

8.0 Audience Segmentation

8.1 Introduction

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

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

8.2 Basis of the Audience Segmentation

8.2.1 Use of In-depth Interviews

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

The rationale for using an in-depth interview method was that the development of any audience segmentation required an in-depth understanding of people as individuals, e.g. their attitudes, behaviours, practices, motivations and barriers. Obtaining such understanding is best achieved in the privacy and security of in-depth interviews¹⁷ because they enable frank disclosure by the participant.

8.2.2 A Knowledge – Behavioural Segmentation

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

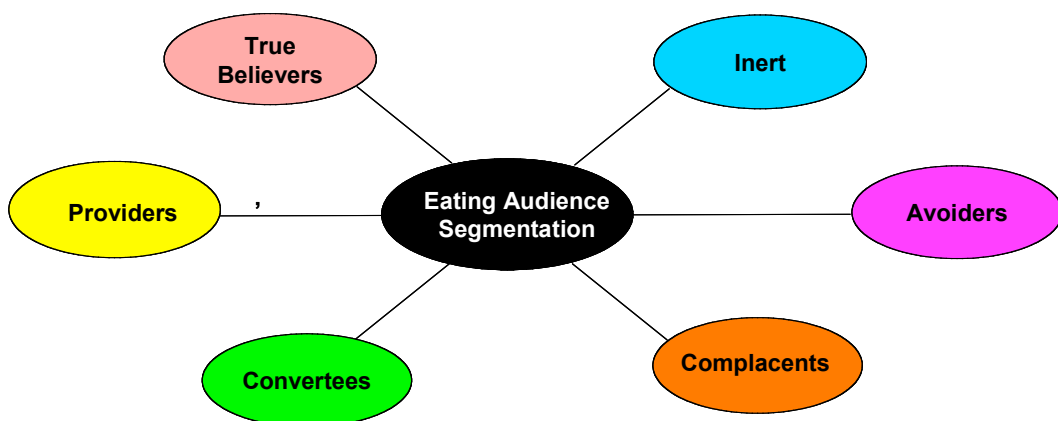
¹⁷ In-depth interviews are a dialogue between one participant and one researcher.

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

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

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

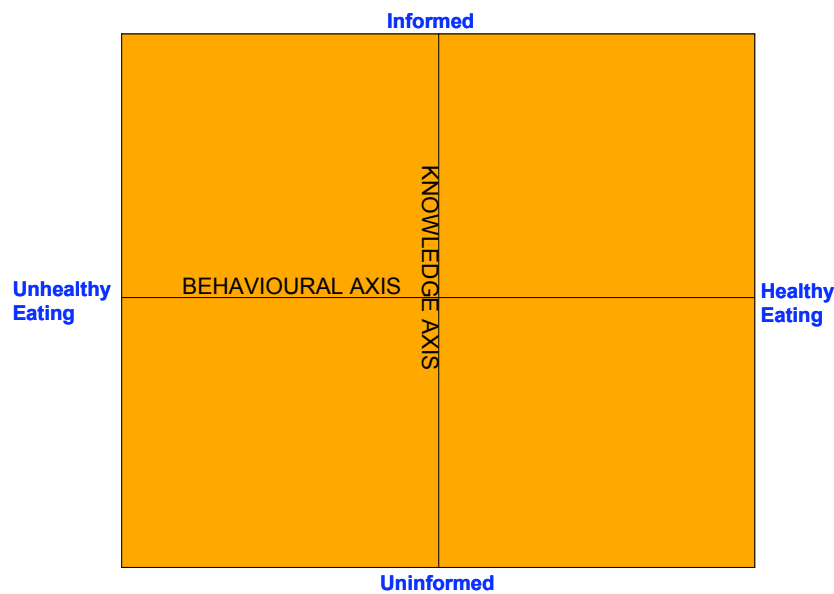
Six distinct groups (referred to here as 'eating segments'), were identified in this study as shown in the diagram below. The segment names (except for the Provider segment) were developed by the researchers to reflect the essence of the respective segments in relation to healthy eating.



8.3 Segmentation Map

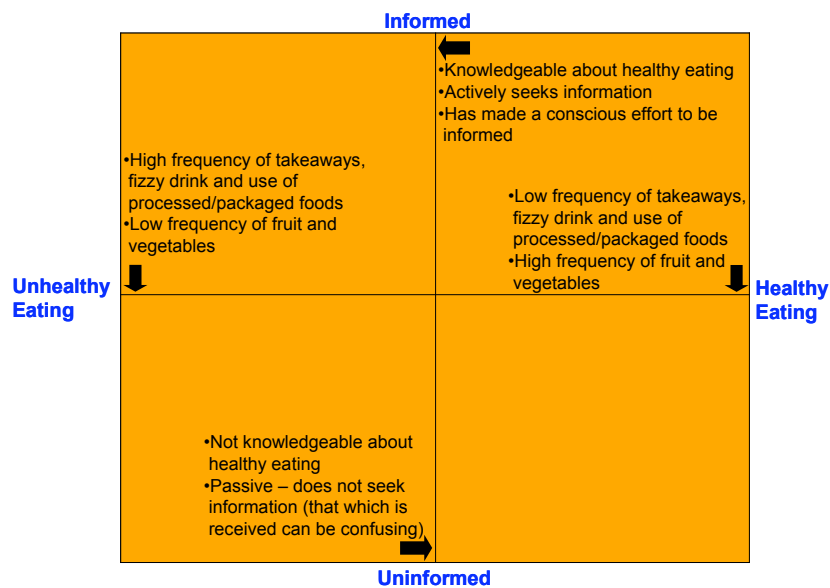
8.3.1 The Axes

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



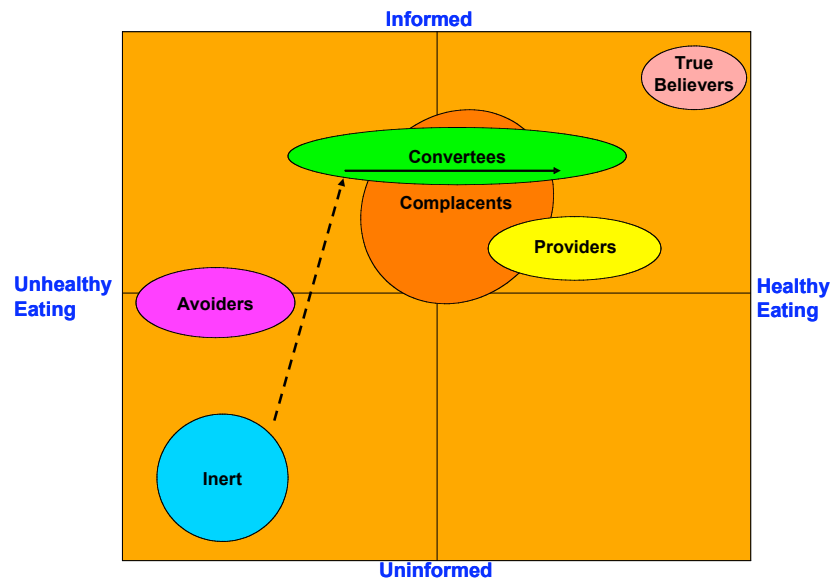
8.3.2 Meaning of Axes

The diagram below describes the meaning of each axis.



8.3.3 Positioning of the Segments

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

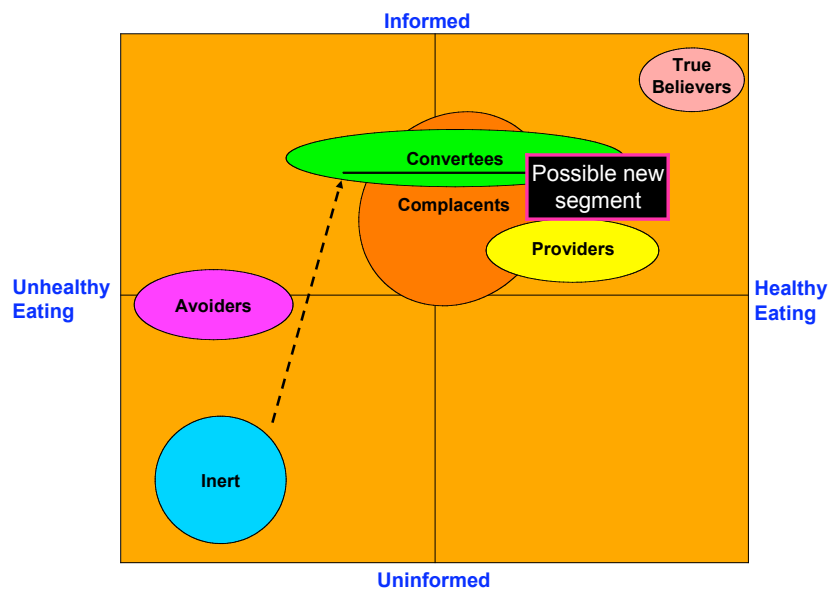


The meaning of the arrow on the Convertees segment is defined in that segment's profile (see later).

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

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

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



8.4 Segmentation Profiles

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

8.4.1 True Believers – ‘zealously practice healthy eating’

‘You are what you eat’

As People

- True Believers were very knowledgeable about healthy eating and zealously ensured that their family/whānau engaged in healthy eating behaviour with few exceptions, e.g. special occasions such as birthdays.
- Individuals in this segment were passionate about their family/whānau and were driven to ensure their partner and children were looked after in the best possible way. They personally felt highly responsible for all aspects of their partner’s and their children’s well-being and had perfectionist, unyielding views about what should and should not happen to ensure that their family/whānau was looked after in the best possible way. This controlling approach to managing one’s family/whānau was driven by love. True Believers were typically brought up in this type of environment and were simply acting out in adulthood, what they had experienced during their childhood.
- True Believers comprised a mix of stay-at-home mothers¹⁸ and those in full-time employment (in one case, a father). Those in full-time employment typically received considerable support from other family/whānau members (often their own mother), to ensure that the household ticked over efficiently and effectively while they were at work. Those providing support were required to adhere to the True Believer’s eating rules, regardless of whether they were in the True Believer’s home or their own home.

¹⁸ Who may have chosen to be a stay-at-home parent to reinforce the values they grew up with.

Eating Knowledge

- True Believers were the key decision-makers regarding what would and would not be eaten in their household. They were very well informed about healthy eating, and tended to pass this information on to their children. They actively sought information to keep themselves abreast of new information about what did and did not constitute a healthy diet, and made dietary changes to reflect current thinking. They were typically well versed in interpreting nutritional information on products at supermarkets, purchasing only those that met known criteria for healthy food (e.g. less than three percent fat).
- The discerning nature of True Believers meant they considered and weighed up things carefully when it came to what their family/whānau would and would not be given to eat. While they would try new foods, these were well researched (through a variety of means including the Internet, promotional material, women's magazines, talking to sales assistants at health food and organic stores, and reading labels). Marketing hype for food and eating carried little weight with True Believers, rather, they sought their own evidence to back up claims.

Concern about Healthy Eating

- True Believers expressed relatively high levels of concern around healthy eating because they saw diet as central to the health and well-being of their family/whānau both now and in the future. It was perceived as one means of helping their children to maximise their potential. They reasoned that a child who ate healthily was more alert and performed better at school, and therefore had a better opportunity of maximising his/her potential in life, e.g. having better career and incoming earning prospects.
- This segment had an almost exclusive health-focus when it came to eating, with the nutritional benefits of food emphasised for health reasons. The adage, 'we are what we eat' was the mantra of the True Believer, with the physical body often likened to being a temple – something to be respected – and not to be abused by eating unhealthy foods or over eating. The nature of food and the size of portions consumed were both important to True Believers.

- The True Believers in this study comprised a mix of low to high socio-economic status people. Overall, True Believers were not cost conscious when it came to healthy eating. Even those in the low socio-economic group were prepared to invest money into healthy eating, reasoning that failure to do this would cost the family/whānau more in other ways, e.g. doctors' bills and time off work. However, True Believers also believed that eating healthily was more affordable than the costs associated with eating unhealthily. There was evidence in this study that it was possible to eat healthily and cheaply.

Eating Behaviours

- True Believers' commitment to their family/whānau (as described earlier) and their zealous belief in the benefits of healthy eating meant they willingly 'invested' time, effort, planning, commitment and persistence to ensuring healthy eating occurred. Being naturally good time managers helped to make it easier for True Believers to make such an 'investment'.
- True Believers had strategies and practices that reinforced healthy eating, as well as healthy eating rules that were strongly and consistently enforced. Unlike segments that prioritised household harmony over healthy eating (e.g. Complacents and Avoiders), True Believers were prepared to (and did) 'go into battle' as necessary to enforce healthy eating behaviour in their family/whānau.

"They have no choice, but to eat what's put in front of them. If they say, 'I don't like this or whatever', we never force them to eat it, but there's no alternative."

Māori Female – Auckland

- True Believer strategies that reinforced healthy eating included: planning meals, always shopping with the plan in mind, sticking to a shopping list, maintaining control of all snacks and meals purchased when away from home, banning unhealthy options such as fizzy drink and lollies from the home, and ensuring there were healthy alternatives on hand. Where children were given choices, mothers (and in one case a father in this study) retained final say over what the children ate. True Believers' children may not have been allowed to spend pocket money on food.
- Rules tended to be more numerous than for other segments, and were enforced. Eating rules included: eat what you are given, everybody eats the same dinner, no snacks after or as an alternative to dinner, dinner is eaten at the table with no television on, no dessert until the main course is eaten, no bread or drinks until vegetables are eaten, no one leaves the table while the family/whānau is eating. Some families/whānau also discouraged children talking while eating dinner.

- In this segment, emphasis was placed on cooking ‘from scratch’ because True Believers wanted to know what was in the food prepared for their family/whānau (this reflected the controlling – but loving – approach mentioned earlier). Limited use was made of processed foods, and takeaways featured rarely – both types of foods were strongly regarded as ‘*unhealthy*’.
- True Believers’ diets were characterised by a low frequency of takeaways, fizzy drinks and use of processed and packaged foods, and a high frequency of healthy, tasty foods, with emphasis on fruit and vegetables.
- True Believers’ children were among the healthiest eaters in this study and appeared to eat this way from choice. They were exposed to a wide range of healthy, tasty foods at home and appeared to reject unhealthy foods when offered them away from home.

True Believer Demographics

The demographic data of participants in this study who were identified as True Believers appear in the table below:

Ethnicity	Socio-economic Status ¹⁹	Number of Children	Age of Children	Location
Pakeha	Low to high	2 to 3	3 to 12 years	South Auckland
Māori				Wellington
Chinese				Christchurch
Malaysian				
Singaporean				

8.4.2 Providers – ‘pride in using your resources’

‘Keeping it close to home, and (for some) keeping costs down’

As People

- Individuals in this segment had been brought up being close to nature, i.e. ‘living off the land’ and had continued this lifestyle in adulthood because it felt natural to do so (and in some instances this approach was also used to help contain food costs – see below).
- Some Providers were cost-conscious and strongly motivated to keep their food budget down and in support of this, to use the food resources they had around them (e.g. produce from their garden, fruit from the local orchard, freshly caught fish, or meat from a neighbouring farmer). In small rural communities this approach to life was often the norm, as was sharing foods with others nearby.

¹⁹ As defined by HSC for the purpose of the SMAR project.

- Some urban Providers in this study grew their own vegetables and took pride in being self-sufficient on this front for at least part of the year. Those not growing their own vegetables took advantage of being able to access fresh produce from nearby produce markets, farmers' markets or market gardens. Urban Providers were less likely than their rural counterparts to be involved with fishing or have access to meat from a farm.
- For Māori Providers, using their own food resources was also motivated by desire to and pride in being able to provide for their whānau (i.e. not just keeping food costs down). Māori Providers reported that their whānau had always gardened/fished/farmed, so it was natural for them to carry on this tradition and they took considerable pride in being self-sufficient in these areas. They had the ability to do this, because they had land to support growing food, and access to other fresh food sources (e.g. fish and meat).
- Māori Providers were generally related to the next door neighbour or whānau down the road, and there was an emphasis on community. In these situations, food would be intentionally shared among whānau, and there may have been shared decision-making as to who would grow what. For example, whānau may have grown a particular range of vegetables to share. Others may have had an orchard and would share fruit within their community. Often, diving or hunting excursions would also provide fresh food for the community rather than for one whānau.

Eating Knowledge

- Providers had an average level of knowledge in terms of healthy eating. They were not especially proactive in seeking information about healthy eating but were reasonably receptive to information that found them, e.g. by way of magazines, television and radio. Providers who lived in small rural communities typically shared such information within their community, with neighbours or whānau members.

Concern about Healthy Eating

- Providers enjoyed food but were not deliberately focused on healthy eating – although this occurred as a by-product of them accessing food resources around them (as outlined above). They tended to be only moderately concerned (or relatively unconcerned) about healthy eating, despite their children being among the healthiest eaters in this study. Providers saw healthy eating as desirable, but it was not the overwhelming focus that it was for True Believers. Rather it was a welcome by-product of their 'do-it-yourself' approach to feeding their families/whānau.

Eating Behaviours

- Providers were replicating the eating behaviours they grew up with in childhood. The old “*tried and trusted*” ways from their past, e.g. reliance on home-grown food and natural, unprocessed foods and avoidance of processed foods, had continued to serve them well (and helped to contain food costs). This reinforced the view that such foods were ‘the best’.
- They kept the diet of their family/whānau simple, with a focus on home-cooked (and often home-grown) foods, limited use of takeaways and convenience. As indicated above, Providers’ focus was on providing for family/whānau using the food resources they had around them. Keeping costs down was also a significant motivator for some. Providers typically cooked their food from ‘scratch’ because it was readily accessible (and more cost effective). As time-rich individuals, Providers had the time, (as well as the energy and motivation) to cook in this way. (These households were likely to have a full-time homemaker or at least one parent working flexible part-time hours).
- The ethos of not wasting food meant Providers were resourceful in making use of food they had produced themselves or had had given to them. They composted so that their gardens continued to produce well. Seasonal surpluses of produce were not wasted, rather they were stored by means of preserving, freezing or turned into accompaniments such as chutneys and pickles. In keeping with the ‘no waste’ ethos, the nature of food available at a given time tended to determine the diet of the Provider and his/her family/whānau. This meant that occasionally some less healthy foods, e.g. mutton flaps, were eaten.

“Whatever hits my table I’ll create something out of it. So if somebody dumps a load of venison on the table or fish or whatever ... it’s to do with what comes in; that’s exactly how it goes ... whatever comes in the door is what I’m making the meals out of really ... like the boys shot a duck a few weeks ago and I sort of said, ‘right, it has to be plucked and gutted – so we will be having duck’ ... it is interesting the different sorts of foods that hit this table and I’ve had to learn how to cook [them] – like wild venison and wild pork, and how to fillet a fish and those sorts of things – because if people come in and say, ‘do you want some fish?’ they mean a whole fish – they don’t mean organised and ready to cook.”

Pakeha Female – Wairarapa

- Relatively few unhealthy foods made their way into the homes of Providers and, as a result, few healthy eating rules existed in such families/whānau because there was not the necessity for them. Providers in this study lived mainly in rural areas, which meant that their children had less ready access to takeaways and other junk foods (such as lollies, chippies and fizzy drinks) that children in some other segments – living in urban areas – routinely bought from dairies.

Provider Demographics

The demographic data of participants in this study who were identified as Providers appear in the table below:

Ethnicity	Socio-economic Status ²⁰	Number of Children	Age of Children	Location
Pakeha Māori	Medium to high	2 to 5	3 to 17 years	Gisborne Wairarapa Christchurch

8.4.3 Convertees – ‘health scare had motivated healthier eating’

‘I want to be around for my family/whānau, especially grandchildren’

As People

- Convertees had a new-found concern about healthy eating, because they were trying to improve the diet of their family/whānau through eliminating or reducing less healthy eating habits. This may have involved distancing themselves from ‘bad’ eating habits they grew up with. For example, some Pacific Convertees were moving away from what they now saw were unhealthy traditional Pacific eating practices (such as boil-ups, corned beef, and little emphasis on vegetables other than taro).

²⁰ As defined by HSC for the purpose of the SMAR project.

- The catalyst for improving the diet of the family/whānau typically came from Convertees personally having a health scare, e.g. a heart attack or being overweight and being told by their general practitioner to make dietary changes to eliminate or manage the situation (or the death of parent, e.g. through a heart attack). Those in this situation had been motivated to make recommended changes to the diet of their family/whānau in order to enjoy better personal health, and to protect the health of their family/whānau. Importantly, Convertees expressed an overwhelming desire to have a future – to be there for their family/whānau (and in the case of grandparents, to be there for their grandchildren).

“I learn to eat healthy food because I was sick the last three years and the doctor said I had [a] heart problem and [was] diabetic and [had] high blood pressure. I woke up ... After that I collapsed ... so I decided I’m not going to [eat unhealthy food] ... I’m going to eat vegetables and watch what I’m eating.”

Tongan Female – Wellington

- Convertees comprised a mix of stay-at-home parents and those in part and full-time employment.

Eating Knowledge

- Convertees were knowledgeable about healthy eating (although less so than True Believers). They were often characterised by the desire to become better informed, and as such were active information seekers regarding healthy eating and ways of achieving this.
- Many Convertees were previously Inerts and had had limited knowledge in relation to healthy eating. However, as Convertees they avidly sought out information on healthy eating to get themselves up to speed and put new learnings into practice.

Concern about Healthy Eating

- Convertees had a high level of concern about healthy eating, often triggered by a personal health scare or that of a close family/whānau member, e.g. a parent.
- Growing awareness of obesity among Māori whānau and Pacific families had been a driver of increased concern about healthy eating among some Māori and Pacific Convertees.

- Convertees may also have been alerted to the need to change their eating habits by steady weight gain, lethargy, or advice from their general practitioner. Television programmes such as *Downsize Me*, gym instructors, and work colleagues may have also functioned as prompts to look at their eating habits, and were also important sources of information on healthy eating.

Eating Behaviours

- Although the eating behaviours of individuals in this segment ranged from moderately unhealthy to moderately healthy, on becoming a Converttee it was common for these individuals to increasingly adopt healthier eating behaviours *over time* (see arrow on the Converttee segment in the segmentation map earlier), as opposed to switching instantly from very unhealthy eating behaviours (as was the norm for Inerts) to healthier eating behaviours. Change occurred over time as Convertees gained experience and confidence with eating more healthily.
- Convertees in the infancy of transitioning their family/whānau to healthier eating, were committed to the journey they were taking to healthy eating but recognised there was still a way to go to fully achieve this.
- Convertees understood the relationship between healthy eating and achieving healthier outcomes for their family/whānau. In some instances, individuals had made health gains since adopting healthier eating behaviours, e.g. weight loss, feeling more mentally and physically energetic and enjoying enhanced self-esteem, and this had reinforced the benefits of healthy eating.
- Some Convertees recognised that healthy eating required planning and were trying to become better planners to facilitate this. Convertees who were already some way down the road toward healthy eating set aside time to plan what their family/whānau would eat over the coming week or so, and factored in time to shop for healthy food and prepare and cook this.
- Some Convertees in part-time or full-time employment were time-poor. When pressured time-wise, it could be easier to reach for convenience foods than to spend time preparing and cooking food. Guilt about doing this was sometimes reduced by choosing healthier bought food such as Subway or chicken and bread rolls from the supermarket.

- Convertees (especially those who were further down the healthy eating track) were limiting unhealthy foods that were previously eaten without concern. For example, some Pacific peoples had sacrificed some cultural traditions around food to protect the health of their family, e.g. reduced or eliminated foods such as taro and dishes with coconut cream. It was typical for Convertees to also limit fizzy drink, junk food and takeaways, items that may have previously been a routine part of their family/whānau diet.
- Some Pacific Convertees ‘walked the talk’ about healthy eating beyond their family, i.e. in their wider cultural community, despite resistance from some quarters. For example, they took healthy food options to church and social functions and good naturedly accepted the less than positive comments about their food contributions. They accepted that it would take time to gain traction with healthy eating ideas, especially among older Pacific peoples, who it was felt could interpret the introduction of non-traditional Pacific food as a rejection of cultural values. ‘Walking the talk’ in their wider cultural community was motivated by wanting to help with bettering the health of ‘their people’.
- Those individuals who were more evolved in adopting healthy eating behaviours, had rules about which foods could and could not be eaten, and enforced these consistently. They were also prepared to go ‘in to battle’ with family/whānau members who did not support their approach to healthy eating.
- The cooking methods and food repertoires of Convertees were not expansive, although there appeared to be willingness to expand these (e.g. through education).
- In a few instances Convertees had become ‘new’ (small-scale) vegetable gardeners, in an effort to gain control over the quality of vegetables consumed (and to help manage food costs).

Converttee Demographics

The demographic data of participants in this study who were identified as Converttees appear in the table below:

Ethnicity	Socio-economic Status ²¹	Number of Children	Age of Children	Location
Pakeha Māori Samoan Niuean Tokelauan Tongan Cook Islander Fijian	Low to high	1 to 5	1 to 16 years	Wellington Gisborne Wairarapa Christchurch Timaru

8.4.4 Complacents – ‘there’s others worse than us’

‘We’re doing okay’

As People

- Complacents lived very time-scarce lives and emphasised that they were trying to ‘do their best’ for their family/whānau within the time available. They claimed that managing a family/whānau and being in full or part-time employment limited the amount of time available to prepare food. In terms of eating, Complacents’ priority was on getting the family/whānau fed as quickly and as easily as possible. This meant food needed to be simple, fast and convenient – these criteria made it easy to opt for less healthy foods. Variety was not seen as especially important because it took time to factor this into the family/whānau diet.

“You know there’s days where tea is veges and chicken nuggets ... I might be a little bit under a misconception, but I think that because we’re eating veges I don’t worry too much about what else we eat – because we probably do have chicken nuggets a bit too often ... I mean they had meat pies just last night with other veges and broccoli ... probably we shouldn’t be giving them meat pies for dinner but they like them, and it’s not like we’re having meat pies seven days a week. I think as long as you balance it all out.”

Pakeha Female – Wairarapa

²¹ As defined by HSC for the purpose of the SMAR project.

"[It] takes a lot longer to cook – to boil potatoes and to prepare vegetables and to cook ordinary average plain food. It's a lot easier to chuck in some fish cakes, fry some chips and nuke some chicken nibbles and mixed vegetables ... they're vegetables but they're microwaved and they're frozen. They're not fresh. So it takes a lot longer to cook plain food than it does fancier stuff these days."

Pakeha Female – Gisborne

Eating Knowledge

- Complacents ranged from average to reasonably high in terms of being informed about healthy eating, however, their eating behaviours were fluid and included a mix of healthy and unhealthy behaviours within individual families/whānau.

Concern about Healthy Eating

- Complacents were relatively unconcerned about healthy eating, because they believed that their family/whānau was 'doing okay' and had a 'healthy enough' diet.
- Their children were not among the healthier eaters in this study but their parents might be surprised to learn this. When they examined their eating practices in this study, they were sometimes surprised at the amount of less than healthy food that had crept into their diets.
- Information collection tended to be passive rather than active. For example, they may have seen advertisements or programmes on television (such as the cooking channel or *Downsize Me*), read something in a magazine, or had a conversation with a friend that touched on healthy eating issues.
- Complacents may have more actively sought information about healthy eating when there was a specific problem to be addressed, but tended to take a targeted rather than global approach to solutions. For example, one mother avoided fatty foods because of a problem with digesting fat – but the rest of the family ate less healthily because it was *her* problem. Another family limited sugar for one child who got "*hyper*". When the child got unmanageable, sugar was severely limited – but the rules were relaxed when the problem appeared less acute – and there was no attempt to cut the whole family's sugar consumption.

Eating Behaviours

- Complacents were typically aware that they were a ‘bit naughty’ in terms of the unhealthy foods eaten but reasoned that because fruit and vegetables were included in the family/whānau diet, that this signified they had their health at heart. Having family/whānau members who were healthy (i.e. not sick), and children who were not overweight and who had plenty of energy, reinforced that their current diet (of a mix of healthy and unhealthy foods) was not a problem.
- Complacents emphasised the importance of having a harmonious family/whānau. They aimed to avoid conflicts because these took time to resolve. With eating being an area that could cause conflict within the family/whānau, it was sometimes easier to allow consumption of unhealthy foods to ‘buy peace’, than go ‘into battle’ on the healthy food front.
- Overall, Complacents were happy to settle for being ‘average’ in terms of their quality of eating, reasoning that “*there are [were] others worse than us*”. Their current approach to eating appeared to work, so there was no perceived reason to make any changes.
- Individuals in this segment may have eaten more healthily earlier in life, e.g. in childhood or in adulthood prior to having a partner and managing the demands of running a family/whānau (in conjunction with full-time or part-time work for some). Complacents had typically moved away from healthier eating for any of the following reasons:

 - Lack of time combined with easy access to unhealthier (more convenient) foods made it easy for Complacents to choose such food because it freed up time in their lives. Marketing of such foods alerted Complacents to quick, easy food options and got them into their consideration set.
 - The influence of a less healthy eating partner, i.e. *partner drag* (as discussed earlier).
 - Prioritising having a harmonious family (as discussed earlier).
- Healthy eating rules may have existed in Complacent families/whānau. However, Complacents tended to have a less stringent, more flexible approach than did more committed healthy eaters. Rules tended to be ad hoc and not thought through, making it difficult for parents to make ‘on the spot’ decisions, e.g. how many biscuits were okay as a snack? What rules they did have were not consistently applied, because sometimes Complacents took the line of least resistance in order to avoid getting off-side with their children.

- The erosion of healthy eating typically started with the consumption of unhealthy snacks and treats rather than meals. Once set in motion, the unhealthy ‘trend’ spread to meals. Pay-offs such as better management of time pressures and less conflict over foods eaten by the family/whānau reinforced this approach and ensured its continuation.
- Some Complacents’ own taste for unhealthy foods and drinks contributed to their children picking up unhealthy eating habits. Parents may have included items such as fizzy drink, chocolate cereals, chocolate biscuits and lollies in the shopping trolley because they enjoyed them. For example, one Complacent mother reported that she bought chocolate cereal not because the children insisted on it, but because she enjoyed eating it whenever “*mummy’s muesli*” ran out.
- In a few cases, Complacents’ children were putting pressure on their parents to improve their eating habits. This had been motivated by learning healthy eating messages at school and wanting their family/whānau to have the benefits of such eating.

Complacent Demographics

The demographic data of participants in this study who were identified as Complacents appear in the table below:

Ethnicity	Socio-economic Status ²²	Number of Children	Age of Children	Location
Pakeha Māori Samoan Tongan Indian	Low to high	1 to 5	0 to 15 years	Gisborne Wairarapa Wellington

²² As defined by HSC for the purpose of the SMAR project.

8.4.5 Avoiders – ‘our diet isn’t healthy but it’s enjoyable’

‘Where’s the evidence that healthy eating makes a difference?’

As People

- Avoiders may have been Inerts who had transitioned to Avoiders as they had become more knowledgeable about healthy eating.
- Avoiders valued family harmony and were keen to avoid conflicts. In terms of healthy eating, apart from not wanting to implement this for personal reasons (discussed later), they were not prepared to implement it because of the discord it would cause among family/whānau members (especially children).

Eating Knowledge

- Avoiders had an average level of knowledge in relation to healthy eating. Much of their knowledge had been picked up from the food marketing and diet industries, and was therefore conflicting.

Concern about Healthy Eating

- Individuals in this segment may be moderately concerned about healthy eating (although some would have denied this). Avoiders’ increased knowledge about healthy eating (e.g. through healthy eating messages) had raised the idea of a potential connection between healthy eating and good health. However, Avoiders were resistant to healthy eating messages because of the conflicting information about what was and was not healthy eating, and no perceived definitive evidence being presented that healthy eating made a real difference to health. The researchers suggest that Avoiders’ resistance to healthy eating messages was possibly a ‘strategy’ to make them feel less guilty about actively choosing to eat unhealthily.
- Some Avoiders picked up much of their information from food marketers and the diet industry. Overall, Avoiders were not active information seekers. For some families/whānau this appeared to be a tactic that enabled them to remain in denial (e.g. thinking along the lines of: ‘if I don’t know, I don’t need to do anything differently’ or ‘if I don’t know, then it can’t hurt me’).

Eating Behaviours

- Avoiders were loath to give up the less than healthy foods they enjoyed. They justified their unhealthy eating approach by citing their good health and lack of weight issues as evidence that their diet was fine.
- Avoiders enjoyed tasty (but often unhealthy) food and in some cases, large portions of it. By resisting healthy eating messages, Avoiders could live out their engrained eating habits without needing to feel guilty. Further, allowing consumption of unhealthy foods made them popular with their children, and this in turn helped to maintain family harmony – a quality much desired by Avoiders.
- Avoiders typically did not have eating rules in their families/whānau. Rather, they believed that if people stayed active and did not smoke or consume alcohol excessively, that they could largely eat what they wanted to and remain in good health.
- Some Avoiders claimed that healthy eating was too expensive and cited this as a reason for not taking it up. However, the researchers suggest that cost was less likely to be the real reason for these Avoiders not eating more healthily, rather it was a further justification for not doing so.

Avoider Demographics

The demographic data of participants in this study who were identified as Avoiders appear in the table below:

Ethnicity	Socio-economic Status ²³	Number of Children	Age of Children	Location
Pakeha Māori Pacific	Low to high	2 to 3	1 to 15 years	Auckland Wairarapa

²³ As defined by HSC for the purpose of the SMAR project.

8.4.6 Inerts – ‘healthy eating isn’t on the radar’

‘The kids are very active’

As People

- Like Complacents, Inerts described very time-scarce lives and tried to ‘do their best’ for their family/whānau within the time available.
- Inerts may not have been aware of their own unhealthy eating status or if they were, it was not a concern to them. They had always eaten the (unhealthy) food they currently ate and because it had not caused any perceived health problems to date, they saw no reason to make changes. Diet-related illnesses in the wider family/whānau had not acted as trigger points to change (as was the case with some Converttees).
- Individuals in this segment were time-poor and cash-strapped – both factors influenced the eating behaviours that occurred in their family/whānau. Lack of money meant Inerts worried about having enough money to put food on the table for their family/whānau. Concern about filling stomachs was a priority.
- Individuals in this segment comprised a mix of full-time and part-time workers. Shift work and low paid work were common.

Eating Knowledge

- Inerts had a limited understanding of the relationship between healthy eating and good health. At the best they may have been aware of more serious eating-related conditions, e.g. obesity, but considered these would be distant events and not something to worry about now. Generally the perceived benefit of healthy eating was not becoming overweight. However, given Inerts may have been inactive or overweight and were not strongly motivated by aesthetic concerns, neither condition was a trigger to change their eating behaviour.
- These individuals were not active information seekers, and found it hard to sort through the many conflicting messages about food in the media. Most Inerts simply did not try to do this because they were not sufficiently interested in food and, in many cases, did not have the skills to critically assess messages. In a few cases (females), Inerts perceived that the diet industry was a reliable source of information about what food was healthier. Overall though, Inerts found it too difficult to sort through food messages and, as a result, did not give healthy eating messages to their family/whānau. However, there was evidence that some Inerts may have been receptive to healthy eating information if the instructions seemed achievable and affordable.

Concern about Healthy Eating

- Most Inerts were not concerned about healthy eating because it was not on their radar (discussed below). However, a few had a very minor interest in it.

Eating Behaviours

- Inerts had a low level of interest in food as reflected in their limited cooking and food repertoires, and their perception of food as fuel and the preparation and cooking of meals as chores. In terms of food, emphasis was on having foods that were fast, convenient and filling and that provided the most volume for money (the latter reflected that Inerts were typically cash-strapped).
- Like Complacents and Avoiders, Inerts valued family harmony and were keen to avoid conflicts. The researchers suggest that implementing healthier eating in the families/whānau of Inerts would almost certainly result in discord in the family/whānau and this could be a barrier to moving in this direction.
- Unhealthy eating was the norm, with Inerts consuming a high level of processed and convenience foods, takeaways and fizzy drinks. Fruit and vegetables were not a usual part of their diet (a deliberate effort had to be made for their inclusion) and dinners tended to be based on meat and carbohydrates.
- Little or no eating rules existed in Inerts' families/whānau, and those which did exist were rarely enforced.
- Inerts were primarily assemblers of food as opposed to cooking 'from scratch'.

Inert Demographics

The demographic data of participants in this study who were identified as Inerts appear in the table below:

Ethnicity	Socio-economic Status ²⁴	Number of Children	Age of Children	Location
Pakeha Māori Samoan Fijian Indian	Low to medium	1 to 4	1 to 16 years	Auckland Gisborne Wellington Christchurch

²⁴ As defined by HSC for the purpose of the SMAR project.

8.5 Summary of Segment Profiles

A summary of demographic data by segment is provided in the table below for comparison purposes.

Variable	True Believers	Providers	Convertees	Complacents	Avoiders	Inerts
Essence as people in relation to eating	'You are what you eat'	'Keeping it close to home, and (for some) keeping costs down'	'I want to be around for my family/whānau and grandchildren'	'We're doing okay'	'Where's the evidence that healthy eating is good for you?'	'The kids are very active'
Knowledge about healthy eating	High	Moderate	Moderate and increasing	Moderate but may be out of date	Varies - may reject information received	Low
Concern about healthy eating	High	Moderate to low	High	Moderate to low	Varies – may be in denial	Low
Eating behaviours	Fanatically healthy and very disciplined.	Healthy as a result of DIY approach.	More healthy than in past. Making gains in some areas (e.g. fizzy & takeaways).	Less healthy than in past. Subtle erosion of healthy eating habits (e.g. through convenience foods and snacks).	Unhealthy is the norm.	Unhealthy is the norm.
Ethnicity	Pakeha Māori Chinese Malaysian Singaporean	Pakeha Māori	Pakeha Māori Samoan Niuean Tokelauan Tongan Cook Islander Fijian	Pakeha Māori Samoan Tongan Indian	Pakeha Māori Pacific	Pakeha Māori Samoan Fijian Indian
Socio-economic status	Low to high	Medium to high	Low to high	Low to high	Low to high	Low to medium
Number of children	2 to 3	2 to 5	1 to 5	1 to 5	2 to 3	1 to 4
Age of Children	3 to 12 years	3 to 17 years	1 to 16 years	0 to 15 years ²⁵	1 to 15 years	1 to 16 years
Geographic location	South Auckland Wellington Christchurch	Gisborne Wairarapa Christchurch	Gisborne Wellington Wairarapa Christchurch Timaru	Gisborne Wairarapa Wellington	Auckland Wairarapa	Auckland Gisborne Wellington Christchurch

²⁵ 'Prevalence' of babies and pre-school aged children noted in the Complacent segment.