant regularly allowed her teenage son to borrow her cigarettes when he was broke, because she identified with his need to smoke and understood the physical cravings for a cigarette.

Non-smokers

Non-smokers were more confident than smokers in pushing an anti-smoking message to their children. Unlike smokers, they felt they were on solid ground because they were practicing what they preached. Non-smokers who had grown-up in smoking households could be particularly vehement in their anti-smoking stance, because they had witnessed the impact of smoking on the health of their parents and often siblings. Non-smoking parents would often have strict rules about smoking family members (e.g. grandparents, aunties and uncles) not smoking around their children, or in their home. They would also give repeated, non-smoking messages to their children.

Non-smokers who lived with a smoking partner were in a difficult position and had to decide whether or not to speak out against the other parent's smoking. Their willingness to make a fuss about smoking could be pivotal to their partner managing to quit. In this study, the researchers found that the personality of the non-smoking parent (i.e. whether they tended to be confrontational or non-confrontational) was influential in whether or not they were willing to 'condemn' the actions of their smoking partner in front of the children. In more than one family/whānau, the non-smoking parent actively or tacitly supported the habit of the smoking parent (and in one case a teenager) as a means of avoiding household conflict.

> *"When they don't have that nicotine hit they get crabby, and so to avoid that we will give our last twenty bucks to give those idiots a packet of smokes. On a full pay-day if we have got twenty bucks, I would rather give it than put up with the addiction of [them] not having a smoke."*
>
> **Māori Female – Gisborne**

Some non-smoking parents effectively excused the behaviour of the smoking parent to the children, because they did not want to 'make waves' in the relationship or increase the stress levels in the household. For these people, it was more important to project a united parental front, and maintain household harmony, than it was to actively promote an anti-smoking stance to their children. Importantly, this reluctance to speak out against smoking, and in some cases to chide the children for doing so, undermined the anti-smoking messages children were receiving from other quarters, such as school. This theme is illustrated in the quotes below that have been drawn from a Pakeha family focus group.

> *[Interviewer asked a smoker: "Do you talk to the kids about smoking?"]*
>
> *[Smoking mother] "Um, yes … never to do it. It's dirty. That I will try and give up one day. All the bad things – don't try it. You don't want kids to smoke basically."*
>
> *[Interviewer asked the above smoker's partner: "What do you say to them?"]*
>
> *[Non-smoking father] "Not to give Mum grief."*
>
> **Pakeha Family Focus Group – Gisborne**

Other non-smokers in this study were willing to speak out strongly against smoking, and to force the issue with the smoking partner. In one case, a non-smoker tolerated his partner's smoking until she became pregnant with their first child. At that point, his tolerance abruptly ran out.

> *"… he was a very tolerant non-smoker but he was not having a bar of it when I was carrying his child, so that was it."*
>
> **Pakeha Female – Wairarapa**

In some cases the willingness to court conflict over smoking – combined with children who may have been ardently anti-smoking as a result of messages from school and anti-smoking campaigns – created considerable household tension, with children taking sides with one or other parent.

6.1.3 Low Concern About Smoking – Influencing Factors

Overview

The group of participants who said they were relatively unconcerned about smoking included smokers and non-smokers. These people perceived that smoking was less socially acceptable than in the past, and had lost or was losing its glamorous connotations. In support of this, they perceived there to be less smoking on television and in movies than in the past.

Smokers

Smokers who expressed low levels of concern about smoking as an issue for their family/whānau were, to a certain extent, in denial about the impact of their smoking on their children. While they did not want their children to take up smoking, they downplayed their role in influencing their children's behaviour, and played up the relative influence of peers.

Some smoking parents believed their children may well take up smoking in the future, but this was not a strong concern for them. While they knew smoking was unhealthy in theory, they had been smoking for many years or even decades and saw no evidence that their health was suffering. They believed their smoking was under control. There was a belief among such smokers that they could stop smoking when (and if) they did get sick, and that this would be almost as good healthwise as stopping earlier (i.e. before there was concrete evidence of the need to). The researchers noted that some in this group regarded experimenting with smoking as a natural part of growing up.

Some smokers believed that the non-smoking messages delivered by schools would be sufficient to deter their children from smoking. They cited the fact that their children nagged them to stop smoking, and brought home anti-smoking messages, slogans and stickers, as evidence that the message had got through to their children (and would presumably stick). Young children of one parent who smoked were able to repeat a range of anti-smoking messages during a family focus group interview, and told their mother that they wanted her to stop smoking.

By emphasising the influence of schools (in promoting non-smoking) and peers (in encouraging smoking) over their own influence, smoking parents effectively abdicated responsibility for encouraging their children not to smoke, enabling them to continue smoking themselves.

Non-smokers

Non-smokers who were relatively unconcerned about their children smoking often expressed faith that their children would follow their example in not smoking, and had not seriously considered the alternative – that they might not. Some non-smokers reported that their children were never around smokers, and therefore smoking was not familiar to them and was not likely to become relevant. Some of these parents had quite small children (less than eight years old) and had not yet witnessed their children's potential for rebellion against parental values, nor the power of the peer group. Some also expressed confidence in their parenting skills and the values they had instilled in their children, and in their ability to tackle the issue of smoking should they ever need to.

It is worth noting that where members of the wider family/whānau were smokers, non-smokers' levels of concern about smoking were higher. This was because they were aware of the potential negative impact of children being around smokers, whether or not they chose to act on this.

6.1.4 Cultural Differences

Only a few cultural differences were identified in relation to concern about smoking, as outlined below.

Māori

Many Māori whānau included smokers (parents and teenagers) and reformed smokers. These whānau typically had high levels of concern about smoking as it pertained to their whānau.

Pacific Peoples

For one Tongan participant, the thought of females smoking was embarrassing. This participant reported that traditional Tongan families regarded smoking as 'mens' business'.

> *"I think in our custom smoking tends to be men – not girls' stuff. That is what the parents said when they were married in the islands. But now [it's] not a big thing for girls to smoke any more. But [for] the families that are really sticking to their culture it is a big thing."*
>
> **Tongan Female – Christchurch**

Asian Peoples

Indian participants reported that in India it was less acceptable and common for women to smoke, at least in public (this situation was similar to that reported above for traditional Tongan families). Indian male migrants who were smokers or reformed smokers, reported that in India they had only smoked amongst male friends and colleagues. They contrasted this to New Zealand, where they regularly smoked (or had smoked) openly with female colleagues.

In India, smoking was regarded as a vice and as a result it was considered disrespectful to smoke in front of one's elders. Indian smokers in this study admitted that their smoking habit was often kept 'secret' from family members. In one instance, a male participant indicated that his wife was not aware of his smoking behaviour.

6.1.5 Impact of Smoking on Family/Whānau Functioning

Most smoking parents in this study attempted to physically remove themselves from children in the household when they were smoking. Typically, parents took their cigarettes outside or into another room. However, young children may have wanted to follow them, particularly when it was the mother who was smoking.

Most parents also encouraged, and in some cases insisted, that adult smokers visiting their household smoked outside.

> *"Not around my kids. Not around my house. The grandparents aren't allowed to smoke while they're with the kids."*
>
> **Māori Female – Christchurch**

However, parents felt they had less control over other caregivers smoking around their children when it was happening away from the child's home (e.g. at a smoking grandparent's home, or in their car). Other caregivers such as grandparents may have smoked around children and, because parents were grateful for their support they did not feel they were able to enforce rules outside their home.

> *"He [grandad] smokes outside at his house too. So, he's pretty good like that. But he just tends to smoke in the car and if the children are in the car he will still smoke in the car – which is a bit of a sore point with my husband … he doesn't think that his father should smoke while the children are in the car."*
>
> **Pakeha Female – Wairarapa**

When parents did feel strongly enough about passive smoking to make a fuss, it may have meant that their children saw less of the smoking relative, or were not allowed to visit their home.

> *"… because we don't like it [smoking] she [the grandmother] is on strict instructions that she can't have our children sleep-over because her house just stinks of cigarette smoke. So they don't get a sleep-over and she is quite upset about it. She gives up every now and then and goes back to it … she kind of thinks it is a little mean that we don't stay overnight anymore, but really I think the message is that our girls don't need to be coughing and spluttering by the next morning because they really do seem to be quite sensitive to it. Maybe we wouldn't have noticed it so much, if they weren't that sensitive to it and perhaps it would not have been an option that we chose, but because they are [sensitive to smoke] we don't sleep-over."*
>
> **Māori Female – Auckland**

Some smoking parents relied on schools to promote the anti-smoking message, on their behalf as it were. However, parents who continued to smoke undermined the anti-smoking messages coming from other sources, such as school, or from the other non-smoking parent. This had the effect of setting up conflict for children as to who they should believe, and where their loyalties lay.

Households where one of the two parents smoked faced additional conflicts. Parents in this study reported that their bolder children would often hassle and challenge the smoking parent. Where a non-smoking parent discouraged such attacks out of loyalty to their smoking partner, this further undermined anti-smoking messages from other sources.

Parents often explained away a smoker's behaviour to children with the message that smoking was powerfully addictive and therefore was 'out of mummy's control'. The researchers note that while this message was well-intentioned, it reinforced the idea that once hooked, the smoker had no personal choice in the matter, but was in smoking's thrall.

Smokers who had tried (sometimes on numerous occasions) to quit were aware of the impact of these attempts on their family/whānau. Parents who tried to give up smoking tended to upset the emotional equilibrium of the home – getting crabby and grouchy with their children and partners. Some parents in this study were reluctant to sacrifice household peace in the 'here and now', for the longer term health gains of successfully quitting.

> *"I know she [wife] would like to give up but I also have to watch her when she's trying to give up … she gets really grumpy – very short … everyone is probably quite a bit tense for a week … [putting pressure on her] doesn't help. If anything, it would probably make her more inclined to go and have a smoke, if I gave her grief about it."*
>
> **Pakeha Male – Gisborne**

6.2 Gambling

6.2.1 Overall Level of Concern

Overall, there was a relatively low level of concern about gambling among participants. Many families perceived that problem gambling was a remote risk for their children, because the parents themselves were not gamblers, and the children were not exposed to gambling. A non-gambling family environment was seen as a key protective factor against future problem gambling.

Unlike smoking, which most participants believed their children would be confronted with at some point while growing up, many people felt that gambling was a relatively low profile activity that was effectively ghetto-ised – taking place in venues (i.e. pubs, casinos and the TAB) removed from children's daily lives.

Problem gambling was strongly associated with pokie machines and casinos and, to a lesser extent, with the TAB. Lotto, Instant Kiwi and a flutter on the horses (e.g. the Melbourne Cup) were seen as entirely different – as occasional, harmless fun. While many participants loosely associated Lotto and Instant Kiwi with being gambling activities, they were not associated with problem gambling. Very few people made a link between taking a weekly Lotto ticket or buying a scratchy for 'a bit of fun' and potentially developing a gambling problem.

A small number of families/whānau in this study were highly concerned about gambling and the potential for their children to become involved in problem gambling. These included Māori, Pacific and Pakeha families/whānau where family members (e.g. grandfathers, husband, sister) or close friends had been or still were problem gamblers, and the negative effects of having a problem gambler at close quarters were very real and not forgotten.

> *"I did have a friend, her marriage broke up because her husband was at the casino all the time, spending money they didn't have."*
>
> **Māori Female – Auckland**

> *"My brother, he is a gambler. He is at the pub gambling all the money he has made, and I have seen two relationships [of his] break down because of problem gambling."*
>
> **Māori Female – Auckland**

6.2.2 High Concern - Influencing Factors

The key influence on concern about the potential impact of gambling on the family/whānau appeared to be direct experience of problem gambling. For example, parents in this study who were themselves children of problem gamblers had a heightened awareness of the potential dangers for their own family/whānau.

These people had experienced the damage (violence, lack of money for essentials, relationship problems and emotional and physical neglect) that could result when a family/whānau member had a gambling addiction.

Participants who had first-hand experience of the impact of problem gambling on the family/whānau were not complacent about the potential harm gambling posed. As a result, they were more likely to acknowledge the potential harm to their children, and to at least have considered how they might reduce this threat. Some parents in this group had broached the subject of gambling with still quite young children, rather than waiting until a problem emerged.

A few participants, however, felt that problems with gambling in the family were symptoms of generally addictive behaviour, with the particular problem area (gambling, alcohol, smoking, or eating) being defined by individual personality and tastes. These people tended to assume less individual responsibility for the (potentially) harmful behaviour because it 'ran in the family'.

Despite heightened awareness of problem gambling, most families with direct experience of problem gambling did not make a link between buying Lotto or Instant Kiwi and more problematic forms of gambling (such as TAB betting, casinos and pokies). At least some of these families/whānau still saw Lotto as the 'way out' of financial struggles, and communicated this to their children in word, and in action (by making a 'big deal' of the televised weekly draw).

> *"I don't think what I'm doing is harmful, you know, the scratchies or the Lotto when I buy it. I don't feel as though that's harmful. I mean not at this stage or at any stage. I think it's the degree … it's gambling that's the problem … [my eight year old] understands how we can win some money and she always asks me afterwards, 'are you checking it?', and after checking it, 'did we win Daddy? Did we win some money?' … it's maybe building an anticipation of a pay-back or something, a feeling for her. It's not a major … I've told her that if we win Lotto we'll get a new house. She always asks, 'when are we going to get our new house?' and I'll say, 'working towards it' or 'when the Lotto comes in then we'll get a new house'."*
>
> **Samoan/Tokelauan Male – Wellington**

Only one participant in this study, himself the child of a problem gambler, openly made the connection between supposedly harmless forms of gambling, and developing a gambling habit.

> *"I got concerned with the oldest one – we were going to get Lotto and scratchies – they liked the idea they were going to get money and I said, 'no, that's not a kids' thing'. The reason they make it a one dollar scratchy is the kids influence the parents to have one. The reason – when they do grow up they will think, 'I am going to do that now'. Gambling starts that chain reaction … it became a concern when she [my daughter] kept asking when we went shopping [for a scratch ticket]. Now when we go shopping she doesn't ask, she doesn't expect any of that. Now when I go and get a Lotto, we don't get a scratchy."*
>
> **Samoan Male – Wellington**

6.2.3 Low Concern – Influencing Factors

Families who expressed little concern around gambling, could be divided into two groups:

- those where little or no gambling occurred in the family/whānau
- those where gambling was normalised within their community

Little or No Gambling in the Family/Whānau

Where little or no gambling occurred in the family, parents saw little cause for concern about gambling. In these families, problem gambling was seen as a distant threat, and gambling addiction was something that happened to other people – people who gambled. Where parents were not gamblers themselves, gambling activities were not part of their life, and typically they did not understand the appeal of gambling.

> *"Not being exposed to it. Not being around it – as a result I am not concerned about it having an affect on my family. Our lifestyle is busy with other things that don't include those things [i.e. smoking, drinking and gambling]."*
>
> **Māori Female – Auckland**

As a result, such parents tended to be complacent about the threat of gambling harm to their children. Because their children had not been exposed to gambling activity, they assumed that gambling would hold no appeal to their children. Unlike smoking and drinking alcohol, peer pressure was not seen as an influence in children getting involved in gambling. Such parents believed that their children would not be at possible risk in terms of gambling until they become legally able to enter bars and casinos – at which point, the children will be beyond the parents' control.

> *"Very unconcerned [about gambling] because he's so young and it's not a problem. But in the future, I don't think our kids are going to be problem gamblers. I think there'd have to be a trigger, maybe addiction, bad finances or material things."*
>
> **Māori Female – Auckland**

As a result of a mixture of complacency, naivety and helplessness, anti-gambling messages were not typically given to children in these families/whānau. The rationale being that if you were not exposed to it, you had no reason to talk about it, and no prompt to do so. Parents professed that just as they would not know 'where to start' when it came to gambling, they also would not know where to start in terms of warning children off gambling. There was also a slight fear of rousing children's curiosity by raising the subject.

> *"I mean, I wouldn't even know where to start … because it's not an issue in our life, it's not something that I've kind of prepared the children for. I just hope they'll go down the road that X and I have … I would be at a loss as to how to do that [minimise the likelihood of the children taking up gambling] … I've never had anything to do with it – I mean, all I could do is hope and pray."*
>
> **Pakeha Female – Wairarapa**
>
> *"Sometimes, I don't know, if you forewarned them, would it not make them more curious? I don't know."*
>
> **Pakeha Female – Gisborne**
>
> *"They don't really know what gambling is ... when it comes to smoking, I talk to them when they ask questions. If we have big conversations about it, it makes it a bigger deal. We tend to only address certain issues as they come up."*
>
> **Māori Female – Auckland**

Gambling Normalised in the Community

Some of the families/whānau who expressed low concern about gambling reported that gambling was a common and socially acceptable activity within their community. For example, gambling activities such as Housie were a normal feature of some Pacific communities.

Some Pacific churches were also seen to endorse gambling – which effectively counteracted anti-gambling messages: 'if the church said it was okay it cannot be that bad.' It is worth noting that at least one Pacific church in Christchurch was reported as taking a strong anti-gambling stance.

However, some Pacific churches ran well-attended Housie evenings, and there were reports of Pacific families going on gambling sprees just prior to church donation times in order to win more money to give to the church. The researchers note that this behaviour may be more common in churches where donations were made public, and considerable pride or shame was attached to the amount a family contributed.

> *"I don't agree with it because the church leaders are meant to be helping people out of poverty but running Housie is the opposite. It is just making the church rich and the poor people poorer and Polynesians always look up to their church leaders so they will go there, they will spend money there."*
>
> **Tongan Female – Auckland**

While gambling was normalised behaviour in terms of upbringing for some Māori, there was no evidence from this study that it was currently so in Māori communities. Some Māori participants recalled gambling as being very much a part of their upbringing, both as a fundraising activity for marae or schools but also as a social past-time, either for fun or as a money-making venture.

> *"Both of my parents played poker … and we were very young when we learnt how to play poker. We used to play with our cousins after netball, just go home and play with 25 cents or how ever much we had then … Pretty much 15 years ago when we were at school, [as] kids, we were pretty much into gambling every day. Ten cent coin here, ten cent coin there, but we didn't realise how much of an addiction, or how bad it really was."*
>
> **Māori Male – Auckland**
>
> *"It used to be the communal thing. It was like a social thing. On Monday nights at this one's [house] and Tuesday nights at someone else's house for cards, then for Housie and you'd go with your friends."*
>
> **Māori Female – Auckland**

6.2.4 Cultural Differences

Māori and Pacific families/whānau were more likely to have had direct experience of problem gambling and gambling harm than were Pakeha families in this study. However, there were no notable differences in attitudes to gambling and problem gambling *between* Māori and Pakeha families/whānau.

Some cultural differences in gambling attitudes and behaviours were noted in Pacific and Asian families in this study.

Pacific Peoples

Some Pacific peoples in this study believed that first generation Pacific migrants were particularly vulnerable to problem gambling because they were exposed to casinos and pokie machines for the first time when they come to New Zealand. One father noted that his own father's problem gambling was part and parcel of his parents' traditional marriage – whereby the father gambled away his pay packet without direct challenge from his *"docile"* Samoan wife.

A number of Pacific families in this study had been affected by problem gambling. In several families, one or both parents were children of problem gamblers (or had grandfathers who were problem gamblers), and had experienced the pressures this placed on their family first-hand. They described going without food, and being neglected by the problem gambling fathers, whose pay packets, focus and energies were devoted to gambling rather than to their family.

> *"Dad was a gambler and an alcoholic. And that impacts, that definitely impacts on the family unit and it takes over … where do I start? There was no food in the cupboards … when Mum was paid she would spend all her pay on shopping, whereas Dad would go and spend it at the pub or on gambling, or at the races … Dad wouldn't come home with his pay, he'd go missing for days. What could you do? How was Mum supposed to survive with little kids?"*
>
> **Samoan/Tokelauan Male – Wellington**

Pacific adults – like other adults who had grown up with a problem gambling parent – did not want to repeat that parent's behaviour, and were anxious that their children should not fall into problem gambling. One of these parents was among the very few in this study who initiated discussion with their children about gambling, pointing out the pitfalls of it.

Pacific families who were concerned about gambling perceived that it was a particular problem in their community because of the combination of relatively low incomes, the novelty of gambling to Pacific migrants, and the normalisation of gambling (and even encouragement) by Pacific churches.

> *"It's definitely a dangerous thing at the moment, especially for Pacific communities … unfortunately I think it's a 'bright light' thing. They see money, ding, ding, ding. The Pacific communities are always influenced by westernised things – where they come from there is nothing like that. Nothing like that at all. When they come to New Zealand there's an opportunity to work hard, to get money to do those things."*
>
> **Samoan Male – Wellington**

Some younger Pacific families seemed to be taking a stand against gambling being a 'normal' part of their church and community, and actively spoke out against this practice and ensured that their children understood their family's position on this. This could cause some tension, especially when other family members (within and outside the household) continued to gamble.

Asian Peoples

Some Asian participants (notably Chinese in this study) had grown up knowing how to gamble from an early age and prided themselves on having acquired this knowledge early in life.

> *"One thing from when I was a kid – mahjong – I learnt to play it very early – about three I think. We used to gamble quite early. [It was] fun but also taught you about winning and losing – little wins and big wins. Just the way gambling works – it was [a] brilliant way of learning."*
>
> **Chinese Male – Auckland**

Chinese participants in this study also commented on the attraction of gambling activities to new migrants to New Zealand, who had not been exposed to legal gambling activities and venues in China.

> *"In China [it] is forbidden, illegal – they forbid any gambling game. So for me when I first came [to New Zealand] it was quite a new thing for me, so I feel quite curious about it and I went a few times and I spent twenty dollars or something just to try my luck … and when my parents came to visit me I took them to the casino just for a visit because they had never had this kind of place to go in China – very, very different from China."*
>
> **Chinese Female – Christchurch**

Chinese people, in particular, placed considerable importance on wealth because it was a means of signalling one's success to others (and reinforcing it to the self). For Chinese participants, gambling was often the vehicle used to try to increase personal wealth.

> *"I was born in Malaysia … unlike Chinese in China – there is a lot of restriction in mainland China. In Malaysia, Singapore and Hong Kong when you are rich you want to splash money around and you want to show others you have money to splash … Money is the most important thing for Chinese – sorry to say [that]."*
>
> **Chinese Male – Auckland**

> *"I am New Zealand-born also and trying to portray the good image all the time. Showing you have lots of wealth, taking people to go out, giving gifts. [In] mainland China it was like [a] sea of people everywhere – [a] sea of people. People trying to find a way to claw your way up … chances are bad … but here there is chance of getting there [and making money from gambling helps you to 'make it']."*
>
> **Chinese Male – Auckland**

There was some feeling among Chinese participants that their culture sanctioned parents and friends intervening to curb problem gambling behaviour. In contrast, they perceived that New Zealanders adhered to a western ideal of individualism that inhibited them from interfering with another's rights and freedoms, even when their motivation was to protect that person from harm.

> *"I think this is the western way – you have your personal space. But in China I think the family could enforce you to stop – if your family found out that their son was in gambling, well the parents would endorse you to have to stop or [a] friend could drag you out. But in western people, you very [much] respect your own privacy, very [much] respect each other – so maybe that is more difficult to stop someone."*
>
> **Chinese Male – Christchurch**

Little or no gambling was reported by Indian families in this study. Some Indian parents bought scratchies occasionally and felt they were harmless fun. They did not link such behaviour to problem gambling.

6.2.5 Impact of Gambling on Family/Whānau Functioning

For families/whānau where no gambling took place, gambling had no impact on family functioning. However, in some families/whānau where low levels of gambling took place, children were observing and taking part in both Lotto and Instant Kiwi and the ritualised behaviour associated with these 'games'.

In a couple of Pacific families in this study, Lotto represented the 'big break', with children being told that Lotto might enable them to finally buy a house. In one of these households, the Lotto draw was anticipated and watched with great excitement.

In a number of households in this study, children were given Instant Kiwi tickets to scratch, often as a treat or a spontaneous supermarket purchase (Instant Kiwi tickets were clearly visually appealing to children). In some cases children made no link between scratching the ticket and winning money. In other cases, the children were given any 'winnings' they made, and may have been allowed to 'reinvest' them on the spot.

All but one participant believed there was no harm in children taking part in these activities because they simply represented 'a bit of fun' and were not considered to be real gambling. The exception to this was one Pacific father, the son of a problem gambler, who observed his young daughter's eagerness to 'reinvest' her Instant Kiwi winnings. As the child of a problem gambler, he felt the need to 'educate' his daughter about the lure of gambling, and the (low) likelihood of greater returns, convincing his daughter it was better to spend her money on tangible things.

Some Māori participants in this study knew first hand the negative impact of gambling on themselves, their partner, family members and friends. Gambling was a major cause of tension and conflict in some whānau, causing financial hardship, marriage break-ups and whānau members fighting among themselves because money that should have been used to provide for the whānau had been 'wasted' on gambling.

> *"My brother, he is a gambler. You know – addicted to the pokies … he is at the pub gambling all the money he has made, and I have seen two relationships break down because of problem gambling. One of them has recently reconciled but [he is] still carrying on [gambling]. But I don't know if it [the relationship] is going to last this time."*
>
> **Māori Female – Auckland**
>
> *"Yeah my brother. He almost broke up from his wife with cards and gambling, pokies and stuff. They are still together though only just though. And just his excuse was there was nothing wrong with him, you know it is a fun thing."*
>
> **Māori Male – Auckland**

> *"… my sister is the one who has really gotten into the gambling – and it became a problem with her husband to the point where I was going to buy the groceries for the week for them, because she was spending all their money and to make sure that they have got food in their mouths and that. He doesn't, he wouldn't give her anything and I would go down there and I would think, 'I can't keep doing this, because I can't afford to do this'. And what we did was we just made everybody [in the whānau] know. We just let everybody know that she has got a problem ... and everybody was slowly having to say no [to giving her money]."*
>
> **Māori Female – Auckland**

Gamblers may have asked whānau to look after their children while they gambled or asked them for money to gamble or pay their debts. Refusal either impacted (or was likely to impact) on the relationship.

> *"I refused to look after their kids … I said, 'I am not going to look after your kids while you go and gamble [the] money'."*
>
> **Māori Female – Gisborne**

Māori participants in this study who knew first-hand the negative impact of gambling on themselves, their partner, family members or friends, were eager for their children or grandchildren to avoid becoming gamblers. However, with few exceptions, they did not specifically speak to their children and grandchildren about the 'pit-falls' of gambling.

> *"So it's all about teaching them about other things instead of focusing on talk about gambling. We try to say to work hard, or get a good education. We do not specifically say, 'do not gamble' or 'do not buy raffle tickets'. We just focus more on what we hope is going to be good for them, rather than on money."*
>
> **Māori Male – Auckland**

In this study, there were some reports of children participating in TAB betting with adults. The children were allowed to pick the horses to bet on, and this was seen as relatively harmless time spent with adults. At least one participant said she had grown up doing the same thing, and it never caused any harm and she had never started gambling herself. This reinforced a widely held view that it was not gambling itself that was a problem, but addiction to gambling when it was associated with losing money the gambler cannot afford to lose.

Participants also reported children being involved in Housie, with one mother using a night at Housie as a reward and bonding time with her step-son. Another child went to Housie with his grandmother and was a source of pride in the family because he could play a number of Housie cards at one time. As with other forms of perceived harmless gambling, Housie was regarded as a bit of social fun rather than potentially problematic.

Some Pakeha participants reported strained family relationships because of the gambling behaviour of a close family member, and how this could impact on the well-being of individuals involved.

> *"Actually in gambling there is an issue but it's to do with my mother's husband – who is a step-father to me – who spends a lot of money at the TAB ... it is not easy to talk to him about it ... I have mentioned it a few times but it never seems to get anywhere. My mother is always complaining to me on the phone about it … they are both pensioners, a lot of it [money] goes to the TAB and I have to listen to her talking on and on about what I [she] could have done with that money if he hadn't spent it … I think she is a bit scared of him, scared of his overbearing kind of attitude so she puts it back on to me … it affects how she acts, it affects her attitude, it affects everything."*
>
> **Pakeha Female – Wellington**

> *"Gambling is not a problem for me but it is for my husband, he has a gambling addiction problem and that makes my life difficult because I have to make sure that what money comes into the house is paying what I need to pay."*
>
> **Pakeha Female – Wellington**

6.3 Alcohol Consumption

6.3.1 Overall Level of Concern

Overall, families/whānau in this study expressed a high level of concern about alcohol consumption as it related to their family/whānau. Like smoking (and unlike gambling) parents believed that alcohol was something that their children would be confronted with, and needed to make decisions about, simply as part of growing up.

Like smoking, alcohol was seen as something that teens may want to experiment with as a means of asserting their independence and impending adulthood. Like smoking, peers were seen to be influential in encouraging experimentation with alcohol. Unlike gambling, which many parents assumed would not enter their children's orbit until adulthood, alcohol was seen as something that children would need strategies to deal with.

It was fairly common for parents in this study to confess that they were not sure how best to equip their children to handle alcohol. They were unsure about whether and at what age to start allowing teens to drink alcohol at home in the company of family/whānau, and at what age alcohol should become an acceptable part of young people's socialising away from home. Parents were unsure how to 'normalise' alcohol so that teens did not become binge drinkers, and how to teach their children to manage the risks associated with alcohol (such as car accidents, violence, and unplanned sexual activity).

Parents who did not drink alcohol at home themselves may simply have wanted to avoid the issue. However, parents were generally aware that whatever their own values and behaviours were in relation to alcohol consumption at home, alcohol was ingrained in New Zealand society and its consumption was seen as a key rite of passage into adulthood. Parents knew that as their children grew up and developed independent social lives, they would increasingly find themselves in situations where alcohol was available to them.

6.3.2 High Concern – Influencing Factors

There was generally a higher level of concern about alcohol consumption among families with children who were approaching or who had already entered their teens. As discussed earlier, parents were aware that their children would have to confront and manage the issue of alcohol as part of growing up. When a child's peers drank alcohol, and the child was socialising in situations where alcohol was available, parents tended to express higher levels of concern.

This concern was mitigated in some families however, because of the trust already established between the parent(s) and child. Some parents were confident that their child had the character and social skills to resist peer pressure, and to manage alcohol without bingeing or getting into risky situations.

This tended to be seen in families/whānau which encouraged open communication between parents and children, and where children had input into setting rules, with compliance expected in return. Some families/whānau had formal or informal contracts in place where, for instance, the children agreed to call the parent at any time for a ride home should they be in an uncomfortable or potentially dangerous situation.

One family had an agreement that the teenage children could only drink alcohol that the parents had provided. These parents frequently offered to host parties in order to retain control over their children's alcohol consumption. They believed that by avoiding a total prohibition they avoided making alcohol more attractive to their teens, and they showed their children that they were trusted but that trust entailed responsibility.

Concern was higher where there was a history of alcoholism or alcohol dependency within the family/whānau. Parents who were themselves dependent on alcohol may have been aware that alcohol was a problem for them, or that they could not do without it. Alcohol-dependent parents were aware that their children may be also susceptible to alcohol dependency.

Parents also noted that a history of alcoholism or alcohol dependency in the family/whānau could be a protective factor, because children had witnessed the destructive effects of alcohol. The parents too may have been more vigilant about their children's use of alcohol, and were proactive in initiating discussion around their children's use of alcohol, rather than leaving it to chance or hoping for the best.

> *[Interviewer: "Do you have rules with alcohol consumption with your oldest (child)? Does she drink?"]*
>
> *"Oh, she tried it. She bought home a bottle of Midori and she said, 'I'll drink some', and I said, 'not on your life'. And she'd obviously drunk it, it was only a little bottle. I explained to her about her father and said, 'do you want to end up like your father?' No, because she can't stand him, because of his drinking. He's not a good father anyway, but he's a nice person, put it that way. And she stopped it. Yes, she stopped it on her own."*
>
> **Pakeha Female – Christchurch**

One participant, whose ex-husband was an alcoholic, encouraged her 17 year old son and his friends to drink at her house – rather than elsewhere – so that she could supervise them and prevent anyone from driving drunk. This mother also held up the father's drinking as an example they should not follow.

There was a high level of concern when parents were recovering alcoholics. They wanted to protect their children from drinking or being exposed to people who did drink. In two such Māori whānau alcohol was not allowed on to the property, and the parents openly discussed alcohol with their children.

> *"I lose trust in people consuming alcohol because with them comes a whole new side of them that you don't know exists. I don't partake, I take myself away from the party and take my children with me. I am very strong about that now that I am a non-drinker. I just know what I was getting up to and the effects alcohol had on me and others around me. I don't expose my children to it."*
>
> **Māori Female – Gisborne**

Families/whānau may have expressed a higher level of concern about alcohol when a parent's use of alcohol was creating problems within the family/whānau. Such individuals may not have considered they had a problem with alcohol, however, other family/whānau members may have had a problem with the individual's use of alcohol. Examples of this included a father who reported that his binge drinking and frequent hangovers left him too tired and unmotivated to carry out the physical work required to run the family farm effectively. In this case, the mother had confronted him about his drinking, which was affecting not just his farm work but his relationship with her and their teenage and pre-teenage children.

6.3.3 Low Concern – Influencing Factors

Some parents in this study consumed little or no alcohol themselves, perhaps having the occasional glass of wine or beer on special, social occasions. In some of these families/whānau the parents assumed that their children would follow their example, in refraining from alcohol consumption, or being very occasional drinkers. The researchers comment that in these families/whānau, the children were typically still young (less than ten years old). These parents' assumptions about their children's behaviour in relation to alcohol consumption had not yet been tested.

These families/whānau may have regarded alcohol consumption as a possible issue for future discussion, but had not thought about how they would handle the issue, and because they did not drink themselves, gave alcohol consumption little thought at present. Their position around alcohol as it related to their children appeared to reflect a mix of optimism, complacency and naivety. A preventative approach to the issue was missing.

Some families/whānau expressed lower concern about alcohol consumption because they were aware that their teenage children had experimented with alcohol and did not like the taste. The researchers note that the parental assumption that this would guard against the child's future consumption of alcohol may be mistaken, with the issue of how to handle alcohol simply deferred, rather than permanently shelved.

Another group of low-concern parents simply regarded experimentation with alcohol as a normal part of growing up. They were likely to have drunk heavily themselves as adolescents and young adults, although few reported drinking heavily now. They expected that their teenagers would drink to excess, but aside from the risk of drink-driving (which received a high profile through schools and other educational campaigns), they believed it was a phase their children would grow out of.

6.3.4 Cultural Differences

This study found few cultural differences in attitudes to alcohol between Māori and Pakeha families. Some cultural differences in attitudes to alcohol were noted in Pacific and Asian families in this study.

Pacific Peoples

Some Pacific families expressed low concern about alcohol consumption because alcohol was not a feature of their community, and their church (synonymous with their community) proscribed drinking. Samoan and Tongan families attending two different churches in Christchurch followed their church's dictates with regard to drinking. One family avoided alcohol altogether, and the other only drank alcohol in social situations outside of the Pacific community – such as a work Christmas party – when it might be considered rude to abstain.

Low concern about alcohol consumption was expressed by some Pacific parents because their children were still very young and the parents had not yet had to confront the issue.

One Pacific father expressed concern about his teenage daughters drinking in uncontrolled situations, such as on the street or at parties. While he did not approve of drunken teenagers of either gender, he was particularly concerned that drunken girls were vulnerable to unplanned sexual activity or sexual assault. He also felt it was socially inappropriate for young girls to appear to be intoxicated in public. (This view may be shared by other cultures, but was not noted in this study).

Asian Peoples

Some Chinese women in this study reported that alcohol held little appeal for them. While they drank only small quantities infrequently, their husbands drank more regularly. Within Chinese culture it was more acceptable for men to drink lightly regularly, and more acceptable for men to consume a greater amount of alcohol on social occasions.

> *"Growing up I had a lot of uncles who were heavy drinkers. Whenever we had family gatherings the majority of time they were drunk."*
>
> **Chinese Female – Auckland**

Among the Indian participants in this study, it was not common for the women to drink socially, especially in the presence of males. Where this did occur it was usually in the context of socialising with friends on special occasions. In the Indian culture it was accepted that males would drink socially with male friends.

6.3.5 Impact of Alcohol Consumption on Family/Whānau Functioning

In this study, the key ways that alcohol consumption impacted on family/whānau functioning was that it placed stress on relationships of family/whānau members and deprived families/whānau of money for essentials, e.g. food. In some cases this resulted in strained but continuing relationships, while in others it had led to severed relationships.

Where people were drinking heavily and were dependent on alcohol, their life had come to effectively revolve around alcohol, leaving little or no time for other things, including time spent with family/whānau. For example, one mother in this study reported that her alcoholic ex-husband had become increasingly distanced from the life of the family as his drinking worsened. His drinking prevented him from being an effective father and active family member.

Some families/whānau placed limits on the exposure their children had to other family/whānau members (and family friends) where alcohol was involved, particularly where heavier drinking was involved. This was motivated by not wanting children to be exposed to inappropriate use of alcohol or seeing significant family members in an impaired condition.

> *"… his dad was enjoying a drink and then coming around for a visit. Because the boys were seeing [their grandfather] tipsy … although they couldn't really tell, the boys were just thinking, 'oh he's happy' … [my husband] said [to his father], 'if you want to do that, don't come round. I don't want my boys to see their grandfather like that. You're more than welcome to drink, just don't come round when you're drunk'."*
>
> **Māori Female – Wellington**

Where one parent in a family/whānau had occasional binges on alcohol, the resulting hangovers sometimes impacted on their contribution to the household (e.g. it limited their ability to generally pull their weight and to get things done) as well as on their overall outlook (which could in turn impact on the other household members).

> *"I was accused [by my wife] of drinking far too much there about a year ago – but then I knocked it on the head a bit. She's the boss ... I was spending a bit of money on it … too much time off … not wanting to do stuff. Yeah … [I] get a bit more done [now], yeah. Things don't seem to go wrong quite as much as they used to … shit would happen – seemed to happen – more regularly … [you'd] probably be a bit more optimistic I guess when you're not drinking as much. I think alcohol can be a bit of a depressant … drinking too much can sort of lead you to see the dark side of things a lot more than perhaps is real."*
>
> **Pakeha Male – Wairarapa**

Where household money was being spent on alcohol this left less money for food and other necessities for the whānau. This was particularly an issue for low income families with little disposable income. In some instances a choice had been made (in the past at least) to purchase alcohol over providing food for the family/whānau.

> *"It used be a choice between buying food for the kids or buying drink for me. Often it was not a straight forward decision."*
>
> **Māori Female – Gisborne**

Some parents in this study attempted to keep their drinking, and any after-effects of drinking, effectively hidden from their children. They did this by only drinking away from home, and ensuring that children were in bed before returning home after drinking sessions. One father reported waiting until his children were asleep before coming home drunk, and said his wife tended to do the same if she had been out drinking.

> *"When we do go out we come home when they are asleep. They must be asleep so they don't see us in that state. When I come home, I always come home and, as best I can, shower up before I go to sleep."*
>
> **Samoan Male – Wellington**

> *"When I come home the girls are sleeping so I don't want them to see me in my drunken state … so I'm a little bit concerned just only because I drink and I don't want my kids to drink … kids look at their mothers as if they're God. So I don't want them to look and for them to think it's okay for them to drink at a young age."*
>
> **Niuean Female – Wellington**

It was recognised by some participants that alcohol use could create dependency, which led to poor health and could exacerbate existing health problems. In some families/whānau where this situation had occurred, relationship tensions had arisen when other family members had invested time but 'failed' to persuade drinkers to change their drinking behaviour because of the negative impact it was having on their health. Inability to secure the desired outcome left 'helpers' feeling in a negative state through their frustration and sense of personal failure.

6.4 Physical Activity

6.4.1 Overall Level of Concern

Overall, physical activity was of low concern for the majority of Pakeha and Asian participants, and for some Māori in this study. However, there was evidence of greater concern about physical activity among some Māori whānau, and among Pacific families.

Some relatively inactive parents reported that their young children were naturally active, and many school age children were involved in organised sports. Parents were often relatively unconcerned about their own levels of physical activity, whether or not they perceived themselves as physically active.

Any concerns that were expressed around physical activity tended to be linked to weight concerns, with adults who were keen to lose weight recognising that increasing their activity levels was one way of achieving this.

6.4.2 High Concern – Influencing Factors

Pacific and Māori participants who expressed concern about physical activity in relation to their family/whānau were aware of the relationship between physical activity, diet and obesity, and some other health conditions such as diabetes, renal failure and heart conditions.

> *"My partner and I always try to be active. Well I've got quite a few in my family who are very big, obese. With some of them it's being big-boned but you can do something about it."*
>
> **Māori Female – Christchurch**

These families/whānau may have had a health scare, or have been told by their doctor that they needed to lose weight and exercise in order to manage a health issue such as high blood pressure, diabetes, or a heart condition. Some Pacific families (as well as some Māori whānau) were also aware of ongoing messages about physical activity in the media, and that the Pacific community was a target for public education and interventions to address obesity, and particularly childhood obesity.

These factors had heightened concern about physical activity and motivated some Pacific families to integrate more physical activity into their daily routines. This included encouraging school age children to participate in organised sport.

A couple of Pacific fathers were aware of the need to be physically active as a means of controlling their own weight, and had joined gyms in order to improve their own fitness and to lose weight. These fathers were also encouraging physical activity on the part of their children and, in one case, their wife. In these cases, the fathers saw physical activity as a means of not only controlling weight, but increasing their children's confidence and enjoyment of sport. A teenage daughter in one such family enjoyed team sports, and was also aware of the use of physical activity as a means of controlling her weight.

> *"I was like eleven when I started weighing myself. If I was over 75 [kilos], I'd run, run, run and I started going to the gym with my dad."*
>
> **Niuean-Samoan Female Teen – Wellington**

Both wives in these families saw physical activity as a way of controlling their weight. In one case, the mother preferred to keep physically active rather than having to restrict her diet.

However, while some Pacific families were highly concerned about physical activity and understood its relationship to health, they still had relatively low levels of physical activity. Stated barriers to being more physically active included not being in poor (physical) health and lack of time because of work and family commitments.

Where families/whānau expressed moderate levels of concern around physical activity, this was often linked to weight concerns. In some cases, family/whānau members had become more physically active, e.g. taken up running or a team sport or joined a gym, as a means of controlling their weight. In other cases, the family/whānau simply regarded being physically active as normal rather than being a remedial measure.

Families/whānau who expressed moderate concern around physical activity were more likely to take a preventative approach to good health, whereby exercise was part and parcel of being healthy, and lack of exercise was a cause of weight gain or obesity.

6.4.3 Low Concern – Influencing Factors

Overall, physical activity was of low concern to most Pakeha and Asian participants and to some Māori participants in this study. A number of family/whānau perceived that they were physically active and therefore had no concerns about physical activity. Some families/whānau who expressed low concern were involved in sports – both parents and children – and this was the family norm. In this case, especially, low concern did not mean that physical activity was regarded as low in importance.

In many of these families/whānau, being physically active was seen as a key driver of good health, and because they felt they were 'fit', they also considered themselves healthy. Some Māori whānau regarded sports people and athletes as excellent role models for them because these people set high standards and provided the inspiration for whānau to get fit and healthy.

Some relatively inactive parents reported that their young children were naturally active, had lots of energy, and were always 'running around'. Parents interpreted this as a crude sign that their children were healthy. The same parents were often relatively unconcerned about their own levels of physical activity, whether or not they perceived themselves as physically active.

Among relatively unconcerned family/whānau there was an important link between attitudes to physical activity and weight. Many participants assumed that if no one in the family/whānau was obviously overweight, then the family/whānau members must be getting enough exercise. From this point of view, if a person was not overweight, there was no problem. For people who held this view, the same often applied to notions of healthy eating (see Section 6.6 – Healthy Eating in this report): if a person was not overweight, he/she must be 'getting it about right' in terms of food eaten.

Even where parents were overweight, this was not of sufficient concern to motivate them to become more physically active. Unlike some parents who had increased their level of physical activity in order to enhance their physical attractiveness, these parents were not motivated by vanity. Nor did they perceive sufficient pay-off in becoming more active in order to lose weight.

> *"I worry a bit about whether I'm getting overweight and things like that, but I've always been large … and it's only my belly … most of the time it doesn't really worry me at all, I suppose, because I think part of it is due to, through my music – you know, you breathe differently and you breathe more using your diaphragm so you extend your stomach anyway … I've stretched my stomach muscles and that's why."*
>
> **Pakeha Male – Gisborne**

Where weight was an issue for some family/whānau members there was sometimes a reluctance to tackle the issue head-on, particularly if it risked creating conflict within the family/whānau. This was particularly the case when pre-teen or teenage girls were overweight. On the one hand, parents were concerned that this was unhealthy physically and emotionally and would have liked their daughters to eat better and to exercise more so that they became fitter. On the other hand, parents (especially mothers) were anxious about 'giving' their daughters eating disorders and undermining their self-esteem by focusing on their weight. Parents were also reluctant to appear to be singling one child out by focusing on their weight or attempting to control their diet, when other children in the family/whānau continued to eat what they pleased.

Parents were faced with conflicting messages about overweight being unhealthy, that diets did not work, that teenage girls easily developed eating disorders, and that people should accept and love themselves and others the way they were. When parents were relatively slim and healthy themselves, they perceived that any comment on their child's weight would have seemed like criticism and withdrawal of love and approval. When parents were themselves overweight, it would have felt hypocritical to make comments about their child's weight. In either situation parents could feel helpless.

6.4.4 Cultural Differences

The only clear cultural differences in relation to physical activity in this study was found among Pacific and Māori families.

Pacific Peoples

Pacific families in this study typically expressed higher levels of concern about physical activity, although this was not universally true. One family in this study was experiencing push-back and ridicule from other members of their Tongan community for trying to do more exercise.

Some Pacific families in this study were aware that the Pacific community was a target for public education about obesity, and commented that this had influenced their attitudes to physical activity. These families accepted the Pacific community being targeted on the issue of obesity, and recognised there was a link between obesity and (lack of) physical activity (as well as eating). Some Pacific peoples recognised that their size and traditional diet made them a target for public education around obesity.

Some Pacific parents in this study said that they expected their children to be larger than their non-Pacific peers because Pacific peoples are *'naturally'* of larger build. Comment was made that in Pacific cultures, there was the traditional belief that 'big' equated with 'healthy'. However, there was evidence in this study that this traditional belief was being challenged, as some Pacific peoples adjusted to the idea that 'big' could also cause health problems and shorten life expectancy. Some Pacific parents saw their own tendency to put on excess weight replicated in their young children, and wanted to avoid their children developing weight problems and health complications in later life.

Some Pacific families were getting the message about the importance of physical activity, and had integrated regular activity into their daily lives. A traditional interest in team sports had supported this move.

Māori

Some Māori whānau were moderately concerned or very concerned about physical activity. Growing awareness of obesity among Māori whānau had been a driver of increased concern around physical activity.

6.4.5 Impact of Physical Activity on Family/Whānau Functioning

This study suggests that a parent who felt overweight and unfit was less willing to engage in family outings that involved physical activity. Conversely, a parent who felt fit would have more energy for playing with young children.

Younger children often needed their parents' encouragement and active involvement to get involved in physical activity. One Pacific father reported that his eight year old threw basketball hoops with him 'for hours', but wandered inside if left to her own devices.

Parents who were relatively inactive were modeling behaviour for their children, e.g. snacking in front of the television as a leisure activity, but they may have been unaware of this connection and may have simply told their children to 'get outside' and play (without dwelling on the example they were setting by not being more physically active themselves).

There was evidence in this study that one family/whānau member getting active could have a flow on effect to other family members. One Pacific father joined a gym because he was unhappy with his recent weight gain and wanted to regain some of his earlier (youthful) fitness and looks. As part of joining the gym he received advice from instructors about the influence of nutrition and activity on energy levels and fatigue (physical and mental). He then made the connection with his young daughter falling asleep at school, and resolved to take greater interest in what his girls were eating and to encourage their involvement in school sports.

In some families/whānau, physical activity was a bonding activity, with the family/whānau going for walks, or bush walking or cycling together. This was also seen as an opportunity for children and parents to talk together.

Some Māori, Pacific and Pakeha parents with a strong sports focus actively encouraged their children to play sport. This then became a core feature of how the whānau worked – they supported and watched each other play and this took up most of their non-working time.

Asian families tended to incorporate physical activity into their everyday lives, and supported and encouraged children to participate in sport if they were interested.

6.5 Healthy Eating

6.5.1 Overall Level of Concern

Levels of concern around healthy eating in this study 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 described 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 behaviour around healthy eating. These segments are based on the in-depth interviews carried out with individual family members, and are outlined in detail in the companion report to this document: see Section 8.0 – Audience Segmentation in the *Healthy Eating in New Zealand Families/Whānau* report *(December 2007).* 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 a healthy diet as central to the health and well-being of their family/whānau, and as 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.
- **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. This may have involved distancing themselves from the less healthy eating patterns they grew up with. They were eating more healthily than in the past, and had become active information seekers in their quest for a healthier 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, meat from a neighbouring farmer. They experienced considerable pride in being able to provide for their family/whānau (and, importantly for some Providers, had the benefit of being able to keep their food budget down).

- **Complacents** – these individuals were relatively unconcerned about healthy eating, because they believed that they and their family were doing okay and had a 'healthy enough' diet. Their children were not among the healthier eaters in this study, but their parents might have been surprised to learn this. When they examined their eating practices in this study, Complacents 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 have been moderately concerned about healthy eating (although some denied this), but were resistant to healthy eating messages because they were not convinced that healthy eating really made a difference to health, 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 found it hard to sort through the many conflicting messages about food in the media. Most simply did not try.

6.5.2 High Concern – Influencing Factors

Families/whānau in this study who expressed high levels of concern around healthy eating recognised that it played 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 that contributed to overall quality of life of 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 were 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.

> *"I guess I want to minimise as much risk for my daughter so that she doesn't hit the same pattern that I've managed to get myself into. It stems from my upbringing and with my Dad having steak and sausages, eggs for breakfast, and that sort of thing. So it sort of developed into that pattern. That's not going to happen to my daughter. I'm always sort of looking over her shoulder saying, 'what's that'?"*
>
> **Māori Female – Auckland**

Some of these families 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 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.

> *"Very concerned because of family history of heart disease."*
>
> **Māori Female – Christchurch**
>
> *"Me, my weight. The worry of dialysis. That's my main worry, with the history in my family … because my dad and my aunty both died of that."*
>
> **Māori Female – Auckland**

Recognising that these conditions were 'in the whānau' provoked different reactions. Some Māori were actively becoming fitter and eating more healthily to reduce the likelihood of getting sick in the future. The grandparents in one whānau had high blood pressure and high 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 drivers for these behavioural changes were the strong desire to 'be around' for mokopuna and each other.

> *"X and I, when we discovered [we had high blood pressure] we were home alone. We said, 'well we better start looking after ourselves. We've only got each other'. X said, 'I want to be here for my moko. I need to live, to see them grow' … and then I had high cholesterol … of course it was all around what we ate, what we drank, all of that stuff, something we [had] never really worried about [before]. We just ate what we wanted to and everything but once we went … when it was found out that he had high cholesterol as well, well then we said, 'right, we've got to start looking after ourselves' … Yeah, I would say being in good health is probably the most important thing for us because then we'll be able to do the things we want to do, with each other and our moko [mokopuna]."*
>
> **Māori Female – Gisborne**

Note: Some whānau had a lower concern about conditions that were in the whānau and took a more passive or 'wait-and-see' approach. They did not take steps to forestall or reduce any potential health risks (possibly because they appeared to be dormant or were not an immediate problem).

6.5.3 Low Concern – Influencing Factors

The segments least concerned about healthy eating were Complacents and Inerts. Providers were moderately concerned (to relatively unconcerned) about healthy eating but it was not their main focus. Avoiders may have been moderately concerned but were 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. As discussed in relation to physical activity (see Section 6.5 – Physical Activity, above), some relatively unconcerned family/whānau made a link between healthy eating and weight. Provided family/whānau members were not obviously overweight, it was assumed that their diet must be relatively healthy or at least 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. 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 physically active.

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

> *"We could do better but I think most people could do better. But I think we're doing all right … they're eating veges, they're eating meat … 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 …"*
>
> **Pakeha Female – Wairarapa**

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, there may have been a whānau history of health conditions which they acknowledged but took a wait-and-see approach toward. Māori whānau in this group tended to be in the lower socio-economic group, where the cost of food rather than quality of it was the key factor.

6.5.4 Cultural Differences

Some cultural differences in attitudes toward healthy eating were noted in Pacific and Asian families in this study. Few differences were found between Māori and Pakeha families (in relation to 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

Pacific families in this study who expressed high levels of concern about healthy eating, typically fitted 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).

> *"We used to have boil ups and we didn't have much veges, and we were brought up more with Island food. My kids don't eat Island food when they go and see my family or [my husband's] family. We don't cook Island food here. My girls have choices what they want to eat. I didn't."*
>
> **Niuean Female – Wellington**

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, who were self-conscious about their larger, heavier bodies).

> *"The Pacific girls eat a lot from the canteen and some Pacific kids don't have anything to eat. When you see the white kids eating, they eat out of jam jars of fruit and a lot of healthy things … like fruit, they have hummus and all that kind of stuff … 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."*
>
> **Niuean-Samoan Female Teen – Wellington**

Pacific families were also found in the Complacents, Avoiders, and Inert segments. Some Pacific peoples in the Avoider and Inert segments 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. However, 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. As a generalisation, these Pacific families tended to be less well informed about health matters and questioned the credibility of some health messages.

As mentioned earlier, some Pacific families were aware that the Pacific community was a target of public education around obesity. Pacific families in this study recognised that they were physically bigger than other cultural groups in New Zealand, and that their size and traditional diet made them a target for public education around obesity.

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'. However, some Pacific peoples had re-thought this traditional Pacific belief and encouraged portion control (as well as sports) to combat a tendency to be overweight. However, attempts to restrict a larger child's food intake sometimes created conflict between parents, or between parents and grandparents. The researchers note that willingness to re-define notions of healthy body size may be linked to education, and was more prevalent among younger, New Zealand-born or raised Pacific adults.

> *"She [wife] feels that 'he's just a boy, let him eat his food' … I don't want him to eat so much that he becomes obese, and she works with that. Every now and again I'll say, 'no [son] you've had enough', and [my wife] will say, 'no, you can't do that to him'. That's where we sort of disagree."*
>
> **Samoan-Tokelauan Male – Wellington**

Asian Peoples

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

Chinese

Chinese families in particular expressed high levels of concern regarding healthy eating, believing 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 their traditional 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.

Indian

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 'better eating options' raised since arriving in New Zealand.

In contrast, those 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 actually have been less healthy than it was perceived to be, e.g. convenience foods such as deep fried snacks such as samosas, bhajyas were commonly consumed.

6.5.5 Impact of Healthy Eating on Family/Whānau Functioning

The main caregiver in a family/whānau (usually the mother) needed to be energetic and organised to make healthy eating happen consistently. When the main caregiver was sick, tired or unmotivated, the household diet tended to slide. The impact of a mothers' health, in particular, on the household diet cannot be overstated.

Stressors that were identified in this study as having had a negative impact on the family/whānau diet included parents getting sick (particularly mothers), having a new baby in the house, pregnancy and morning sickness, long working hours and shift work, fitting in after-school activities, and the need to juggle numerous children's routines. Such pressures increased the likelihood of people reaching for quick and easy food options, e.g. takeaways, to feed their family/whānau.

Parents in this study were powerful eating role models for their children. This study found examples of role modeling of both healthy and not so healthy eating practices. Parents with a sweet tooth tended to 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 these foods too.

> *"We have got Weetbix, we have got cornflakes, we have got Honey Pops, we've got Coco Chex and we've got mummy's muesli … unfortunately there's always a chocolatey cereal … they could probably do without having chocolatey cereal for breakfast but … I quite like it too ... when mummy runs out of muesli she will have the chocolately cereal."*
>
> **Pakeha Female – Wairarapa**

Parents tried not to pass on bad eating habits to their children, however, this sometimes resulted in double standard behaviour, for example, night-time snacking (e.g. on fizzy drink, chocolate, lollies, biscuits) once the children were safely in bed. However, the children usually knew these foods and drinks were in the house, and had a way of 'sniffing them out', and nagging for them when the parents' resolve was low. Awarding children with treats was sometimes a way of buying peace and time-out from their demands.

> *"Because [my wife] is there 24/7 she needs a bit more of a break, so she's more tolerant to give snacks so they [the children] will go away and just be quiet and leave her alone … actually, I do that sometimes [laughs]."*
>
> **Samoan-Tokelauan Male – Wellington**

For many parents, giving (and withholding) food was bound up with expressing their love and care for their children. In this context, denying popular foods and insisting on unpopular foods could be emotionally taxing for parents, and some were not up for the battle (some or all of the time). Some fathers in this study were more comfortable in the enforcing role (e.g. insisting vegetables were eaten or saying no to treats) – but mothers did not always allow this.

This study indicates, that if parents were taking action to eat more healthily on behalf of their own health (e.g. to manage an existing health condition, for weight control and/or to increase energy levels) they were more likely to also take action on behalf of their family/whānau, especially children.

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*