

**RESEARCH REPORT**

**2007**

**NEW ZEALAND CHILDREN'S  
FOOD AND DRINKS SURVEY**

**COMMISSIONED BY THE:  
HEALTH SPONSORSHIP COUNCIL**

**PREPARED AND CONDUCTED BY:  
NATIONAL RESEARCH BUREAU LTD**

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## FOREWORD

The rates of overweight and obesity and associated comorbidities are generally accepted to have reached epidemic proportions in children and adults in New Zealand and many other countries in the developing and developed world. The *Healthy Eating, Healthy Action (HEHA): Oranga Kai – Oranga Pumau* Strategy provides the basis of the New Zealand Government's approach to improve nutrition, increase physical activity and reduce obesity, all identified as population health priorities in the New Zealand Health Strategies.

The Health Sponsorship Council (HSC) has recently completed the first phase of its social marketing programme – *Feeding our Futures* - which contributes to the HEHA framework. The programme aims to help parents establish good eating practices for New Zealand children. The *Children's Food and Drinks Survey* provides extremely important baseline information against which the impact of this programme can be evaluated. The Survey also will facilitate the planning of future social marketing and other programmes that contribute to the overall HEHA Strategy as it relates to children.

Some of the information generated is encouraging. For example, all or almost all parents and caregivers reported that tap water, fresh fruit and fresh vegetables were available in their home and drinking water and eating plenty of fruit and vegetables were the two main things that parents and caregivers said meant that children were eating and drinking healthily.

Parents and caregivers thought that they should play a "big role" in making sure that children eat and drink healthily. Walking the talk may be a challenge, however, with only around one-half saying they tried to set a good example by what they eat and drink "all of the time", and promoting the benefits of role modelling could be a future focus for social marketing.

Most parents and caregivers tended to see the benefits of children eating and drinking healthily in functional terms – more energy / better health – rather than in nutritional terms. There may be scope to improve knowledge of these benefits, especially as a quarter of parents and caregivers said that explaining the benefits of healthy eating to children was one of the strategies they thought they could use to help their children eat and drink healthily. Parents and caregivers appear receptive to this type of information – when asked what help they could be given, education, directly or through schools, and information were the two things they mentioned most often.

Most parents and caregivers said they were already using or were confident they could use the types of strategies promoted by *Feeding our Futures* to get their children eating and drinking healthily, for example, about 60% of children are involved in meal preparation and cooking.

This level of involvement and confidence among parents and caregivers suggests that the "tip-based" approach of *Feeding our Futures* is supporting and reinforcing what parents and caregivers are already doing or trying to do. Despite parents and caregivers' best efforts and intentions, however, the latest Health Survey (2006/07) shows one in five children are overweight and a further one in twelve are obese, suggesting that factors outside of parents and caregivers' direct influence are countering good practices in the home.

Other data gathered are less encouraging though not surprising. Availability and consumption of sugary drinks, burgers and sausages, and pies and pastries appeared to be greater among those living in the most deprived areas (where rates of obesity are the highest) than among those living in the least deprived areas. Concern about children gaining weight and, to a lesser extent, eating unhealthy foods appears not to be on parents and caregivers' radars. Almost three-quarters of parents and caregivers said they "hardly ever/never" worried about their children gaining weight and around six out of ten said they were concerned "hardly ever/never" or only "once in a while" about their children having unhealthy foods and drinks.

There are also a number of findings which may be unexpected, such as the observation that nearly three-quarters of parents and caregivers support a total ban on advertising unhealthy foods at times when children watch television.

Results such as these represent a challenge to legislators who are generally reluctant to implement legislative measures which may be deemed to limit freedoms of expression and choice. Other information will guide future public health programmes as well as measures aimed at high risk population groups and individuals. The HSC is to be congratulated on generating this mine of information for everyone involved in measures aimed at controlling the now global epidemic caused by over consumption of inappropriate food choices and lack of physical activity.

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# A. INTRODUCTION

## 1. BACKGROUND

New Zealand is experiencing a rapid rise in the rate of obesity among both adults and children, with significant implications for public health. In New Zealand, one in twelve (8%) children are obese and a further one in five (21%) are overweight. One in four (27%) adults are obese and a further one in three (36%) are overweight.<sup>1</sup> Being obese or overweight adversely affects people's health by increasing the likelihood of chronic diseases, including type 2 diabetes, hypertension, coronary heart disease, some cancers, and stroke.

To respond to this growing problem, the *New Zealand Health Strategy* identifies improving nutrition, increasing physical activity, and reducing obesity as population health priorities. Because these issues are inter-related, the Ministry of Health has developed a strategic framework – *Healthy Eating Healthy Action: Oranga Kai – Oranga Pumau* (HEHA) – to develop a united approach to improving population health in these three areas.<sup>2</sup>

As part of HEHA, the Ministry has commissioned the HSC (Health Sponsorship Council) to develop and deliver a Healthy Eating Programme using social marketing to increase public awareness and understanding of the benefits of improved nutrition and to facilitate behaviour changes supporting healthy nutrition practices.<sup>3</sup> The first phase of this national social marketing programme is *Feeding our Futures*.<sup>4</sup>

*Feeding our Futures* aims to help New Zealand parents establish good eating practices for children that will support them in achieving healthy diets as they grow. When good nutrition and healthy eating practices are established in childhood, they are more likely to continue into adulthood, promoting positive health and overall wellbeing for the future. *Feeding our Futures* offers tips and advice for parents that can be carried out regularly at home.

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<sup>1</sup> Ministry of Health. 2008. *A Portrait of Health. Key Results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health.

<sup>2</sup> For information about HEHA visit: [www.moh.govt.nz/healthyeatinghealthyaction](http://www.moh.govt.nz/healthyeatinghealthyaction)

<sup>3</sup> For information about the programme and the evidence that underpins it visit: [www.hsc.org.nz/nutrition.html](http://www.hsc.org.nz/nutrition.html)

<sup>4</sup> For information about *Feeding our Futures* visit: [www.feedingourfutures.org.nz/index.html](http://www.feedingourfutures.org.nz/index.html)

The first stage of the programme includes a mass media campaign that talks to parents about healthy eating in the home, through television, print and radio advertising, as well as unpaid media. Over time, the programme will work with public health providers and priority communities and support them to help parents and caregivers to achieve healthy diets for their children and families, whether at home or in the wider environment.

The programme aims to benefit children, particularly those aged 8 – 12 years. It does this by providing parents and caregivers with information that helps them to have a positive influence on their children's diets. The 2002 *Children's Nutrition Survey* found that the nutrition status of children 5 – 7 years old is appreciably better than that of older children (7 to 14-year-olds).<sup>5</sup> Parents and caregivers of older children need new strategies and ways of continuing to ensure that their children are eating well. *Feeding our Futures* seeks to support parents and caregivers by reinforcing the important role they play and providing them with tips for healthy eating that they can adopt as their children move into their teenage years.

The programme prioritises parents and caregivers in Maori, Pacific and low socio-economic households, to ensure the messages are most effective for these groups. These audiences also have been identified as priority groups in the HEHA Strategy.

The 2007 *Children's Food and Drinks Survey* surveyed New Zealand parents and caregivers to provide baseline information for evaluating the impact of the social marketing programme and informing the development of future phases of the programme.

## 2. PURPOSE OF THE SURVEY

The *Children's Food and Drinks Survey* is designed to benchmark parents and caregivers' current knowledge, attitudes and views about healthy eating, and the extent to which they already use, or feel confident they can use, a range of tips (strategies) promoted by *Feeding our Futures* to help parents and caregivers provide healthy diets for their children.

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<sup>5</sup> For information about the 2002 Children's Nutrition Survey visit: [www.moh.govt.nz/moh.nsf/wpg\\_index/Publications-NZ+Food,+NZ+Children+-+results+Summary#6](http://www.moh.govt.nz/moh.nsf/wpg_index/Publications-NZ+Food,+NZ+Children+-+results+Summary#6)

These strategies include encouraging families to eat together, getting children involved in food preparation and cooking, promoting healthy snacking, and encouraging children to eat more fruit and vegetables, and drink water and milk, rather than sugary drinks.

The *Children's Food and Drinks Survey* also collected information about the foods available to, and eaten by, New Zealand children to provide context for the other information collected by the survey and to track changes in children's diet over time. Parents and caregivers were asked about the availability in the home of selected "healthy" and "less healthy" foods and drinks, and whether and how often their children ate and drank them. Parents and caregivers also were asked whether and how often they ate and drank these foods and drinks to compare their diets with those of their children.

Children also were asked to take part in the survey to provide their views about a range of topics and to complete a booklet about all the foods and drinks they eat and drink, and how often they eat and drink them. This booklet was based on the Ministry of Health's Food Frequency Questionnaire from the 2002 *National Children's Nutrition Survey*. Unlike the national nutrition surveys, the *Children's Food and Drinks Survey* was not designed to collect comprehensive information about children's nutrition, rather it aimed to collect information about children's diets to contribute to the evaluation of *Feeding our Futures*.

### 3. DESIGN AND IMPLEMENTATION OF THE SURVEY

HSC commissioned National Research Bureau (NRB) to help it design the survey and carry it out. NRB also was responsible for processing and analysing the results and preparing the report in association with HSC's Research and Evaluation Unit.

To help decide what the scope and content of the survey should be, the HSC commissioned the Health Promotion and Policy Research Unit at the Wellington School of Medicine and Health Sciences, at the University of Otago, to provide advice on the design and potential topics for the survey. Advice also was provided by the Healthy Eating Programme's Public Health Reference Group for Improving Nutrition. Advice from both these groups provided the basis for drafting the survey design and instruments, which were then tested and refined in a pilot survey by NRB.

### 4. CONTENT OF THE REPORT

Following this introduction is a description of the survey design and method (section B – full technical details of the survey and the questionnaire will be published in a companion report on the *Feeding our Futures* website). The key findings are then described in eight sections:

- Section 1: availability and consumption of foods and drinks.
- Section 2: eating and food preparation practices.
- Section 3: planning, food preparation and shopping.
- Section 4: decision-making, monitoring and role modelling.
- Section 5: efficacy and support for parents and caregivers.
- Section 6: views and concerns about children's diets.
- Section 7: the role of parents/caregivers and others in healthy eating for children.
- Section 8: awareness and views of advertising and promotion.

This report describes the main findings from the survey. Other publications are scheduled that will explore and report on the results in more detail. These include a series of *Research Bites* that will summarise information from the *Children's Food and Drinks Survey*, as well other recent research for the Healthy Eating Programme.

This report describes the responses of the parents and caregivers who were interviewed. Separate reports will describe the responses of the children who were interviewed and the results from the booklet that collected information about all the foods and drinks that children said they eat and drink.

## B. SURVEY DESIGN AND METHOD

This section describes the main features of the design and implementation of the survey. A companion technical report describes these aspects of the survey in more detail (this report is available on the *Feeding our Futures* website).

### 1. OBJECTIVES

The general objective of this survey was to provide baseline information to evaluate the HSC's Healthy Eating Programme, including the first phase of the programme – *Feeding our Futures*. The survey also was designed to provide information to inform the development of the programme.

Phase one of the programme targets parents and caregivers with the aim of communicating practical messages and support for providing a healthy diet for their children, with a particular focus on children 8 to 12 years old.

The survey interviewed parents and caregivers with children aged 5 to 16 years old. Although the first phase of the programme focuses on 8 to 12-year-olds, baseline information was collected about children in this wider age range, as future phases of the programme may target younger and older children.

Parents and caregivers were asked about their views and experiences and also asked to answer questions about the diet and eating practices of one of their children. In one-half of households the child also was interviewed and then asked to complete and return a booklet that collected information about all the different foods and drinks they usually eat and drink.

The survey also collected demographic and socio-economic information about the parents and caregivers and their children to help understand and interpret their knowledge and behaviours. This information included: parents and caregivers' age, gender, ethnicity, country of birth, the year they arrived in New Zealand (if born overseas), educational qualifications and employment status; the age, gender, and ethnicity of the child chosen for the survey; and the household size and composition, annual household income, the household's weekly expenditure on food and beverages, and dwelling type and ownership (ie, owned or rented).

### 2. GENERAL SCOPE AND TYPE OF SURVEY

The 2007 *New Zealand Children's Food and Drinks Survey* is a nationwide survey of parents and caregivers of children aged 5 to 16 years. A number of the questions were about a child in this age range. If there was more than one 5 to 16-year-old in a household, then one of these children was selected at random. This child is referred to as the nominated child or "their child" in this report. In one-half (50%) of the households, also selected at random, the child also was asked to complete a short interview and then, after the interview was finished, to complete a booklet to record all the foods and drinks they usually ate and drank. The booklets were mailed back to NRB when they were completed. All the children that agreed to complete a booklet (called the Food Questionnaire) were given a ten-dollar gift voucher as a thank-you for taking part in the survey.

People were interviewed using a structured questionnaire that was developed to meet the project objectives. The questionnaire was tested in a pre-survey pilot to make sure that the questions were easy to understand and answer. The survey was carried out in people's homes, with households and survey participants selected at random. Interviews with parents and caregivers and the children chosen for the survey were administered face-to-face by trained interviewers.

Answers were recorded in survey software on laptop computers (a process known as Computer-Aided Personal Interviews – CAPI). The answers from completed questionnaires were combined into an electronic database, which, after coding and editing, was used to produce tables showing the number and percentage of responses to each question. This report includes the tables showing the answers of parents and caregivers. The results from the children's interviews and the Food Questionnaire will be published subsequently in separate reports. The data tables and other supplementary information will be made available on the *Feeding our Futures* website.

### 3. QUESTIONNAIRE DEVELOPMENT AND TOPICS

The Health Promotion and Policy Research Unit at the Wellington School of Medicine and Health Sciences, at the University of Otago, provided advice on the potential topics for the survey. Advice also was provided by the Healthy Eating Programme's Public Health Reference Group for Improving Nutrition.

Based on advice from both these groups, the topic areas for the survey included:

For **parents and caregivers** the interview collected information about:

- Their views on eating and drinking healthily.
- Their knowledge and views about the healthiness of selected foods and drinks.
- The availability of selected foods and drinks in the home.
- How often the selected foods and drinks were eaten and drunk by the child chosen for the survey, if these foods/drinks were available in the home.
- How often they (ie, the parent/caregiver) ate and drank the selected foods and drinks, if they were available in their home.
- Their child's behaviour in relation to shopping, helping prepare meals, and eating meals and snacks.
- Their views about strategies to get their children to eat and drink more healthily.
- Their awareness and views of campaigns and advertising about eating more healthily.

For **children** the interview collected information about:

- Their food preferences.
- Their views about the healthiness of certain foods and drinks.
- The pocket money they received or earned each week, how much was spent on foods or drinks, and what types of foods or drinks they bought.
- Where they ate their evening meal and whether or not the TV was on or off.
- Whether they helped with shopping for, and preparing, food and what they liked/didn't like about these activities.
- Foods and drinks eaten/drunk while going to/from school.
- The extent to which they watched TV, DVDs or videos, and played computer games.

The **booklet completed by children** (with help from a parent/caregiver if needed) collected information about:

- How often they ate or drank a wide range of foods and drinks.

The booklet was based on the Food Frequency Questionnaire used in the Children's Nutrition Survey conducted for the Ministry of Health in 2002.

For each of these topics, the HSC project team and NRB, as the survey provider, developed specific questions. Following discussion about each question's fit to the objectives of the survey, and the likely ease with which the questions could be answered by parents and caregivers and their children, a pilot questionnaire was designed. The pilot questionnaire contained more questions than were scheduled for the final version. This allowed the pilot to examine the likely distribution of replies, as well as people's cognitive reactions to the questions, in order to arrive at the best mix of questions to meet the survey objectives, as well as making sure that the time the interview took was acceptable to survey participants and consistent with the survey's budget.

Open-ended questions that required participants to verbalise their own views were a key component of the questionnaire. In total, there were 25 open-ended questions for the adults and 16 for the children who were interviewed. This approach allowed people to express their views about eating and drinking and what eating healthily might mean in their own terms. This was an important part of this benchmark survey, allowing these topics to be explored in detail.

Average interview durations for the final questionnaire were 50 minutes for the parents and caregivers and 21 minutes for the children (excluding completion of the Food Questionnaire booklet). Paper-based versions of the CAPI questionnaire and the Food Questionnaire are available on the *Feeding our Futures* website.

## 4. SAMPLE AND SAMPLING

The survey sample is defined as a nationwide, multi-stage random probability sample of parents and caregivers of children aged between 5 and 16 years. A supplementary sample of children aged 5 to 16 years also was obtained by interviewing a child in this age group who lived in the same household as the parent/caregiver.

Meshblocks are the smallest geographical unit for which the Census data are collected and processed by Statistics New Zealand, and these formed the first level of sampling. Systematic, random procedures were used to draw first the meshblock, then the dwellings within the meshblock. If a dwelling had a child aged between 5 and 16 years, who usually lived there, the interviewer asked who the person was who was responsible on a day-to-day basis, for providing, cooking and managing the food of the child or children. An interview was then undertaken (where possible) with this person.

Interviewers also selected a 5 to 16-year-old child, as many of the questions were asked about a specific child. If there was more than one 5 to 16-year-old in the household, then a child was selected at random for the child-focussed questions. In addition, in one-half (50%) of households, this child was asked to take part in an interview to provide the child's perspective on a number of topics and then to complete the Food Questionnaire.

The sample design allowed for increasing the number of Maori and Pacific people interviewed by contacting and screening additional homes in each meshblock. In these homes, only people in one of these two ethnic groups were eligible for the survey.

Interviews were conducted with a total of 1,133 parents and caregivers and 547 (out of 579 sampled) children. This equates to an unweighted response rate of 75% for the parents and caregivers, and 94% for the children. Of the 547 children who answered questions, 424 completed and returned the Food Questionnaire (ie, 73% of the child sample). The children's responses will be presented in a separate report.

The sample bases for analysis of ethnicity used the prioritised approach<sup>6</sup>, which resulted in the following sub-samples for the parents and caregivers:

Maori	287
Pacific peoples	330
Asian peoples	78
Other ethnic groups	437
<u>Refused to select an ethnic group</u>	<u>1</u>
TOTAL	1,133

## 5. INTERVIEWING

Upon identifying the eligible respondent in each sampled home, the interviewer presented a printed brochure from the HSC. This brochure explained the role and content of the survey and questionnaire, and the respondent's rights. It also gave contact phone and email addresses in the event that the person wished to know more about the survey. A copy of the brochure is in the technical report.

The title "New Zealand Children's Food and Drinks Survey" was chosen for the survey to avoid mentioning "healthy eating" when introducing the survey and so potentially compromising questions at the start of the interview that asked about healthy eating.

Interviews were conducted using CAPI. Interviewing took place in the respondent's home. Interviewing aids included the software-driven questionnaire and a set of showcards that were used to show potential responses to closed-ended questions. Using a laptop computer also allowed parents and caregivers and children to be shown illustrations of a selection of foods and drinks to help them answer questions about these. Verbatim answers to open-ended questions were typed into the software on the laptops as they were spoken. Interviewers transferred completed interviews on a weekly basis to a database on NRB's website. Interviews were conducted from June 2007 to early October 2007.

<sup>6</sup> Prioritisation is a classification that assigns the ethnicity of a person who has given multiple responses to just one ethnicity. This process means that the total number of responses equals the total survey population. The order of prioritisation is Maori, Pacific, Asian, other groups, and then New Zealand European. For example, a person with two ethnicities recorded as Maori and Tongan, would have a prioritised ethnicity of Maori. All of the ethnic groups that people said they belonged to are recorded in the survey dataset and so ethnicity can be analysed using other approaches, such as total response.

## 6. DATA PREPARATION

Data preparation included checking and, if necessary, editing responses for accuracy and consistency. Editing and checking are largely concurrent in software-driven questionnaires, as the question order and answer options are controlled electronically. Coding of the open-ended questions, however, required a thorough inspection of the range of unique replies given orally by respondents. Those replies that contained similar themes, albeit expressed in different words, were assigned a common code. One or more of these codes was then assigned to each open-ended question.

Creating this code set enabled the open-ended questions to be converted to numeric data in the dataset, and so the percentage of people giving the different responses could be calculated. These grouped responses are included in the data tables. Examples of the verbatim responses also are included in the report.

## 7. WEIGHTING AND TABULATION

The survey dataset was weighted to recognise each respondent's initial probability of selection based on the main demographics (this adjusts for the fact that, because only one adult is interviewed, people in larger households are under-sampled relative to adults in smaller households). Weighting also adjusted the data for differences in response rate. For the sub-sample of children, age, gender, and ethnicity groups were benchmarked to the proportions for the respective groups in the 2006 Census of population. The weighting procedure is outlined in the technical report. Note that it was not possible to benchmark the proportion of parents and caregivers in the sample against Census data as the definition of 'parent or caregiver' used for the survey is not used in the Census.

The weighted responses (number and percentage) are presented in tables that are the basis for describing the findings from the survey. These tables are designed to provide ready comparisons between the overall (total survey) finding and those of each of a range of specific population groups. These are largely demographic groups based on the age of the nominated child and their parent/caregiver, the gender and ethnicity of the parent/caregiver, household composition, household income, location (urban/rural) and a measure of socio-economic status based on the deprivation index.

## 8. STATISTICAL ERROR AND THE CONFIDENCE INTERVAL

Figures from surveys are subject to variation that arises from the use of a randomly drawn sample, rather than a survey of the total population of interest. Different random samples drawn the same way may produce slightly different results (ie, in the survey percentages); this is known as sampling variation. The extent of this variation falls within known ranges and is expressed as a confidence interval. The larger the sample, and the closer the figure of interest to 100% or 0%, the narrower the interval.

The principal findings to the closed-ended questions in this survey are presented in the form of bar charts that enable ready, visual comparison of the results. Set into the top of each bar is a "whisker", a line that shows the likely range of variation within which the true figure may fall (ie, the figure that would have been obtained if all parents and caregivers had been asked the questions rather than a sample). This range is the confidence interval.

For the *Children's Food and Drinks Survey*, the interval shows the range within which a figure would likely fall for 90 out of any 100 different random samples. In this regard, it is useful to bear in mind that the true figure for the population is more likely to be close to the actual figure found in the survey, rather than to the figures at either extreme of the confidence interval.

Calculation of these confidence intervals needs to take into account that the survey employs a complex sample design, rather than a simple random sample (SRS). The technical report describes this aspect in more detail and presents the relevant information on confidence intervals.

Confidence intervals reported here have been individually calculated using a statistical procedure known as the Jack-knife Replicate procedure. This follows from the survey sample being a complex one, using stratification and screening. In such cases, the standard formula used for a SRS is not appropriate.

Confidence intervals are an indicator of whether or not differences between survey results for different sub-groups are statistically significant (ie, whether or not they occur by chance). If confidence intervals for two figures do not overlap, the difference is statistically significant. The difference between two figures may be statistically significant when confidence intervals overlap. These differences can be detected using significance tests but significance tests have not been used when analysing data for this report.

## 9. NON-SAMPLING ERROR

Non-sampling error relates to how well people understand and answer the questions in a survey and how well they communicate their answers to the interviewer. This includes aspects such as correctly recalling time periods and frequencies of behaviour, and candidness of replies. The piloting of the questions will have reduced potential errors of this kind, but the amount remaining, as with all survey questionnaires, cannot be estimated. The *Children's Food and Drinks Survey* is designed to monitor trends and proceeds on the assumption that these sources of error remain relatively constant from one survey to the next.

## 10. DIFFERENCES BETWEEN SUB-GROUPS

It is generally accepted that, while statistical significance remains the basis for defining prevalence and key changes in social surveys, readers are not best served by only reporting findings that reach chosen significance levels. Small differences of little practical value may be highlighted if the sample is large, while differences of practical or interpretive value may be masked if the sample base is not large.

As this report is for a wider, non-technical audience, readily understood English-language terms have been used to draw attention to relative differences between groups of people taking part in the survey. This approach encourages a richer appreciation of the findings. The expressions used are "more likely/less likely" where the size of the difference is proportionately large in relation to the figures described, and "slightly more/slightly less likely" where a difference is evident but less marked. This treatment is appropriate also to the attitudes, perceptions and social behaviours reported. For the technical researcher, a dataset and data dictionary are available for performing statistical investigation.

It also should be noted that when the number of respondents in a sub-group is small (<30) the difference between this sub-group and others is not commented on, as the estimates of results may be subject to a very wide margin of error.

## 11. ADDITIONAL NOTES

The figures presented in tables and graphs in this report may not sum to 100 due to rounding. Where answer options have been combined, this percentage may not equal the sum of the percentages of the individual answer options due to rounding.

Categories used in the tables include:

Ethnicity – for this survey, people's ethnicity is assigned using the prioritised approach (see footnote six). European/Other includes everyone who did not say their ethnicity was Maori, Pacific or Asian.

Deprivation Index – the deprivation index combines nine census variables from the 2006 Census that reflect aspects of material and social deprivation. A score is provided for each meshblock in New Zealand and so the index applies to areas rather than individuals. The index, therefore, is an indicator of someone's likely socio-economic status, rather than their actual status. A value of 10 indicates that the meshblock is in the most deprived 10 percent of areas in New Zealand, according to the NZDep2006 scores. In the tables in this report, the index is grouped into three categories: 1-3 (low) = the least deprived areas; 4-7 (mid) = areas of mid-deprivation; and 8-10 (high) = the most deprived areas.

Household Composition – this is generated from a survey question asking who usually lives in the respondent's household. As this was a survey of parents and caregivers, the four household composition categories include: "single parent/caregiver family" (ie, no other partner/spouse/caregiver); "two-parent/caregiver family" (ie, respondent is mother or father (biological or foster/adoptive) or caregiver with one other partner/spouse); "extended family" (ie, respondent is mother or father (biological or foster/adoptive) or caregiver with one other partner/spouse and other relatives but not friends/flatmates/other); and "other households" (none of the above). A parent/caregiver was defined as the person mainly responsible for providing, cooking and managing the food and drink for 5 to 16-year-old children who were usually resident in the household. Caregivers included, for example, a grandparent or an older child living in the household.

Location – this is based on the Statistics New Zealand classification of locations. In this survey, the definitions Urban and Rural are used. The main urban centres form one category – 'Urban'. The remaining areas are Minor Urban and Rural, which together make up the 'Rural' category.



## C. EXECUTIVE SUMMARY

Over 1,100 (1,133) parents and caregivers of 5 to 16-year-olds took part in a nationwide, in-home survey from June to early October 2007. Parents and caregivers were asked a series of questions about one of their children (who was chosen at random for the survey and is referred to as "their child"), as well as about their own views and experiences of healthy eating. In addition, over 500 (547) of the children selected for the survey were interviewed to provide their perspective on a number of topics. Over 400 (424) children also completed a booklet after the interview to provide information about all the foods and drinks they ate and drank. The survey included parents and caregivers and children who were Maori, Pacific, Asian, and of European and other ethnicities.

### 1. AVAILABILITY AND CONSUMPTION OF FOODS AND DRINKS

To provide information about children's diets, parents and caregivers were asked whether selected foods and drinks were available in their home and, if so, whether and how often their child ate or drank these types of foods and drinks. A list of twenty-two different foods and drinks was used to represent foods/drinks that can be considered more and less healthy.

Almost all parents and caregivers (97%) said that **tap water** was available in their home. Of these parents and caregivers, almost all (97%) said that their child drank tap water. Over one-half (56%) of parents and caregivers said that **bottled water** was available in their home and, when it was available, eight out of ten (80%) parents and caregivers said that their child drank it. Over one-third (35%) of parents and caregivers said that **flavoured water** was available in their home and three-quarters (75%) of these parents and caregivers said that their child drank flavoured water.

Just under seven out of ten (69%) parents and caregivers said that **full-sugar carbonated drinks** were available in their home and almost nine out of ten (89%) of these parents and caregivers said that their child drank full-sugar "fizzy" drinks. Just under six out of ten (58%) parents and caregivers said that **diet carbonated drinks** were available in their home and almost eight out of ten (79%) of these parents and caregivers said that their child drank these types of "fizzy" drink.

Between eight and nine out of ten (85%) parents and caregivers said that **fruit juice** was available in their home and the majority (93%) of these parents and caregivers said that their child drank fruit juice. Over one-half (56%) of parents and

caregivers said that **other types of juice**, including juice from concentrate, powder and cordials, were available in their home and nearly nine out of ten (89%) of these parents and caregivers said that their child drank these types of juice.

Just under three-quarters (73%) of parents and caregivers said that **full-fat milk** was available in their home and over nine out of ten (93%) of these parents and caregivers said that their child drank full-fat milk. Seven out of ten (70%) parents and caregivers said that **low-fat/soy milk** was available in their home and over three-quarters (78%) of these parents and caregivers said that their child drank these types of milk. Over one-half (54%) of parents and caregivers said that **flavoured milk** was available in their home and of these parents and caregivers over eight out of ten (83%) said that their child drank flavoured milk.

Of the ten selected drinks that parents and caregivers were asked about, most said that their children did not drink these very often (ie, *1-4 days a week or less*). The exceptions were **tap water** (90% of parents and caregivers who said that tap water was available in their home said their child drank it daily), **full fat milk** (69% of parents and caregivers who said that this type of milk was available in their home said their child drank it daily), and **low-fat/soy milk** (52% of parents and caregivers who said that these types of milk were available in their home said their child drank it daily). (Note: readers are referred to the full text for more information about the frequency with which children consumed each of the twenty-two foods and drinks).

All parents and caregivers (100%) said that **fresh fruit** was available in their home and the majority (98%) of these parents and caregivers said that their child ate fresh fruit. Over nine out of ten (91%) parents and caregivers said that **tinned or frozen fruit** was available in their home and a similar proportion (90%) of these parents and caregivers said that their child ate tinned or frozen fruit.

Almost all parents and caregivers said that **fresh vegetables** were available in their home, with less than 1% saying that fresh vegetables were never available. Nearly all (99%) parents and caregivers said that their child ate fresh vegetables. The majority (97%) of parents and caregivers said that **tinned or frozen vegetables** were available in their home and of these parents and caregivers the majority (96%) said that their child ate these types of vegetables. Almost all parents and caregivers said that **taro/kumara/potatoes** were available in their home, with less than 1% saying that they were never available. Almost all parents and caregivers (99%) said that their child ate these types of food. Over eight out of ten (81%) parents and caregivers said that **fried potatoes** were available in their home and the majority (97%) of these parents and caregivers said that their child ate fried potatoes.

Parents and caregivers said that **fresh fruit** and **fresh vegetables** were eaten more often by their children than the other types of fruit and vegetables they were asked about. Eight out of ten (80%) parents and caregivers (who said that fresh fruit was available in their home) said their child ate fresh fruit daily and almost seven out of ten parents and caregivers (68% of those who said fresh vegetables were available) said that their child ate fresh vegetables this often.

Over nine out of ten (92%) parents and caregivers said that **burgers and sausages** were available in their home and the majority (96%) of these parents and caregivers said that their child ate these foods. Just over two-thirds (67%) of parents and caregivers said that **fried chicken or nuggets** were available in their home and of these parents and caregivers over nine out of ten (93%) said that their child ate fried chicken or nuggets. Over eight out of ten (81%) parents and caregivers said that **fried fish** was available in their home and just under nine out of ten (89%) of these parents and caregivers said that their child ate fried fish.

None of these foods was eaten frequently; less than one in ten of the parents and caregivers who said that these types of food were available said that their child ate them 5 days a week or more often. **Burgers and sausages** were eaten more frequently than **fried chicken/nuggets** and **fried fish**. Almost one-half (47%) of parents and caregivers, who said that these foods were available in their home, said that their child ate burgers and sausages *1-4 days per week*, while the majority of parents and caregivers saying **fried chicken/nuggets** and **fried fish** were available in their home said that their child ate these foods *less often* than once a week or *never*.

Just under eight out of ten (79%) parents and caregivers said that **pies and pastries** were available in their home and of these parents and caregivers over nine out of ten (93%) said that their child ate pies and pastries. Over nine out of ten (94%) parents and caregivers said that **potato or corn crisps and snacks** were available in their home and the majority (97%) of these parents and caregivers said that their child ate these types of snacks. Over nine out of ten (93%) parents and caregivers said that **sweets, lollies and chocolates** were available in their home and the majority (97%) of these parents and caregivers said that their child ate sweets, lollies and chocolates.

**Potato/corn crisps and snacks** and **sweets, lollies and chocolates** were eaten more frequently by children than **pies and pastries**. Between four and five out of ten of those parents and caregivers who said snacks and sweets were available in their home said that their child mostly ate these types of foods *1-4 days per week* (48% of these parents and caregivers said this about crisps and snacks and 44% said this about sweets), while the majority of parents and caregivers saying that

pies and pastries were available said that their child ate these foods *less often* than once a week (62%) or *never* (7%).

**Potato/corn crisps and snacks** were eaten more frequently by children than **sweets, lollies and chocolates**, with almost three out of ten (28%) parents and caregivers (who said these foods were available) saying their child ate potato/corn crisps and snacks 5 days a week or more often, compared with one in ten (10%) parents and caregivers who said their child ate sweets/lollies/chocolates this often.

Parents and caregivers also were asked whether and how often they ate and drank the twenty-two selected foods and drinks. Their answers, as well as how their consumption of these foods and drinks compare with their child's, are described in sections 1.10 to 1.12.

The extent to which parents and caregivers said the different foods and drinks were available in their home and consumed by their child varied with the age of the children, the ethnicity of parents and caregivers and the deprivation index of the area they lived in. Readers are referred to the full text for information about the differences in the availability and consumption of the twenty-two foods and drinks.

Almost one-third (32%) of parents and caregivers said that there had been changes in the **kinds** of foods and drinks that their child had eaten and drunk over the last six months. The most common change mentioned was *change of personal preferences/tastes/choice*; this was mentioned by just under one-quarter (24%) of parents and caregivers saying that there had been changes.

Just under one-half (49%) of parents and caregivers said that there had been changes in the **amounts** of foods and drinks that their child had eaten and drunk over the last six months. Nearly six out of ten (59%) parents and caregivers saying that there had been changes said the reason was that their child now *eats more*, although they couldn't give a specific reason for this, while just over five out of ten (54%) said the change was because their child *eats more* because she/he is *growing bigger/getting older/experiencing a growth spurt*.

When asked about the extent to which the child chosen for the survey usually ate and drank the same things as everyone else in the household, just over six out of ten (62%) parents and caregivers said that their child *has the same things nearly all the time*. Just over one-third (35%) said she/he *has some of the same things, but has different things*, and 3% said *mostly has different things*.

Almost one-third (32%) of parents and caregivers said that there had been changes in the kinds of foods and drinks that they had eaten and drunk over the last six months. The two reasons for these changes mentioned most commonly by parents and caregivers saying that there had been changes were for *health reasons* (24%) and for *weight loss* (19%).

## 2. EATING AND FOOD PREPARATION PRACTICES

### Meal time practices at home

Over one-half (53%) of parents and caregivers said that their child sometimes had her/his main meal in front of the TV, computer or PlayStation. Of those parents and caregivers who said that this happened, over one-quarter (26%) said that it happened every day.

The majority of parents and caregivers (98%) said that their child sometimes had her/his main meal of the day sitting down with the rest of the household. Of those who said this, almost six out of ten (58%) said that it happened every day. Just over six out of ten (61%) parents and caregivers said that their household sometimes had the main meal in front of the TV. Of those who said this, just over two out of ten (21%) said that it happened every day.

Seven out of ten (70%) parents and caregivers said that their child had a sit-down breakfast daily. Four percent (4%) of parents and caregivers said that they did not have a sit-down breakfast on any day of the week.

Almost six out of ten (59%) parents and caregivers said that their child had a sit-down lunch daily. Two percent (2%) said that they did not have a sit-down lunch on any day of the week.

The majority (86%) of parents and caregivers said that their child had a sit-down evening meal every day. Less than 1% said that their child did not have a sit-down evening meal on any day of the week.

The majority (83%) of parents and caregivers said that their child *had breakfast every school day*. Six percent (6%) said that their child *never ate breakfast on school days*. Eight out of ten (80%) parents and caregivers said that their child *had breakfast every weekend day*. Three percent (3%) said that their child *never eats breakfast on weekend days*.

### Food taken to school from home

The majority (93%) of parents and caregivers said that their child took food and drink to school from home. Five percent (5%) said *no*, this happened *rarely*, on the *odd occasion only*. Of those parents and caregivers who said that their child took food and drink to school, over eight out of ten (81%) said that this happened every school day (ie, all five school days).

### Food preparation and cooking practices

Six out of ten (60%) parents and caregivers said that they *always cook with oil or margarine*, rather than butter or lard. Only 1% of parents and caregivers said that they never cook with oil or margarine, rather than butter or lard. Around one-half (45%) of parents and caregivers said that they *always trim the fat off meat*, including corned beef, while 5% said that they did not cook or eat this type of food.

Just over one-third (35%) of parents and caregivers said that they *always skim the fat off boiled meat*, although over one-third (36%) of parents and caregivers said that they did not cook or eat boiled meat. Three out of ten (30%) parents and caregivers said that they *always remove the skin from chicken*. Three percent (3%) of parents and caregivers said that they did not cook or eat chicken. One in ten (10%) parents and caregivers said that they *drain the fat off corned beef*, although three-quarters (75%) of parents and caregivers said that they did not cook or eat corned beef.

Over one-quarter (28%) of parents and caregivers said that they *always add salt* to food. A similar proportion (26%) said that they *rarely or never* do this. Over one-quarter (27%) of parents and caregivers said that they *cook or use low-fat foods always*, while under one-quarter (23%) said that they do this *rarely or never*. Eight percent (8%) of parents and caregivers said that they *always add butter, margarine or sauce to vegetables*, while over one-third (36%) said that they *rarely or never* do so. Three percent (3%) of parents and caregivers said that they *always fry or deep fry food rather than grill or bake*, while over six out of ten (61%) said that they *rarely or never* do so. Three percent (3%) of parents and caregivers said that they *use sweeteners, rather than sugar always*, while over eight out of ten (85%) said that they do this *rarely or never*.

### 3. PLANNING, FOOD PREPARATION AND SHOPPING

Just under three-fifths (58%) of parents and caregivers said that their child helps to plan meals *sometimes*, while over one in ten (14%) said that their child does so *often*. Fifteen percent (15%) of parents and caregivers said that their child does this *rarely* and a similar proportion (13%) said that their child *never* helps to plan meals.

Around one-third (35%) of parents and caregivers said that their child helped with shopping for food **every week or most weeks**. Ten percent (10%) of parents and caregivers said that their child helped with the main food shopping by going along *several times a week* and 25% said this happened *nearly every week*. Most parents and caregivers (65%) said this happened *about every second week* (16%), *about every third week* (13%), *less often* than about every third week (25%), or *never* (11%).

Parents and caregivers replies were similar when they were asked whether and how often their child helped with the main food shopping by unpacking the groceries afterwards. Around one-third (36%) of parents and caregivers said this happened **every week or most weeks** – *several times a week* (9%) and *nearly every week* (27%), while almost two-thirds (64%) said this happened less often – *about every second week* (15%), *about every third week* (10%), *less often* than about every third week (22%) – or *never* (17%).

Fewer parents and caregivers said that their child helped them to prepare or cook food **every week or most weeks**. Under one quarter (23%) of parents and caregivers said that their child helped them to prepare or cook food *several times a week* (8%) or *nearly every week* (15%). Over three-quarters (78%) of parents and caregivers said that this happened less often – *about every second week* (23%), *about every third week* (15%), *less often* than about every third week (24%) – or *never* (16%).

### 4. DECISION-MAKING, MONITORING AND ROLE MODELLING

#### Decisions about takeaway foods, snacks and food taken to school

Just under one-half (47%) of parents and caregivers said that they and their child choose together the type of **takeaway foods** that their child ate at home. Just over one-quarter (26%) said that their child chooses (*he/she does*), just under one-fifth (19%) said that they themselves choose (*you do*), and 5% of parents and caregivers said that they *don't buy takeaways for home eating*.

Around one-third (37%) of parents and caregivers said that their child chooses (*he/she does*) or that they *choose together* (32%) what their child eats **other** than the **main meal** at home, and just over one-quarter (26%) said they themselves choose (*you do*).

Just over two-fifths (41%) of parents and caregivers said that their child chooses (*he/she does*) what they eat for **snacks**, over one-third (35%) said they *choose together*, and around one-fifth (21%) said that they themselves do this (*you do*).

Just over two-fifths (41%) of parents and caregivers said that they themselves choose (*you do*) what food their child **takes to school from home**, over one-third (36%) said that they *choose together*, and just under one-fifth (19%) said *he/she does* this.

#### Monitoring food eaten away from home and between meals

Just over two-fifths (42%) of parents and caregivers said that they *often* asked their child what foods or drinks they had when they were **away from home**. Just over one-third (34%) said they did this *sometimes*, and around one-tenth said they did this *rarely* (11%) or *never* (14%).

Just under six out of ten (59%) parents and caregivers said that they often kept a check on what foods and drinks their child had **at home between meals**. One-quarter (25%) said they did this *sometimes*, and around one-tenth (8%, each) said they checked what their child ate and drank between meals *rarely* or *never*.

#### Role modelling

Over one-half (55%) of parents and caregivers said that they tried to set a good example at home by what they eat and drink *all of the time*, while just over one-third (35%) said that they try to be a good role model *fairly often*. Few parents and caregivers said that they tried to set a good example *occasionally* (6%), *rarely* (2%), and *never* (1%).

For parents who said that they tried to set a good example by what they eat and drink at home *all of the time*, the reason they mentioned most commonly for doing this (mentioned by just under one-half (47%) of these parents and caregivers) was that they liked *to set a good example/want them to follow my example*. This also was the reason most commonly mentioned by parents and caregivers who said that they tried to set a good example at home *fairly often* and *occasionally* (mentioned by 44% and 20%, respectively, of parents and caregivers who said they tried to set a good example *fairly often* and *occasionally*).

For parents and caregivers who said that they tried to set a good example at home by what they eat and drink *rarely* or *never*, the reason given most commonly for doing this was that they ate *unhealthy food/drinks* (mentioned by 20% of parents and caregivers saying they tried to set a good example *rarely* or *never*) and/or that they didn't *like healthy food* (mentioned by 16% of these parents and caregivers).

Just over two-thirds (67%) of parents and caregivers said they talked to their child *often* about foods that **may or may not be good for them**. One-quarter (25%) of parents and caregivers said that they did this *sometimes*, while 5% said that they did this *rarely*, and 3% said that they *never* talked to their child about foods that may or may not be good for them.

## 5. EFFICACY AND SUPPORT FOR PARENTS AND CAREGIVERS

Six out of ten (60%) parents and caregivers said that they found it *easy* to get their child to eat and drink healthily. When asked why they found it easy, the reason mentioned most commonly by parents and caregivers was that their child *has been brought up to eat healthily* (this reason was given by 28% of parents and caregivers saying that it was *easy* to get their child to eat and drink healthily).

Thirteen percent (13%) of parents and caregivers said that they found it *not easy/hard* to get their child to eat and drink healthily and the three most commonly given reasons for this were that their child did not *like veges* (in general or specific ones), was a *fussy eater* (or it was *hard to get her/him to eat meals*), and *that their child likes junk food, eg, pies, takeaway, chips* (these reasons were given by 19%, 17% and 17%, respectively, of parents and caregivers who said it was *not easy/hard* to get their child to eat and drink healthily).

Just over one-quarter (26%) of parents and caregivers said it *depends* (some easy and some hard) and the reasons they gave most commonly were that it depended *what food is available/what's on offer* and that their child *sometimes eats healthy food and sometimes doesn't* (these reasons were given by 16% and 14%, respectively, of parents and caregivers who said "it depends").

Asked how confident they were that they could use a range of strategies to get their child to eat and drink healthily, around six out of ten parents and caregivers (between 55% and 64% for the various strategies) said that they were already using these. Most other parents and caregivers felt confident that they could use these strategies, with between one-quarter and one-fifth saying *I am sure I can*, and around one-tenth saying *I think I can*.

The strategies included encouraging families to eat together, getting children involved in food preparation and cooking, promoting healthy snacking, and encouraging children to eat more fruit and vegetables, and drink water and milk, rather than sugary drinks. A list of all the strategies is in section 5.2.1.

When asked what other things parents and caregivers could do to help children eat and drink healthily, the things suggested most commonly (mentioned by around one-quarter of parents and caregivers) were to *have healthy foods available in the home* (26%), and to *educate them* [ie, the children]/*explain the benefits of healthy eating* [to them] (25%).

When asked what kind of help they think they needed in order to use strategies to get children to eat and drink healthily, just under one-fifth of parents and caregivers said *education/educating the parents* (19%) and a similar proportion said *education through schools/help from schools* (17%).

## 6. VIEWS AND CONCERNS ABOUT CHILDREN'S DIETS

### Views about what eating and drinking healthily means

The main things that parents and caregivers said counted as having their child eating and drinking healthily were when they: *eat plenty of fruit and vegetables* (mentioned by 66% of parents and caregivers); *drink plenty of water* (mentioned by 40%); *eat balanced meals/a variety of food from all food groups* (mentioned by 24%); and *eat meat/red meat* (mentioned by 21%).

Parents and caregivers thought that the two main benefits of children eating and drinking healthily were that they *have more energy/able to be more active/more stamina* (44%) and that they have a *healthy body/better health and fitness/improved well-being* (44%).

The majority (92%) of parents and caregivers thought that children like theirs could get problems from not eating and drinking healthily. The problems mentioned most commonly by these parents and caregivers were that children *tend to gain weight/will be overweight/obese* (38%), that they *get sick/are more susceptible to illness/have a poor immune system* (31%), and that they *lack energy/are not as active/have low stamina* (27%).

## Views about which foods and drinks are healthy and unhealthy

Parents and caregivers were asked to say whether each of the twenty-two foods and drinks that they were asked about in the survey were *healthy* or *unhealthy*.

Drinks viewed as *healthy* by the highest proportion of parents and caregivers were tap water (95%), bottled water (90%), low-fat/soy milk (89%), and full-fat milk (75%). The drinks viewed as *unhealthy* by the highest proportion of parents and caregivers were full-sugar carbonated drinks (95%), diet carbonated drinks (84%), and other juices, which include juice from concentrate, powder and cordials (75%).

All parents and caregivers (100%) viewed fresh fruit and fresh vegetables as *healthy*. A high proportion also viewed taro/kumara/potatoes (93%) and tinned/frozen vegetables (88%) as *healthy*. Two-thirds (66%) of parents and caregivers viewed fried potatoes as *unhealthy* and 8% viewed tinned/frozen fruit as *unhealthy*.

More parents and caregivers viewed all the different types of meat and fish (burgers and sausages / fried chicken or nuggets / fried fish), and pies, pastries, snacks and sweets as *unhealthy* rather than *healthy*. One-quarter (25%) of parents and caregivers thought burgers and sausages were *healthy*, while one-third (33%) thought these were *unhealthy*. (The other parents and caregivers, just over four out of ten (42%), had no view either way.) Only 4% of parents and caregivers thought fried chicken or nuggets were *healthy*, while 84% thought they were *unhealthy*. Seven percent (7%) of parents and caregivers thought fried fish was *healthy*, while 76% thought it was *unhealthy*. Only 3% of parents and caregivers thought pies and pastries were *healthy*, while 85% thought they were *unhealthy*. One percent (1%) of parents and caregivers thought potato/corn crisps and snacks and sweets/lollies/chocolates were *healthy*, while 80% and 90%, respectively, thought these foods were *unhealthy*.

## Concerns about children gaining / losing weight and eating unhealthy foods

Almost three-quarters (73%) of parents and caregivers said that they were concerned about their child **gaining weight** *hardly ever or never*, while eight percent (8%) said that they were concerned about this *most days, ongoing*. Similar proportions of parents and caregivers said that they were worried about their child **gaining less weight** or **weighing less** than was best for her/him *hardly ever/never* (75%) and on *most days, ongoing* (4%).

Just under four out of ten (38%) parents and caregivers said that they were concerned *hardly ever/never* that their child was having too much of the unhealthy kinds of foods and drinks, while just under one in ten (9%) said that they were concerned *most days, ongoing*.

## 7. THE ROLE OF PARENTS/CAREGIVERS AND OTHERS IN HEALTHY EATING FOR CHILDREN

Almost all parents and caregivers (99%) thought that they should play a "big role" in making sure that children eat and drink healthily and just over eight out of ten (81%) thought that food manufacturers should play a "big role". Around three-quarters thought that schools (76%) and GPs and other health professionals (75%) should play a "big role". Around seven out of ten (71%) thought that broadcasters should play a "big role". Just under two-thirds thought this about Government (63%) and the whole community (64%). Just under six out of ten thought that social and welfare agencies (59%), supermarkets and dairies (58%), and sports clubs or organisations (58%) should play a "big role". Around one-half thought this about places that sell fast food/takeaway food (50%) and restaurants where people eat on the premises (48%). One-third (33%) of parents and caregivers thought that churches should play a "big role".

## 8. AWARENESS AND VIEWS OF ADVERTISING AND PROMOTION

Over two-thirds (67%) of parents and caregivers said that, in the last three months, they had seen or heard some advertising, or noticed leaflets or posters, that explained the ways that they can help their children eat and drink healthily. Of these parents and caregivers, over eight out of ten (81%) said they had seen/heard television advertising, while just under one-half (46%) mentioned leaflets or posters. Just under one-quarter (23%) said they had seen advertising in daily newspapers and just over one-fifth (21%) mentioned community newspapers.

Just over three-quarters (76%) of parents and caregivers who had seen or heard advertising in the last three months could describe it. Of those parents and caregivers who said that they could describe the advertising, leaflet or poster, just under three out of ten (29%) said it *showed/promoted/explained about healthy food generally*. One-fifth (20%) of parents and caregivers, who said that they could describe the advertising they had seen or heard, mentioned 5+ *A Day* and 14% mentioned *Push Play/30 minutes a day*.