HM Government

HEALTHY WEIGHT, HEALTHY LIVES: CONSUMER INSIGHT SUMMARY

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HEALTHY WEIGHT, HEALTHY LIVES: CONSUMER INSIGHT SUMMARY

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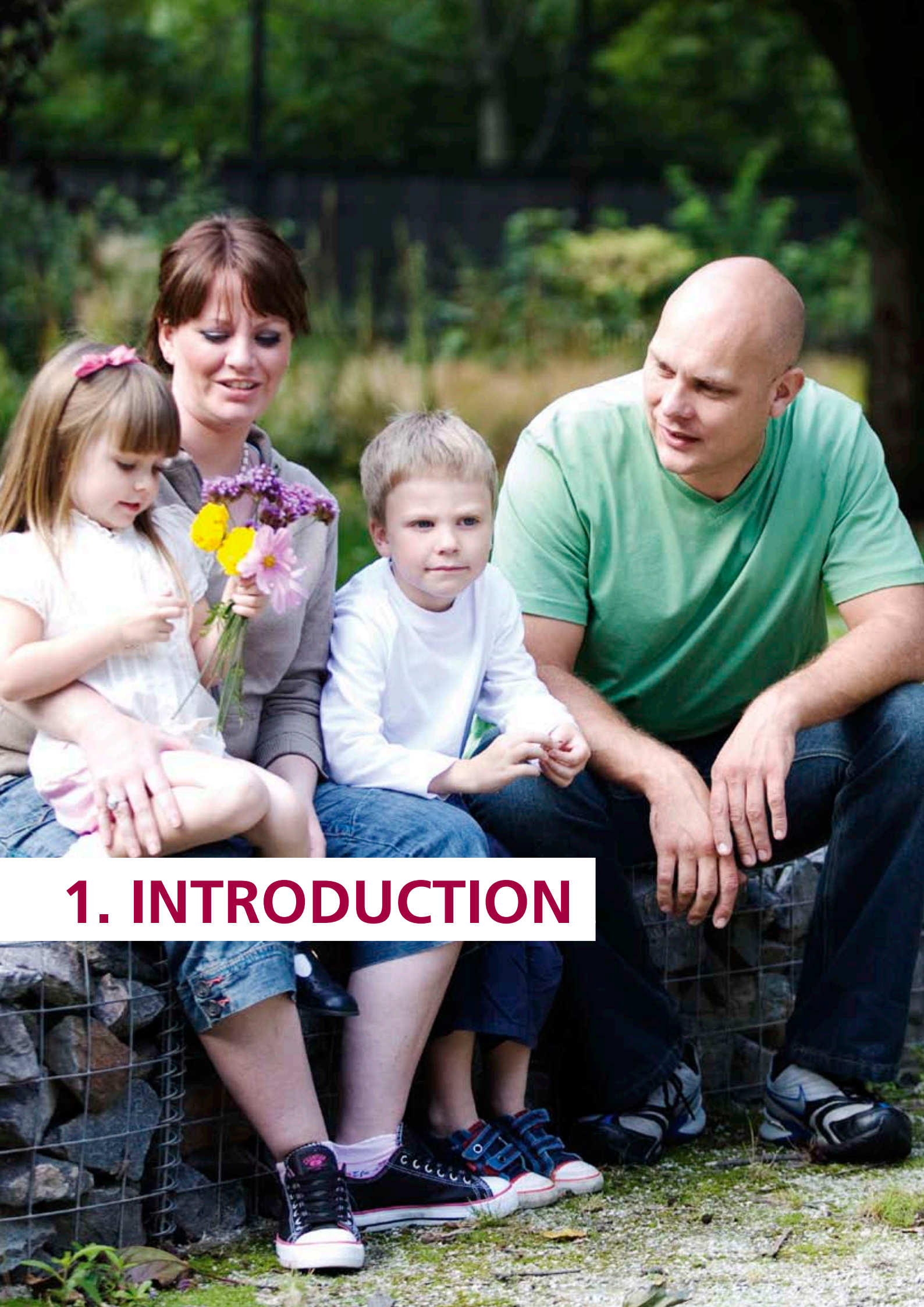


1. INTRODUCTION

This report is a summary of the results of research carried out for the Department of Health into families' attitudes and behaviours relating to diet and activity. The research was carried out to enable interventions to promote healthy weight in children and families to be more effectively targeted and delivered. It is intended for use by obesity/health weight teams within primary care trusts (PCTs) and local authorities, but will also be of interest to anyone involved in the commissioning or implementation of initiatives aimed at encouraging families to improve their diet and/or increase their levels of activity.

The report sets out the background to this research and provides an overview of the national marketing strategy it is intended to inform. It then looks at families' attitudes and behaviours under three headings:

- health, weight and parenting;
- healthy eating; and
- physical activity.

Each chapter includes a summary of relevant findings, plus direct quotes from families taking part in the research.

The report then moves on to look at how families can be grouped into clusters based on their attitudes and behaviours to help us understand and target these families, before providing recommendations on developing effective interventions and communications. Quantitative research suggests that, of the six clusters identified, clusters 1, 2 and 3 require specific support and help to improve their children's diet and physical activity levels. These clusters were therefore prioritised in the qualitative research and the recommendations that flow from this allow national and local interventions to promote healthy weight to be more effectively targeted and delivered. Indeed, the three priority clusters are the families who are being targeted initially in the cross-government national marketing programme to promote healthy weight.

This report is based on a range of analyses commissioned by the Department of Health from a number of research and marketing organisations, but primarily from TNS, 2CV and Ethnic Dimension.

Please see Appendix A for a summary of research methodologies used.

2. BACKGROUND

In January 2008, the Government published *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England*. This laid out our ambition to be the first major nation to reverse the rising tide of obesity and overweight in the population, by enabling everyone to achieve and maintain a healthy weight. Our initial focus is on children: by 2020, we aim to reduce the proportion of overweight and obese children to 2000 levels. The strategy sets out a framework for action in five main areas: children, healthy growth and healthy weight; promoting healthier food choices; building physical activity into our lives; creating incentives for better health; and personalised advice and support. As part of Healthy Weight, Healthy Lives, we are developing a three-year social marketing programme to help us all maintain a healthy weight by helping parents make healthier food choices for their children and encouraging more activity.

The final report of Lord Darzi's NHS Next Stage Review, *High Quality Care For All*, foresees an NHS with a stronger focus on preventative healthcare. It sets out a vision for PCTs to commission comprehensive wellbeing services, on an 'industrial scale', on key public health challenges including obesity.

Health Inequalities: Progress and Next Steps identified the significance of obesity as one of the most important long-term challenges facing the nation's health. The Government will test a 'full service model' of local programmes and greatly enhanced services which will seek to ensure that all individuals and families have the information, support and services they need to make healthy decisions on food and activity, right from pregnancy through to old age.

As set out in *Ambitions for Health*, we must ensure that our policy development and all of our public health interventions are informed by our understanding of what motivates people.[1] The Healthy Weight, Healthy Lives research programme was developed to provide insights into the attitudes and behaviours of families with children under the age of 11 in relation to diet and physical activity. These insights on diet and activity will underpin national and local service design in addition to the development of the social marketing programme.

The research sought to develop a rounded picture of the role food and activity currently play in family life, the attitudes driving behaviour relating to diet and activity, and which families exhibit behaviours and attitudes that could put their children at risk of obesity. The research also looked at what activities and communications might start to shift attitudes and therefore change behaviour.

To date, the research programme has consisted of five phases:

1) a review of the existing evidence base in both academic and market research;

2) a quantitative segmentation of families of children aged 2–10 using the TNS Family Food Panel and bespoke surveys;

3) qualitative research into current behaviours and attitudes and opportunities for intervention focusing on those families identified as a priority in the segmentation;

4) proposition research aimed at identifying the most effective ways of tackling the issue of family diet and activity levels and promoting behaviour change; and

5) qualitative research with six ethnic minority communities: Pakistani, Bangladeshi, Black African, Gujarati Hindu, Punjabi Sikh and Black Caribbean communities.

The review of the evidence has been published as *The 'Healthy Living' Social Marketing Initiative: A review of the evidence* (Medical Research Council (MRC), 2007), which is available from the Department of Health website. This document summarises the subsequent research phases.

Further research is currently being carried out to develop more insight into current weaning practices in all communities.

NOTE ON INSIGHTS INTO ETHNIC MINORITY COMMUNITIES

Research into the behaviours and attitudes of six ethnic minority communities (Pakistani, Bangladeshi, Black African, Gujarati Hindu, Punjabi Sikh and Black Caribbean) in relation to diet and activity was carried out as a separate project in order to take full account of cultural differences. Insights based on this research are summarised at the end of each chapter of the report.

3. THE NATIONAL MARKETING STRATEGY

The research findings have driven the development of the cross-government national marketing programme for promoting healthy weight, as announced in *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* in January 2008. Critical insights include the following:

- Parents do not associate themselves or their families with the terminology of 'being obese' or 'being fat'. Instead, the focus should be on the behaviours that lead to obesity.

- Campaigns should reflect parents' own priorities by focusing on children's long-term happiness. Parents recognise that they can sometimes be too lenient and struggle to make the trade-off between long-term and short-term happiness. They are also unlikely to change their behaviour for its own sake, but will do so if they think it will benefit their children.

- Parents don't want to be lectured. They want empathetic messages from peers, not diktats handed down from the great and the good and/or the government.

- Diet and activity must be treated separately. When messages try to incorporate both, parents usually focus on diet and ignore activity. They do not make an explicit connection between activity and health, nor do they automatically see activity as their responsibility. Combining messages can also be misinterpreted as sanctioning unhealthy behaviour – 'children can eat anything they like as long as they run around and burn it off'.

The marketing programme which has been developed in response to the research is described in brief below.

THE MARKETING PROGRAMME: AN OVERVIEW

The programme aims to bring about a societal shift, resulting in fundamental changes to the behaviours that lead to people becoming overweight and obese. The programme will not tell people what to do; rather, it will seek to recruit them to a lifestyle movement in which they can all play a part.

It will:

- create a new 'movement', called Change4Life, which will speak to and for the public on issues relating to diet and activity, and underpin all public-facing marketing and communications;
- direct people to a suite of targeted products and services (including those developed and delivered locally);
- build a coalition of partner organisations across government, local services and the commercial and third sectors, uniting them under a common banner; and
- create targeted campaigns that communicate simple, universal messages at the same time as taking account of people's individual needs and circumstances.

The programme launch will focus on the long-term health consequences of poor diet and activity levels and will emphasise the relevance of these issues to people across the whole of society.

Specific targeted campaigns and initiatives will be developed for the following groups:

- pregnant women;
- parents of children aged 0–2 years;
- those ethnic minority communities shown by the Health Survey for England and Department of Health research to be most at risk; and
- families with children identified as having the highest risk of becoming overweight: initially clusters 1, 2 and 3.

The campaign will seek to 'reframe' the issue of obesity so that families begin to personalise the issues of poor diet and low physical activity

levels as critical risk factors. The Department of Health will then schedule messages promoting diet and physical activity to fit into the natural calendar of family life (for example, messages about physical activity will be timed to coincide with school holidays).

Future target audiences may include young people and 'at-risk' adults.

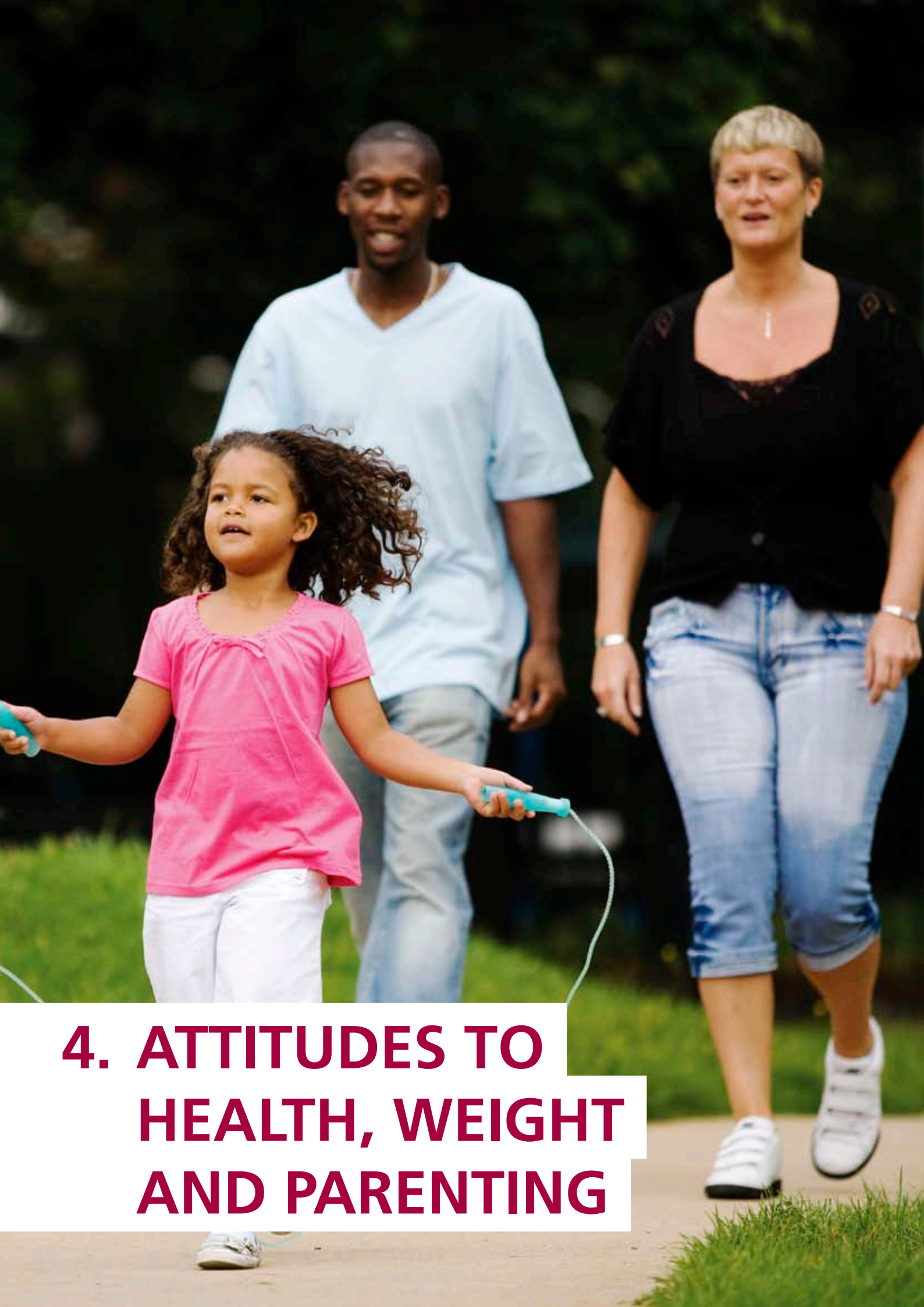
All activity will drive people to a central website and helpline which will give them access to tools, support, advice and information to improve their family's diet and physical activity levels. In particular, there will be a tool that will help people search for services and activities in their local area.

The Department of Health team will make marketing plans available in advance of all activity and will provide a campaign toolkit to give local and regional teams everything they need to develop activity locally. It is recommended that, wherever possible, local organisations join up any marketing or communications activities that are run so that:

- local activity can benefit from the umbrella support provided by the national campaign; and
- people who are motivated by the national activity can easily find locally delivered products and services.

In addition, the Department of Health recommends that local areas:

- design interventions or services that support the national movement: for example, opportunities for children to get their hour a day of physical activity, or opportunities for families to trial different ways of achieving five portions of fruit and vegetables per day;
- ensure that details of all services (such as breastfeeding cafés, walking buses or cookery classes) can be found on the Change4Life website;
- synchronise any behavioural guidance with that provided by the Department of Health campaign (so that people are not given conflicting advice);
- explore ways in which they can recruit local partners, whether from the commercial or voluntary sector, to the movement;
- when appropriate, use the brand name for new communications; and
- when appropriate, use the central helpline and website as the 'call to action' in communications.



4. ATTITUDES TO HEALTH, WEIGHT AND PARENTING

Many families are putting their health at risk through their high intake of unhealthy food and lack of physical activity. While parents are prepared to acknowledge that childhood obesity is a problem in the general population – TNS found that 80 per cent of respondents agreed that obesity was a problem for children in the UK – awareness and perception of personal risk are very low. Parents take a reactive approach, assuming that, as long as their children seem happy and aren't obviously unwell, they are healthy. Parents are reluctant to impose control over their children's diet and activity levels, equating free choice with happiness and empowerment.

This section of the report provides an overview of parents' attitudes to their children's health and weight and to parenting itself. It is based primarily on work commissioned from 2CV, with additional input from the TNS segmentation and the MRC evidence review. It also includes an overview of the attitudes of parents from ethnic minority communities.

HEALTH

Parents were unaware of the risks associated with behaviours such as sedentary lifestyle or constant snacking

Many parents underestimated the risks associated with their children's diet and levels of physical activity. Unhealthy behaviours like eating a lot of convenience foods, high levels of unhealthy snacking and sedentary behaviour were prevalent, yet perception of risk was low. Priority cluster families were also largely unaware of their own risk behaviours; they exhibited 'optimistic bias' – underestimating how many unhealthy foods they consumed and overestimating the amount of activity their children did.

Parents believed that happy children are healthy children

Because they can't immediately 'see' the consequences of unhealthy behaviour, parents tended to take a reactive rather than a proactive approach to health and wellbeing. Many parents assumed that their children were 'healthy' as long as they seemed happy and provided they had no obvious health problems.

The desire to make their children happy often led parents to embrace unhealthy behaviours

This emphasis on 'happiness' means that parents often unconsciously prioritised satisfying children's immediate needs over safeguarding their long-term health. Many of the activities that children enjoy – like eating convenience food or spending hours in front of the TV – can make for an unhealthy lifestyle. Indeed, the idea of challenging poor diet or sedentary behaviour was linked with unhappiness.

> *'They love it when we go to McDonald's once a week, because there are never any arguments and everyone's happy. We all have a good time there, so why not go back?'* Mother, Birmingham

Research indicates that parents feel that this was reinforced by a constant stream of advertising messages equating fun and pleasure with sedentary play and branded convenience foods. These have a far more powerful effect on attitudes and behaviours than any pro-health messages.

It can be hard to engage with the concept of 'healthy living'

Adopting a healthy lifestyle was seen as hard work, stressful and unrealistic. It was also strongly linked to 'middle class' values and activities – yoga classes, gym membership, buying organic food. Many priority cluster families saw healthy living as the preserve of stay-at-home mums who can afford not to work and instead spend their time exercising and shopping for and cooking healthy meals. At the same time, they identified strongly with those commercial brands that seem to align themselves with their personal priorities and promise rewarding, positive experiences.

> *'... a packet of biscuits, a DVD and a pizza or watching favourite soap operas… [are] far more connected to the lives of high-risk families, and reinforce their disconnection from the world of health.'*

Concerns about health are a low priority

For some families, particularly those with low socio-economic status, concerns about a poor diet and low activity levels were not a high priority. A study in the East of Scotland cited in the MRC evidence review found that parental concerns about the health effects of a poor diet were rated as 'relatively unimportant' compared with the risks associated with drugs, smoking, alcohol and sex.[2]

WEIGHT

Parents had an inaccurate picture of their own and their children's weight

While childhood obesity was acknowledged as a problem, parents often did not recognise that it was relevant to their own family. The following example showed that:[3]

> *'In a study of 277 parents of children aged 7–8 years, 40 per cent of overweight mothers and 45 per cent of overweight fathers estimated their own weight to be "about right". In the same study, approximately half of obese children were correctly identified by the parents, but only a quarter of overweight children were correctly classified.'*

In the TNS segmentation, parents of children who would be classified as overweight and obese according to their height and weight measurements did not appear to know that their children had a problem. Across all the clusters, only 11.5 per cent of parents with obese and overweight children identified that their children were obese or overweight.

Labelling children as 'overweight' was seen as unfair and potentially damaging

Priority cluster parents were reluctant to evaluate their children on the basis of their weight, or even to discuss the issue with them. They also raised a number of specific barriers. For example, some parents believe that weighing a child is an over-simplification that doesn't allow for individual rates of maturation and factors such as 'puppy fat'. Parents also worried that their children would be labelled as overweight or obese at an early age, putting them at risk of emotional damage, eating disorders and bullying.

Parents disassociated their families from the issue of obesity

Parents often refused to acknowledge that their children were overweight, even when told so by a health professional.

'I went to the doctor once and he said my daughter was "obese". I thought it was totally ridiculous – I mean she doesn't even look overweight.' Mother, Birmingham

Parents' sensitivity to labelling their children as overweight and obese was not only a result of their inability to accurately identify their child's weight status. Qualitative research revealed that childhood obesity was often connected in parents' minds with cases of severe neglect and abuse and was therefore seen as irrelevant to their own family situation. This perception was reinforced by media stories that depict '14-stone 9-year-olds' and other examples of extreme obesity. They were also alienated by the academic and medical language associated with obesity: terms like 'clinical' or 'morbid' obesity encouraged priority cluster families to disassociate themselves from the issue and think, 'This is nothing to do with me.'

Awareness of the health risks associated with being overweight or obese was limited

The relatively low importance attached to concerns about diet and activity could be partly explained by a lack of awareness of the health risks associated with poor diet and inactivity. Data from Cancer Research UK cited in the MRC evidence review:

'… shows that only 38 per cent of adults recognise that obesity is a risk factor for heart disease and just 6 per cent are aware of the link to cancer. Awareness of the health risks for children is particularly low.'

PARENTING

The research suggests that parenting styles can have a strong influence on children's weight. The MRC evidence review includes the finding that:

'The risk of overweight among children aged 4.5 years is significantly greater among parents classified as permissive (indulgent, lacking discipline), neglectful (emotionally uninvolved, lacking rules) and particularly authoritarian (strict disciplinarians), compared to authoritative parents (respectful of child's opinions but maintaining clear boundaries) (Rhee et al., 2006).'

Choice was seen as a way of empowering children

Many parents, particularly those in the priority clusters, saw giving their children free choice over what they eat and how much exercise they take as a way of empowering them. During the supermarket shop, parents allowed children to choose what food and drink goes into the basket, and to select 'treats' in return for good behaviour.

'Choice' in relation to food and activity was particularly important to families who are experiencing deprivation and therefore may have restricted choice in other aspects of their lives. For some parents, giving children greater freedom in relation to diet and activity was a conscious reaction to the way they themselves were brought up.

> *'When I was a kid, our dinner was put on the table and if you didn't eat it you went hungry. I can remember sitting there starving because I hated my greens. Today, kids have so many things to play with that I didn't have: PlayStations, DVDs. I just want my kids to have everything I didn't. So, now I am fortunate enough to be able to give them what they want and I do!'* Mother, Newcastle

Parents underestimated their own importance as role models

Although children are being given considerable choice over what they eat and what they do, parents' own poor diets and sedentary behaviour shape their children's behaviours and attitudes.

> *'I know she's fussy because I'm a fussy eater. I pull a face when Bob puts any vegetables on my plate. I always have. I try to force her to eat her veg but she won't have any of it. I am not sure what else I can do.'* Mother, Newcastle

The MRC evidence review also noted that parents' approach to feeding their children different foods was likely to have an impact on their children's responses:

> *'Parents will often act anxiously when feeding children healthy food such as vegetables and excitedly when giving them less healthy foods such as ice cream (Benton, 2004; Birch et al., 1984).'*

While parents were to some extent aware of the influence they exert, they dramatically underestimated its impact. Researchers observed that, in relation to both diet and activity, children increasingly voiced their parents' attitudes as they got older. For example, some cited after-school activities as too time-consuming and expensive; a view they were likely to have picked up from adults.

ATTITUDES TO HEALTH, WEIGHT AND PARENTING IN ETHNIC MINORITY COMMUNITIES

Observational research conducted among the six communities identified a number of factors as having a strong influence on parents' attitudes to diet and activity. However, these factors impacted in different ways in some communities:

- **The importance of education:** Many Bangladeshi, Pakistani and Black African parents were concerned that their children did well at school in order to create opportunities for betterment in the future. As a result, children from these families were often expected to spend their free time at home on additional studies or receiving extra tuition, particularly among Black African and some Pakistani households. This impacted on the time available for physical activity. Educational attainment was also important to many Gujarati Hindu, Punjabi Sikh and Black Caribbean parents, but there was also a desire to see their children achieve in other spheres such as sports and music. Thus, these parents were more likely to encourage their children to be active and to participate in out-of-school activities to facilitate this desire.

- **The impact of faith:** Religious faith played a central role in the lives of many Bangladeshi, Pakistani and some Black African families. Muslims from these three communities were expected to adhere to religious food requirements (such as eating halal foods and observing religious fasts). Many Muslim children (Pakistani, Bangladeshi and some Black African) and some Christian children (Black African) were also expected to attend religious classes outside the home after school and/or at the weekend, limiting the time available for other interests and activities. Attending religious classes after school could also impact on children's diets. For example, some Muslim children were observed eating two evening meals: before and after attending religious classes. Faith was also important to the lives of many Gujarati Hindus and Punjabi Sikhs but this was more likely to be practised as a personal experience in the home and appeared to make fewer demands on their everyday lives. There were some dietary observances. Some Gujaratis did not eat meat, other Gujarati Hindus and Punjabi Sikhs avoided eating beef. In contrast, religion played a less central role in the day-to-day lives of Black Caribbean families in the sample and did not impact on food or activity behaviour among parents or children.

- **The role of cultural foods:** Cultural foods played a central role in the lives of many Pakistani, Bangladeshi, Black African, Gujarati Hindu and Punjabi Sikh families as a means of maintaining cultural and ethnic identities. Pakistani, Bangladeshi and Black African parents were often very much focused on ensuring their children's consumption of cultural foods cooked in traditional ways which were not always healthy because of, for example, the high levels of fat used. Cultural foods were also important to

Gujarati Hindu, Punjabi Sikh and some Black Caribbean parents but these were consumed as part of a wider repertoire of cuisines at family mealtimes, providing variety.

- **Gender roles:** The prevalence of traditional gender roles among Pakistani, Bangladeshi and Black African families meant that boys had greater freedom to take part in activities out of the home, while girls were likely to stay at home with their parents. These gender differences were less evident among Gujarati Hindu, Punjabi Sikh and Black Caribbean families and girls were as encouraged to pursue interests outside the home as boys.

- **Parenting styles:** Many parents from the Pakistani, Bangladeshi and Black African communities exercised considerable control over their children's daily routine and the freedom and time children had for activity. Food was one area where parents seemed more willing to loosen controls and children generally had greater freedom over food choices. Discipline and respect were also very important to Gujarati Hindu, Punjabi Sikh and Black Caribbean parents. However, for many of these parents, overall parenting styles were more child-centred than authoritarian. As a result, children were given greater opportunities to pursue interests and activities of their choice although parents tended to exercise control over food choices. A few Black Caribbean, Gujarati Hindu and Punjabi Sikh parents had a more relaxed and 'hands-off' approach to parenting, giving their children greater choice and freedom over both food and activities.

- **Impact of family elders:** Particularly in Bangladeshi and Pakistani communities, grandmothers tended to have a significant influence on parenting styles and in particular on diet. Mothers often cited their own mothers or mothers-in-law as barriers to making family diets healthier, and stated that they regularly indulged grandchildren with unhealthy snacks and encouraged them to 'feed their children up'. Their own responsibilities towards members of the extended family often curtailed mothers' ability to take part in physical activity and, by extension, opportunities for children to be active. Family elders in Gujarati Hindu and

Punjabi Sikh communities were treated with respect and reverence by parents and children. However, women from these communities felt that their immediate priorities were their own family and largely felt supported by their extended family in their attempts to make their children's diets healthier and for them to be more active. Extended family had less impact on Black African and Black Caribbean parents.

The following content provides an overview of the six communities' prevailing attitudes to health and weight.

Attitudes to health and weight among ethnic minority communities

Pakistani, Bangladeshi and Black African parents generally took a reactive approach to health, defining this simply as the absence of illness. They were less likely to define health in terms of their child's emotional and psychological wellbeing. Rather, they looked at whether their child was 'functioning' satisfactorily: going to school, doing their homework and observing their religious obligations.

> *'Good health helps them in the classroom and in their studies.'*
> Black African father, London

By contrast, many Gujarati Hindu, Punjabi Sikh and Black Caribbean parents defined their children's health more broadly in terms of their emotional, psychological and physical wellbeing, with a view that these were necessary in helping their children achieve their future potential.

> *'It is important that the children are happy, enjoy life and enjoy their childhood. Health is not just about eating the right foods.'*
> Gujarati Hindu father, Birmingham

Childhood obesity was not an overt issue

Many Gujarati Hindu, Punjabi Sikh, Black Caribbean and younger Pakistani, Bangladeshi and Black African parents had some awareness that childhood obesity was a government concern, which they had gleaned from the mainstream media. Awareness was lower among older Bangladeshi, Pakistani and Black African parents, who also tended to be less engaged with the media. Generally, parents of all ages and across all six communities were unlikely to see the issue as relevant to them. This was due to lack of awareness of the long-term risks attached to poor diet and low activity levels and/or a tendency to misjudge their child's weight among some and a belief that they were already 'doing enough right' among others.

'I have to be careful about what she eats – but she sneaks and eats, but I won't worry unless she gets really fat; she might just grow out of it.'

Black Caribbean mother, London

One significant difference between these six communities and the clusters identified by TNS is that it is possible to talk to them about obesity directly. Direct, rational messages about obesity and health were very motivating to parents and obesity did not carry the same emotive connotations as it did for priority cluster families in the main segmentation.

An overweight child was not always perceived negatively

Many Pakistani, Bangladeshi, Black African and some older Black Caribbean parents were more concerned about their children being underweight than overweight, and often cited family pressures to have 'chubby' children. For these families, there was a sense that being 'big' was appealing, desirable and a sign of health and wealth.

'Where I come from, when you are big, that is evidence of good living.' Black African father, London

These attitudes were less evident among Gujarati Hindu, Punjabi Sikh and younger Black Caribbean parents.

Adults were more likely to modify their diets than their activity levels

Overall awareness of adult obesity was higher than for child obesity among the six ethnic minority audiences. Some adults had experienced weight-related health problems themselves, and many had relatives with serious illnesses such as heart disease and high blood pressure. Many had made some attempt to modify their diet, for example by using low-fat milk, swapping ghee for olive oil and substituting wholemeal for white bread, but not all had addressed their levels of physical activity. While some did say they were trying to walk more and take part in other physical activities such as the gym or playing sports, others cited work, family commitments, weather and cost as the barriers that prevented them from being more active.

Family dynamics can impact on children's diet and physical activity levels

Many Bangladeshi, Pakistani and Black African mothers and fathers tended to take on quite traditional gender roles. Among Bangladeshi and Pakistani parents, the majority of mothers did not work outside the home. Although most Black African mothers did have jobs, they still took the main responsibility for childcare. The role of Bangladeshi, Pakistani and Black African fathers in bringing up children was generally limited. Their role was to provide for the family. Some families, particularly among the Bangladeshi and Pakistani communities, claimed that fathers intervening in their children's day-to-day lives would be frowned on by other family members. Where fathers from these communities did play more of a part in their children's lives, their main responsibility was to engage in shared physical activity.

Many Gujarati Hindu and Punjabi Sikh fathers, and some Black Caribbean fathers, were more actively involved in the day-to-day lives of their children. They took an interest in their children's overall diet and activity levels; for example, keeping an eye on how much fresh fruit and vegetables and sweet and savoury snacks their children were consuming and how active they were.

Members of the extended family often played a significant role in children's upbringing. Again, this was particularly the case among Bangladeshi and Pakistani families. The attitudes of these extended family members often impacted on children's diet, and their levels of physical activity.

'It's really hard to stop my in-laws. I try and tell the children not to eat chocolates but they know that when they go and see their grandparents, they have a great big box of sweets and chocolates and who's going to stop them there?' Pakistani woman, Birmingham

5. ATTITUDES AND BEHAVIOURS RELATING TO HEALTHY EATING

The review of evidence carried out by the MRC for the Department of Health suggests that nearly half of all families see food issues as a considerable source of family stress. Parents express the desire to give their children healthy choices but, in practice, children's diets rarely meet this ideal.

This section explores families' attitudes to healthy eating, focusing on some of the most prevalent high-risk behaviours, such as snacking on high-fat, high-sugar foods, and on key issues such as shopping and cooking. It is based on qualitative findings from work commissioned from 2CV with some additional quotes from the MRC evidence review. An overview of the attitudes and behaviours of families in ethnic minority communities is included at the end of the chapter.

CHOICE

Parents have surrendered food choices to their children

In many of the families observed in qualitative research, parents attached great importance to giving their children choice, particularly over what food they ate. One family interviewed during the qualitative research described the following mealtime situation as typical:

> Mother: *'So what do you want to eat? Do you want your favourite?'*
>
> Child: *'Yeah.'*
>
> Mother: *'Well, what's that?'*
>
> Child: *'Fish fingers, waffles and beans.'* Mother and child, Birmingham

Parents allowed their children to keep choosing these foods, regardless of whether or not they believed that the choices were unhealthy. Instant gratification was the priority; and this quickly became a powerful emotional weapon that children used to sustain their preferred behaviours.

> *'I always let them get involved in what goes in the basket because then they get to feel like they are part of things. They end up putting in loads of junk food but at least it means they are excited about eating something that I know they'll eat.'* Mother, London

SNACKING

Snacking was a way of life for many priority cluster families

Priority cluster families used snacks in a number of complex ways: for example, as rewards for good behaviour, as 'fillers' during periods of boredom or to appease conflict. Parents were often unaware of how much they were snacking themselves and how much their children were snacking. They may have a false picture of what kinds of snacks their children are consuming, failing to notice that fruit bowls remain untouched while stocks of snacks that are high in fat, sugar or salt dwindle. Some parents had a misplaced sense of 'control': parents will say that they only allow children snacks when they ask for them, while in reality they never say 'no'. Intrinsic to the problem was parents' lack of awareness about what constitutes an acceptable level of snacking and what kind of snack foods children should be eating.

'The thing that shocked me most of all about my receipts was how many packets of crisps and chocolate biscuits I buy every week. I didn't realise I bought this much. I thought I was quite good at limiting what we have in the house.' Mother, Birmingham

PORTION SIZE

Parents focused on 'filling up' their children

The MRC evidence review highlights the fact that parents were more likely to be concerned with not giving their children enough food than with giving them too much:

> *'In young children there are concerns over a failure to grow and develop rapidly. By school age, parents are often concerned that their children have enough energy for the multitude of activities that they have to do. In older children there is a perceived risk of eating disorders such as anorexia nervosa or bulimia nervosa, despite the absence of evidence that parental behaviour can affect the risk of developing these conditions.'*

It also shows that parents were sometimes preoccupied with getting children to clear their plates, even if this meant that they were eating too much.

> *'Children may be pressurised to "clear the plate" with insufficient regard to appropriate portion sizes for children of different ages (Birch et al., 1987).'*

In the qualitative research, this focus on 'filling up' was demonstrated through parents' shopping choices, which were often dictated by what they knew their children would eat:

'I get these [microwave chips] for him as he is hungry all the time. He can help himself when he needs to and they are always in the freezer so he never has to starve.' Mother, Birmingham

MEALTIMES

Mealtimes were often unstructured and chaotic

In priority cluster families, researchers observed that poor eating habits were exacerbated by a lack of structure relating to meals. There were no set mealtimes, children were allowed to choose what they ate, and parents were often making different meals for different family members. Families rarely sat down to eat together and plates of food were often nutritionally unbalanced, for example because they did not include vegetables. Often this approach to mealtimes was seen as a strategy for coping with fussy children:

'I have to cook different meals for everyone every night of the week. I suppose it could be seen as stressful but everyone eats their meal so for me that's fine. At least there are no arguments or people throwing tantrums.' Mother, London

COOKING

'I don't have time to cook'

The MRC evidence review points to a dramatic reduction in the amount of time families spend preparing food over recent years. Both parents and children believe that a healthy diet means consuming fresh foods and cooking meals from scratch. However, cooking is seen as just another task to fit into already busy lives. Consequently, the average time spent preparing meals shrunk from two hours in 1980 to 20 minutes in 2000. This in turn points to a greater reliance on ready prepared foods. While not inherently unhealthy, ready meals tend to be high in fat, sugar and salt.

Parents lacked knowledge, skills and confidence in the kitchen

While mothers will often cite 'time and convenience' or their own 'laziness' as the reasons why they don't cook from scratch, the qualitative research suggests that in reality the main barriers to cooking meals are lack of knowledge, skills and confidence. Anecdotally, mothers talked about experiencing feelings of rejection in the past when children had refused meals that they had prepared.

Given the pressure parents felt to ensure that their children are not 'going hungry' and the importance they attached to making their children happy, the risks associated with producing a meal the child doesn't like and won't eat are considerable. Many mothers therefore stuck to a limited repertoire of 'tried and tested' meals, which may have had the effect of making their children even more fussy about what they will and won't eat.

> *'We have a basic set of different meals that I know the kids will eat. Fish fingers, chicken nuggets, chips and burgers.'* Mother, London

The idea of cooking from scratch or using fresh foods tended to make mothers anxious. Observation suggests that this sense of anxiety is often passed on to children when they are in the kitchen. Most children were disengaged from the process of cooking and, like their parents, saw mealtimes as stressful.

SHOPPING

Shopping for food was seen as confusing and time-consuming

The qualitative research carried out by 2CV included an accompanied shopping exercise. This showed that priority cluster families demonstrate a lack of interest in and engagement with what they perceived to be 'dull, uninteresting' health foods.

'You see this stuff here [muesli] is just so dull. That doesn't make you want to pick it up and put it in your basket. Whereas all the colourful ones down there [Frosties] really catch your eye and get the kids interested in eating it.'
Mother, London

Priority cluster families also tended to see shopping for food at the supermarket as a tiring and stressful experience. As a result, parents tended to buy the same food over and over again. Convenience foods were viewed as familiar and reassuring. By contrast, gathering the ingredients needed to make a meal from scratch was seen as confusing and time-consuming.

'If I was to try and make a lasagne I would have to buy a million things which would take me ages to find all over the shop, then I'd probably forget something like the lasagne sheets so it would all be a waste of time and effort.'
Mother, London

Fresh fruit and vegetables in particular caused confusion. Parents didn't know what they were, nor how to prepare and cook them.

'I mean, what is this? I need cooking instructions to know how long to put something like this in the oven for. Why don't they give you instructions?'
Mother, Birmingham

Healthy food was often seen as expensive and wasteful

The MRC evidence review includes some key findings on expenditure on food in general and on 'healthy food', notably fresh fruit and vegetables, in particular.

'The proportion of income spent on food has declined substantially since World War II. Low-income groups, however, spend a much larger proportion of their gross income on food than their high-income counterparts. For example, the UK ***National Family Food Survey*** *(Department for Environment, Food and Rural Affairs, 2005) shows that around 10 per cent of total income in higher-income households was spent on household food and drink compared to 28 per cent of total income spent in households where individuals were unemployed or had never*

worked. Since food is a major component of expenditure for low-income groups, the perception that healthy eating may be more expensive acts disproportionally in this group to deter changes in eating habits.

'Many parents are concerned about the cost associated with wasted food, either the deterioration of fresh food before it is consumed, especially fresh fruit and vegetables or those foods not enjoyed and therefore not consumed by the family. In low-income families there is no economic flexibility to experiment or for food to be rejected (Dobson et al., 1994).'

Parents made a distinction between 'kids' foods' and 'adult foods'

Many parents thought of 'kids' foods' – items like fish fingers, waffles and chicken nuggets which manufacturers package and present as being 'child-friendly' and which may be high in fat, sugar and salt – as a separate category. There was an assumption that adult foods, with their complex flavours and textures, are not suitable for children. In turn, children started to develop a sense of ownership over 'kids' foods' and to associate eating them with a sense of independence and control.

'Value' was seen as both financial and emotional

There was also a perception that 'kids' foods' are better value for money than fresh foods. On reflection, most parents agreed that in objective terms this is probably not the case. However, they also perceived value in terms of emotional return: convenience foods may be more expensive, but children were happy and excited at being given the foods they wanted and would usually clear their plates.

'I think that sometimes it's just cheaper to buy frozen waffles than buying potatoes and making my own mash. Maybe it's not? But it's definitely easier and I know they will get eaten so there is no waste. That's important for us because money is tight.'

Mother, Newcastle

This perception of value was reinforced by marketing. Many priority cluster families were heavily influenced by price promotions and in particular by 'buy one, get one free' offers. Families will often consume products purchased in bulk during the same week to maximise the saving on their overall weekly supermarket spend.

'Last week they had three packs for the price of two on chicken nuggets so we bought them. It was good for us because we spent less and the children got nuggets every night last week till they were all gone.'

Mother, Birmingham

The more choice, the better

Parents frequently mentioned the importance of choice, and supermarkets were praised for offering access to a wide range of products that met the different needs of different family members. In turn, the vast range of products available reinforced children's increasingly diverse taste preferences. The MRC evidence review emphasises the importance to both parents and children of being allowed to choose what they eat.

'A survey by National Opinion Poll showed that most mothers (always or often) respond to requests from their children to purchase products. Children want to be accepted and belong to their peer group through their choice of food as much as their choice of clothes or music (Birch, 1980).'

Fathers equated convenience foods with treats

Day to day, mothers usually had the most influence over children's attitudes to diet and activity, and their behaviour. But researchers observed that, when fathers were given control, they often opted for convenience foods or chose to go out, for example for McDonald's or fish and chips. Because they rarely had the opportunity to influence food choices, when they did they were keen to make sure it was a positive experience.

ATTITUDES TO DIET IN ETHNIC MINORITY COMMUNITIES

Food played a central part in the Bangladeshi, Pakistani and Black African communities surveyed. Considerable emotion was invested in cooking and consuming 'good' food, and sharing it with others. For women in particular, food fulfilled a number of functions: taking time and effort to cook 'proper' meals demonstrated their love for their families; sharing abundant food with family and friends was a sign of status; and the ability to cook ethnic meals from scratch was a sign that women, particularly those in traditional families, had been well brought up by their own mothers.

'Food is very important. There is an African saying, "without food there is no life, no enjoyment".'

Black African mother, London

Less time, energy and emotion was invested in food and food preparation by the Gujarati Hindu, Punjabi Sikh and Black Caribbean families researched. This was due to the fact that parents had other priorities and concerns. Many women worked outside the home, time for leisure for all family members was considered important and some mothers were involved in taking children to a range of after-school activities. As a result, speed and convenience were important factors when it came to food preparation and cooking.

'Sometimes when I am tired or have had a hard day at work then I cook pasta or jacket potatoes. It doesn't take that long as compared to making rotis and shak. I don't want to spend all night in the kitchen. I need time for me.'

Gujarati Hindu woman, London

The giving and sharing of food

Giving and sharing food was particularly important to the Bangladeshi, Pakistani and Black African women. An 'open house' mentality was widespread, with many mothers talking about the need to be prepared at all times for the arrival of unexpected guests. Most families had large freezers stocked with pre-prepared traditional meals and snacks as well as Western snacks.

Families regularly got together with relatives and friends to share 'feasts' of traditional foods, and most families ate together as often as possible.

'I don't know if it's the famine mentality but I want to know that if 10 people turn up now I would be able to feed them.'
Black African mother, London

When entertaining, the focus for many Gujarati Hindu, Punjabi Sikh and Black Caribbean women was social interaction. Providing good food was important but women did not feel they had to provide a wide range of cultural foods in large quantities. Many women often socialised with people from other ethnic communities so there was less pressure to provide more time-consuming traditional celebratory foods.

'When friends pop around, I don't feel I have to put on a spread. I don't need to impress them with my cooking. They are here to see me.' Gujarati mother, Leicester

Family diets were well planned, but there can be too much emphasis on quantity

The research suggests that family meals are generally less ad hoc among the six ethnic communities surveyed than families in the general population, perhaps due to the greater role of home-cooked cultural food which requires more planning, particularly among the Bangladeshi, Pakistani, Black African, Gujarati Hindu and Punjabi Sikh households.

Among Bangladeshi, Pakistani and Black African families, portion sizes tended to be large and children were strongly encouraged to clear their plates. Often, adults and children in these families ate two traditional meals in the course of the same evening: adults, for example, sometimes ate with their children and then had another portion of food before bedtime, while a number of Muslim children were eating a meal both before and after attending religious classes. Snacking between meals was not always monitored by parents among Bangladeshi, Pakistani and some Black African households, and celebratory 'feasts' involving family and friends were regular occurrences.

Large portion sizes and multiple evening meals were less evident and children's snacking was more likely to be controlled in Gujarati Hindu, Punjabi Sikh and some Black Caribbean households surveyed. However, meals in some relaxed Black Caribbean families were more ad hoc with children and adults more likely to be eating different meals and children consuming snacks between meals with little sanction by their parents.

A wide range of foods were eaten

The families surveyed consumed a wide range of traditional and Western foods. Evening meals were most likely to be cultural foods among the

Bangladeshi, Pakistani and Black African families. Cultural foods also formed a key part of the Gujarati Hindu and Punjabi Sikh families' meals but home-cooked Western food was also eaten to provide variety. Most Black Caribbean families were eating Western food as their everyday meals, reserving cultural foods for the weekend. Pakistani and Punjabi Sikh families also ate traditional breakfasts such as parathas and yoghurt, while Gujarati Hindu families enjoyed South Indian foods such as idlis and dosas as an occasional weekend treat.

Western foods formed part of the food repertoire of almost all the families surveyed. Among Bangladeshi, Pakistani and Black African families, these were mainly consumed by children and mostly in the form of snacks and convenience foods. Few families from these communities prepared Western meals from scratch. Many Gujarati Hindu, Punjabi Sikh and Black Caribbean women were preparing a range of Western meals from scratch, such as pasta and jacket potatoes, as well as Western convenience foods such as pizzas as their evening meals.

Everyday breakfast foods included cereals and toast, butter and jam. Where children took packed lunches to school, these usually included sandwiches, fruit, crisps, yoghurt, a fruit drink and occasionally a treat such as chocolate. Children across the sample, especially Bangladeshi, Pakistani, Black African and some Black Caribbean, enjoyed sweet and savoury snacks including crisps, cakes and biscuits between meals. Fast foods such as frozen pizza, chips and burgers constituted regular weekend 'treats' for children from the Bangladeshi, Pakistani and Black African communities. These were enjoyed by Gujarati Hindu, Punjabi Sikh and Black Caribbean children, usually as part of a wider range of 'treats'.

The table opposite provides a brief summary of the range of cultural foods consumed among the communities surveyed.

The role of women among different ethnic minority communities can impact on the family's diet

Cooking was almost exclusively the preserve of Bangladeshi, Pakistani and Black African women, who tended to take a great deal of pride in being able to cook 'properly'. Most spent time preparing traditional family meals each day, and many also prepared special foods and extra dishes for guests in advance. For women living in the most traditional households, cooking was an important area of control and influence and a useful way of demonstrating that they have been well brought up and showing respect for their husband's family. Many saw cooking as an enjoyable activity, perhaps because it represented 'time out' from looking after children, partners and other family members.

Gujarati Hindu, Punjabi Sikh and Black Caribbean women had the main responsibility for cooking but many partners did occasionally enjoy preparing the families' meals. As many women from these communities were working outside the home, cooking was often driven by speed and convenience. As a result, fewer dishes were usually prepared and children and adults in most households were expected to eat the same meals.

Cooking practices can vary across ethnic minority communities

Many Bangladeshi, Pakistani, Black African, Gujarati Hindu and Punjabi Sikh women were preparing their meals from scratch on a daily basis. Most Bangladeshi, Pakistani and Black African women were using traditional cooking

BLACK AFRICAN	BANGLADESHI	PAKISTANI	GUJARATI HINDU	PUNJABI SIKH	BLACK CARIBBEAN
Starch-rich: rice, yams, cassava, potatoes, maize	Starch-rich: rice	Fibre (chapattis) and starch (rice)	Rice, roti	Roti, rice	Rice, yams, dumplings
Meat stews, soups, fried meats, beans (pork, beef, chicken often in the same stew)	Mainly fish curry, occasionally other meats	Red and white meat, fish and vegetable curries, lentils	Lentils, vegetable curries, yoghurt curry No meat (women), meat in restaurants (men)	Lentils, vegetable curries, chicken/ pork/lamb curries All meats except beef	Peas, chicken, soups (e.g. Saturday chicken soup), curried goat, salt fish (Saturday breakfast) All meats and fish
Little consumption of vegetables except cooked into stews and soups	Little consumption of vegetables except cooked into curries	More consumption of vegetables for mothers and children, lentils but lots of red meat for men	High consumption of vegetables, salads usually part of everyday meals	High consumption of vegetables, salads usually part of everyday meals	Side vegetables and salad
Palm oil used for frying and for taste	Use of ghee and oil for preparation of curries	Oil for deep frying and preparation of curries	Olive/vegetable oils	Olive/vegetable oils	Olive/vegetable oils
Fruit for school packed lunches, after-school snacks and desserts for some	Fruit for school packed lunches, after-school snacks and desserts for a few	Fruit for school packed lunches, after-school snacks and desserts for some	Fruit for school packed lunches, after-school snacks and desserts for all	Fruit for school packed lunches, after-school snacks and desserts for all	Fruit for school packed lunches and desserts for all

methods passed on by their mothers. More 'westernised' women across these three communities and Gujarati Hindu, Punjabi Sikh and Black Caribbean women enjoyed experimenting and would sometimes create 'fusion' foods that combined Western ingredients such as pasta with traditional spices and flavourings. Many Gujarati Hindu, Punjabi Sikh and Black Caribbean women were also confident in preparing Western meals such as lasagne from scratch.

Generally, most parents believed that their diets and those of their children were healthy because they were eating traditional meals, prepared from scratch.

'I like seeing them eating my food. It makes me happy and lets me know that they are healthy and strong so I will always tell them to eat up. I don't think it can make them fat, it's all natural food.'
Black African woman, London

However, the research identified some unhealthy cooking practices. Many Bangladeshi and Pakistani women were using ghee and oil in the preparation of curries and biryanis, while Black African women often used palm oil as the basis of stews and soups. Deep frying was widespread, and many women did not see alternative cooking methods such as baking or grilling as appropriate.

'I can't cut down on the oil because my mother-in-law says that the food doesn't taste the same.' Bangladeshi mother, Oldham

Many Gujarati Hindu, Punjabi Sikh and some Black Caribbean women had adapted their cooking habits: using oil rather than butter as the basis of curries and stews and using cooking methods which required less fat such as pressure cookers and steamers.

'It's rare that I will fry anything, it's usually baked or grilled.'
Black Caribbean woman, London

Consumption of unhealthy 'Western foods' was unregulated by many parents

Bangladeshi, Pakistani and Black African children were being allowed to consume large quantities of Western convenience foods in addition to their traditional family meals.

Parents' attitudes to this tended to be relaxed and indulgent.

'He'll have his real dinner later. I'm just giving [him] his fish and chips now as a snack.'
Black African woman, London

While these parents were aware that these snack foods could be unhealthy, parents believed that the effect was balanced out by their consumption of 'healthy' traditional foods.

'They can have what they want as long as they eat my African food. I don't worry. I know that they are going to get a balanced diet anyway.' Black African woman, London

This tendency was sometimes reinforced by the attitudes and actions of extended family members. In some Bangladeshi and Pakistani households, grandparents were actively giving sweets and sweet foods to children even if this was against the wishes of the parents.

'My mother-in-law has a big box full of chocolates and biscuits and she will give them to the kids behind my back even when I tell her that this is not good for the children and the children's teeth are rotting. She just won't listen.'
Bangladeshi mother, Oldham

Some Black Caribbean and a small number of Gujarati Hindu and Punjabi Sikh children were also given the freedom to eat large amounts of Western convenience foods as part of their evening meals by more indulgent parents. Other Gujarati Hindu, Punjabi Sikh and other Black

Caribbean parents were generally restricting their children's intake of Western convenience foods and snacks.

Shopping

Bangladeshi, Pakistani and Black African families shopped at both Western supermarkets and a range of specialist ethnic grocery stores on a regular basis. Supermarkets were generally used for household products and staples such as bread, milk and eggs, Western snacks and convenience foods like biscuits, crisps and fish fingers, and 'children's' foods such as cereals, yoghurts and drinks.

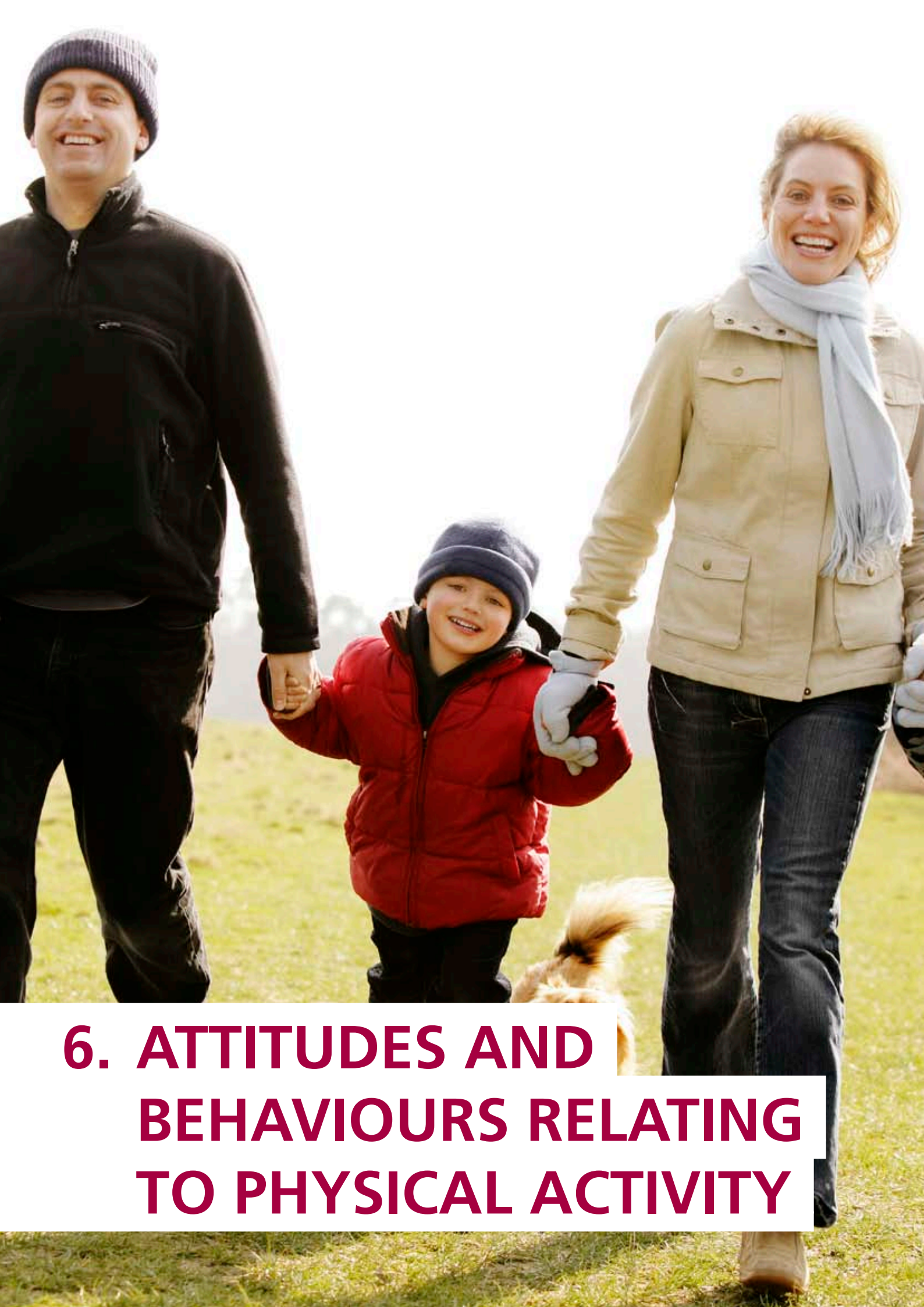
Local ethnic shops and market stalls were used weekly for the purchase of fresh and frozen fish and meat and both 'specialist' and 'mainstream' vegetables, and once or twice a month for staples such as rice, chapatti flour, oil, spices and exotic fruit drinks. Halal meats were usually bought at specialist halal butchers although younger respondents were beginning to buy meat from those Western supermarkets that stocked halal produce.

> *'You know you are going to get the type of fish we need for our Bengali curries, cut in the way we need. You also get the range of Asian vegetables we like.'*
> Bangladeshi woman, Birmingham

Most respondents did not write a shopping list, instead buying essentially the same items each time. Younger, more educated respondents were more likely to browse and look for new recipe ideas. They also bought a broader range of convenience foods, and were more likely to respond to branding than to special offers. Children were involved in choosing which brands to buy.

> *'I tell her we are going to buy yoghurt but I let her choose which brand. It depends on which characters she's into at the moment.'* Pakistani mother, London

Accompanied shopping trips were not conducted with the Gujarati Hindu, Punjabi Sikh and Black Caribbean samples as a great deal of learning into general shopping behaviour had been taken from the Bangladeshi, Pakistani and Black African samples.



6. ATTITUDES AND BEHAVIOURS RELATING TO PHYSICAL ACTIVITY

Increasingly, sedentary behaviour is seen as desirable and aspirational. Physical activity is seen as a low priority and, in many cases, as something that children need not concern themselves with or that will be 'taken care of' at school. Opportunities for families to get involved in activities together are limited, and growing numbers rely on their cars even for short, 'walkable' journeys. Children's own attitudes to exercise and activity are heavily influenced by those of their parents.

This section explores those attitudes under the headings of sedentary lifestyles, structured exercise and day-to-day activity, and active travel. It is based on the 2CV qualitative research, with additional quotes from the MRC evidence review.

SEDENTARY LIFESTYLES

Children were allowed and encouraged to be sedentary

The MRC evidence review highlighted the prevalence of inactive lifestyles where 'sedentary lifestyles are the default'.

In qualitative research conducted for the programme, researchers observed high levels of sedentary behaviour among children in priority cluster families. It was apparent that many parents tended to encourage this, both as a way of controlling children and stopping them from behaving boisterously, and as a way of bonding with them by getting them to join in with the sedentary activities that parents themselves prefer.

> *'Sometimes I just tell them to sit down and play quietly or watch TV because their running around gets on my nerves. It's much nicer when we're all sat together and enjoying ourselves because we really get to talk and cuddle and that's important to me.'*
> Mother, Birmingham

Sedentary behaviour was seen as a status symbol

Sedentary behaviour was often linked to expensive, aspirational entertainment products like games consoles and TVs. This goes some way to explaining why a sedentary lifestyle was seen as a status symbol: as something the family has earned, and as compensation for working hard the rest of the time.

> *'We both work very hard all week to provide a nice home for our family. When it comes to the weekend, we want to sit down and enjoy what we have at home. We all watch TV together and it's nice we can enjoy what we pay for.'* Mother, Newcastle

Having paid for expensive toys such as PlayStations, parents will also put pressure on children to get 'value for money' by using them regularly.

STRUCTURED EXERCISE AND DAY-TO-DAY ACTIVITY

Children wanted to be active

Research found that, in some cases, children wanted to be more active but were actively discouraged by their parents, either because the parents themselves lacked motivation or did not have the confidence to take part in physical activity. Children up to about the age of 9 were particularly likely to want to take part in exercise with their parents, for example by going on family bike rides. Older children were more likely to express a preference for sedentary behaviour, reflecting their parents' lack of interest in activity and exercise.

Parents believed their children were already sufficiently active

Many parents also claimed to believe that their children were getting enough exercise during the school day to justify sedentary behaviour at home. In most cases, researchers believed that they were confusing high energy levels with high levels of activity.

> *'I cannot believe that my children are not active. They are non-stop. In fact, it takes all my energy trying to calm them down. It's natural for kids to be active so I am not worried. It's not like they need to exercise like adults. They're kids!'* Mother, London

However, it seems likely that parental beliefs about their children's high activity levels reflect their tendency to underestimate the amount of exercise they themselves take, as identified in the MRC evidence review:

> *'There is a significant gap between people's perceptions and their actual level of activity. 47 per cent of men and 57 per cent of women reporting no physical activity over the last four weeks believed themselves to be "very" or "fairly" active. Sports Council and Health Education Authority (1992) Allied Dunbar National Fitness Survey.'*

Physical activity was a low priority

Parents were often more concerned with making sure that their children are well provided for materially than ensuring that they're getting enough exercise. There are a number of reasons for this. One is parents' failure to perceive sedentary behaviour as having a potentially negative impact on their children's health. Others include the lack of importance parents attached to structured exercise and their lack of understanding of the difference between this and 'being active'. Some parents believed that, if their children were taking part in structured exercise once a week at school, they did not need to undertake other activity on a daily basis. Some associated the need to start exercising with reaching adulthood, the point at which they believed people start to become less active.

Out-of-school sports activities were seen as 'too expensive'

Parents tended to regard extracurricular sports activities as costly and inconvenient. Some cited concerns about the risk of paying for a whole term's activity when their child could get bored and drop out. They also complained about the amount of 'running around' they had to do as a result of their children's out-of-school activities.

> *'It costs so much as we have to pay termly, especially when they all want to do something… [Then] when she said she didn't want to go anymore, she stopped straight away.'* Mother, Birmingham

Researchers observed that parental attitudes influenced children's own responses to out-of-school sport with the result that they too start to view it as costly and inconvenient.

Parents were reluctant to exercise themselves

It was apparent in priority cluster families that parents were discouraging family activity because they themselves did not enjoy exercising. Mothers in particular tended to have body-image issues that inhibited them from taking part in structured exercise with their families. This was compounded by the lack of 'safe' places to exercise with other mothers.

> *'I haven't exercised since I was at school. The idea of joining a gym or something just seems terrifying now. There isn't anywhere round here I would feel comfortable exercising in public. I am sure there are mums out there like me who could get together but I've no idea how.'* Mother, London

As a result, some mothers actively discouraged their children from leaving the home to exercise.

> *'I know it's selfish, but I sometimes don't want them to go off to dance class because I like keeping them home with me while I still can.'* Mother, Newcastle

Mothers also tended to devolve responsibility for activity and exercise to their partners. Fathers can have a positive influence on children's activity levels, for example by taking them on walks or bike rides or playing football with them at the weekends. However, this did not appear to be occurring regularly enough to make a substantial difference to children's overall activity habits.

Playing outside was seen as being too dangerous

Parents were often reluctant to let their children play outside, whether or not they were accompanied by an adult, because of concerns about safety and the nature of the local environment. They also wanted to keep their own children away from older children, who might be a negative influence.

> *'There are always gangs hanging around the parks and there is broken glass and things like that, so I don't want them playing there.'* Mother, London

> *'I don't want her playing outside. I've seen what it's like. There are older kids who are into drinking, drugs and sex. I don't want her out there with all that.'*
> Mother, Newcastle

The MRC evidence review backed these findings, and also highlighted some further potential barriers:

> *'A MORI* ***Survey of sport and the family*** *found that 80 per cent of parents believed "children today get less exercise because parents are afraid to let them go out alone". Meanwhile, children report busy roads, car pollution and lack of playground equipment as barriers to outdoor play (Hesketh et al., 2005). Protests from neighbours about noise are another hindrance to active outdoor play. The impact of these negative attitudes has seen a dramatic reduction in the freedom of children to play outdoors. The radius from home in which children can roam alone (their play range) had shrunk to a ninth of what it was in 1970 (Wheway and Millward, 1997).'*

ACTIVE TRAVEL

The MRC evidence review shows that there has been a marked decline in walking and cycling among both adults and children over the last 20 years:

> *'Statistics from the Department for Transport show that the number of 5–10-year-olds driven to school increased by more than a third, from 28 per cent in 1989/91 to 39 per cent in 1999/2001. Children who report walking or cycling to school are more physically active than their counterparts who report using motorised transport (Cooper et al., 2003; Cooper et al., 2005).'*

Like sedentary leisure activities, researchers observed that priority cluster families saw cars as a symbol of status and a means of exercising power and control over their own lives.

'Everyone drives their kids to school. I mean I could walk, easily, but I don't because all the other mums drive and I don't want my son feeling like his mum makes him walk when all the other kids turn up in their parents' cars.'
Mother, Birmingham

As a result, many were using cars even for short, walkable journeys, for example to school or the local shops. Many parents reported that their children strongly resisted the idea of walking to school and cited the simplicity, speed and convenience of the car; but it seems likely that their own reluctance to walk was a major reason for their car dependency, and a powerful influence on their children's attitudes and behaviour.

ATTITUDES TO PHYSICAL ACTIVITY IN ETHNIC MINORITY COMMUNITIES

Overall, levels of physical activity were low among both adults and children in the sample from the Bangladeshi, Pakistani and Black African communities, and particularly so among women. Parents tended to believe that their children's activity levels were adequate, believing that they got enough exercise at school and 'ran around' at home more than they actually did. Awareness of the level of physical activity needed to ensure good health was low.

Overall activity levels were higher among Gujarati Hindu, Punjabi Sikh and Black Caribbean children. Many were actively participating in physical activities after school and had more freedom for outside play. Activity levels were low among many adults from these three communities.

There were a number of barriers to physical activity

Taking part in physical activity, particularly organised activity, was not the norm for Bangladeshi, Pakistani and Black African communities. Additionally, many parents' top priority was to ensure that their children were properly educated and, in Muslim families (Bangladeshi, Pakistani and some Black African), this included religious instruction. As a result, for some children, free time out of school hours was spent on homework and extra studies (mainly Black African and some Pakistani children) as well as attending religious classes outside the home. This placed restrictions on the time available for physical activity.

Low activity levels were observed particularly among Bangladeshi, Pakistani and Black African women. This was partly due to the fact that some Bangladeshi and Pakistani mothers were expected to spend their time caring for their immediate and extended families, and therefore found it hard to justify spending time away from home being physically active. Improving health was not a compelling reason to exercise,

especially for older Black African women, who believed that 'big is beautiful' and adopted a fatalistic approach to health. Other mothers cited tiredness and lack of time due to work and family pressures. Many who had walked regularly in their country of origin said they no longer did so due to bad weather. Despite this, mothers expressed a real desire to increase their levels of activity in order to improve their health and lose weight.

> *'I would love to be able to go swimming or take the kids but there is so much else to do. There's the cooking for the mother-in-law, looking after my sister who is disabled and after running around after four children, I'm exhausted.'*
> Bangladeshi mother, Birmingham

As far as their children were concerned, safety was often a key issue.

> *'I just don't let him out. I worry about him going out on his bike and then hanging around the shops with his friends. You just don't know what they will be tempted into. That's when they go bad.'* Bangladeshi father, Oldham

Low income levels and lack of safe outside space limited some Black Caribbean children's opportunities for being more active. Mothers living in homes without gardens were concerned about allowing their children to play unsupervised as they could not 'keep an eye out for them'.

> *'I don't allow them to play out; it's too rough round here.'*
> Black Caribbean mother, London

The above barriers were less evident among Gujarati Hindu, Punjabi Sikh and some Black Caribbean households.

Children wanted to be more active

Bangladeshi, Pakistani, Black African and some Black Caribbean children were keen to take part in more physical activity, mainly to relieve boredom.

> *'There's nothing to do at the weekend but sit and watch TV. You need to tell parents to get out with their children even if it's cold.'* Pakistani boy, London

Most children, having fulfilled their after-school commitments, were left to their own devices, with many opting for sedentary activities such as watching television, playing computer games or listening to music. Research showed that children wanted more opportunities for unstructured outdoor play as well as greater participation in sports such as swimming, football and cricket.

> *'I feel sad that I can't play out with my friends. I think I have been allowed out to play only three times in my life.'*
> Black Caribbean boy, London

Many Gujarati Hindu, Punjabi Sikh and some Black Caribbean children had been given the opportunity by their parents to pursue interests in a range of after-school activities. Many children were involved in a range of sports and dance activities.

Gender differences can affect overall activity levels

Girls were just as interested as boys in becoming more physically active. However, for most Bangladeshi and Pakistani families, it was more acceptable for male children to participate in physical activities outside the home, while girls were generally expected to remain in the house after school and at the weekends. From about the age of 11, girls were also expected to start helping their mothers with household tasks. This was not true of Black African, Gujarati Hindu, Punjabi Sikh and Black Caribbean families.

> *'In my spare time I help my mum with the dishes and help her iron the clothes. I enjoy doing that.'*
> Pakistani girl, Birmingham

Attitudes among more involved fathers

Younger Bangladeshi, Pakistani and Black African fathers, particularly those born and brought up in the UK, were more likely than their older counterparts to be involved in playing sports at the weekend, particularly cricket and football. Often, they took their male children along. Female children were generally not seen as their responsibility.

Gujarati Hindu, Punjabi Sikh and Black Caribbean fathers of all ages generally encouraged their sons and daughters to be physically active. Many spent time playing in the garden with their children or involving them in activities such as cycling and football.

7. HOW FAMILIES DIFFER: SEGMENTATION OF FAMILIES OF CHILDREN AGED 2–10

Analysis of a sample of households with children aged between 2 and 10 carried out by TNS showed that they and their families could be divided into six broad groups or clusters according to their attitudes and behaviours relating to diet and physical activity. TNS then drew on additional data to add information on each cluster's demographic make-up, levels of food consumption and levels of obesity and overweight. Please see Appendix A for more details.

Subsequently, 2CV used observational research techniques to identify the actual food habits and activity levels that lie behind families' perceived and claimed behaviours. See Appendix A for more information about the research methodologies used.

Understanding these clusters, their motivations and the opportunities and challenges they face, as well as their levels of food consumption and physical activity, is an essential step towards developing interventions and planning communications that accurately target the needs of different audience groups.

This table shows how the quantitative research sample was divided between the clusters and the percentage of children within each cluster who were obese.

Children 2–10		**UK 1990 Reference**	
Measures = INDIVIDUALS		**%**	**Size**
	Total	**>95th percentile obese**	**Percentage of children**
Total clusters	883	17.8	100.0%
Cluster 1	120	15.8	13.6%
Cluster 2	168	23.8	19.0%
Cluster 3	131	24.4	14.8%
Cluster 4	153	13.7	17.3%
Cluster 5	169	14.8	19.1%
Cluster 6	142	14.1	16.1%

Source: TNS Childhood Obesity Consumer Segmentation Research

The table on page 42 provides a summary of the key characteristics of each cluster, and of the tasks facing communicators and health professionals in persuading families within each group to change their behaviours and attitudes.

	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5	Cluster 6
Description	Struggling parents who lack confidence, knowledge, time and money.	Young parents who lack the knowledge and parenting skills to implement a healthy lifestyle.	Affluent families, who enjoy indulging in food.	Already living a healthy lifestyle.	Strong family values and parenting skills but need to make changes to their diet and activity levels.	Plenty of exercise but potentially too many bad foods.
Family diet	Seek convenience, eat for comfort, struggle to cook healthily from scratch.	Children fussy eaters, rely on convenience foods.	Enjoy food, heavy snackers, parents watching weight.	Strong interest in healthy diet.	Strong parental control but diet rich in energy-dense foods and portion size an issue.	Eating motivated by taste, diet includes both healthy and unhealthy foods.
Physical activity	Seen as costly, time-consuming and not enjoyable. High levels of sedentary behaviour.	No interest in increasing activity levels because parents perceive children to be active.	Believe family is active, no barriers to child's activity except confidence.	Family active although believe children not confident doing exercise.	Know they need to do more: time, money, self-confidence seen as barriers.	Activity levels are high, particularly among mothers.
Weight status	Mothers obese and overweight.	Families obese and overweight. Fail to recognise children's weight status.	Families obese and overweight. Low recognition of children's weight status.	Below average levels of obesity and overweight.	Parental obesity levels above average, children below.	Low family obesity levels but child overweight levels are a concern.
Demographic	Low income, likely to be single parents.	Young, single parents, low income.	Affluent parents of all ages, households vary in size.	Affluent older parents, larger families.	Range of parental ages, single parent families.	Average incomes, younger mothers, households vary in size.
Intent to change	High, but fear of being judged and lack of confidence are powerful barriers.	Currently low due to lack of knowledge, but willing to accept help once alerted to risks.	Low intent to change and likely to deny that problems exist.	Low intent to change but already leading a healthy lifestyle.	Low intent on diet but significant intent to change on physical activity.	Highest among the clusters for both diet and physical activity, so influencing them is not a priority.
Potential task	Build confidence, increase knowledge and provide cheap convenient diet solutions.	Increase understanding of risks of current lifestyle and develop parenting skills.	Encourage recognition of problem and awareness of true exercise and snacking levels.	Learn from successful techniques used by cluster.	Focus on increasing activity levels and educate on portion size.	Focus on providing cheap, convenient, healthy high-energy foods to fuel active lifestyle.

TYPOLOGIES AMONG ETHNIC MINORITY COMMUNITIES

The research found that, due to their differing cultural drivers, the six ethnic minority communities surveyed – Pakistani, Bangladeshi, Black African, Gujarati Hindu, Punjabi Sikh and Black Caribbean – did not fit neatly into the mainstream segmentation shown above. Instead, it was found that mothers within the six communities fell into four broad groups. The characteristics of these groups are summarised in the following table.

	Typology 1	Typology 2	Typology 3	Typology 4
Description	Mainly Gujarati Hindu, Punjabi Sikh, Black Caribbean. Some Black African, Pakistani and Bangladeshi. Higher socio-economic group (SEG). High levels of English. Usually born or mainly brought up in the UK. Living in nuclear families with shared parental responsibilities.	Black Caribbean, Indian and Black African. Usually born in the UK or lived here for many years. Low to average incomes and education levels. Good levels of English. Living in nuclear and single parent families.	Mainly Bangladeshi, Pakistani, Black African. Some Indian and Black Caribbean. Lower SEGs. Good levels of English. Mix of those born abroad, born/brought up in the UK. Living in nuclear families but often close to extended family.	Usually Pakistani, Bangladeshi. Some Black African. Usually recent arrivals or arrived as marriage partners, typically from rural areas. Lowest SEGs. Poor levels of English. Often living in extended families or with families living in close proximity.
Overall attitudes	Value own culture and tradition but actively participate in Western culture. Confident in own beliefs and set of values. Children's education is important but also achievement in other areas.	Stressed, busy lives, long working hours (esp. fathers) – little family support. Value own culture and tradition but participate in Western culture. Relaxed, indulgent attitude to parenting but education is important.	Often confident, articulate. Rooted in own culture (even if demeanour is Western). Value and mirror attitudes of parents. Education is very important and instilling traditional cultural values in children.	Lack confidence in general. Lives often confined to own ethnic groups – little interaction with other communities. Often succumb to attitudes of family elders, more limited control over own lives or those of their children.
Eating behaviour	High awareness of health messages. Confident in putting these into practice. Fresh, home-cooked meals, both cultural cuisine and Western/ other cuisines. Appropriate portion sizes.	Some awareness of health messages. Enjoy food but not necessarily cooking (but have the skills).	Relatively high awareness of health messages but believe 'they know best'. Fresh, home-cooked cultural meals, cooked in traditional ways.	More limited understanding of health messages. Mainly traditional cultural foods. Lots of cultural and Western sweet and savoury snacks.

	Typology 1	Typology 2	Typology 3	Typology 4
Eating behaviour (continued)	Adapted cooking methods. Healthy snacking for children and rationed sweet foods as occasional treats/ rewards.	Convenience more often the norm (pre-packaged and home prepared). Snacking habits for children and adults. Children can dictate meal choices. Meal times are as and when.	Western meals in addition to rather than replace. High levels of snacking on sweet and savoury foods with little monitoring. Large portion sizes for adults and children.	High value placed on Western brands, esp. for children's foods. Little monitoring of snacking or fizzy drinks. Large portion sizes, often multiple evening meals.
Attitudes to physical activity	Understand value for wellbeing and increasing performance. Positively encourage children to be active outside school. Parents attempt to be active themselves (but not always possible). Try to do more as a family.	Believe kids are active enough at school. Low activity among adults.	Understand value but often have other priorities. Believe school activities are sufficient. Parents not particularly active, little focus on family activity.	Little real understanding of the value or need. Children's time taken up with religious instruction or left to own devices. Women and girls may have restricted access to activities outside the home.
Weight status	Average weight for children and fathers. Mothers can be overweight.	Overweight and obese children and adults. Children's weight status not always recognised.	Average to overweight children. Mothers can be overweight/obese.	Problems of both overweight and underweight children. 'Big' children are culturally more acceptable. Weight often a problem for family elders.
Potential risk	Low risk but still interested in finding out what more they can do.	High risk. Need educating on diet and physical activity levels.	Mid to high risk. Need educating on portion sizes, levels of snacking, cooking methods and physical activity.	High risk. Need educating on diet and physical activity levels for all the family.

EXPLORING THE TNS CLUSTERS

The remainder of this chapter looks at each of the clusters in turn, combining findings from the TNS segmentation with additional quotes and insights taken from the qualitative research carried out by 2CV.

CLUSTER 1: LACKING TIME, MONEY AND KNOWLEDGE

Pen portrait

Life is tough for cluster 1 families; convenience and comfort is everything. Looking after the children is mum's job, but she finds it hard and lacks the confidence to enforce rules. Mum tends to be overweight, and uses diet foods to try to keep her weight down. Money is a worry, and snack foods and the TV are a source of comfort and escape for the whole family. Cluster 1 families think adopting a healthier lifestyle means giving up the few things they enjoy in life. They also believe they don't have time to cook from scratch and that exercise is too expensive. They know their children should be more active and eat more healthily, but making changes seems too hard.

In their own words…

'When I'm feeling down, I'll treat myself to a sticky cream cake. I think that's totally normal, as I can't afford to go out and drink.'

'We're not like that, you know, like organic types and mums that have the time to cook all day because they don't have to work.'

Size of cluster: Cluster 1 represents 13.6 per cent of children in the sample.

Household size, social class and income: Households contain two or three people, and are most likely to fall into social class C2. Typically, levels of both education and income (less than £12,500 per year) are low.

Age of mother: Mothers are typically aged between 25 and 34.

Obesity levels: Mothers have the highest obesity levels of any cluster and are often on calorie-controlled diets. Fathers' obesity levels are below average, perhaps because many are manual workers. Child obesity levels are lower than the cluster average.

Children's diet: In comparison to other clusters, children consume below-average amounts of fruit and vegetables, fresh meat and fish, home-made foods and juice, and above-average amounts of fizzy drinks, snack foods, diet foods and drinks and processed foods.

Children's activity levels: Seventy-nine per cent of parents report that their children are active for one hour a day – the lowest level among the clusters. Levels of TV watching and computer gaming are the highest in the clusters, at 3.4 hours a day.

Key attitudes: Find buying, cooking and getting children to eat healthy foods difficult; don't enjoy preparing or cooking well-balanced meals; would pay to make life easier; believe exercise is costly, time-consuming and not enjoyable; believe it is not safe for children to play outside.

Awareness of risk and intent to change: Seventy-four per cent of parents with obese or overweight children do not recognise that their children have a problem. Qualitative research found that although families in this cluster had some awareness of the risks inherent in their diet and activity levels, they were also fatalistic and convinced that it would take too much effort to change. The researchers therefore conclude that it would require a lengthy period of engagement and support to change their behaviour and attitudes.

CLUSTER 2: LACK THE KNOWLEDGE AND PARENTING SKILLS TO IMPROVE THEIR FAMILY'S LIFESTYLE

Pen portrait

Having had children very young, cluster 2 families lack the experience and resources to develop good parenting strategies. Children are difficult to manage, and tend to dictate their own diet and activity levels. Food can be a battleground. Parents often find it easier to 'give in' and let children have the processed foods and fizzy drinks they want. Children prefer playing indoors on their computers to going outside. Cluster 2 parents want to be 'good' parents, but this does not currently translate into concern about family activities and diet, perhaps due to a lack of knowledge about how to lead a healthier lifestyle and lack of awareness about the consequences of not doing so.

In their own words…

'I kind of make it up as I go along; a lot of it is from the way mum brought me up, I don't really know any other way.'

'She's a really fussy eater. She'll find any excuse not to eat her dinner and snacks on crap all day…it's just how she is now, I don't think she'll change.'

Size of cluster: Cluster 2 represents 19 per cent of children in the sample.

Household size, social class and income: Typically single-parent households with incomes below £12,500 per year. Most families in the cluster belong to social classes DE.

Age of mother: Mothers are usually aged between 17 and 24.

Obesity levels: Levels of obesity in all family members are higher than average across the clusters.

Children's diet: In comparison with children in the other clusters, cluster 2 children consume above-average amounts of fizzy drinks, processed foods and fresh meat and fish. They eat below-average levels of diet food and drink, home-made food, fresh fruit and vegetables, fruit juice and snack foods.

Children's activity levels: Ninety-five per cent of parents believe that their children are active enough already. Children spend three hours a day watching TV or playing computer games, in line with the cluster average.

Key attitudes: Actively trying to persuade children to eat healthy foods, but find that children are fussy eaters; enjoy snacking; believe their children prefer to play inside and struggle to get them to play outside; believe their children are not confident doing physical activity.

Awareness of risk and intent to change: Ninety-two per cent of parents with overweight or obese children don't recognise that there is a problem. Qualitative research demonstrated that parents in this cluster were largely unaware of the risks associated with their diet and levels of activity. However, once they understood the issues they were willing to make changes and eager to get the support they felt they needed to help them do so.

CLUSTER 3: AFFLUENT, OVERWEIGHT FAMILIES WHO OVER- INDULGE IN UNHEALTHY FOODS

Pen portrait

Cluster 3 families are proud of having 'bettered' themselves. Dad is likely to work in middle management; mum may have a part-time job to earn extra money for luxuries. Their children's educational attainment and material possessions are key priorities. They enjoy food, and believe themselves to be well informed about healthy eating. Although the whole household is likely to be overweight, cluster 3 parents don't recognise the problem. They are often in denial about the healthiness of their children's diets and their true activity levels. Cluster 3 mums in particular are unlikely to encourage their children to exercise because they lack the confidence and motivation to do so themselves.

In their own words…

'I don't go to the gym and I'd never go for a run as I know the curtains would be twitching and everybody would be looking at me.'

'I went to the doctor once and he said my daughter was "obese". I thought it was totally ridiculous; I mean, she doesn't even look overweight.'

Size of cluster: Cluster 3 represents 14.8 per cent of children in the sample.

Household size, social class and income: Cluster 3 families are relatively affluent and typically belong to social class C1.

Obesity levels: Levels of obesity among parents are above average and mothers are often on calorie-controlled diets. Child obesity is the highest in any cluster, at 24.4 per cent.

Age of mother: Typically, mothers are aged between 35–44.

Children's diet: In comparison with children in other clusters, cluster 3 children eat above-average amounts of fresh fruit and vegetables, home-made food, snack foods, diet food and drink, and fresh meat and fish. Consumption of juice, fizzy drinks and processed food is below average.

Children's activity levels: Ninety-five per cent of parents believe that their children are active for an hour a day. Levels of TV watching and computer gaming are low, at 2.6 hours per day.

Key attitudes: Knowledgeable about diet and exercise; believe diet and physical activity are key ways to help obese children lose weight; enjoy preparing and cooking well-balanced meals; believe that the family often undertakes physical activities together; don't see cost as a barrier to physical activity; self-conscious about exercising in public.

Awareness of risk and intent to change: Ninety-one per cent of parents with an overweight or obese child don't recognise that the child is overweight or obese, and the intention to improve diet or increase levels of activity is below average. Qualitative research concluded that these families were in denial: although they have a high awareness of the risks associated with poor diet and activity levels, they do not see these as relevant to their own situation. Researchers concluded that motivating them to make changes would mean undermining their perceptions about their current diet and activity levels.

CLUSTER 4: LIVING HEALTHILY

Pen portrait

Cluster 4 families take food very seriously. They are interested in organic, environmentally-friendly and Fairtrade products, and check labels for additives and E-numbers. They work hard to feed their children healthy food, and successfully limit their consumption of processed foods and carbonated drinks. One of the reasons for their success is that mothers in particular provide a positive role model: they don't eat when bored, or view 'bad' foods as a treat. However, cluster 4 families are also likely to drive their children to school, and children can lack confidence when it comes to physical activity.

In their own words…

'We're both quite foodie, and I seek out specific new recipes that can bring healthy food into the home. My daughter eats what we do, so her diet is very healthy too.'

Size of cluster: Cluster 4 represents just over 17 per cent of children in the sample.

Household size, social class and income: Households consist of five or more people, and belong to social classes AB. Families tend to be affluent.

Age of mother: Typically, mothers are aged between 45 and 64.

Obesity levels: Mothers and children in cluster 4 are the least likely of all the clusters to be obese. Fathers' levels of obesity are also below average.

Children's diet: Compared with children in other clusters, cluster 4 children consume above-average amounts of fruit and vegetables, home-made food and juice, and below-average amounts of snacks, fizzy drinks, processed foods, diet food and drinks, and fresh meat and fish.

Children's activity levels: Eighty-five per cent of parents believe their children are active for an hour a day. Levels of TV watching and computer gaming are low, at 2.6 hours per day.

Key attitudes: Actively encourage children to eat healthily; will indulge when eating out, so 'bad' foods are not seen as taboo or a treat; mothers are keen exercisers, but believe children aren't confident doing physical activity; mothers insist on driving children to school although they would rather walk or cycle.

Awareness of risk and intent to change: Qualitative research concluded that these families already had a high awareness of the health risks of poor diet and low activity levels and were constantly looking for additional information and new strategies to increase activity levels and improve their diet.

CLUSTER 5: STRONG PARENTING SKILLS BUT NEED TO MAKE CHANGES

Pen portrait

Cluster 5 parents are great believers in traditional family values and think children should eat what they're given. While this has some benefits – children are not 'allowed' to become fussy eaters – these families are also traditional in their eating habits. They reject the idea of dieting or detoxing, and associate 'health foods' with fanaticism about diet. While barriers to healthy eating are rooted in beliefs, barriers to exercise are more practical. At the same time, cluster 5 families say they would like to be more active.

In their own words…

'We have meat and two veg pretty much every night as it's good food that will fill them up.'

'One minute you should be eating blueberries, the next it's something else. I think it's all just hype.'

Size of cluster: Cluster 5, the largest cluster, represents 19.1 per cent of children in the sample.

Household size, social class and income: Social classes are mixed, and incomes are middling.

Age of mother: Typically, mothers fall into the oldest (45–64) or youngest (17–24) age group.

Obesity levels: Levels of adult obesity are above average, while levels of child obesity are slightly below.

Children's diet: In comparison with children in other clusters, cluster 5 children eat above-average amounts of snacks, processed foods, fresh meat and fish, and below-average amounts of juice, fizzy drinks, diet food and drinks, fruit and vegetables and home-made food.

Children's activity levels: Ninety per cent of parents believe their children do an hour's activity each day. The amount of time spent watching TV or playing computer games is above average at 3.2 hours.

Key attitudes: Believe that children should eat what they're given; wary of what they perceive as health 'fads', for example organic food; think exercising is too expensive; would like the whole family to be more active, but find it hard to persuade children to play outside.

Awareness of risk and intent to change: Although child obesity levels are relatively low, 92 per cent of parents with an overweight or obese child don't recognise the issue. Research concluded that these families understood the risks associated with their behaviour, but needed greater encouragement to make changes.

CLUSTER 6: PLENTY OF EXERCISE BUT TOO MANY BAD FOODS

Pen portrait

Mums are the driving force behind cluster 6 families' active lifestyles, and are often keen joggers and cyclists. Food fuels their high levels of physical activity. They are driven by taste and convenience, and they tend not to exclude foods, probably because they believe they are active enough to burn it off. They are open to ideas about improving their diet and incorporating more exercise into their lives.

In their own words…

'My husband and son jog to school every morning. We generally eat healthily but sometimes we'll treat ourselves because we know we're burning it off.'

Size of cluster: Cluster 6 represents 16.1 per cent of children in the sample.

Household size, social class and income: The typical cluster 6 family is relatively affluent and lives in London or the south-east. Households vary in size, and generally belong to social class C2.

Age of mother: Mothers are typically aged between 17 and 24.

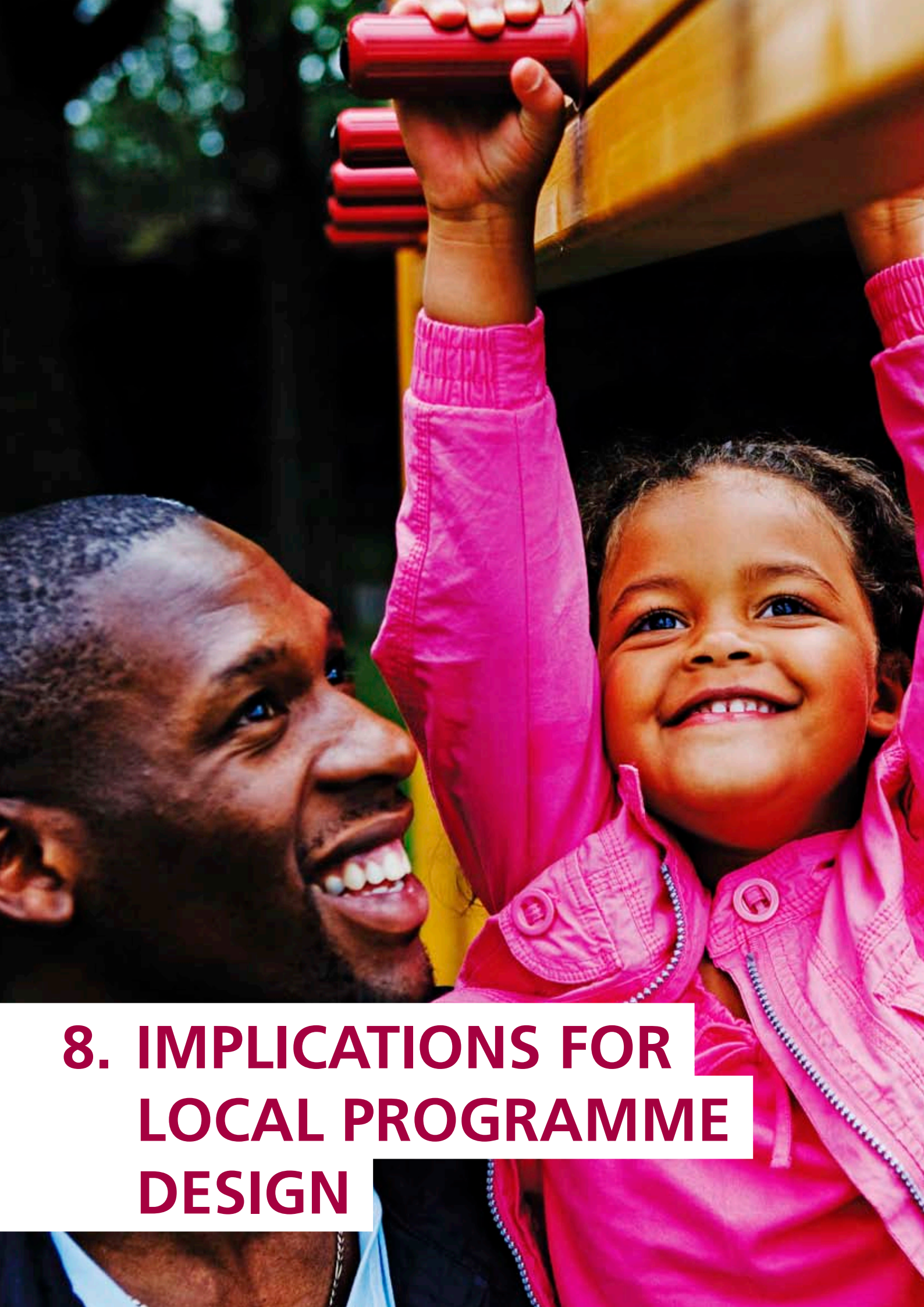
Obesity levels: Obesity levels are below average for mothers, fathers and children, although child overweight levels are a cause for concern.

Children's diet: In comparison with children in other clusters, cluster 6 children consume above-average amounts of fruit and vegetables, home-made food, snack foods and diet food and drinks. Consumption of juice, fizzy drinks, processed foods and fresh meat and fish is below average.

Children's activity levels: Ninety-two per cent of parents believe their children are active for an hour a day. The amount of time spent watching TV and computer gaming is below average at 2.8 hours per day. Levels of activity are high.

Key attitudes: Concerned with the taste rather than the healthiness of food; buy convenience foods; enjoy eating out; avoid saturated fats and high-salt foods; family often does physical activities together.

Awareness of risk and intent to change: Ninety per cent of parents with an overweight or obese child don't recognise that the child is overweight or obese. The qualitative research concluded that these families have a high awareness of the health risks of poor diet and low levels of activity. They are constantly on the look-out for additional information and new strategies to increase activity levels and improve their family's diet.



8. IMPLICATIONS FOR LOCAL PROGRAMME DESIGN

The findings from the research programme led us to the conclusion that there is a need for a national mass engagement campaign to 'reframe' the issue of childhood obesity in a way that enables parents to engage fully with the issue and take proactive steps to prevent obesity in their children. To do this, it will be important to raise their awareness of what 'unhealthy' behaviour is and the risks associated with it, and the benefits associated with making 'healthy' choices.

The next step will be to plan specific interventions aimed at changing families' attitudes and behaviours. The research suggests that the key to designing effective interventions is to engage the whole family, presenting healthy behaviours as enjoyable family experiences, positioning change as a positive choice and focusing in particular on the beneficial impact of a better diet and increased physical activity levels at the same time as making it clear that children's happiness is the first priority.

Based on the research, the national Change4Life marketing programme will be looking to develop activity in the following areas:

- structured mealtimes – creating awareness among parents of the importance of limiting unhealthy and excessive snacking between meals;
- shopping and cooking – giving parents and their children the knowledge and skills they need to shop for and prepare healthy meals. This will include challenging the belief that 'kids' foods' and 'convenience foods' offer better value than fresh, healthy foods;
- portion size – working in partnership with the Food Standards Agency to help parents understand how much food their children should be eating;
- improve food literacy – giving parents a better understanding of the components of a healthy diet (in particular, advice on how to reduce consumption of foods high in fat and added sugar);
- sedentary activity – encouraging parents to limit their children's screen time and replace it with family activity;
- outdoor play – increasing levels of family activity, in particular outdoor play, and reducing levels of sedentary behaviour. This will include providing safe, family-friendly environments where children can play, helping families understand the value of structured exercise, and making exercise more inclusive and accessible; and
- active travel – encouraging families to use their cars less for short, walkable journeys.

In *Healthy Weight, Healthy Lives: A Cross Government Strategy for England*, the Department set out commitments to tackle obesity and promote healthy weight across five themes:

1. Children: healthy growth and healthy weight
2. Promoting healthier food choices
3. Building physical activity into our lives
4. Creating incentives for better health
5. Personalised advice and support

This section provides an overview of seven areas, recommended by 2CV, where the research is particularly relevant to the design of interventions, based on feedback given by families involved in the research during workshop sessions. The seven areas are organised against the first three themes of *Healthy Weight, Healthy Lives* for ease of reference against the strategy and other guidance documents. There is also a checklist for ensuring that interventions are as effective as possible.

As the research focused primarily on families with children under 11, it is most relevant to areas 1–3 of the strategy and recommendations are grouped accordingly.

The section also includes an overview of specific programme design implications for ethnic minority communities.

1. CHILDREN: HEALTHY GROWTH AND HEALTHY WEIGHT

'Set early parenting strategies'

Guidance on food and activity needs to start as early as possible, ideally when children are aged between 0 and 2 years. Providing specific guidelines both pre- and post-birth would reduce the likelihood of families getting into bad habits, but it is likely that this would need to be reinforced by health professionals. Guidance that involves close monitoring of children's behaviour would be seen as time-consuming and impractical.

The research showed that food guidelines will need to provide an element of choice at the same time as setting some parameters. For example, parents should be encouraged to move away from offering children a completely free choice ('What do you want for dinner?') to providing a limited choice between equally healthy options ('It's carrots or peas, you choose'). Families would also welcome general 'parenting' guidance, for example on the importance of sitting down to eat as a family. Guidance should not be too punitive.

Guidance on physical activity should be inspiring and specific. Parents need ideas on what kinds of activities they and their children can do, not just guidance on how much they should be doing. Targets must also be achievable.

2. PROMOTING HEALTHIER FOOD CHOICES

'Make cooking fun'

Interventions in this area should focus on building up mothers' confidence in their ability to prepare meals and on getting children involved in the process. Families responded well to the idea of 'cooking clubs' where mothers and children could learn to cook together and to using school recipe books comprising recipes created by other mothers. These avoided the potentially alienating middle-class overtones.

'Inspire healthy family meals'

To be effective in reducing their reliance on convenience foods, interventions in this area will need to inspire families to make healthy choices about food at the point of purchase, for example in the supermarket. This is likely to call for close co-operation with private sector partners, for example food manufacturers and supermarket chains. Ideas like price promotions, category management based on healthy meals and developing a range of 'healthier kids' foods' were all well received by parents.

3. BUILDING PHYSICAL ACTIVITY INTO OUR LIVES

'Encourage active in-home play'

Encouraging active play around the home could be a powerful way of tackling the very high levels of in-home sedentary behaviour exhibited by at-risk families. Children can be encouraged to get active by dancing to music. While entertainment devices such as TV and games consoles can act as barriers to raising activity levels, it may also be possible to harness their power to encourage active in-home play. There was strong interest across clusters for their potential to use entertainment technology to increase the levels of in-home family activity and entertainment through partnerships with gaming manufactures and TV channels (e.g. Nintendo Wii, dancemats and trampolines).

'Encourage active out-of-home play'

Priority cluster families recognised that out-of-home activities usually offer fun, positive experiences. However, many cited barriers including a lack of inspiration and a lack of accessible activities in the local area.

Ideas such as visibly transforming local parks and free leisure attractions were well received. They could also help families reconnect with their own neighbourhoods. Families also responded positively to the idea of creating new and 'safe' ways of exploring the local area, for example by setting up cycle routes. Where appropriate, thought should also be given to subsidising activities to make them accessible to families on low incomes.

Parents also need more information about family activities. This must be delivered through appropriate channels – for example, families in the less affluent clusters may find it difficult to access information online.

'Get families walking'

Interventions that create regular opportunities for families to walk instead of taking the car could be a highly effective way of increasing their daily activity levels. Families often cited walking as a positive family experience. The success of 'walk to school' initiatives was widely recognised, but many families either lived away from the route or had stopped taking part because the school had withdrawn incentives for children taking part.

Success in this area depends on widening the scope and availability of walking buses and incentive-driven walking and ensuring that such initiatives are ongoing, not just one-off events. Setting up rotas would also help parents share the workload. Employing dedicated wardens to organise and facilitate would have a positive

impact on uptake. 'Bikeability' and 'Kerbcraft' initiatives could also help combat parents' concerns about the safety of children travelling without them. Walking buses could also be promoted as opportunities to meet and socialise with other families; something that mothers in particular find appealing.

'Develop active communities'

Increasing activity levels in the community as a whole may act as an incentive for individual families. This could be achieved by increasing the availability and accessibility of after-school community-based exercise and activity opportunities for children. To overcome parents' (and in particular mothers') lack of confidence about participating in exercise, structured exercise activities targeted at them should feel 'home grown' (i.e. by mothers, for mothers). Mothers in particular also stated that they were looking for community-based activity but didn't know where to find it, pointing to a need for better provision of information. Some mothers also felt that letting their children take part in after-school activities meant losing out on time that could otherwise be spent together, suggesting a need for activities in which the whole family could take part.

PROGRAMME DESIGN IMPLICATIONS FOR ETHNIC MINORITY COMMUNITIES

While there is considerable overlap between attitudes to diet and physical activity across all parts of the community, there are also significant differences. As a result, the research recommends that those seeking to engage

INTERVENTIONS CHECKLIST

1. Start early: New parents with children under two and pregnant women are particularly receptive to information and advice, and have not had time to get into bad habits.

2. Target the whole family: This provides an opportunity to encourage parents to role model positive behaviours which have a powerful impact on children.

3. Target specific clusters: Families in clusters 4 and 6 already have high levels of awareness of healthy behaviours. The inclusion of messages designed to appeal to cluster 4 in particular may alienate families from lower socio-economic groups (see chapter 7 for more information about the clusters).

4. Play down 'health', play up 'happiness': The most effective interventions are likely to play down the 'health' benefits and play up the emotional and psychological benefits of change. Focusing on children's happiness is a strong motivator. Parents are more likely to make changes if they believe it will make their children happy.

5. Make it fun: Although interventions such as cookery clubs have clear health benefits, the main motivation for families is the opportunity to do something enjoyable together. This, rather than the overt health benefits, is likely to be the most successful selling point.

effectively with ethnic minority communities through interventions will also need to take into account the following factors.

- **Cultural appropriateness:** Families could be encouraged to be more active by providing opportunities to take part in culturally appropriate and acceptable activities, for example dancing, walking, cricket and football. Adults may respond positively to opportunities to take part in activities with other people from the same ethnic background. Linking children's physical activity to school (by, for example, setting up more after-school clubs) could help many parents – who tend to prioritise their children's education over exercise – to see physical activity as more culturally acceptable.

- **Adapting existing eating habits:** Interventions should focus on ways of making traditional ethnic meals healthier, for example by using slow cookers or pressure cookers and swapping ghee, butter and palm oil for alternatives such as olive oil. Guidelines should also be provided on 'translating' current health messages into specific changes to traditional meals, and on healthier snacks and treats for children.

- **Engaging community leaders and workers:** Getting key community influencers to promote the value of physical activity for both male and female children could help parents feel that they have been given cultural and religious 'licence' to encourage their children to be more active. For Bangladeshi and Pakistani women brought up abroad, key influencers such as GPs, health visitors, community health promotion workers and practice nurses are also trusted sources of information.

- **Engaging the extended family:** Extended family members tend to have a significant influence over children's food intake and family eating habits in general, especially in Bangladeshi and Pakistani families. Interventions must therefore target extended family members, in particular grandmothers. Engaging with these older members of the community could also be a step towards breaking down the widely held perception that an overweight child is a healthy child.

- **Using children to reach parents with limited English:** For Bangladeshi and Pakistani women brought up abroad, children are the most important source of information about health issues and guidelines. Children are already feeding back to their parents about health issues covered during lessons and their school's healthy eating policies.

- **Using one-to-one, community-based interventions:** These are particularly crucial for those with limited English and whose engagement with mainstream media channels is therefore likely to be restricted. These interventions will need to be targeted at specific communities in order to overcome cultural and religious barriers.

9. RECOMMENDATIONS FOR COMMUNICATING ABOUT DIET AND ACTIVITY

Engaging families, particularly priority cluster families, with messages about diet and activity and persuading them of the benefits of changing their behaviour will mean developing a new language and tone of voice. This will help ensure that the interventions described in chapter 8 succeed in securing participation among the target audience and overcome the risks of deselection. Research carried out by 2CV found that to be effective, communications should focus on either diet or physical activity, not both. At the same time, they should use an empathetic, parent-to-parent tone of voice.

This chapter summarises why messages need to be separated out and 'what works' best in terms of both language and imagery, and then gives some examples of communications and explains how families taking part in the 2CV workshops reacted to them. It draws on the qualitative proposition research carried out by 2CV. It also includes specific recommendations for communicating effectively with ethnic minority audiences.

WHAT WORKS: TAKING DIFFERENT APPROACHES TO DIET AND PHYSICAL ACTIVITY

- Where messages about diet and activity are combined, diet messages dominate, and the activity component is ignored, regardless of the order in which messages are presented.

- For diet, parents' awareness of the problem is high. They are actively engaged with risk behaviours and likely to acknowledge the need for change.

- For activity, parents tend to believe their children are already active enough. They are less likely to see their children's activity levels as their responsibility and more likely to dismiss the need for change.

- Some parents find it difficult to make the link between diet and activity, and will reject communications that try to make that connection clear.

- Linking messages about diet and activity may reinforce the belief already held by some parents that 'it doesn't matter what they eat as long as they are active', thus serving to perpetuate unhealthy diets.

- To be sufficiently motivating the research concluded that communications relating to diet and activity must occupy very different emotional territories:

  – The most effective propositions around diet were those that outweighed the short-term negative consequences associated in parents' minds of trying to change their child's diet (e.g. time, cost, convenience, child fussiness) with the greater long-term negative consequences of failing to change their behaviour.

  – The most motivating propositions around physical activity were those that focused on positive, non-health-related benefits, such as creating happy family memories.

WHAT WORKS: LANGUAGE

- Direct references to 'obesity' and 'weight' alienate parents and may mean they fail to recognise themselves as part of the audience for a campaign or intervention.

- Focusing on future dangers, which most parents are willing to acknowledge, will reduce the risk of parents 'opting out' of a

communication because they don't believe their children are currently overweight or inactive.

- Language should be empathetic. Use 'we', rather than 'us' and 'you'. The most successful communications were those that felt as if they were written by 'another parent'.
- Don't tell parents what to do. This alienates them.
- Use 'could happen' rather than 'will happen' when talking about negative consequences.
- Use the kind of colloquial phrases that parents use themselves, like 'bags of energy'.
- Acknowledging their concerns and reflecting them back to parents, by using phrases such as 'It's hard to say no to your kids' and 'You don't have to turn into a health fanatic to do something about it' demonstrates understanding and empathy.
- Don't be judgemental. Avoid talking about the 'right' foods or 'good' and 'bad' energy.
- If talking about weight is necessary it is important to use clear, simple language. Explain jargon and define terms such as 'overweight' and 'obese'.

WHAT WORKS: IMAGERY

- Images of happy, healthy children draw parents in and encourage them to identify with a shared goal.
- Images of adults make parents more likely to think 'They're not like me, so this doesn't apply'. Images of children are likely to appeal to adults, regardless of their background.
- However, images of very overweight or obese children also encourage deselection since the majority of parents with overweight and obese children may be unaware of or sensitive about their children's weight status.
- Settings should be familiar and everyday, for example local parks, gardens, the kitchen.
- Avoid anything – toys, environments, clothes – too aspirational or 'middle-class'.
- For physical activity communications focus on images of children playing as opposed to taking part in specific sports or types of exercise, as this may lead parents to see the communication as irrelevant.
- For the same reason, in communications around diet avoid images of children eating specific foods.
- Imagery should reflect the fact that families, particularly those in the priority clusters, often don't fit the stereotype of two parents and 2.4 children.

SAMPLE COMMUNICATIONS TESTED IN RESEARCH

Families attending the workshops run by 2CV were asked for their reactions to propositions relating to diet and physical activity. The most popular propositions are shown below with a summary of comments and reactions. It should be noted that these are not fully developed public-facing communications but are designed to provide an indication of the kind of messaging that could work with families. The Department of Health is using these propositions as the basis for further creative development but the exact messages will not appear in any campaigns.

Diet: killing with kindness

Aim: to motivate parents into changing their behaviour by showing them that their desire to love and nurture is actually harming their children. At the same time, it recognises why they do it and that their motives are good.

Why this proposition works:

- Shocks parents by showing how their desire to love and nurture their children could lead to negative outcomes.
- Makes parents reconsider the trade-off between the short-term pain of changing their children's diet and the long-term consequences of failing to do so.
- Combines shock with empathy, by recognising why parents often give in to their children's demands and acknowledging that any harm caused is unintentional.

'That's really horrible… but in a good way. That makes me really think about all those times I give in and it makes me want to go home and throw all our sweets and crisps in the cupboard away.'
Mother, Liverpool

How the proposition should be adapted:

- The idea of 'killing' can be seen as scaremongering. The phrase 'killing with kindness' was most successful with parents when they understood it to mean long-term, cumulative damage to children's health.
- The approach wouldn't work for messages relating to activity, because parents find it hard to make the connection between inactivity and long-term health problems, or to understand the concept of 'giving in' or 'setting limits' in this area.

Activity: every activity counts

Make family time fun
They grow up so fast, what will they remember best? It's the things you do together, like everybody making a meal or getting out to the playground, that make the best memories.

So don't let family time just be about sitting in front of the TV – do something to remember.

GIVING THEM A DAY TO REMEMBER IS A WALK IN THE PARK

Aim: to persuade parents that taking part in activities together is a great way of bonding with their children and to reflect on their own childhood experiences. Reminding them that children grow up fast adds urgency.

Why this proposition works:

- Disarms parents by tapping into positive experiences and the happy memories associated with engaging in activities with their children.
- Parents identify strongly with the idea of shared activities as a way of strengthening the bond with their children.
- Reminds parents of special moments in their own childhood, and stimulates the desire to make sure their own children have similar positive experiences. Makes parents realise they're not currently doing enough physical activity with their children.
- Friendly, direct language.

'Wow, that really works for me. When I [see] that, it makes me want to go home right now and do more things with my kids.'
Mother, Liverpool

How the proposition should be adapted:

- Imagery needs to avoid seeming too middle-class.
- The ideas don't work for messages relating to diet, because the idea of making food a shared activity on a regular basis makes parents anxious and does not reflect their current experience.
- There is a risk that it could be interpreted as supporting the idea of using unhealthy foods as treats.

'I can't see this working for mealtimes. It's too stressful with the kids around. I know they enjoy it but it makes it really hard work for me.' Mother, Nottingham

Activity: energetic, happy children

Happy children
Eating the right food and burning it off gives kids bags of good energy and stops bad energy.

Good energy is what they need for fun and play (and for sleeping well afterwards).

Bad energy (from the wrong foods and sitting around) is what causes tantrums and tears.

To keep your kids happy, give them bags of good energy and get them using it.

Aim: To convince parents that children are happy when they're active, and to show them that exercise delivers benefits other than fitness, for example by helping children sleep well at night.

Why this proposition works:

- Because the children in it look energetic and happy.
- Positive images effectively convey the idea that activity will help them make friends.

'Children should be active. I know my children are happier when they are running around than when they are stuck indoors. It does make me think I should let them do this more.'
Mother, Nottingham

How the proposition should be adapted:

- It may be too rational and lack the strong emotional hook needed to persuade priority cluster families to change their behaviour.
- The distinction between 'good' and 'bad' energy is hard to understand (and not scientifically well grounded).
- The imagery looks too middle-class.
- This approach wouldn't work for messages relating to diet, as equating food with happiness reinforces the appeal of junk/treat foods.

COMMUNICATING WITH ETHNIC MINORITY COMMUNITIES

Parents from the Bangladeshi, Pakistani and Black African communities were surveyed for responses to a number of propositions. They found it easier to connect with messages focusing on diet than on activity. They responded much more positively than their mainstream counterparts to direct, hard-hitting messages about childhood obesity that put across a clear rationale for behaviour change. More emotional, 'softer' messages were less effective.

In the research, the propositions used with the mainstream audiences (as outlined above) were adapted to make them more appropriate for these three ethnic groups, in the main by altering the visuals to include images of people from minority ethnic backgrounds. Two further propositions were developed and tested, in response to the fact that parents were so clearly motivated by their children's future success and attached such high importance to their education.

'Killing with kindness' was the most successful proposition among men and women across all the three groups. It was seen as easy to understand and engaging. More specifically, it prompted parents to think about their current behaviour and examine their motives for allowing their children to eat unhealthy foods. Parents agreed that it was difficult to deny their children the food they wanted and admitted that they often gave in to their demands. Most understood that in their desire to indulge their children they could actually be causing them harm, and that it would be kinder to the children in the long term to give them healthier foods.

'It's straight to the point and it's like a wake-up call, that what you are doing in the name of love could be harming your children and no one wants that.'

Pakistani woman, Bradford

'Some people need a reality check, they need to be shocked. My kids don't want to eat normal food. They like to eat junk, so I understand this.'

Black African woman, London

By contrast, the 'Every activity counts' proposition was less well received. Parents did not respond to the idea of using family activities to generate happy memories, and could not understand the link between the proposition and the need to improve diet and increase levels of physical activity. Many felt that other, sedentary, shared activities such as religious instruction or helping with homework were more important than exercise. The image of a boy bowling was seen as irrelevant, and overall the approach was seen as too 'soft' and as failing to provide a sufficiently clear, direct call to action.

'What is this really about? Is it about family time? Well, that can be about lots of things. And what does this say about having a healthy lifestyle? I just don't understand it.'

Bangladeshi woman, London

'Time spent going to church together is also an activity, not just jumping around. It should not be purely physical.'

Black African man, London

One of the additional propositions developed for the three minority ethnic groups was 'Energy for learning.' This was designed to tap into the groups' preoccupation with their children's education and future prospects.

This proposition attracted a very positive response. It was seen as straightforward and easy to understand. Parents found the message credible and motivating, in part because it related back to health messages they had already heard about the importance of a good breakfast in helping children concentrate at school. The overall tone was seen as positive and motivational. The proposition also spelled out clearly what parents could do to improve their children's prospects.

'The idea of linking children's health to learning and education is what will get parents to take notice because they all want their children to do well.'

Bangladeshi man, London

'Knowing what breakfast is ideal helps us all. If you send the children to school with the right kind of food they will be full of energy and concentration.'

Black African man, London

10. FUTURE WORK

Achieving and maintaining a healthy weight for all children regardless of ethnicity or life circumstances is a complex area covering a large number of different behaviours. The Department of Health is currently carrying out research in a number of areas in order to increase understanding and inform the development of marketing campaigns and interventions. For the latest information on the Change4Life marketing campaign, please visit www.nhs.uk/change4life.

WEANING

Research is being conducted with mothers (including mothers from ethnic minority communities) to:

- get a better understanding of current weaning practices among parents;
- find out what mothers currently know about good weaning practice;
- understand the triggers and barriers to healthy weaning;
- understand how family members, food manufacturers and marketers influence attitudes and behaviours; and
- explore messages that could support behaviour change and promote healthy weaning practices.

SEGMENTATION MAPPING

Work is under way to produce a more detailed geographical mapping of the clusters identified by TNS for use at local level. Other research will provide additional lifestyle data about the cluster families and in particular about their media consumption and shopping habits.

POSSIBLE AREAS FOR FUTURE RESEARCH

Although the current focus is on preventative strategies relating to families with children under 11 years, the Department is also exploring the need for further research to:

- inform understanding of diet and activity levels among teenagers and adults; and
- identify those communication strategies that are most effective in encouraging the uptake of targeted interventions for obese and overweight children.

COMMISSIONING LOCAL RESEARCH

Healthy Weight, Healthy Lives: A toolkit for developing local strategies provides guidance on setting up local social marketing programmes. It is recommended that any further local research focuses on exploring the most effective ways of developing local interventions. This will involve using the national work to inform initial intervention design, and then testing those interventions with parents – or even involving them in the development process. This will help ensure that interventions are tailored to the local environment as well as generating further insights into parents' attitudes and behaviours.

QUALITATIVE RESEARCH AND SEGMENTATION MAPPING

It is anticipated that, should the mapping work prove successful, qualitative research could complement this work. For example, if the mapping work identifies a large number of cluster 1 mothers in a particular local area, those developing intervention strategies for that area may wish to conduct further qualitative research with these mothers to identify locally specific barriers or interventions that could deliver behaviour change.

APPENDIX A: RESEARCH METHODOLOGIES

TNS WORLDPANEL, 2006

The study set out to identify how households with children aged 2–10 years could be grouped into clusters according to their attitudes and behaviours relating to diet and physical activity. Data was gathered from a sample of 883 children and their families via three questionnaires: one completed, individually, by both adults in the household; one completed by the household 'gatekeeper' (the person responsible for food shopping); and one additional survey written by the Department of Health which focused on attitudes and behaviours in relation to physical activity. The additional questionnaire also examined the extent to which parents intended to change their own and their families' lifestyles, the factors that either motivated them to change or acted as barriers to doing so, and their knowledge and understanding of what constituted a healthy lifestyle. Participating families were also asked to keep a two-week food and drink diary.

The 217 attitudinal and behaviour statements from all three questionnaires were gathered and analysed, with questions grouped into factors. A cluster analysis was then carried out, based on these factors, and participating families grouped into six clusters. These clusters were then described according to their attitudes to healthy eating and physical activity, their claimed behaviours, their demographic background, their body mass index (BMI), MOSAIC coding, and food and drink consumption.

2CV INSIGHT, JULY 2007

2CV recommendations for a mass engagement campaign, October 2007

2CV set out to explore the attitudes and behaviours demonstrated by the clusters in more depth. The methodology was designed to reflect the complexity of the issue and to overcome the barriers to gathering information on such a sensitive topic. It also aimed to get beyond claimed and perceived behaviour and discover the actual attitudes and behaviours of priority cluster families.

The research was split into four stages:

- **Stage 1:** The research team interviewed members of the programme's expert review group to capture expertise and insights that could inform the project.

- **Stage 2:** Families were asked to carry out pre-tasks including making a short film, 'A day in the life of my kids', recording a week's worth of 'kitchen cam' footage, and keeping diaries recording what they ate and how much physical activity they did.

- **Stage 3:** Researchers spent two days with each family in the three priority clusters (and also with cluster 5 which was deemed to demonstrate heightened risk factors but not to be a priority cluster), observing their behaviour, carrying out formal interviews with both parents and children, and accompanying them to the supermarket and out to dinner. Families were then invited to take part in a further optional interview with a clinical dietitian. Families in the remaining two clusters (clusters 4 and 6) took part in in-depth interviews, but not in the immersion exercise.

- **Stage 4:** Families in the three priority clusters, and also cluster 5 families, took part in workshops looking at the intervention strategies and marketing concepts developed by 2CV and the Healthy Weight Social Marketing Team.

2CV TESTING OF POTENTIAL MESSAGES, 2007

2CV tested eight possible proposition territories, each representing a different approach to communicating the issue of 'childhood weight'. Each of the eight territories featured two 'adcepts', which explored different visual styles, tones and ways of bringing the propositions to life. The propositions were discussed in 12 'mini-friendship groups', each consisting of four or five representatives from clusters 1, 2, 3 and 5. All discussions were held in participants' homes. At the end of the discussions, participants were asked to take part in a diary room exercise where they could privately record their views on the winning propositions.

ETHNIC DIMENSION, MARCH 2008

Research among ethnic minority communities was focused on six audiences – Black African, Bangladeshi, Pakistani, Gujarati Hindu, Punjabi Sikh and Black Caribbean – and was conducted in two phases. The first phase focused on the Bangladeshi, Pakistani and Black African communities and within this phase four stages were completed, the findings from each informing the next. The second phase was conducted among the Gujarati Hindu, Punjabi Sikh and Black Caribbean communities. Two stages were completed with these communities which built on the learnings from phase 1.

- **Stage 1:** Ethnographic family home visits: Researchers conducted six home visits among

each of the six communities. Before the visits, mothers were asked to complete a record of the family's meals over a one-week period, and children aged 6 and over were asked to write down and draw the foods they liked, foods they disliked, the things they liked to do and the things they did not enjoy. Each home visit conducted amongst Bangladeshi, Pakistani and Black African families lasted five to six hours and included an accompanied shopping trip. Taking account of the learnings from phase 1, home visits among Gujarati Hindu, Punjabi Sikh and Black Caribbean families were conducted as slightly shorter visits and did not include accompanied shopping trips.

- **Stage 2:** Gallery visits: Women and children aged between 8 and 11 from the Bangladeshi, Pakistani and Black African communities were taken separately around a number of 'installations' of visuals including a display of current health messages, collages of 'everyday' and 'celebration' foods and images of physical and sedentary activities.

- **Stage 3:** Small group discussions: Researchers held a number of mini-group discussions with mothers of children aged between 2 and 11, and paired in-depth discussions with fathers from the Bangladeshi, Pakistani and Black African communities.

- **Stage 4:** Health expert interviews: A number of individual in-depth interviews were undertaken with health visitors and other professions involved in providing advice on diet, nutrition and health to families from all six ethnic minority communities.

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