

## First Step Social Marketing Pilot Project 2010-2012

### Introduction

Support from the Start, the East Lothian Equally Well test site, is a partnership approach to reducing health inequalities in the early years of life. One of the four main outcomes for Support from the Start was to explore how to get communities, parents, grandparents and carers involved in key health improvement challenges in the early years.

A key contribution to this outcome has been the social marketing pilot that took place in First Step, an early years community based voluntary organisation.

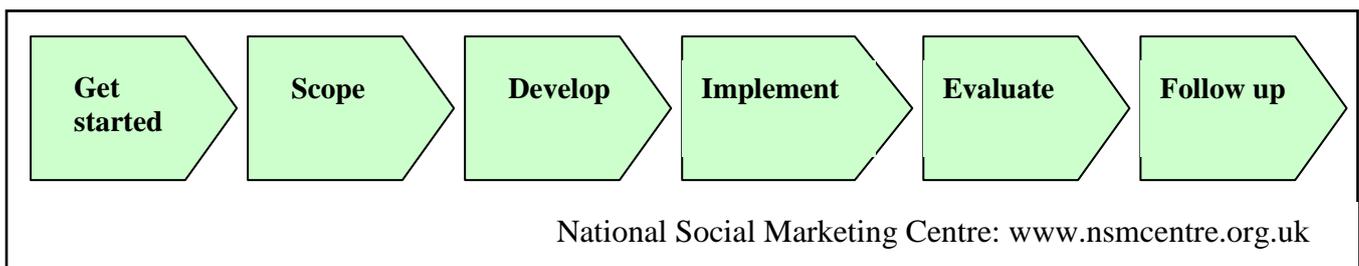
Social marketing is an evidence based approach to behaviour change. It uses key concepts and principles from commercial marketing alongside a range of social science approaches. It has been gathering growing evidence and interest in its effectiveness as a health improvement approach.

The main objectives of the social marketing pilot were to:

- Work collaboratively with parents and community members to identify key early years health issues for parents, children and the wider community
- Work with parents, children and services to develop agreed approaches, activities related to communication and or marketing on key early years health messages
- Link with a range of agencies and services that can support the dissemination of agreed approaches and activities.
- Learn how community based early years organisations can use 'social marketing' techniques to develop an enhanced role in health improvement for parents and children.

The following report uses the six stage social marketing process model (Diagram 1), to describe the pilot project.

**Diagram 1:**



## Get Started

Unlike many other social marketing projects across the country, the First Step pilot was in the unique position of supporting parents and grandparents to identify the particular focus of the pilot. Before this could happen key stakeholders were brought together to explore what a social marketing approach was and how it could be taken forward with First Step users.

A multidisciplinary steering group (Appendix 1) was set up to drive forward the work. The group, chaired by Health Promotion, provided expertise and local intelligence to progress the work. Although there was a wealth of health improvement experience within the group, none had used a specific social marketing approach before.

Changes in First Step management during the early months of the pilot alongside the perception that social marketing was a new way of working meant the project took longer than anticipated to get started. This was in part due to the new and sometimes complicated terminology used in social marketing and the time required to understand what was unique about a social marketing approach that set it apart from other more familiar approaches such as community development.

Around this time there was a growing national interest in social marketing and a Scottish social marketing online toolkit was in development. The steering group benefitted from liaising with another Equally Well test site that was implementing a large scale social marketing approach and also from training delivered by the National Social Marketing Centre.

From the knowledge gained through these early experiences, the steering group decided to use the recognised six step process model (Diagram 1) to help develop and deliver the work. Benchmark criteria (Appendix 2) also developed by the National Social Marketing Centre were used to keep the project in line with core social marketing principles and concepts.



### **Key Learning Point 1:**

- Gain an understanding of the key concepts and principles of social marketing before starting a project
- Discuss why you think social marketing complements other approaches you have used or why you think it differs –this might help clarify if it is the right approach to use for your intended outcomes

## Scope

The primary purpose of the scoping stage was to gain a deep understanding of the audience worked with and identify behavioural goals and interventions that help achieve these goals.

As discussed, unlike other social marketing projects which started with a pre-determined issue, First Step worked with parents and grandparents to help them identify what health issue they would like to explore. First, a health lifestyle questionnaire set up through Survey Monkey was completed by parents and grandparents. This was followed by discussions on health in existing First Step groups. The advantage of using pre-existing groups was that individuals already knew each other and had formed as a cohesive group. It also allowed First Step staff to continue to support the specific groups e.g. the Young Mums or the Grans group with their regular business rather than create additional demands on staff and parents or grandparents time.

The findings from the questionnaire and subsequent focus group discussions started to reveal an interest and need for a focus on food and health. Other parallel activities provided further insight into concerns and behaviours of First Step users. The first of these was part of a wider Support from the Start activity, which asked groups to complete a scrapbook and take photographs in response to the question “Does the physical space of our communities contribute to creating good health in the early years and support parents in raising healthy children?” Steering group members met with parents that had taken part in the scrapbook activity, had a worthwhile discussion about the process and gained an understanding of some common themes expressed by the parents.

Secondly, and again independent of the Social Marketing pilot, Dr Jeni Hardin, then a Senior Lecturer at Napier University, approached First Step to interview young mums as part of her research into nutrition. The findings from this preliminary research, titled, “Food Practices amongst mothers of young Children” were made available to the steering group.

Information from the survey, focus groups, scrapbook and university research provided insight into local health concerns and informed the priority issue for the social marketing approach. The evidence from these scoping activities confirmed that food and health would be the focus for the social marketing project.

A Challenge Statement (Appendix 3) was developed which helped set out the issue in detail. Producing a Challenge Statement was a useful and quick process to complete and provided the project and other interested parties with a brief summary of the issue.

Although a great deal of useful information was generated with the First Step users, it proved challenging for the parents to identify specific goals around food and health. The steering group, which included a number of First Step

staff who could advocate on behalf of the parents, developed six main behavioural goals. Setting specific goals or objectives is an essential part of a social marketing approach as it clarifies what outcomes a project will work towards. The following main goal and specific sub-goals were proposed by the steering group:

**Main Goal:** To maintain and improve healthy food practices amongst First Step users.

**Specific Sub Goals:**

- To start the day with a healthy breakfast
- To replace one unhealthy snack a day with a healthy snack
- To be able to cook healthier meals on a budget
- To be able to cook more meals from scratch
- To learn to share parenting strategies around food and children
- To understand the relationship between adult (parent) food practices and their children's food practices

The acceptability of these goals was tested out with First Step families using a participatory approach. Utilising the planned First Step 21<sup>st</sup> Birthday Gala and in order to capture as many of the First Steps users as possible, the goals were displayed in a prominent place during the gala activities. Parents and grandparents were encouraged to indicate which goals they would be interested in working towards and add comments in relation to these goals.

At the same time, the parents and grandparents were asked to take part in a short survey on current breakfast and snacking habits.

A full survey report is available on request however some of the main findings are listed below:

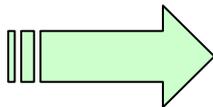
- Significantly more children had breakfast seven days a week compared to adults
- The most popular breakfast food for both adults and children was cereal, followed by porridge and then toast
- The breakfast cereals consumed by children often had a high sugar content
- The majority of adults and children had snacks throughout the day
- The range of snacks consumed by adults and children was relatively similar for example, crisps, chocolate, biscuits and fruit
- Fruit appeared to be a popular snack choice with children but was often described alongside other snacks, such as, "apple and crisps" or "chocolate and fruit"

The survey helped provided baseline information on behaviours related to breakfast and snacks. Using this information alongside desk based research and the information gained earlier in the scoping stage, the steering group performed a barriers and competition analysis (Appendix 4). As social marketing involves people changing behaviour e.g. giving up one behaviour

for another behaviour, the idea of “exchange of value” and identifying the barriers and competition for the behaviours is important.

The analysis was a helpful way to focus attention on what got in the way of changing behaviour and how any interventions the project took forward would need to offer something more valuable than the current behaviour. The group found this process a useful reality check about “what you’re up against” when they were promoting healthier behaviours against less desirable behaviours. For example, the analysis identified that cereals were a main competitor in relation to eating a healthy breakfast. Clever marketing by commercial companies often promotes cereals as a convenient and healthy breakfast option. Add to this the eye-catching packaging, links to popular TV programmes and movies and the cereal became an attractive option. The interventions to help First Step participants choose healthier breakfast options therefore needed to carefully consider this, and is described in more detail in the **Implement** section.

The next stage was to explore potential interventions that would support the achievement of the behavioural goals. This is discussed in the **Development** stage.



### **Learning Point 2**

- Allow plenty of time for this stage
- Be confident that your existing skills set in health improvement will go a long way to support you take forward a social marketing approach
- Don’t assume a common understanding of health amongst participants
- Be flexible with your engagement process and build in staff time to take this forward
- Consider engaging with existing groups within your organisation or community to inform developments
- Do spend time explore the barriers and competition to the desired behaviour

## **Develop**

A key feature of the development stage was to choose interventions that contained a mix of methods, that is, a range of activities and a range of marketing strategies.

The pilot project explored each of the goals and agreed a number of activities to implement in a staggered approach for the goals. During the exploration stage the group agreed that the goal “To understand the relationship between adult (parent) food practices and their children’s food practices” should not be a separate goal but something that would inform achievement of the other goals. Additionally the two goals relating to cooking meals were merged to create one goal, namely “Prepare and cook healthy meals on a budget”.

One of the underlying principles of social marketing is that interventions are informed by theory. The Cycle of Change (Prochaska and Diclemente<sup>1</sup>) informed the development of the interventions. The 5-stage cycle of change model acknowledges that individuals are at different stages with their thinking or action in relation to behaviour change. The social marketing interventions sought to recognise this by providing activities that ranged from general awareness raising about healthy eating, to targeted skills based cooking sessions.

In reality the development and implementation stage ran concurrently. This was to support First Step staff build in the interventions into the ongoing work of First Step and plan staffing and events accordingly. It also allowed each intervention to learn from the previous one in terms of successes and challenges. The interventions are described in the section below.

## **Implement**

### **Goal 1: To start the day with a healthy breakfast.**

First Step arranged a Big Breakfast event with an open invite for any First Step user to attend. The idea behind this activity was to create a social and friendly way to bring parents and grandparent together to try out different breakfast options and gain new information about key healthy eating messages. The baseline survey revealed that a number of parents were not having breakfast and one identified barrier to this was time. The event emphasised the benefits of having breakfast and offered an opportunity to try breakfast options that were quick, easy and healthy.

The event, as with all the other activities, was held in First Step as it was a place that parents and grandparents were familiar with and comfortable attending. The Big Breakfast was advertised as a social event through the use of posters, flyers and word-of mouth. The day was selected carefully, to allow for maximum participation from staff and the existing different groups that took place in First Step.

As well as First Step staff, an Oral Health Promoter and Food and Health Development Officer supported the event by provided information, resources and interactive activities based on the breakfast theme. This included highlighting the sugars in breakfast cereals and offering alternatives that were healthy and quick.

### **Goal 2: To replace one unhealthy snack a day with a healthy snack.**

Following on from the Big Breakfast event, a Super Snack session was held. Taking on board some learning from the previous event the session made different use of the physical space to allow groups the option to “pop into” the snack session. Again this event was support by First Step Staff, the Oral Health Promoter and Food and Health Development Officer.

### **Goal 3: Prepare and cook healthy meals on a budget.**

Through discussions between staff and parents, it was identified that gaining new skills and confidence in relation to cooking meals would be helpful for the Young Mums group. Following on from Food Hygiene training offered to a number of staff, parents and grandparents, a programme of cooking sessions was offered. It was felt appropriate to offer the cooking session to the young mums initially and run separate sessions for the rest of the project. This “audience segmentation” was to support the mixed skills and confidence of the young mums and to create a safe and fun environment for them to learn and participate.

The sessions were led by one of the mums with staff there for support. A chosen meal was prepared and cooked and then all participants were able to sample the food. A bag of ingredients and the recipe were supplied by First Step for the mums to take home to encourage them to prepare the dishes themselves. Most parents reported making the meal that night or soon afterwards.

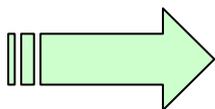
Staff encouraged involvement with these sessions with an underlying emphasis that the process not the end product was important. The existing relationship that staff members had with parents was important to gauge how to develop activities and support participation. The staff -parent relationships were an important feature of the success of the cooking sessions in a way that bringing in an outside worker to deliver them would not have been.

At the end of the cooking sessions, a Bring a Dish Day was held. This event encouraged all First Step users to come together with a food or snack they had made, along with the recipe. During this event participants were encouraged and supported by staff to share hints and tips about the food or mealtimes in general. Some conversations that took place were around difficulties with children and trying new foods, and practical tips for cooking. Staff were able to clarify information given.

### **Goal 4: Learn and share parenting hints and tips about food and meal times.**

In addition to the Bring a Dish day above, parents took part in a focus group that was run as part of their existing group time, to reflect on some of the events that had taken place in First Step.

Parents were also supported to be involved with the development of a healthy eating keepsake. An A4 folder was designed, developed and printed for First Step users. The folder, named after a parent’s suggestion of “Simply Feeding Families”, contained recipes and hints and tips developed by parents. It was issued to all First Step users involved in the projects and sample copies given to relevant partner agencies.



### Learning Point 3

- Bring service users on board when appropriate - which may not be right at the start
- Strike the right balance between providing new activities and the core business of the organisation
- Consider if you really need to use social marketing terminology with everybody
- Allow time to support parent, grandparents and carers to take part and come up with their own ideas
- Allow enough time to promote activities
- Develop activities that can be embedded into the everyday practice of an organisation

### Evaluate

The primary outcomes for this pilot project were to test out the social marketing approach with one organisation and share the learning from the experience. Throughout the pilot phase good communication has been sought with relevant stakeholders, and early on in the pilot a *Stakeholder Communication* grid was developed to ensure that steering group members were linking into appropriate people or groups. More detail is provided on how the learning was shared in the **Follow On** section.

In relation to the behaviour goals that were set, a repeat survey was conducted with First Step user to gather information on people's breakfast and snacking habits.

The survey took place approximately six months after the baseline survey on breakfast and snack habits. During these six months a number of activities took place in First Step to help First Step users work towards goals around healthy eating. These goals included:

- starting the day with a healthy breakfast
- replace one unhealthy snack a day for a healthy snack

It should be noted that the sample size from the repeat survey was smaller than the initial survey and the findings gave an indication of breakfast and snack habits rather than a rigorous scientific evaluation.

The findings appeared to indicate that more people were having breakfast in the morning but it was not possible to conclude if the breakfast was a healthy choice. From this survey alone, there was not conclusive evidence to suggest that First Step users had replaced unhealthy snack choices with healthy snack choices.

The survey was conducted in relatively short timeframe after the breakfast and snacking activities had been provided. It would be beneficial if the survey could be repeated, with a wider audience and more in-depth questions added to find out if there had been any significant changes to the related behaviours.

The evaluation of the behavioural goals relating to preparing meals on a budget and sharing parenting tips were qualitative and built into the everyday activities of First Step.

First Step staff observed changes in behaviours of some of the parents.

Some reported differences included;

- Parents looking at and discussing menus and recipes at times out with any of the planned activities. Staff highlight that this was something that wouldn't have happened before the pilot project
- One First Step parent who informed staff that she only had one meal a day which was a takeaway, later self reported that she had been cooking meals at home as a result of the cooking sessions
- Healthier snacks being given to children by their parents
- Parents taking ownership of making birthday cakes for their children, to bring to the nursery, something staff had previously done.
- Yong mums were drinking less sugary drinks
- Children are offered milk and water rather than sugary squash.
- Parents who had been cooking convenience foods were now feeling confident enough to be cooking for extended family from scratch

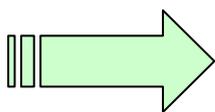
Other developments took place alongside the social marketing pilot however the pilot did help keep a strong focus of food and health throughout First Step. For example, the development of a vegetable patch in the grounds of First Step would have occurred without the pilot project however the strong food and health focus supported the further development associated with the vegetable patch e.g. children being involved in planting, growing, picking the vegetables; being more involved in preparing their own snacks and lunches and more fresh produce used for nursery snacks and lunches.

Staff within the nursery part of First Step were also more likely to highlight food related issues to parents for example, discuss new foods the children had tried and liked.

First Step staff facilitated group discussions with their users on the impact of the social marketing work and alongside this encouraged parents and grandparents to share their experiences, hints and tips with each other. Practical information was captured in the health eating keepsake folder, described in the previous section. Staff reported the following points that were highlighted during the group discussions:

- “Parents felt that they should ideally turn mealtimes into a real sociable family experience. Mealtimes can be good times for coming together but they can be also be stressful. In this project through discussions and activities some families have been reassured that it is not unique to them to have issues when feeding a family. Mealtimes can be messy and emotional. Most families were trying to eat at the table however, in one case the children were climbing out of the chairs and high chair and mum was finding this stressful.”

- “Parents shared on occasions it was just about getting through the day. They discussed that the some children's behaviour changes quickly around food and although they can be picky and faddy, most of these behaviours change over time. They expressed as long as you have a clear idea of where you want to be with routines with your family eventually you will achieve this in most cases. The group realised during the project that they felt they were not alone with their difficulties and this supported them in making changes because of these discussions.”
- “Some children are fussy eaters and this project has helped some parents identify that if the children assist in the growing or making of food they are more interested in eating.”
- “Parents recognise that some children do have food preferences. They now have noticed that by giving a good variety of different tastes and food and by offering only limited choice at a time then children usually will eat better. “
- “All parents in the discussions said that they have swapped unhealthy snacks for healthier snacks. They are buying less crisps and convenient snacks like "dairy or chocolate dunkers" and buying things like bread sticks instead. They have noticed a difference in their shopping bill because of this. One parent said that if she thinks her child is hungry before bed time she will give them porridge instead of a sugary snack.”
- “Some of the mums who were weaning were more confident about making their own food for their children rather than buying jars.”
- “Parents felt that being part of the project had made a difference to them by letting them try cooking from scratch and finding they were enjoying the result and hoped that we would continue with the events and groups.”
- “In the new term new parents have been given the "Simply Feeing Families Folder". The feedback has been very positive. One mum has said that she has used many of the recipes and finds them easier to follow than other cookbooks. She finds them economical and she would not have tried to cook from scratch in the past.”
- Other reported benefits have been related to learning about portion size and being more aware of multi-buys cost and calories



#### **Learning Point 4**

- Plan this as early as possible
- Be prepared to be flexible and realistic with the evaluation
- Consider long term evaluation to demonstrate sustained change

### **Follow-up**

#### **1. Sharing the learning**

A number of methods were employed to share the learning with others in East Lothian and wider. They were as follows:

An In-Service training session was provided to all First Step staff early on in the pilot, to help broaden the understanding of social marketing within the organisation.

Throughout the pilot phase, First Step staff provided updates to Support from the Start Champions Action Learning Sets and more recently linked into the new local community early years planning group.

A Continuing Professional Development (CPD) day was offered to all specialists in the Lothian wide Health Promotion Service. This event, which was positively evaluated, provided participants with the opportunity to explore and gain an understanding of the social marketing approach.

A presentation to the Support from the Start Board was given part way into the pilot.

The Steering Group took part in the Support from the Start, Happy Healthy Bairns conference and provided a poster display of the social marketing work to date.

Members of the First Step Steering group presented at an East and Midlothian wide Health Bites seminar. These seminars were free local health inequalities events open to anyone working or living in these areas. The seminar, which was attended by twenty-three participants, was evaluated well.

It is anticipated that this final report will also provide an additional source of information for other projects, stakeholders and planners considering a social marketing approach to address health improvement and inequalities.

## 2. Behaviour Change

As previously mentioned observational changes in behaviour were made by staff and reported by parents, however, measuring specific changes in eating habits was not fully captured.

It has been recommended that a follow up survey takes place to establish if any lasting and significant behaviour change was achieved.

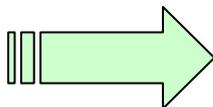
## 3. Other

The legacy at First Step: First Step hope to continue with the cooking sessions and plan further food hygiene training. Practice in the nursery has changed as described in the evaluation section session. Staff reported an increase in confidences and skills in a small group of the parents.

The steering group have been crucial to driving the process and keeping a focus on the main issues. Having the group allowed for questions to be asked and reflection on what was working well and what was not.

First Step staff also commented on the importance of informal peer support from parents and grandparents and how they learnt to incorporate that within the approaches taken.

While this project explored how social marketing could be taken forward within one organisation, (a downstream approach with practitioners and individuals), it didn't explore, during the pilot phase, an upstream approach with planners and policy makers. While this was out with the scope of this project it is important to note that without addressing wider determinants on health the effect of social marketing on individual behaviour change will be limited. For example, issues such as income maximisation, food affordability and access, food production, housing conditions (e.g. suitable family space for cooking and eating), and transport availability to local shops can all affect the food and health issues identified with this pilot project. In order to have a wider and more sustained impact these wider determinants also need addressed.



### Learning Point 5

- Think about the most efficient way to share your experiences throughout the life of your project not just at the end point
- Where possible, plan time in your schedule for follow-up events
- Reflect on if you can incorporate an upstream approach to influence the wider determinants of health

## **Conclusion:**

The pilot project has delivered on its four main objectives to: work collaboratively with parents to identify health issues, and approaches to address these; to make links with appropriate agencies and to share the learning gained from using a social marketing approach.

The impact of this pilot on behaviour change is less clear however this may have been due to the timing and methods used to gather this information, rather than a lack of impact. Small shift in behaviours that are not easy to quantify and measures have been observed by First Step staff who work closely with the parents and grandparents Whether this is directly attributable to the social marketing developments or is reflective a combinations of approaches used in and by First Step is difficult to determine.

Advantages of the social marketing approach were that some principles did direct the steering group to consider certain issues in more depth than they may have with other health improvement methodology. Examples of this were considering barriers and competition to healthy behaviours and the notion of an exchange value (giving up one behaviour for another had to have some value in it)

It was felt that a number of the principles, such as, customer orientation, segmenting and using a theory base were common to other approaches. However as these principles were described in new terminology there was some confusion as the group searched for new meaning or different principles behind the terms.

Social marketing is a valuable health improvement tool to be familiar with and can offer other organisations some unique principles to follow. It worked well within an organisation that; already worked alongside their clients in a partnership way; could support small groups with intensive developments and were familiar with similar approaches such as community development.

**Report prepared by:**  
**Morag Nicholson**  
**Senior Health Promotion Specialist**  
**Updated May 2013**

**With contributions from**  
**Jane Holden, Tina Pollock and Sandra Henderson at First Step**

## Appendix 1

### First Step Social Marketing Steering Group membership

Morag Nicholson, Senior Health Promotion Specialist, NHS Lothian (Chair)

Jane Holden, First Step Project Manager

Tina Pollock, Early Years Manager, First Step

John Boyce, Public Health Practitioner, East Lothian CHP

Diann Govanlock, Community Development worker, East Lothian Council

Eleanor MacAskill, Health Visitor, East Lothian CHP (until 2012)

Mary Preston, Pre-school Education Officer, East Lothian Council (until 2010)

Pauline Homer, Childcare Development Officer, East Lothian Council (until 2011)

Marjorie Shepherd, Food and Health Development Officer, East Lothian Council (from 2011)

Carolanne Golightly, Oral Health Promoter, NHS Lothian (from 2011)

Sandra Henderson, Outreach Worker, First Step (from 2011)

Lucie Frances, Family Learning and Development Officer, First Step (from 2011)

Stella Thomson (parent) (from 2011)

Lorraine Shyngle (parent) (from 2011)

Lynne Claperton (parent) (from 2011)

## Appendix 2

### Benchmark Criteria

	<b>Benchmark Criteria</b>
1.	Customer orientation
2.	Behaviour and behaviour goals
3.	Theory-based and informed
4.	Insight driven
5.	Exchange analysis
6.	Competition analysis
7.	Segmenting and targeting
8.	Intervention and marketing mix

Ref: National Social Marketing Centre: [www.nsmcentre.org.uk](http://www.nsmcentre.org.uk)

## Appendix 3

<b>Challenge Statement: May 2011</b>	
<b>What is the presenting issue?</b>	Some First Step users are self reporting eating habits that are not as healthy as they could be
<b>What is likely to happen if no action is taken?</b>	The individuals and potentially their families continue eat in the same way and this could negatively affect their health
<b>In terms of “behaviour” what are the key challenges? (describe the issue in terms of behaviour rather than a policy aim)</b>	<ul style="list-style-type: none"> <li>• Lack of easily accessible, affordable healthy options therefore buying what they can, where they can and when they can</li> <li>• Lack of skills and sometimes knowledge to prepare healthy meals</li> <li>• Missing meals and snacking on unhealthy options</li> <li>• Emotional relationship associated with feeding their children e.g. wanting to eat something rather than nothing, using mixed-message strategies to manage their children’s eating habits and behaviour</li> </ul>
<b>Who are directly affected by the issue now?</b>	<ul style="list-style-type: none"> <li>• Primary care giver – usually the mum</li> <li>• Partners</li> <li>• Grandparents</li> <li>• Children at First Step</li> <li>• Siblings</li> </ul>
<b>Who could be affected in the future?</b>	<ul style="list-style-type: none"> <li>• All of the above</li> <li>• Local food suppliers</li> <li>• Local agencies involve in health improvement particularly those with specialist knowledge in food</li> <li>• Local health care staff</li> </ul>
<b>What is driving the concern now? (e.g. relevant national or local policy drivers)</b>	Overwhelming evidence and support for a focus on early years. Equally Well (2008)

<ul style="list-style-type: none"> <li>• Health Inequalities remains a significant challenge in Scotland</li> <li>• The poorest in our society die earlier and have higher rates of disease</li> <li>• Priority areas are -children, particularly in the early years where inequalities can first arise, and killer diseases such as heart disease and cancer</li> <li>• Physical environments that promote health lifestyles for children including opportunities for health eating should be a priority for local authorities and other public services</li> </ul> <p>Early Years Framework(2008)</p> <ul style="list-style-type: none"> <li>• A focus on engagement and empowerment of children families and communities</li> </ul> <p>Health Eating, Active Living (2008)</p> <ul style="list-style-type: none"> <li>• Commitment to tackle to increasing incidence of obesity, and support to achieve and maintain healthy weight</li> </ul> <p>Maternal and Infant Nutrition Framework (2011)</p> <ul style="list-style-type: none"> <li>• Action to address the fact that poor diet (and other factors) during pregnancy and child's subsequent early years can have serious impact on child health, development and future outcomes</li> </ul>
<p><b>What relevant targets are already in place or expected shortly?</b></p> <p>Scottish Government National Outcomes:</p> <ul style="list-style-type: none"> <li>• Our children have the best possible start in life and are ready to succeed</li> <li>• We lead longer, healthier lives</li> </ul> <p>Linked HEAT targets:</p> <ul style="list-style-type: none"> <li>• Increase the proportion of new-born children exclusively breastfed at six to eight weeks from 26.6 per cent in 2006/07 to 33.3 per cent in 2010/11.</li> <li>• Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014</li> </ul>
<p><b>The challenge statement (set out the challenge)</b></p>
<p>To change unhealthy food practices of First Step users</p>

Template accessed from [www.socialmarketing-taysidetoolkit.com](http://www.socialmarketing-taysidetoolkit.com)  
May 2011

## Appendix 4

### Barriers and competition to the behavioural goals

#### Behavioural Goals

Maintain and improve healthy food practices amongst First Step users

1. To start the day with a healthy breakfast
2. To replace one unhealthy snack a day with a healthy snack
3. To be able to prepare and cook healthier meals on a budget
4. To learn and share parenting hints and tips around food and children

## 1. To start the day with a healthy breakfast

<b>Direct competition</b>	
Competing behaviour	Eating unhealthy breakfast No breakfast Breakfast is a busy time –competing priorities
Competing benefits and motivation	Saving calories for another mealtime Saving the cost of breakfast for something else Can't be bothered – want longer in bed, don't want to tidy up after Pleasant taste, indulgence of a bacon butty, sausage roll Breakfast is less of a priority that getting kids to school, getting to work, travelling... Convenience of cereals (sugar & salt content not always known to consumer)
Personal influences	Not hungry in the morning Habit – never have breakfast Culture
Wider influences	Fast food industry (Greggs, McDonalds), shop prices, availability, accessibility Cereals
<b>Indirect Competition</b>	
Social marketing messages	Other messages?? Do this, do that - may switch off Buy this cereal...its grrrrreat! Freebies included with unhealthy options
Everyday life	Lack of time Too busy getting kids ready, Getting organised for work
Wider environmental forces	Eat something convenient “on the “run”

## 2. To replace one unhealthy snack a day with a healthy snack

<b>Direct competition</b>	
Competing behaviour	“good” parenting to give children a treat
Competing benefits and motivation	Convenience Cost Crisp, sweets won’t “go-off” Peer pressure Pester power – easier to give in
Personal influences	Conviction that their children won’t eat fruit and veg? Treat given because of particular emotions –reward, comfort, guilt, bribery
Wider influences	Availability Accessibility
<b>Indirect Competition</b>	
Social marketing messages Everyday life Wider environmental forces	Branding of products/ association to film/TV characters “you can be like Buzz Lightyear if you eat this snack...”

### 3. To be able to prepare and cook healthier meals on a budget

<b>Direct competition</b>	
Competing behaviour	Habit to carry on doing what you do Not a priority to cook
Competing benefits and motivation	Too much effort – want to spend time enjoying self Too much time – need to spend time on other things Too much money – don't have spare cash to try things: money budgeted for essentials like rent etc.; can't afford to waste food if they won't eat it
Personal influences	Lack of cooking skills, Can't cook –won't cook Lack of skills to plan or organise meals Belief that healthy food is expensive Reluctance to waste new or healthy food because children/they won't eat it Myths that certain foods/ foods from certain places go "off" Fear of the unknown Lack of knowledge on where to get "raw" products Lack of confidence to try cooking Opinions, judgements on healthy meals
Wider influences	Availability of healthier foods at reasonable prices Transport Size of house particularly cooking, storage and eating space The way wages or benefits are paid
<b>Indirect Competition</b>	
Social marketing messages Everyday life Wider environmental forces	Farmfood "great food at amazing prices" Armchair bargains on...burgers" (32 burgers for £3) Feed your family cheaply – 3 for 2 offers, BYGOF

#### 4. To learn and share parenting hints and tips around food and children

<b>Direct competition</b>	
Competing behaviour	Behaviour of child Give a choice of food rather than presenting only one option Wanting child to eating something rather than nothing
Competing benefits and motivation	Easier to “give into child demands” Trying to do the right thing Losing control of mealtimes
Personal influences	Lack of confidence to try new tips. Lack of confidence to pass on any hints Personal beliefs, culture, parents relationship with food, parents relationship with child Belief that “child won’t do..., won’t try..”
Wider influences	Being judged by others Mixed parenting messages Doing things the way you were brought up
<b>Indirect Competition</b>	
Social marketing messages	Feed your family on a budget, feed your family quickly KFC family meals served at a nominally cheaper price Greggs “The home of Fresh Baking” Iceland - now to feature “ real mums “ in their adverts
Everyday life Wider environmental forces	Lots of healthy but competing messages about parenting. Positive messages – Play, Talk, Read campaign, Smoke Free Homes,.....

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