'Insight and Action to Help Stem the Rise of Childhood Obesity':

Full Report of Qualitative Findings

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CONTENTS   **PAGE NUMBER**

A. EXECUTIVE SUMMARY

Research overview
A multi-staged qualitative research programme (including pre-tasks, family immersions, in-depth interviews, semiotic analysis and intervention workshops) was conducted amongst the 6 key clusters identified by TNS in their quantitative segmentation identifying key risk families for childhood obesity.

The research focused on providing a rich and textured insight platform from which to define new messages and intervention strategies for the reduction of childhood obesity in children 2-11 years.

Specifically, the research was designed to fuel insight for the Behaviour Change Strategy by going beyond claimed and perceived behaviour into a detailed understanding of actual behaviour and ways in which to create behaviour change.

The focus of the research was families who exhibit a range of attitudes and behaviours that lead them to fall within a risk cluster for childhood obesity. These families did not necessarily perceive themselves to be at risk and therein lay the overall challenge for this research and the importance of delivering truly actionable strategic (and tactical) findings for Department of Health.

A cultural framework for childhood obesity
The culture of 'consumption' that predominates in the UK today was having a direct effect on the high risks of childhood obesity observed within certain families during this research.

The parenting styles observed within families at risk of childhood obesity frequently revolved around the provision of 'free choice' as a means of parents empowering their children. This was particularly the case in the highest risk clusters where allowing children to make their own choices around food and sedentary behaviour was often a straightforward reaction to the deprivation many families experienced in other aspects of their lives and parental upbringing.

Children were learning to 'over-indulge' as a way of life. This was both in terms of poor diet choices and the lack of activity or indulgence in sedentary behaviours. This way of life was positively aligned with a sense of a child's overall well-being and 'happiness'.

Parental 'modelling' was a key contributory factor behind the risk behaviours for childhood obesity. Whilst parental modelling was recognised by parents, its impact was seriously underestimated and de-prioritised in the pursuit of meeting a child's immediate needs.

The concept of health for at risk families was more likely to be equated with emotional happiness than physical. As long as kids appeared happy, this was the most important thing. In fact, the idea of challenging poor diet and sedentary behaviours was often equated with a sense of 'unhappiness'. Physical health in this sense was often de-valued in relation to emotional health and happiness.

This disconnection from the world of health was supported by the notion that health was a 'middle class' concept. Many high risk families rejected the notion of health brands, products and behaviours and labelled them with negative connotations related to an alien middle class world they felt disconnected from.

The world that spoke more directly to them was the world of brands. The brand messages that at risk families were surrounded by were providing a very different set of messages about the role of health in their children's lives. The constant stream of messages that equate pleasure and fun to sedentary play and branded convenience foods was acting as a more powerful tool for shaping attitudes and behaviours than any health messages were.

The whole area of 'childhood obesity' was in itself an incredibly problematic concept, as was the language surrounding it. At risk families completely disengaged themselves and their lives from the subject of childhood obesity or child weight and tended to view the issue through the lens of the mass media: very extreme cases / cases of parental neglect. This media-led concept of childhood obesity was deeply entrenched within the mindset of at risk families and therefore was seen as an issue that did not relate to them. The complex (often academic) terminology that surrounds the issue further added to the sense of disconnection families felt when asked to engage with the subject.

At risk families also strongly rejected the notion of their child being evaluated according to his or her weight. There were many barriers in place that parents were using to accept their own child's weight from being a problem. Moreover, there was a strong negative reaction to the idea that their child could be labelled as having a weight issue at an early age in life.

It is our opinion that before any change in attitude or behaviour can take place amongst at risk families, a new concept and language around the issue of childhood obesity would need to be found and disseminated. A new sense of awareness and engagement with the issue would need to be created that allows parents to recognise the issues they actually face. This would also require cultural backing to support behavioural change.

Creating behaviour change: overall issues
It is our belief that first and foremost the behaviour change strategy needs to create awareness amongst families of the specific behaviours that put families at risk. In this research parents seriously misperceived the risk attached to their diet and activity behaviours.

Many high risk behaviours were observed across all clusters: heavy use of convenience foods, heavy snacking, high levels of sedentary behaviour and low levels of structured exercise. This was coupled with a low perception of risk within individual families: children not 'appearing' overweight and children appearing sufficiently active.

This would suggest that the key to successful behaviour change will be in turning parents' predominantly reactive approach to their children's health into a proactive one.

Across all at risk clusters identified in the TNS quantitative segmentation there appeared to be a number of different ways in which this may be achieved:

Overall:
- Engage parents to become positive role models for their children by encouraging children to 'pester' their parents to be more active and have healthier diets

For diet:
- Limit excessive grazing by sensitising parents to recognise the importance of limiting snacking as early as when children are 0-2 years old and therefore set good snacking patterns before the bad patterns set in
- Help parents to reduce the chaotic behavioural patterns that take place at mealtimes (planning, limiting children's choice over foods) as early as when children are 0-2 years old before bad behaviour patterns take hold
- Build mums confidence in the kitchen by providing mums and children with the basic skills and ideas to make food preparation a rewarding, shared experience for all the family
- Challenge the value of 'kids foods' and 'convenience foods' in terms of the belief that the value for money (financial and emotional) is higher than for healthier and fresh foods by supporting parents in their quest to find appealing, healthy foods

For activity and exercise:
- Increase general activity levels at a whole family level by providing parents with an understanding of the importance of sufficient daily activity and the difference between this and often less appealing forms of structured exercise
- Reduce the fear of free roaming play within communities where deprivation has led to an increased sense of fear of allowing children to play freely in the local / community by providing safe, family-friendly environments
- Challenge the value of sport outside of school-based activities by raising the value perceptions of structured exercise and making them inclusive

and accessible for families who may currently feel under-confident in sporting environments

Creating behaviour change: the clusters

The quantitative clusters offered a powerful way of understanding the different motivations, needs, attitudes and behaviours of the target audience. The clusters enabled the identification of differing levels of awareness of risk behaviours and willingness to engage with behaviour change.

However, as most risk behaviours were recognisable to a certain degree across all clusters, it may be imprecise to create specific intervention strategies targeted at specific clusters. Rather a broad range of intervention strategies may be required to reach the broadest range of families.

The high risk clusters that were most likely to show willingness to engage with intervention strategies were clusters 2 and 5. These clusters currently have a low awareness of their specific risk behaviours but were very willing to engage with the idea of behaviour change once their awareness of the risks was raised.

The high risk clusters that were likely to take more time to engage with intervention strategy were clusters 1 and 3. Cluster 1 displayed low conscious awareness of their risk behaviours but was also very resistant when faced with the prospect of changing. On the other hand, cluster 3 displayed relatively high awareness of specific risk behaviours but did not consciously attribute them to their own family behaviours.

The overall strategy
Taking the learning from this piece of research into account it is likely that tackling the issues around childhood obesity would require a long-term, integrated intervention strategy with two key aims:
- To engage at risk families with a mass media engagement campaign that reframes the issues of childhood obesity and raises awareness of the risk behaviours
- To empower at risk families with a set of multi-component intervention channels that provide families with the knowledge and skill set to lead healthier lives in terms of diet and activity/exercise levels

It is likely that mass engagement would need to precede mass uptake of interventions and would require more than the simple provision of information. Interventions would need to touch the lives of families in a deep and emotional way.

This research has suggested that it will be particularly important to target on parents of children 0-2 to ensure the creation of successful mass engagement and behaviour change. This would involve targeting parents who are yet to

become parents and are therefore more likely to be open to actively seeking knowledge and skills for parenting. Furthermore, the on-going support of health professionals would be vital for delivering and reinforcing any intervention strategy.

It is our opinion that effective and sustained behavioural change could be achieved most powerfully if it happens at a whole family level. The most effective way of delivering this may be through the children themselves, especially via schools who can target parents through the children. In order to ensure that children communicate directly to parents it is likely that this will depend on how motivating and engaging school initiatives are for children and how capable they are of creating talking points between children and parents in the home. Furthermore, all intervention streams would require the support of social and environmental backing to ensure behaviour change is truly sustainable, particularly through local community and environmental change.

The mass engagement campaign
Based on the findings of this research a mass engagement campaign would be required to reframe the issue of childhood obesity in a way that enables parents to fully engage with the issue that may lead to behaviour change. This would be likely to involve a mass drive to get families healthy across the UK rather than singling out families with 'obesity issues'. We would suggest that finding a new concept and language to communicate the issue will be critical for successful communications.

Although we did not explore any specific communications propositions within this particular piece of research we are able to recommend some interesting starting points for communications territories:
- Reframing the issue of risk behaviour (poor diet and low activity levels) within the negative framework of longer-term effects on children's health (physical and emotional effects) within the positive framework of good diet and high activity levels leading to more energy ('good things in = good things out' and 'LazyTown')

It is likely that the tonality of any mass engagement campaign will be critical for its success. The learning from this research would suggest that creating a playful expression of health would be more compelling than a dictatorial, school text book expression of health.

Designing interventions
We would recommend that the key to 'winning' interventions would be through framing every diet or activity initiative as a positive family experience with the child's happiness at the heart of every strategy. Intervention strategies that were perceived as stress inducing or having the potential to make children (and parents) unhappy were less likely to be motivating on a mass scale.

As we have already alluded to, we believe that it will be important to develop and implement multiple intervention strategies to reach the broadest group of at risk families. It is likely that attempts to target specific intervention strategies towards specific clusters would be imprecise as there was huge amounts of overlap between cluster risk behaviours and huge amounts of variation within cluster behaviours.

Parents of children 2-11 years responded more openly to interventions designed to increase levels of activity than interventions designed to change poor diet behaviours.

It is our opinion that the reason for this was that parents knew that when their families engaged in activity they tended to have a positive experience but when they tried to change their family's diet behaviours they tended to have a very negative experience.

This was not intended to suggest that parents were more eager to become more active. Many parents (esp. mums) had deep-seated issues around being active (e.g. low self-esteem, attaching low femininity to activity). However, they had experienced high levels of happiness from their children being active versus high levels of unhappiness from their attempts to change their children's diets.

The insight generated, explored and developed through this piece of research identified a number of key intervention streams that were designed to provide territories for Department of Health to focus on when developing intervention strategies:

- 'Setting Early Parenting Strategies' through guidelines for diet and activity levels for parents of 0-2 year olds (NHS, local government, health professionals)
- 'Make Cooking Fun' by raising mums confidence for meal preparation and engaging kids in the pleasure of cooking fresh meals (local government, local communities initiatives)
- 'Inspire Healthy Family Meals' by challenging the safety of convenience foods and encouraging the consumption of healthier meals when carrying out the supermarket shopping (partnerships with brands / retailers)
- 'Encourage Active In-Home Play' by turning in-home sedentary behaviours / forms of entertainment into more active experiences (partnership with entertainment brands / TV programmes)
- 'Encourage Active Out Of Home Play' by reinforcing an active family mindset through pleasurable out of home family activities (partnerships with entertainment / local community initiatives)
- 'Get Families Walking' by providing safe ways of creating daily walking patterns to replace using the car (making 'walking buses' really work)
- 'Develop Active Communities' by creating a sense of shift within the local community for organised activity and exercise opportunities that

encourage parents and children to be active together (local government, schools)

B.   BACKGROUND and OBJECTIVES

1. Background

The rising number of overweight and obese people within the population is having a profound effect on the nation's health, with obesity affecting children to an increasing degree.

The government's Health White Paper '*Choosing Health: making healthier choices easier'*, sets out government commitments for action on obesity, including stemming the rise in obesity among children aged under 11 years old.

This reflects the Public Service Agreement (PSA) shared by the Department of Health, Department for Education and Skills and Department for Culture Media and Sport to halt the year-on-year rise in obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.

To contribute to this PSA target, The Department of Health launched the Obesity Social Marketing Programme in March 2007. This is aimed at reaching children and their influencers with a series of messages and interventions. The initial phase of the programme will focus on children age 2-11 and their influencers, primarily parents and carers.

An earlier stage of desk research identified parental behaviours and attitudes as a key influence on childhood obesity levels. This desk research concluded that there were four key factors in parental influence:
- Parents not prioritising physical activity for their children or as a family;
- Limited parental responsibility in food choices;
- Parents not valuing health relating to diet and exercise over other values and priorities;
- Parents having the perception that healthy eating is too hard.

Based on these four focus areas identified in the desk research a 'Behaviour Change Strategy' was developed. The behaviour change strategy was agreed after extensive consultation with stakeholders in government, the private sector and NGOs. The supra goal of the behaviour change strategy is to increase physical activity levels and/or reduce calorie intake in those children under 11 whose families exhibit the key risk behaviours

Whilst the Behaviour Change Strategy was being developed, quantitative research was commissioned with TNS to explore these four focus areas by developing a segmentation of parents with children aged between 2-11 years old. The quantitative study defined six target audience clusters which represented distinct types of families with regard to risk behaviour (reported and actual) and attitudes towards childhood obesity, healthy eating and physical exercise.

The qualitative research detailed in this document was required to integrate and reconcile the findings with the existing strategic priorities outlined in the behaviour change strategy and build a richer picture the segments generated in the quantitative work.

In particular, the qualitative research was required to understand the discrepancy between perceived, claimed and actual behaviour amongst parents and children within at risk segments. This was in relation to both diet and exercise/activity attitudes and behaviours in order that specific messages and interventions could be designed to tackled actual behaviour change.

2. Research Objectives

The primary objective behind the qualitative research was to provide a rich and textured strategic platform from which to design behaviour change interventions (for both healthy eating and physical exercise) amongst parents and children at risk of obesity in terms of:

- Parental attitudes to health living
- Everyday language around the issue of obesity, diet and activity
- Discrepancies between claimed, perceived and actual behaviour
- Triggers and barriers to healthy eating, physical exercise and active travel (motivations, ability and opportunity)
- Key differences and priorities for key triggers and barriers across the segments
- Successful strategies currently being employed by parents
- Key incentives and triggers that motivate parents to overcome barriers
- Parental guilt, blame and denial and how it can be avoided
- The obesity 'debate' (including media sources)
- Who and where they want to receive help / messages from (government, NGO's and private sector)

C. METHODOLOGY and SAMPLE

1. Overview of the research approach

The methodological approach was designed to address the complexity of the issues around childhood obesity and to overcome the barriers of researching a highly sensitive issue. Specifically, the different elements of the approach were designed to get behind claimed and perceived behaviour and uncover the actual attitudes and behaviours for at risk families.

The research approach was set out across a number of stages that allowed for the findings to emerge and develop organically. By sequentially staging the way that the families involved were introduced to the different objectives we were able to cut-through to real behaviour. Equally, by gradually introducing our families to the different elements of the research methodology we were able to instigate a deeper level of sensitivity and involvement in the research that fostered a deeper level of engagement and trust between the families and the research team.

All stages of the research were conducted in consultation and collaboration with Dr Helen Croker of UCL and with the Obesity Social Marketing Team in order to ensure all learning was assimilated by the team and objectives could be refined and developed.

The visual below demonstrates the different stages / elements of the research:
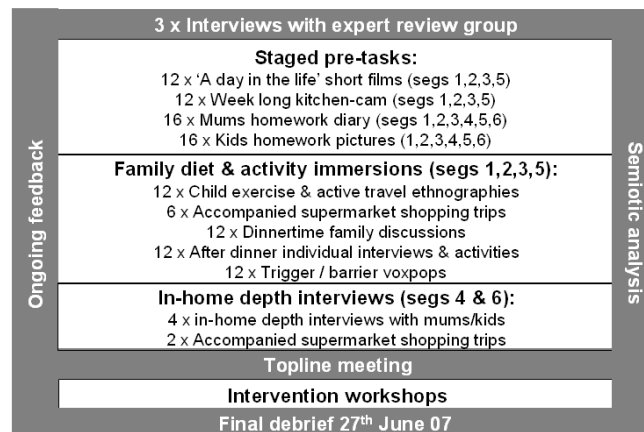
2. The Research Process and in more detail and rationale behind the methodology

The different elements of the methodology presented below are presented in the order in which they were conducted.

Interviews with the Expert Review Group
Prior to conducting any research with families a number of depth interviews were conducted with members of the Expert Review Group. The interviews were focused around understanding existing knowledge held by the different review group members in terms of nutrition and exercise/activity. Specifically, questions were based around methods and insight for going beyond claimed and perceived behaviour and uncovering actual behaviour and motivations for this behaviour.

Interviews were conducted with Susan Jebb, Harry Rutter, Ken Fox & Chris Holmes.

Semiotic Analysis
A piece of semiotic and discourse analysis was conducted concurrently with the qualitative research. The semiotic analysis was designed to provide a broad, contextual platform of insight that could act as a cultural framework for the qualitative research with at risk families. The analysis explored the cultural and historical signs and symbols driving perceptions of childhood obesity in the UK as well as the role of brands and communications in supporting and sustaining significant cultural frames.

The semiotic analysis was merged within the qualitative findings at the final debrief.

Staged Pre-tasks for Families
Prior to conducting face to face research all families taking part in the research carried out 4 pre-tasks. The pre-tasks were rolled out sequentially over a period of 2 weeks and were delivered in this way to help overcome some of the barriers to exposing actual at risk behaviours.

Our belief that families (and specifically mums) would be disinclined to reveal their true attitudes and risk behaviours in relation to family diet and activity levels meant that we needed to be careful how we introduced them to the research objectives. Starting by sending out different pre-tasks allowed us to gradually introduce them to the research but also structure the tasks in a way that ensured we would get a truer record of actual behaviour.

Staged Pre-tasks for Families: 'A Day In The Life Of My Kids' short films
The first of the pre-tasks was to make a short film about a 'day in the life' of the children. We asked all mums taking part to make a short film of 2 days in their kids lives (1 typical weekday, 1 typical Saturday or Sunday). They were asked to

film all the key activities their kids take part in from morning to night e.g. brushing their teeth, eating their breakfast, watching TV, travelling to school, playing outside, any after school activities etc. This task was designed to capture everyday life so that we could analyse the footage to see how much time is sedentary and how much physical activity takes place.

The video footage gave us a good picture of the general activity levels of each family and specifically their children.

Staged Pre-tasks for Families: Week Long Kitchen-cam
The next pre-task they were given was a week long 'kitchen-cam'. For this task the families had a video camera set up in the kitchen. For a week, the family were instructed to switch on the kitchen-cam every time someone went to the kitchen to get some food and explain what they have prepared, why they have prepared it and who was going to eat it. They were asked to do this for all food occasions, from main meals and snacks to a sneaky biscuit when no-one was looking. This task was set up to provide us with a really rich picture of the weekly eating habits across the household and what the specific triggers and barriers were to certain food choices.

The kitchen-cam footage gave us insight into the types of foods being consumed over the course of a week, the type of foods chosen, the amount of control parents had over children's food choices and portion sizes at meal times.

Staged Pre-tasks for Families: Mums and kids homework diaries
The final two pre-tasks were homework diaries: one for mum to complete and the other for the children to complete. These were sent to the families shortly before the research team met with them. The diary completed by mum included questions about her, her life and her attitude to parenting as well as (word and image) collages to capture and explore her language and associations around diets and exercise (see appendix A). Mums were also asked to collect all food shopping receipts so that the actual weekly food shopping could be tracked.

The diary completed by the children consisted of two large pieces of paper and a set of colouring pens. One page was for food, the other activity. Each page had two titles for the children to draw pictures around, they were titled: 'Yummy foods' / 'Yucky foods' and 'Things I love to do' / 'Things I hate to do'. This task was designed to create stimulus for discussion during face to face interviews as well as provide a child's account of the type of diet and activities they found appealing.

Family Diet and Activity Immersions (segments 1, 2, 3 and 5)
The next stage of the research was a period of deep immersion into the lives of different families. All the families were selected to be representative of a different key at risk cluster from the TNS segmentation. The 2-day immersions involved ethnographic observation and behaviour as well as periods of more formal

interviewing with parents and children and accompanied trips to the supermarket and out for dinner.

Each diet and activity immersion took place over a two day period: one typical week day (from getting up in the morning, going to school, coming back from school, evening activity through to going to bed at night) and one typical weekend day (from getting up in the morning, following their activity throughout the day to going to bed at night). By carrying out immersions on both a week and a weekend day any differences in rules, routines and structures that families have on different days of the week were observed. The extended periods of time spend with each family also enabled the research team to develop a comfort level and trust that encouraged the families to behave normally and open up their true thoughts and feelings (where any discrepancies were observed between their claimed behaviour and actual behaviour the pre-task work would be used to challenge this).

Half the sample carried out an accompanied supermarket shopping trip where the research team were able to observe behaviour, interrogate the decision making process and explore the role of pester power and other influencers on purchase.

The research team took part in all activities that the family participated in over the course of the two days, including the dinnertime experience. The family was observed whilst meals were being prepared and consumed. Families were also observed in terms of levels of activity vs. sedentary behaviours.

To explore diet and activity levels at a deeper level we held separate depth interviews with mum and the children after dinner. These interviews were held in the place each family member would naturally go after diner (mum to the kitchen and children to the bedroom/living room to play with toys). The interviews with the children were centred around their activity to elicit a more natural discussion. Where appropriate, we conducted the interviews without mum around so that the child was able to talk to us about any secret snacking or thoughts they would not have discussed as openly if mum was listening. We also used this time to discuss their homework tasks.

Interviews covered the issues of family life and parenting, the role of health in family life, attitudes to exercise / activity and diet and key issues or barriers to healthier living identified by parents themselves. The interviews were naturally quite deep and insightful due to the extensive pre-task work they had completed and the amount of time the researchers had spent with them prior to the formal interviewing. (See appendix B for full discussion guide).

All of the interviews with parents/mums were filmed (providing consent was given).

Following each interview parents were asked if they wanted to take part in an interview with Helen Croker. Helen was described as a Clinical Dietician who was working with the research team on the project and could help them create ways of addressing problems they may have identified with their child's diet and activity levels. Half of the families who took part in the research agreed to meet for a further interview with Helen. Those who refused tended to do so because they were not interested in changing their behaviour and would feel uncomfortable speaking to a professional dietician about their diet and activity levels. Those who agreed to take part were very positive about the experience and tended to be those families who were typically more engaged with changing their overall behaviour.

Family Diet and Activity Depth Interviews (Segments 4 and 6)
The TNS segmentation identified clusters 4 and 6 as less at risk families. We therefore conducted extended in-home depth interviews as opposed to the two day immersion with this cluster. During the depth interviews we spent time with the family talking to them about their thoughts and behaviours in both a structured (depth interview) and less structured manner (around their normal activities). (See appendix B for pre-task).

Topline meeting with Department of Health / Expert Review Group
Following the completion of all of the pre-task work and family immersions a topline meeting was held to share early learning and ideas for new interventions with the team.

2CV provided a document comprising a number of different 'territories' and ideas for developing intervention strategies which were presented and discussed with Department of Health during the topline meeting.

Key intervention territories were prioritised during the meeting and Department of Health took these away to be developed into research stimulus ideas for the subsequent 'Intervention Workshops'.

Intervention workshops (Segments 1, 2,3 and 5)
The final phase of the research programme explored consumer response to the strategic platforms and interventions that had been developed from the previous phases of the project.

The Intervention Workshops were used to explore and develop the new ideas and intervention strategies devised by 2CV/-Obesity Social Marketing Team. As an in-depth understanding of the different attitudes and behaviours of the different clusters had already been gained during the immersions the sessions were used solely to explore the intervention ideas and generate discussion around developing these ideas in an objective environment.
A fresh group of respondents were recruited to take part in the Intervention Workshops. Respondents were not required to divulge any personal information

about their attitudes to parenting, food or activity as part of these sessions to ensure that the situation was de-personalised & left all the mums open to respond to the intervention territories presented in an honest way without fear of being judged.

Stimulus materials included video footage generated in the immersion interviews with parents/mums around the triggers and barriers to healthy diet and activity levels. Specific intervention ideas were presented via stimulus boards created by Department of Health. (See appendix C for stimulus materials).

3. Sample for immersions and intervention workshops

The research comprised of:
- 12 x Diet and Activity Immersions (3 per segment 1, 2, 3 and 5)
- 4 x Diet and Activity Depths (2 per segment 4 and 6).
- 4 x Intervention workshops (1 per segment 1, 2, 3 and 5)

The sample structure for the immersions and depth interviews:

Immersion / Depth / Wshop	Cluster No.	Age	SEG	Supermarket trip?	Location
Immersion 1	1	25 – 34	C2	Yes	Newcastle
Immersion 2	2	17 –34	DE	Yes	Birmingham
Immersion 3	3	34 – 44	C1	Yes	Staines
Immersion 4	5	35 – 64	BC1	No	Newcastle
Immersion 5	5	35 – 64	BC1	No	Birmingham
Immersion 6	1	25 – 34	C2	No	Staines
Immersion 7	1	25 – 34	C2	No	Staines
Immersion 8	2	17 –34	DE	No	Newcastle
Immersion 9	3	34 – 44	C1	No	Birmingham
Immersion 10	2	17 –34	DE	Yes	Staines
Immersion 11	5	35 – 64	BC1	Yes	Newcastle
Immersion 12	3	34 – 44	C1	Yes	Birmingham
Depth 13	4	35 – 64	AB	Yes	Newcastle
Depth 14	6	17 – 34	C2	Yes	Richmond
Depth 15	4	35 – 64	AB	No	Richmond
Depth 16	6	17 – 34	C2	No	Newcastle
Workshop 1	1	25-34	C2	N/A	London
Workshop 2	2	17-34	DE	N/A	London
Workshop 3	3	34-44	C1	N/A	Liverpool
Workshop 4	5	35-64	BC1	N/A	Liverpool

Specific cluster definitions were derived from the data supplied by the TNS segmentation work. (See appendix D for the recruitment screener and pen

portraits used during recruitment). The recruitment screener recruited participants based on their attitudes towards food & activity. Participants were not recruited according to Body Mass Index.

All fieldwork was conducted between 8th May and 12th June 2007 by Amanda Anderton, Selena King, Darren Hanley and Caroline Westwood.

D.   MAIN FINDINGS

1. Childhood Obesity: A Cultural Framework

This first section of the report is designed to provide a cultural context for this issue of childhood obesity in the UK and much of the learning is based around the semiotic and discourse analysis conducted. Elements of this section are also derived from the broader contextual learning generated by the qualitative research programme.

The culture of choice
It is our opinion that many of the issues driving the rise of childhood obesity in the UK can be attributed to the culture of 'choice' that families live in today. This culture of choice can be understood as a direct result of the UK being a highly evolved market-driven society where 'consumption' is the most dominant driving force. The desire for consumption has taken over as a societal guiding force from more traditional modes of authority and structure. This is also reflected in the noticeable erosion of the role of the church, the lack of national identity and the scepticism towards Government that was reflected in the lives of many of the families identified as at risk of childhood obesity.

It is our view that the impact of this drive for high consumption levels can foster an expectation of unlimited individual choice within the way families behave. This appears to lead to many families believing that it is their right (and their children's right) to have what they want, when they want it.

The desire for 'free choice' and 'unlimited consumption' showed a direct effect on the parenting styles observed during the research. Many parents (especially those in the high risk segments) were buying into the provision of choice as a tool for empowering their children in daily life. This had a prominent effect on the way that decisions around food and activity levels were being played out. Many children were being allowed complete control over their diet choices and were choosing to engage in highly sedentary behaviours instead of active.

It is worth noting that 'choice' is especially empowering for families who experience deprivation. When free choice is restricted in other aspects of a family's life they appear to focus on providing total freedom of choice in the areas of life where they are able to do this. For example, many of the high risk families placed great emphasis on the provision of high value goods that encourage sedentary behaviour and convenience foods as a way of compensating for the environmental deprivation and lack of other opportunities parents were able to provide. Similarly, this lack of parental control over diet and behaviour in the home was often cited as a conscious reaction to the way parents themselves were brought up. For examples, many parents had experienced difficult

childhoods whereby food choice was non-existent and high value toys were simply not available.

"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, dvd's. 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!" (Mum, segment 3, Newcastle)

By giving children freedom to choose this frequently often leads to over-indulgent behaviours where children will more often than not chose unhealthy options. In relation to food it appeared that the guilty pleasures were the best pleasures. Children were quickly developing preferences for poor food choices (high fat and sugar foods). In relation to activity, children appeared to quickly develop preferences for sedentary behaviours (usually linked with aspirational entertainment products like gaming consoles / TV etc).

A typical mealtime situation would involve:

Mum: "So what do you want to eat? "Do you want your favourite?"
Child: "Yeah?"
Mum: " Well what's that?"
Child: "fish fingers, waffles and beans"
(Mum & Child, segment 2, Birmingham)

A typical after-school situation would involve:

Mum: "What are you going to do till tea-time?"
Child: "Play on my Nintendo and watch TV"
Mum: "good, well keep the noise down"
(Mum & child, segment 1, Newcastle)

Parents were allowing their children to keep making these choices regardless of any awareness that the choices were 'unhealthy' or even that they were leading to problem behaviours (e.g. hyperactivity, lethargy, and tantrums). The reason behind this appeared be driven by the sense of 'happiness' that children were deriving from their over-indulgence. The happiness and gratification children showed through being able to choose quickly became a powerful emotional weapon which was used to sustain indulgent behaviours. Parents were primarily concerned with making their children happy and as such were meeting their immediate needs over and above consideration of the long term impact of their behaviour.

Parental modelling
Although the children were given freedom to make choices around diet and activity, ultimately it was parents who shaped their behaviour. In reality parents

were the decision makers; they held the purse strings, bought the products, prepared the meals, facilitated the activities and set the boundaries for behaviour. Moreover, parents were modelling and reinforcing their children's behaviours and attitudes through their own behaviour (poor diets and heavily sedentary lifestyles). Whilst parents consciously recognised the direct relationship between what they did and what their children did, they dramatically underestimated the impact this had.

"I know that she is fussy because I am a fussy eater. I pull a face if Bob puts any vegetables on my plate. I always have. I know she gets some of those habits from me but it does worry me how she goes through these phases with eating and 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" (Mum, Segment 2, Newcastle)

Health and happiness
Parents tended to believe their children were healthy providing their children appeared to be happy and had no obvious issues with ill-health. High risk families tend to gauge their child's happiness on their emotional and psychological well-being rather than their physical well-being. The provision of unhealthy foods and the encouragement of sedentary behaviours are often perceived to be expressions of love between a parent and a child.

"To me healthy is about them being happy, like smiling, sleeping well and not worrying about things. I don't really think about whether they are physically healthy because I can see that they are. If they were ill, I would know" (Mum, segment 1, Birmingham)

In essence, many high risk parents place less emphasis on physical wellbeing. Although at a rational level parents *did* show some denial and guilt over allowing their children poor diet and low activity levels, they often over-looked the importance of physical health and de-valued and de-prioritised its importance in the pursuit of emotional and psychological happiness.

Aside from being an expression of love, many risk behaviours appeared to reflect other highly emotional drivers.

The provision of convenience foods was driven by a desire by parents to be seen to provide their children with enough food. Often there was a deep-seated fear that children were going to be seen by others (parents, teachers) as 'going hungry'. In families where the provision of food can at times be quite difficult and financially restricted, greater importance is placed on the provision of food as a means of expressing a sense of 'survival' to the outside world.

The emphasis placed on sedentary behaviour was also considered a reflection of a family's success in life. Its ability to be able to 'do nothing' when possible was frequently perceived as a privilege, something they had earned and something

they wished to display to the rest of society. Being sedentary when out of work/school time was seen as an important compensation for the labour intensive working lives that many parents were forced into in order to provide for their children. This is further compounded by the sedentary nature of high desirable 'status' entertainment devices these families had purchased for their homes (dvd players, Sky Plus, big screen TV's, games consoles).

"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. I can't be out and about all weekend as well. We all watch TV together and its nice we can enjoy what we pay for" (Mum, segment 5, Manchester)

The world of health
Further to this, for many at risk families the world of 'health' (brands, products, and exercise behaviours) was laden with negative and disengaging connotations (highly punitive, stressful, complex, uninspiring and unrealistic). This perception is reinforced by the 'middle class' brand, product and behavioural 'health' values that created a sense of social class around food and activity that tends to alienate lower socio-economic groups. Many families held a common belief that health in the UK today is something that is not accessible to the 'working classes'. Equally, that health it is the privilege of the middle-class mother who can afford to stay at home and focus on creating healthy meals / pay for healthy family activities.

"Health means boring, dull and tasteless and it's about being a member of a top notch gym and going their every day to slave away" (Mum, segment 2, London)

"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" (Mum, segment 1, London)

High risk families appear to be far more heavily influenced by the brands, brand communications and brand experiences they receive on a daily basis than any abstract notion of 'health' that they feel they cannot aspire to. The brands that come into their lives on a daily basis tend to deliver very positive and rewarding experiences for all the family. A trip to McDonalds, a packet of biscuits, a DVD and a pizza and watching their favourite soaps appear to be far more connected to the lives of high risk families and continually reinforce their disconnection from the world of health.

"They love it when we go to McDonalds once a week, maybe even more often because there are never any arguments and everyone is happy. We all have a good time there so why not go back?" (Mum, segment 3, Birmingham)

Looking to the world of brands, communications and retail (supermarkets) will be a critical part of any strategy for tackling childhood obesity. Families look to these as references of how to live their lives and are highly receptive to messages they

receive. Equally, many of these families lived in environments where the opportunities to change their behaviour are not immediately present or appealing and therefore encourage parents to sustain their existing, unhealthy lifestyles.

The concept of childhood obesity
The term 'childhood obesity' was very disengaging for many at risk parents. Parents frequently associated obesity with extreme cases of severe neglect and abuse and therefore something they would never attach to their own family situation. When conceptualising the issue of childhood obesity the image portrayed in the media was the most predominating, for example, the cases of 14 stone 9 year olds featured in the newspapers and local news.

As a result, at risk families did not see their children as being at risk of obesity. This was further compounded by the perception that the term obesity was surrounded by complex and alien academic and clinical terminology e.g. BMI / clinical obesity / morbid obesity. This type of language appeared to distance many at risk families further from the issue.

"Yeah I know one kid like that, they call him Little Timmy, and, oh bless him, his tummy is so big he can't even pull himself out of the swimming pool when they go there and when he runs he gets all out of breath and goes red, oh it's terrible really, but you always see him eating something and his parents are big too"
(Mum, segment 5, London)

"Childhood obesity is all over the news at the moment. Its terrible how parents can allow their children to get like that. I mean, you would just do something about it wouldn't you? I would never let my kids become obese, its just awful"
(Mum, segment 1, Newcastle)

Additionally to this, at risk parents frequently rejected the idea of evaluating their child based on their weight / BMI. In fact, the whole idea of discussing weight with their child was strongly rejected and created very high levels of anxiety for parents.

Parents appeared to have many firm barriers in place when presented with the idea of discussing their child's weight. Many parents believed every child is different and that measures of weight do not allow for individual rates of maturation and other factors affecting weight such as 'puppy fat'. More importantly, parents were highly sensitive, anxious and fearful that their children would be labelled at an early age which they believed had the danger of putting their children at risk of emotional problems, eating disorders and potential bullying.

"I think it's totally wrong to make children aware of their weight – my daughter is bigger than some of the other girls in her class and I'd worry that she'll stop eating and become anorexic because she would think she is fat and the others

would call her names, she is already asking me if her bum looks too big" (Mum, segment 5, Manchester)

"It actually makes me angry to think that someone at school will be measuring my child and telling her she is obese or over-weight. How dare they? Its too early in their lives to be thinking about weight. This is where problems start!" (Mum, segment 1, Newcastle)

Creating a new cultural framework for childhood obesity
It is our opinion that the cultural framework that families at risk of childhood obesity are currently living in presents many complex barriers to engaging with the issue and ultimately for creating behavioural change.

However, the majority of parents want their children to be healthy because they want their children to be happy. It would appear that any childhood obesity strategy needs to make a new connection between a child's happiness and their physical health (in terms of both diet and physical activity levels).

It is our view that to make this happen, first and foremost parents need to recognise that they need to change their attitudes and behaviours towards their family's health before they will want to change it.

Critically then, we believe that tackling the issue of childhood obesity will require the creation of a new awareness and engagement for parents. We would suggest that this is likely to involve a new concept and a new language around the issue that helps to reframe what children's health is in parents' minds. It is likely that this would mean avoiding the issues of 'weight' and 'childhood obesity' in themselves.

Nevertheless, taking into account the deprived environments many of these high risk families inhabit, it is likely that families will not be able to make these changes alone. The provision of cultural backing to support any change (social, environmental and market intervention) is likely to be integral in the successful creation of behaviour change.

2. Tackling the issues of childhood obesity

Overview
It is our opinion that many of the issues that are faced when tackling the issue of childhood obesity can be observed across the clusters provided by the TNS segmentation.

We believe that it is worthwhile starting with these commonalities when designing the childhood obesity strategy.

Creating an awareness of risk behaviours
One of the biggest issues faced in stemming the risk of childhood obesity is the apparent misperception of risk exhibited by parents in risk families. At present there appears to be a very low awareness of the impact that poor diets and high levels of sedentary behaviours may be having on their children's health.

Across all of the diet and activity immersions carried out during this research high levels of actual risk behaviour was observed. This primarily included the heavy use of convenience foods, high levels of snacking, high levels of sedentary behaviour and low levels of structured exercise.

In most cases, parents did not perceive there to be a problem with their family's' behaviour due to the lack of any perceived indicators of risk. Namely, parents did not perceive their children to be overweight and were often perceived to be 'normal' or even underweight. Equally, parents believe that their children had 'normal' or high activity and energy levels. Some parents even told us that they had been advised by health professionals that their child was obese, but that they had disregarded this as they did not think their child appeared to be overweight.

"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. I would worry if she was really fat or didn't have any energy but she runs around all day at school"
(Mum, segment 3, London)

To this point, most parents were not able to see a problem in continuing in the existing patterns of behaviour and envisaged they would do so until they perceived there to be a significant health problem with their child (e.g. excessive weight gain or illness).

Parents were exhibiting what appeared to be a 'reactive' approach to their children's health not a proactive one.

"I know that, touch wood, my children will not put on weight so I let them have what they want, like chocolate, crisps, sweets and cakes"
(Mum, segment 3, London)

Engaging parents to become positive role models

Most of the risk behaviours we observed during the research were being modelled for children by their parents. For example, if mum tended to be a 'fussy' eater or dad had a tendency to be 'addicted' to convenience foods then this tended to be apparent in the children's behaviour. Likewise, parents were passing on their own lack of motivation to be active onto their kids.

"Aaron likes to sit around the house all day with me. He's not really that into playing out with his friends or going to football. None of us really go out that much. We prefer to stay home and watch TV and play board games together"
(Mum, segment 1, Newcastle)

For most of the at risk families mums were playing the most important role influencing children's attitudes and behaviours towards diet and activity levels. This is in large part due to the fact that many dads were either absent or somewhat disconnected from many of the family decisions around diet and activity choices due to work commitments or a traditional attitude towards parenting that deems mum as the primary care giver within the home.

This said, in some cases fathers were having an important impact on children's attitudes to diet and activity. Fathers were sometimes having a positive influence on children's activity and exercise levels. Many fathers would spend time with children at weekends engaging in activities or teaching their children sporting pursuits (e.g. bike rides, playing football or going on walks). However, this behaviour was largely inconsistent and tended to lapse for long periods of time when dads were felt to be too busy or the weather wasn't seen as appropriate. Whatever the case, fathers certainly had more impact on whether children were engaging in family activities than mothers were.

Similarly, fathers sometimes had an influence on children's diet. Fathers often had poor diets themselves and a heavy reliance on junk food and 'treats' in their own diets. Working in manual professions often meant that dads sought energy dense foods during their working day and tended to bring these preferences into the home. This did not always mean that children ate what dads ate. Mum was primarily the gatekeeper for mealtimes and in some cases dads would eat separately from mums and children. However, when dads were given control over food choices these tended to be convenience food driven and more often than not involved convenient out of home eating choices (e.g. fish and chips, McDonald's). Dads would frequently explain that they rarely determined the meal choice of their children so that when they had the chance they wanted to 'treat' them to out of home convenience foods as a means of being able to spend time with their children and bond with them over the experience. Inevitably, many children associated very positive family experiences with these convenience food decisions driven by dads.

However, most at risk parents were prepared to implement positive changes to the diet and activity levels of their family if it was perceived to make their children happy. For example, many parents had engaged with 'walk to school week' and 'fruit taster sessions' initiated by their children's desire to be involved in them. The success of these school-driven initiatives was largely dependent on the promise of a reward for children's participation e.g. to the collecting of gold stars and other privileges based on regular participation.

"We recently did a 'walk to school week' because the kids were getting gold stars for everyday they walked. It was fun and made me want to do it more often because the kids loved walking with their friends and came home everyday excited about getting the stars" (Mum, segment 5, Birmingham)

It is our opinion that there is a good opportunity to harness children's 'pester power' in a positive way to get parents interested in family health, which in turn may lead to positive modelling behaviour from parents themselves.

Issues around diet
A number of the issues with family diets leading to risk behaviours were observed during the family immersions. These included snacking, chaotic meal times, low confidence in the kitchen and the perception that 'kids foods' as convenience foods.

Issues around diet: Snacking
For many high risk families snacking was a way of life. Snacks were being used by parents and children in deeply emotional and complex ways: as reward for good behaviour, as appeasement during conflict, as comfort, as fillers for periods of boredom and as signifiers and punctuators of tasks throughout the course of the day.

Parents were largely unaware of the amount of snacking that was taking place within the household. This was both in terms of the amount of snacking they were doing themselves and the amount of snacking their children were doing. Parents tended to have a total misperception of the amount of control they had over their children's snacking levels and the type of snack foods that were being consumed.

"No, no, they have to ask me if they want a snack – because that way I know what they are eating and can stop them if they have too much" (Mum, segment 3, Birmingham)

"I thought I didn't allow my kids to snack that much but I realised when I looked through my shopping receipts that we must all snack way too much because we buy so many snacks and the cupboard is always bear" (Mum, segment 2, Manchester)

Additionally, many mums believed that they carefully restricted the type of snacks children consumed.

> *"I always make sure that we have fresh fruit around the house and they know they can have that whenever they want it" (Mum, segment 1, London)*

However, in reality many kids would sneak unhealthy snacks when mums were not looking or mums would turn a blind eye and say yes to snacks as long as the kids had asked her permission.

Parents' gross underestimation of the extent to which snacking was apparent was in large part due to the complete lack of awareness they had over recommended snacking guidelines. It was their opinion that without any understanding of how and when to regulate snacking they were powerless to restrict snacking properly.

Issues around diet: Mealtimes

For many families at risk of childhood obesity mealtimes had little sense of structure and few rules were being imposed by parents over how children should behave and how mealtimes should be carried out.

The chaotic nature of most family mealtimes appeared to be characterised by parents doing little planning for mealtimes, not setting any specific times for when meals should happen, allowing children complete control over meal choices, making multiple meals based on individual tastes and preferences, families rarely consuming meals at the table or as a whole family, and poor plating strategies (either a 'one size fits all' approach and/or very imbalanced plate composition). As a result of this approach to mealtimes risky dietary behaviours were observed, including heavy use of convenience foods, over-portioning on children's plates, unbalanced plates (mainly with no vegetables included).

It is our opinion that once these patterns of behaviour have become embedded within normal family life they are very difficult to overhaul. Partly because parents seem to be unaware of them and partly because they become parental coping strategies to defuse mealtime tensions. Most parents are not equipped with the knowledge and skill set to create successful meal time strategies before it is too late.

> *"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" (Mum, segment 2, London)*

> *"I think it's too late now, I wish I had known differently when she was a baby, now I know she won't try any vegetables because its just been going on for too long.*

To try and change things now would be impossible" (Mum, segment 1, Newcastle)

Issues around diet: Building mums confidence in the kitchen
It was apparent from the family immersions that one of the main reasons why family diets are quite poor is that many of the mums had low confidence in the kitchen. They often cited 'time and convenience' or 'laziness' as important barriers to preparing healthy meals for the family. In reality, we believed this was not the case.

With deeper exploration it became apparent that most mums were actually lacking the knowledge, experience and skill set required to prepare healthy meals for all the family. Most of the mums in high risk families appeared to be very under-confident preparing meals. There was a lot of anecdotal evidence from mums suggesting that they had experienced feelings of rejection around mealtimes when children had refused to eat their meals.

Many of the high risk mums employed a limited range of tried and tested meals that were known to have a high success rate. However, this often meant that children's meals were comprised of a fairly limited repertoire and it is likely that they had ended up creating a certain amount of 'fussiness' and 'faddishness' though boredom with their limited mealtime repertoires.

"We have a basic set of different meals that I know the kids will eat. Fish fingers, chicken nuggets, chips and burgers. One week they will say they don't like stuff anymore and I don't understand it because they ate it every night last week"
(Mum, segment 2, London)

The idea of scratch cooking or cooking with fresh foods was often quite anxiety inducing for many mums. From our observational work, this sense of anxiety was often apparent within the children themselves when they were in the kitchen area. Most of the children we met were quite disengaged from the cooking process and viewed mealtimes as quite stress inducing too.

Issues around diet: 'Kids foods' as convenience foods
There was a tendency for parents to classify 'kids foods' very differently to adult foods. 'Kids food' tended to include many 'yellow' foods like fish fingers, waffles, chicken nuggets that were packaged and presented as kid friendly within supermarkets. There was an assumption that many adult foods would be too complex in flavour, colour, taste and texture and therefore not suitable for children.

There was also a perception that 'kids foods' were better value for money than fresh and healthy foods. When parents talked about value for money, they often referred to financial investment and a belief that convenience foods actually cost

less money that fresh ones. However, on reflection most parents concluded that this is probably not the case. The value for money that they are actually referred to was in terms of the emotional return they were making on their investment in convenience foods for kids. For example, the gratitude, the excitement, the pleasure of being able to give their kids what they ask for and the fact that plates are cleared.

"I think that sometimes its just cheaper to buy frozen waffles than buying potatoes and making my own mash. Maybe its not? But its definitely easier and I know they will get eaten so there is no waste. That's important for us because money is tight" (Mum, segment 1, Newcastle)

Before long, it appears that children themselves start to perceive certain foods as their own and will attribute a sense of independence and control to the consumption of convenient kids foods.

The appeal of kids foods is also supported by the way these products are marketed. Many high risk families were heavily guided by price promotion when supermarket shopping. BOGOFs were particularly appealing and if these focused around convenient kids foods these would often be purchased in bulk. As a result there was a tendency for many families to consume the bulk purchase products over the course of 1 week to make a saving on their overall weekly supermarket spend.

"last week they have 3 packs for the price of 2 on chicken nuggets so we bought them. It was good for us because we spent less and the kids got nuggets every night last week till they were all gone" (Mum, segment 2 Birmingham)

Issues around diet: The supermarket shop
The experience of supermarket shopping was commonly felt to be an unpleasant task. With fairly tight budgets and the presence of children during the shop, parents commonly complained of feeling tired and stressed.

This meant that most parents would find themselves succumbing to fairly repetitive purchase decisions, making the introduction of new, healthier foods to the basket fairly non-existent. This also meant that for many risk families there was a tendency to stick to the safety of convenience foods that kids pester for.

The majority of time was spent in the convenience food aisle itself and very little time was spent in the fresh fruit and vegetable section. This is in large part due to the learned behaviour they employ when shopping the supermarket and the desire to make the process as quick and efficient as possible. This can often mean that fresh foods are not even browsed. By contrast, the convenience foods and snacks aisles were enjoyable and reassuring offering the bright colours, brands and price promotions most families are seeking.

"It's so boring shopping for veggies, I can't get any inspiration here" (Mum, segment 3, Birmingham)

"We normally head straight down this aisle to the frozen food. This is where we buy most of our stuff so I don't bother with the other aisles anymore because I just want to get in and get out" (Mum, segment 1, Newcastle)

Additionally mum found shopping for ingredients for a meal prepared from scratch stress inducing due to the complexity of seeking out different ingredients located in different parts of the store.

"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" (Mum, segment 5, London)

Issues around activity
A number of important issues were identified associated with low levels of exercise and activity within at risk families, including high levels of sedentary behaviour, a lack of understanding about general daily activity levels, a fear of free roaming play and the low value placed on out of school activity.

Issues around activity levels: Increasing general family activity levels
Throughout the family immersions it was apparent that many families are largely inactive and had very high levels of sedentary behaviour. There was a tendency for most members of the family to spend large periods of time 'chilling out' either alone or together. This was never perceived to be a risk behaviour. Rather, this was largely seen as something that had been earned when returning from work or school.

Key sedentary behaviours tended to include time spent in front of the TV or playing on game consoles (e.g. Playstation, Xbox, PSP). Parents would often encourage sedentary behaviour either as a means of controlling children and providing them with respite from children's natural activity levels or as a way of bonding with children by encouraging them to behave in the sedentary way that parents themselves preferred to behave.

Parents would also place pressure on their children to play with expensive, 'status' toys like PSPs and Playstations as a way of ensuring that children were making good use out of these costly investments. This pressure to engage with expensive toys also added to the amount of positive reinforcement many children received for being sedentary in their play.

"Sometimes I just tell them to sit down and play quietly or watch TV because their running around gets on my nerves. Its much nicer when we are all sat together and enjoying ourselves because we really get to talk and cuddle and that's important to me"
(Mum, segment 3 Birmingham)

"I am not really an out and about type of person. I like it when the kids are home because now they are both at school I never get to see them" (Mum, segment 1, London)

For many at risk families there was a belief that their children were sufficiently active everyday, primarily when they were at school. This often legitimised the encouragement of sedentary behaviour at home. In most cases there was a misinterpretation of the high energy a child would display at home (chatting, being boisterousness) for activity levels. Equally many parents misunderstood the difference between being active and structured exercise and often believed that structured exercise was enough.

"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. Its natural for kids to be active so I am not worried. Its not like they need to exercise like adults. They are kids!"
(Mum, segment 1, London)

Issues around activity levels: Fear of free roaming play
Many parents would not allow their children to play freely outside of the home (whether they were accompanied by an adult or not). Parents felt that the communities they live in are not safe enough or pleasant enough for their children to play in.

Many high risk families are living in areas of high deprivation with high crime rates, a predominant gang culture, drugs, poverty and poor community facilities. This meant that families would restrict their children from playing away from home (accompanied or not). The main concern for parents was a desire to preserve their child's innocence and in particular, to keep them away from older children who could influence them.

"I don't want her playing outside as 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"
(Mum, segment 2 Newcastle)

This is compounded by poor stature of the local environment. Although out of London most houses would have access to gardens or local playing fields, most of the facilities would be run-down and considered unfit for young children.

"There is always gangs hanging around the parks and there is broken glass and things like that, so I don't want them playing there, actually, I don't even want to go there" (Mum, segment 3, London)

Issues around activity levels: Challenging the value of structured exercise
Most at risk families tended to devalue the role of structured exercise and sport. This was in large part due to the lack of value that exercise played in the lives of the parents themselves. Most parents did not engage with sporting activities and tended to place more importance on the provision of material possessions than their families exercise levels. In some cases children would express a desire to engage with more activity & exercise but would be actively discouraged by their parents (through lack of motivation & confidence). This overt desire to take part in more family exercise activities (e.g. family bike rides) was particularly prevalent amongst children under the ages or 9 or 10 years. There was a tendency for children entering their 'tween' years (9-11) to start to reflect their parents lack of motivation for activity & exercise & demonstrate an increasing preference for sedentary behaviours.

Parents tended to believe that their kids did enough exercise during school time (PE lessons, playing in the playground etc.) and did not really believe that they needed to do more outside of school. Equally, there was a tendency for many parents to believe that after school sports activities are costly and inconvenient. Parents would openly complain in front of their children about how expensive after school activities were and how much 'running around' they had to do. Sadly, many of the children would take on these perceptions themselves and complain that they too thought the after school clubs were too much hassle and money.

"It costs so much as we have to pay termly, especially when they all want to do something…when she said she didn't want to go anymore she stopped straight away" (mum, segment 5, Birmingham)

Underpinning this lack of interest and engagement with activity and exercise appears to be a much deeper seated set of issues around parental confidence for being active. There was a tendency for many mums to attribute the role of 'doing exercise' to her partner / husband. Although many dads would assume this role, their relative absence from the home would in most cases mean that family exercise would rarely take place.

For mums there were many issues around body-image that would prevent her from taking part in structured exercise with her family. This was compounded by perceptions that there were no 'safe' places where she could exercise with other mums who also lacked confidence in their appearance and ability to exercise. Mums appeared to develop an attachment to the home which was bound up in her maternal role. This meant she would sometimes actively discourage her children from leaving the home to undertake structured exercise as she did not want them to leave her behind.

"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" (Mum segment 3, London)

"I know its selfish but I sometimes don't want them to go off to dance class because I like keeping them home with me whilst I still can" (Mum segment 5 Newcastle)

Issues around activity levels: Discouraging car dependency
The levels of car dependency observed during the ethnographic research were very high. Cars were frequently being used for many short, 'walkable', regular journeys. Most significantly, cars were frequently being used to make short daily journeys to and from local schools, local shops, or to nearby relatives houses.

The relationship families had with their cars were very complex. For many, the car represented an important extension of their self-image and a key status symbol to signify success and material wealth to others.

"Everyone drives their kids to school. I mean I could walk, easily, but I don't because all the other mother's 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"
(Mum, segment 5, Birmingham)

For some parents using the car also represented a sense of power or control over their lives. For many parents, especially those in more deprived situations (segments 1 & 2), using the car excessively was almost used as a weapon against the laws and regulations they felt were impressed upon them. There was evidence of parents who regularly and actively flouted the parking laws outside schools as an overt act of resistance to schools preventing them driving to school everyday.

Many rationalisations were made for excessive car-dependency (the simplicity, speed & convenience of using a car). However, in many cases there was a more emotionally complex set of motivations for taking the car, especially for daily school journeys. Many parents would report that their children were resistant to walking to and from school. There was little real understanding of why the children were resisting walking and there was a clear sense of relief from parents that the car was the preferred mode of transport. It is our belief that (much like attitudes to structured exercise) many parents were influencing their children's attitudes towards walking to and from school through their own lack of desire and motivation to walk.

"Its strange, we used to walk to and from school everyday and then last year she just stopped wanting to walk in the mornings. We walk home after school but in

the morning she wants to go in the car or on the bus. I don't know what it is. I don't mind though because its less exhausting for me" (Mum, segment 2, Newcastle)

Nevertheless, many parents were aware of their excessive car dependency and on deeper consideration were prepared to admit that they could easily make many of their regular journeys on foot (especially, daily journeys to and from school).

"Actually when I think about it I know we drives to much and I am not sure why we just don't walk. Its habit I suppose. But it's a hard habit to break!" (Mum, segment 3, Newcastle)

In fact, when many families had experience of 'walking buses' or 'walk to school weeks' the feedback on these initiatives was overwhelmingly positive. There were many positive aspects cited for taking part in organised walk to school initiatives: children being able to spend time with their friends, mums making friends with other mums, children being rewarded for walking at school, mums being able to relinquish responsibility for getting kids to school on some days, and a general feeling of well-being gained from taking part in daily activity / exercise.

The main problems with walk to school initiatives lay within a need to ensure these initiatives were ongoing. Drop out rates were very high primarily because the initiatives were dependent on a voluntary group of parents organising this themselves rather than a more formalised initiative that removed the responsibility from the parents themselves.

"I like the walking bus but it was a couple of the mums from the estate who ran it and they started going a different way so we couldn't join it that easily so we started taking the car again" (Mum, segment 1, Newcastle)

3. Cluster engagement

Overview of clusters

It is our opinion that understanding the segments at a deeper more emotional level offers a powerful way of unpicking the differing motivations, needs, attitudes and behaviours of the different target audiences at risk of childhood obesity. Through deeper exploration of the clusters we have been able to identify the varying levels of awareness that different clusters exhibit of the risk behaviours attached to childhood obesity and predict different levels of engagement with the idea of behaviour change.

It is our belief that targeting specific clusters with specifically designed intervention strategies may be imprecise, as the majority of risk behaviours are represented across clusters. Although the motivations behind risk behaviours may be different, it is likely that the overlapping of key risk behaviours means that there is a high degree of variation within clusters driven by the complexity of individual family situations and circumstances.

From our research we found that segments 1, 2 and 3 exhibited behaviour and attitudes that make them the most at risk of childhood obesity. Segment 5 is still at risk, but at a slightly lower level. In accordance to the quantitative study, Segments 4 and 6 were identified as low risk clusters. However, as we will see, this does not necessarily reflect how the different segments will respond to intervention strategies.

Segment 1 – High Risk of Childhood Obesity

Segment 1 families, tended to be a low SEG cluster (C2D) living in particularly deprived areas with few local facilities or amenities at their disposal (i.e. areas of high crime and low employment rates). Both parents tended to have few qualifications, fairly low aspirations and were in low paid manual jobs. Parents of cluster 1 families also appeared to have few aspirations for their children and were comfortable with their kids following a similar path in life to their own.

With no real social life / hobbies or interests, daily life was focused around the family (including extended family that tended to live very close by). Life was characterised by fear and worry and focused heavily around the provision of money, specific family situations and close relationships.

> *"Money is really tight, I watch every penny and am constantly worrying about paying bills and being able to buy the kids the things they want. I don't really have time to think about anything else" (Mum, segment 1, Newcastle)*

Dad was often absent both physically and emotionally either because he worked away from home or had long working hours, which often meant that parental responsibility fell down on mum. Many of the mums had noticeably low self-

esteem and openly talked about themselves as under-confident parents who found it difficult to enforce parental rules and regulations.

"I really don't like telling the kids off or telling them what to do. Its hard with my partner away all the time being the person who has to discipline everyone on top of everything else I have to do. I prefer to just let things slide so that we can have a nice life together. I guess that means they sometimes are the boss of me!"
(Segment 1, Birmingham)

When it comes to parenting segment 1 mum tended to worry about being judged or scrutinised. As a result they tended to be very defensive about their lifestyles and particularly resistant of being told what to do by outside authorities especially the Government.

The majority of segment 1 mums refused to take part in the additional interview with Helen Croker. In fact, when asked, they would openly refuse and explain that they did not want to be faced by an expert who might criticise their way of life.

Segment 1 placed a heightened sense of importance on the provision of food and considered it one of their few pleasures in life. These families tend to be consuming highly indulgent convenience foods and were using them heavily to provide comfort and escape over the course of the day. Equally, these families tended to be very sedentary. With high levels of unemployment, mums and kids tended to spend large amounts of time at home together watching TV and were largely de-motivated to engage in even the simplest forms of activity (e.g. walking to the shop).

The idea of 'a healthy lifestyle' was considered very unappealing and largely associated with the removal of pleasure, enjoyment and comfort. Although mum was often aware that the family diet and highly sedentary lifestyle was not healthy, she had a strong repertoire of excuses to deflect being judged on this, particularly that exercise, activity and healthy food was too much hassle or too expensive for her.

"If I removed all the treats then that would be no fun and the kids would not be happy and I am not prepared to do this" (Mum, segment 1, London)

"I often have about 4 biscuits with my cup of tea…or when I am feeling down I'll treat myself to a sticky cream cake from the shop. I think that's totally normal as I can't afford to go out and drink" (Mum, segment 1, Birmingham)

In reality, segment 1 had some latent awareness of the risk attached to the family's poor diet and activity levels. After deeper introspection many segment 1 mums were able to admit that they could see how their attitudes to diet and activity were not healthy or risky. However, many segment 1 mums had a fairly

fatalistic attitude towards life which had a profound impact on their attitudes to diet and activity. There was a belief that if bad things were going to happen in life, then they would happen irrespective of what they tried to do to change it. This coupled with their belief that it would be too much effort to change means that they are likely to require a longer period of engagement with the issue before they would consider behaviour change. In fact, it is likely that segment 1 families will need to see a significant shift in the world around them before they start to take action in their own lives.

Segment 2 – High Risk of Childhood Obesity
Segment 2 families tended to be low income (DE) families who lived in very poor social housing, in particularly deprived areas with few local facilities or amenities at their disposal. Many were often receiving Government benefits and support.

They tended to have started their families when they were very young and at a time when they lacked the wisdom and resources for good parenting strategies. Dads tended to work in a low paid, manual job and mum tended to have a part time job (e.g. as a cleaner or school support) to make ends meet. Although segment 2 struggle financially, they tried to make the best of their situation and tended to be quite positive about their lives. In the absence of material wealth, their kids were really important to them and they formed a tight family unit often with high paternal involvement in parenting practices.

The parents in segment 2 were often concerned with the idea of being 'good parents' and this was something they worried about. However, with little guidance or resources to fall back on they tended to use their own (often misguided) upbringing as a benchmark and were making many poor decisions around diet and activity as a result.

"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" (Mum, segment 2, Newcastle)

For segment 2 families, the lack of fundamental parenting skills and lack of support (familial and environmental) meant that kids were often given free rein to dictate their own rules around diet and activity levels. Mealtimes and food choices were largely unregulated by mum and dad and often led to some recognisable behavioural food-related problems (e.g. tantrums / hyperactivity).

"He can get tired and often has bad tantrums…I think it could be partly to do with what he eats" (mum, segment 2, Birmingham)

"She has got really naughty recently and I don't know what to do about it. She won't sit at mealtimes, she won't eat her dinner, she demands iced lollies for breakfast and she won't listen to me or her dad so we just give in" (Mum, segment 2, Newcastle)

Interestingly, activity levels could be quite high in segment 2 families as the kids were often dictating the type of play they engaged with and much of this involved playing out in the street for long periods of time during the evening.

Segment 2 parents were outwardly concerned about their children's diet and the problems they were experiencing around eating and mealtimes but had little knowledge or access to support to find ways to do anything about it before it's too late.

Most segment 2 parents were excited by the idea of meeting Helen Croker for a further interview and relished the opportunity to find new ways of dealing with their lack of parenting skills.

"She is a really fussy eater and she doesn't like sitting down at the table and eating a meal. She will find any excuse not to eat her dinner and then she snacks on crap all day…it's just how she is now, I don't think she will change" (Mum segment 2, London)

A combination of awareness of the issues, concern around the impact of risk behaviours and a strong desire to be good parents made segment 2 more open to engaging with future communications and intervention strategies than segment 1. It is likely that segment 2 families would be early adopters of intervention strategies providing they are given the right access to information and an awareness of the risk actual behaviours themselves. This would be mainly driven by the desire to be the best parents they can be. The primary issue with segment 2 parents is their lack of knowledge, awareness and skill set. Good diet and activity levels will become important to these parents as part of an overall desire to do their best for their children. This does not mean that segment 2 parents are more likely to engage with the existing concept of 'health' than other segments, rather that they have a predisposition and desire to change their behaviour if it is for the good of their children.

Segment 3 – High Risk of Childhood Obesity
Segment 3 families were generally more upwardly mobile than segments 1 and 2. They were (C1) families who placed great stock on having 'bettered themselves' and had often moved to a 'nicer' area with a bigger house and had put their kids in a 'better' school.

"We moved here so the girls could get into a better school. Its not the kind of neighbourhood that me and my husband grew up in but its close by. I try to keep the kids away from those streets if I can because I feel we've moved on from that to something better" (Mum, segment 3, Birmingham)

Dad was often quite successful in his career (e.g. middle management) and mum was often working part-time as an office manager or PA for extra 'luxury' money.

"The money I bring in is for all the luxuries we have, like nice holidays, things for the children and I can splash out every now and then on a new outfit. I don't need to work but I do because I want my kids to have all the nice things I never had"
(Mum, segment 3, London)

Outward appearances were very important to segment 3 families and mums were very likely to present a 'picture perfect' image of family which meant she often overlooked any family problems and specifically overlooked the risk behaviours in her family around diet and activity levels. For her kids, educational achievement and the provision of material possessions were her top priorities.

Segment 3 mums believed it was most important to be a 'dedicated mother', which tended to manifest itself in a strong desire to over-indulge the kids (materially, emotionally and behaviourally). Mums attitude and parenting style was compounded by that fact that dads work commitments often meant his role was quite distant from the home, leaving mum to dominate daily parenting style.

"As their mum I think I should be able to take them to school and pick them up every day. I know some mums don't have the privilege to do that but I think its really important to me even though I work. I would give up my job if it meant I could not be home to have dinner with my kids every day" (Mum, segment 3, Birmingham)

Segment 3 mums were often self-confessed long-term dieters. Mums interest and persistent following of diets meant she was likely to be very knowledgeable about the role of food and activity in a healthy lifestyle. However, her own ineffectiveness in maintaining a healthy diet and her lack of motivation around activity had often modelled 'faddish' behaviours for her kids. Many segment 3 children exhibited faddish behaviours e.g. only eating one food, and then going off it and only eating another food the following week.

" I've been dieting for years, I've done Slimming World, Weight Watchers, Atkins, and even tried that cabbage soup one. Sometimes now I skip meals or eat on the run as I am so busy. My kids sometimes go off their food like I do, its frustrating and I don't know what to do about it" (Mum, segment 3, London)

Main meals were often well-balanced and included fresh foods, good portion sizes and were often eaten with mum at the dining table. However, the real issue for segment 3 was their snacking behaviour. This tended to be completely unregulated and on-going with mums perceiving a much higher level of regulation over snacks than were actually happening. Although the kids were fairly active and energetic, this is unlikely to be enough to tackle the non-stop energy intake from snacks.

Mum also had a tendency to discourage and devalue activity and exercise as she had very low energy and motivation herself due to her tendency to be obsessive about her own weight and body image.

"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 prefer to relax and read a magazine when I get a moment to myself" (Mum, segment 3, Newcastle)

Despite good awareness and knowledge of healthy behaviours, segment 3 tended to display a great deal of denial of her family's low activity and heavy snacking behaviour. It is very likely that she will be resistant to intervention strategy as this would confront her denial and would take longer for the messages to break down her barriers for real behaviour change.

Segment 5 – Medium Risk of Childhood Obesity

Segment 5 consisted of a very broad cross-section of British families. What united them was their typically traditional British values. They tended to see themselves as an average, normal and happy family. Mum and dad both worked to maintain a happy, stable lifestyle for the family and both tended to be in 'jobs for life' and have been since leaving school. Generally, both parents were heavily involved with daily parenting and focused on teaching traditional values, morals and aspirations such as happiness over material wealth, getting married and having kids.

For segment 5 families, daily life was made up of very strict rules and routines dictated by mum and dad. The kids were fairly well-trained and were accepting of the rules and routines that their parents had put in place.

Because segment 5 families had very traditional views, they had a very traditionally British approach to family health and as a consequence tended to be unaware of modern health trends or concepts around health. This lack of awareness could mean they only picked up on elements of health trends (e.g. specific health foods) and often rejected them as 'faddish'. Their views on diet and the importance of activity levels also tended to be very traditional.

For diet they believed it was best to fill kids up with good wholesome food (i.e. meat and potatoes). Meal times were very traditional and energy dense with large portions and a 'clear your plate' strategy rigorously enforced. Indulgence foods were often justified with traditional beliefs about indulgence (e.g. 'a bit of what you want is good for you'). These families had little real understanding of the risks attached to existing diet behaviours

"One minute you should be eating blueberries, then the next it's something else, I think it's all just hype" (Mum, segment 5, Newcastle)

"We have meat and 2 veg pretty much every night as it's good food that will fill them up" (Mum, segment 5, Birmingham)

For activity, they often believe children should use up their energy by being active and as a result encouraged lots of outdoor play but recognised that their children probably didn't do as much activity as they had done when they were children. They were often quite open to increasing activity levels to bring them in line to the way children traditionally used to be.

Despite low understanding of the risks attached to a traditional approach to health (esp. diet), it is likely that once the relevant knowledge is provided to this segment there would be a willingness to change their behaviour. For segment 5 families the familiarity of implementing rules and routines would make them more likely to be early adopters of behaviour change.

Segments 4 and 6 – Low Risk of Childhood Obesity
These segments have been examined together as they were identified as low risk segments and were not researched in as much depth or with a robust sample for drawing specific conclusions.

Families' in segments 4 and 6 were often the highest SEG clusters (AB) living in more affluent communities with good access to open spaces and good community facilities/amenities. Mum and dad tended to have a strong interest in healthy eating/cooking and exercise. Dad tended to have a good career and a fairly high income (usually white collar) so mum was pleased to be able to stay at home and dedicate herself to carrying out the role of mum.

Being a close family unit and supporting each other was really important and both parents were actively involved in designing and implementing their parenting strategy. High importance was placed on hobbies and interests esp. sporting ones, and were considered essential for individual and family development. Mum believed that she had achieved a lot in her life and strongly encouraged her kids to follow their dreams and live life to the full. Creating shared family experiences was also considered one of the most important ways they could ensure their children had a happy and positive approach to life.

Health was a big priority for these families and good diet and activity levels were considered an important part of everyday life. Mum prided herself on being able to prepare healthy well balanced meals that were often cooked from scratch and she encouraged whole family meals on a regular basis. Mum had a high interest in new foods and had always tried to encourage new foods into the kid's diet from an early age making her kids quite experimental. Snacks had always been heavily controlled and frequently consisted of fruit and healthy alternatives. Mum and dad also had very good awareness of the importance of high activity levels and employed a number of strategies to encourage activity (e.g. leaving the back door open / walking to school / family cycling trips).

There was a tendency for segment 4 families to be more concerned with having a healthy diet through their keen interest in food and cooking. For segment 6 there tended to be a heavier focus on structured exercise over food.

"Health has always been important to me and my husband. We are both quite foody 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. I think this is important to make sure we are a tight family who do everything together" (Mum, segment 4, London)

"My husband and my son jog to school every morning. We generally eat healthily but sometimes we will treat ourselves because we know we are always burning it off" (Mum, segment 6, Newcastle)

Segments 4 and 6 were very aware of potential health risks surrounding poor diet and activity levels and were constantly on the look out for new information and strategies that would enhance their family's health. This meant they were more likely to be early adopters of a new movement in health for kids as they will actively seek out the information and then ensure it is incorporated into their lives.

It is likely that these segments should not be the target focus for any new intervention strategies specifically because they are too upmarket and would set the wrong tone for reaching the more at risk cluster families. However, as early adoptors of new and existing health concepts and behaviours it is likely that they will engage with new intervention strategies that come onto their radar as they actively seek new ways to improve their families health. It may be that the uptake of intervention strategies by segments 4 and 6 can be used to leverage the growth of any initiatives of specific franchises developed as part of the strategy to stem the rise of childhood obesity. To illustrate this point, it is likely that the significant growth of the LazyTown franchise has been driven by the middle classes than the more at risk families who are more in need of its positive messages about diet and activity. As a result the LazyTown franchise has experienced a significant growth which has enabled it to extend the reach of the franchise to much broader (lower SEG) audiences. As we saw in the ethnographic research, LazyTown is present in the homes of segments 1 through to 6 and appears to have penetrated all audience groups, whilst pioneered by the more affluent members.

However, we would not suggest that messages or intervention strategies be devised to specifically target clusters 4 and 6. This would most certainly mean messages and interventions that were tonally inappropriate for the most at risk groups. We feel that clusters 4 and 6 will seek out and discover new ideas about family health without having to target them directly.

4   The Strategy for Childhood Obesity

Engagement and empowerment for cumulative change

In our opinion, based on the research programme, there will be an overwhelming need for an integrated strategy of communications and specific interventions to create a cumulative change within the culture at risk families live in. At the moment, most families who are at risk of childhood obesity have no understanding or conception of the issue of childhood obesity or that they have any need to change their current behaviour (in terms of diet and activity).

It is likely that tackling the issue of childhood obesity would require a long-term, integrated strategy with two key aims. These two key aims are to both engage and empower at risk families to make changes to their behaviour.

In order to really **engage** families with the important risks they are facing we believe that a mass engagement media campaign would be needed to reframe the issue of childhood obesity and raise high awareness amongst families who currently perceive themselves as not being at risk. When we talk about reframing the issue of childhood obesity we refer to the need to create a whole new awareness, understanding and conception of the risks attached to the existing diet and activity behaviours observed within at risk families. It is very likely that this will require a whole new way of talking about the issue of childhood obesity including the use of a whole new set of language to describe the issue.

It is likely that mass engagement will be required before interventions would be likely to be adopted. The engagement campaign would need to provide messages that ensure families are aware and understand the reframed issue so that it creates a relevant cultural context for behavioural change. It will be important that the whole cultural context within which at risk families currently live will need to shift before individual attitudes and behaviours can start to change. This means that the whole conception of health as a middle class concept will need to change. Health and family health will need to become an issue that feels relevant to the at risk communities where childhood obesity is most prevalent. Reframing obesity will start a mass shift in attitudes and behaviours that shape the mindset of generations of families to come. It is likely that using the power of the mass media will deliver maximum impact. Furthermore, effective interventions would need to connect with families both deeply and emotionally and will not be sufficient through the simple provision of information.

Our analysis of the different clusters would suggest that some clusters will engage with the reframing of the issue of childhood obesity sooner than for others. Clusters 1 and 3 were shown to be less willing to engage as they had stronger barriers that would need to be broken down first. It is likely that they would take longer to get onboard with the engagement process.

Clusters 2 and 5 currently had lower awareness, but as they were more willing to engage with the idea of behaviour change themselves they would be more likely to be open to the engagement process and become early adopters of different interventions.

Clusters 4 and 6 already had a high awareness of the issue of family health and were more willing to engage, making them the most likely to actively seek information from the engagement process and could be early adopters and potential advocates for the new intervention strategy. As mentioned above, we would not recommend setting out to recruit cluster 4 and 6 families are advocates but rather that they will naturally adopt new attitudes and behaviours to family health of their own accord. This way, they can start to put weight behind (or money in) to specific interventions. Critically though, all messages and interventions should be tonally developed for the more at risk, lower SEG families.

Once families are aware of the issue, it is likely they would then need to be **empowered** by specific interventions in order to action any change to their behaviour. Based on the research, it appears that a series of multi-component interventions would provide families with the knowledge and skills they need to lead healthier lives both in terms of healthier diets and higher activity levels.

Invest early and support with on-going reinforcement
We believe that focusing on pre and post natal parents would be hugely influential for mass impact on a long term basis. It is likely that mothers-to-be and early mothers would be more open to seeking new knowledge and skills. It would be likely that they would be most receptive to mass communications and ground-level interventions.

Further to this, it is our opinion that the role of health professionals would be vital for delivering and reinforcing strategy on an on-going basis by providing advice and access to interventions.

It is our suggestion that effective and sustained behavioural change would only be achieved when it is adopted at a whole family level with parents needing to buy into and model positive behaviours for their children. However, we would suggest that the strategy would be most likely to be effective when driven via children to parents' esp. through schools. The challenge for interventions would be to ensure they were exciting and inspiring enough for children to want to pass on this information to their parents.

However, it is our opinion that to support the strategy parents will require the necessary social and environmental backing. This is because mass engagement and active interventions can only do so much when they are challenging big brands, corporate disinformation and environmental deprivation. We believe the

world in which at risk families exist has to incrementally and visibly change in order to support positive parenting strategies.

5   The Conclusions

The conclusions of this research are in the form of a set of recommendations for designing the mass engagement campaign and a number of territories for designing interventions for at risk families.

The Mass Engagement Campaign
The purpose of the mass engagement campaign would be to reframe the issue of childhood obesity. A successful mass engagement campaign would be needed to re-contextualise the issue of childhood obesity in a way that enables parents to engage with it in a way they currently can not.

It is likely that reframing the issue would involve creating a sense of a mass drive to get families healthy rather than singling out families with obesity 'issues'. Families would need to be able to engage with the issue as a 'normal' and general health issue.

Reframing the issue of childhood obesity would require finding a new language and new way of talking about the issue in a manner that connects with at risk families. In particular, avoiding the label 'obesity' and moving away from the issue of talking about a child's 'weight'. It is our opinion that the campaign should set out to shift parental mindsets from a more reactive to a proactive approach to their children's health.

Through the Intervention Workshops we were able to identify that long term prevention messages were more engaging to this target audience than short-term. Although, parents often seem to be overtly concerned with short-term and immediate issues for their kids such as bullying, there was very little belief in the risk of childhood obesity within the short term. It also seemed that focusing on long-term health implications helped to overcome the barriers associated with the lack of apparent or visible problems children may be facing.

It is our opinion that exploring the power of both physical and emotional touchpoints for long term implications will be important for developing a mass engagement campaign. For example, the idea of children getting cancer later in life versus the idea of parents outliving their own children. We believe it is worth exploring the role for hard hitting messages followed by actionable solutions in driving a new awareness of this issue in the future.

Although we were not able to explore any specific message ideas within this piece of research the idea of expressing a concept of health as a provider of positive 'energy' was very engaging amongst at risk mums. It is our opinion that

there was a role for exploring the role of a more positive expression of family health in this way, not dissimilar to the successful approach employed by 'LazyTown'.

This message would be most effective when it appeared to speak directly to kids, whilst still having relevant messages for parents. This type of message would enable family health to be a positive and appealing issue as it would minimise guilt and de-selection. We found that the 'energy' concept was best conceived as: 'good things in to get good things out' / 'you are what you eat' / 'good food = good energy and bad food = bad energy'.

LazyTown was an example identified as a template for success. This TV programme was massively popular with parents and kids. Interestingly, it appeared to have few of the traditional class divides that other conceptions of health suffer from and was present in the homes of all clusters. The programme appears to successfully reverse the kudos attached to convenience foods and replaces it with kudos for healthy food and activity. It also successfully appealed to parents through kids by making health fun! Part of the way in which it achieved this was by setting simple moral tales that children could understand (healthy goodies vs. unhealthy baddies), rather than proposing abstract notions of health. It also performs a fantasy of health that extended beyond the programme format and into the children's own play as well as creating active incentives/rewards for health.

Another example of a template for success was Innocent for Kids (brand of smoothies). This was taken from the semiotic analysis where we can saw that Innocent for kids had captured a playful version of health for kids that spoke to parents and children at the same time. It is worth noting that the Innocent brand itself would not reach this target audience as it is too upmarket. However, what it does successfully is 'shows' health rather than 'telling' health to families (i.e. is demonstrates the benefits of health rather than dictating the benefits). It successfully hands the child's health back to parents without inducing guilt. Although its brand positioning and price point is off target for at risk families its simple messages and tonality were on cue as it has a child-to-child tonality, making health fun and successfully recruiting children as ambassadors.

By contrast, The Great Grub Club was given as an example of 'what not to do'. We believe the tonality of this initiative was inappropriate for at risk families.The dictatorial approach to health through the strapline 'being healthy is fun' was not reflective of the language and beliefs of at risk kids and parents. Equally, the graphics were more school book rather than cartoon graphics/characters and terminology such as 'gang' would be very inappropriate for at risk clusters in highly deprived areas.

The Interventions
It is our belief that once the mass engagement campaign has started to raise people's awareness and engaged them with the subject that interventions will be most successful.

From the response shown to the interventions presented in the workshops, it appeared that the key to designing winning interventions was by framing every food and activity initiative as a positive family experience. Critically, all interventions would put the children's happiness at the heart of the idea. Any interventions that were perceived to make kids unhappy or make family life less pleasant would not be motivating on a mass scale. Conversely, if an intervention was perceived to make children happy, parents were more willing to make changes to their own behaviour.

Before people are engaged with the issue it is difficult for us to predict the uptake of interventions, as perceptions, beliefs and attitudes may be different from the present. However, based on the research it seemed that for at risk families it would be more challenging to change attitudes and behaviours around food than activity. We believe this was because positive family experiences through increased activity levels was more easily understood and was therefore potentially a quicker win for intervention engagement. Conversely, positive family experience through changing (decreasing) food intake was not as easily understood and in fact, was often associated with very negative experiences.

Intervention Streams
Our final set of conclusions are presented below in the form of 7 key territories for developing intervention ideas and strategies:

1.   'Set early parenting strategies'
It is likely that parental guidelines around food and activity should be set in the early days of parenting at 0-2 yrs. Once poor diet behaviours have set in and low activity levels become the norm it was very difficult to change family behaviour on a mass scale without one-on-one intervention. By providing specific guidelines around food and activity pre and post natal this would be more likely to be set by parents themselves. However, it would be likely that these guidelines will need on-going reinforcement from health professionals.

In terms of diet, food guidelines that would allow mum to control food through limiting choice would be most effective (e.g. 'its carrots or peas, you choose'). General 'parenting' guidelines around mealtimes would also be welcomed (e.g. the importance of whole family meals). Food guidelines that feel punitive would be most likely to be rejected as they often go against what parents would want to do themselves (e.g. no TV during meals). Guidelines / interventions around portion size would be less well received as they could often be found as too restrictive and not allowing for individual differences.

For activity it would appear that guidelines were not effective unless they were specific and inspiring for parents (i.e. parents could not translate 40 mins of at home activity time into specific ideas). It would appear that guidelines for parents around activity would require careful consideration to ensure they feel achievable and don't leave too much responsibility in the hands of the parents to come up with ideas.

Food and activity guidelines that involve parents closely monitoring their child's behaviour would be very ineffective as they would be too time intensive and controlled for most parents to implement.

2. 'Making Cooking Fun'

This key intervention stream for development was focused around making cooking fun for mum and the family. The benefit of this intervention strategy would be through making meal preparation a positive and rewarding family experience for the whole family. The success of this intervention would be in helping to ensure that healthy meals start to become a staple part of the family diet and that children's involvement in the meal preparation helps to build their appreciation of healthy food.

We believe that this intervention should focus on addressing mum's under-confidence when it comes to meal preparation and the disengagement of children in the food preparation process by equipping mums with knowledge/skills. We found that the idea of 'cooking clubs/school recipe books' for mums and kids worked well to illustrate how this intervention could be implemented.

3. 'Inspire Healthy Family Meals'

A powerful intervention territory would be around helping to reduce the reliance of families on convenience foods by inspiring healthy family meals at the point of purchase (i.e. in the supermarket). By inspiring the purchasing of ingredients or food products that dictate healthy family meals and kids meals at the point of sale this would significantly reduce the reliance on convenient foods for kids.

It is likely that this intervention strategy will require close cooperation from private sector partners and specifically from food brands and supermarket chains. During the research the idea of a healthy meal inspired category management and promotions (e.g. BOGOFs) as well as the production of a range of 'healthier kids foods' were both well received as ways to address this risk behaviour.

4. 'Encourage Active In-Home Play'

It is our opinion that encouraging channelled active play around the home would be a powerful way of tackling the very high levels of in-home sedentary behaviour that is exhibited within at risk families.

At present we are up against some strong barriers against encouraging sedentary behaviour in the home (TV's, games consoles). It may be to our advantage to actually harness the power of these in-home entertainment devices to encourage the role of active in-home play for families.

There was strong interest across clusters for the potential to use in-home entertainment technology to increase the levels of in-home family activity and entertainment through partnerships with gaming manufacturers and TV channels (e.g. Nintendo Wii, dancemats, trampolines).

5. 'Encourage Active Out Of Home Play'

It is our opinion that interventions that encourage families to break out of their routines around in-home sedentary family time would be a powerful way of increasing whole family activity levels.

Whilst currently much family time was spent at home and in front of the TV there was an acknowledgement amongst at risk families that out of home family activities were very powerful ways of accessing family fun experiences. One of the key barriers was the lack of inspiration and accessible activities in the local area.

We believe that providing inspirational and accessible out of home family activities with benefits for both parents and children will be key for increasing active play out of home. Additionally this would have the power to override cost barriers if the activities were subsidised (e.g. local attractions).

The idea of visibly transforming local parks and free leisure attractions was well received across all clusters and could have potential to create a buzz and desire to reconnect with the neighbourhood families live in. The idea of creating new and 'safe' ways through which families can explore the local area (e.g. cycle routes/lanes) was also well received.

6. 'Get Families Walking'

It is our opinion that interventions that are able to create regular situations where families would be inclined to walk instead of taking the car would be a key way of increasing daily activity levels to a noticeable effect.

Families often cited these types of walking experience as positive family experiences and something that could be easily implemented. The success of 'walk to school' initiatives was widely recognised but for many families there was a lack of daily incentive to take part, either because they were off the 'route' or because kids were no longer being incentivised at school.

The success of this intervention would be through widening the scope of walking buses and incentive driven walking. The role of specifically employed 'wardens' who organise and facilitate would make a big different to uptake of this idea.

Equally, we believe that 'Bikeability' and 'Kerbcraft' initiatives ould also support parents' concerns around the safety of children travelling without their parents present (see appendix for definition of these initiatives).

7.   'Develop Active Communities'

It is our opinion that to ensure there would be sufficient incentive for families to get active and stay active, there is a need to shift activity levels within the community as a whole. This appeared to be particularly important for mums of pre-school kids who told us that they actively sought community based support for social activity.

Alternatively, developing active communities could be done through increasing the availability and accessibility of after-school, community based exercise and activity opportunities for kids, especially if they were to be organised according to individual school years.

In order to overcome parents (esp. mums) lack of self-esteem to engage with public exercise it will be important to ensure that structured exercise activities within the community feel home-grown by women who share a similar lack of confidence i.e. created by mums for mums. This would be a key way to ensure parents and children began exercising together.