

Child invisibility

Childhood obesity policy of Aotearoa New Zealand

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed _____ Date_01.07.22_____

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A completed application for Ethics Approval for Research Projects form (EA1) was submitted to Auckland University of Technology Ethics Committee (AUTEC) and the guidelines, procedures, and exemplars of the AUTEC were adhered to.

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Abstract

Currently occurring at epidemic levels in Aotearoa New Zealand, childhood obesity warrants urgent policy intervention. Well-informed policy for complex issues is essential, however, little is known about how children have informed past Aotearoa policy about childhood obesity. This research project sought to understand this case using Merriam's case study methodology with data from four relevant policies and six policy contributors. A qualitative analysis demonstrated that child participation in policy about childhood obesity was minimal due to low visibility or *invisibility* of children during policy development. Childhood obesity is complex, and children experienced cultural *exclusion* and restrictive *advocacy* from adults operating in a *culture of child invisibility*. A discussion of these findings culminated in a recommendation to policymakers to write future policy about childhood obesity within a new *culture of child visibility*. In this theoretical policy culture, child participation needs to be included to overcome problematic issues of power created by adults. However, future policy needs to be predicated on rights-based documents to enforce participation. Lastly, child participation and visibility are sustained by citing issues of social injustice as a leading cause to childhood obesity. The findings of this study around policy cultures could have implications for future Aotearoa childhood obesity policy and other child policies where health inequities are a prominent factor.

Chapter One: Introduction

1.1 Introduction

Childhood obesity affects one third of the child population in Aotearoa New Zealand¹. Occurring at epidemic levels nationwide, this is an issue that has required increasingly urgent government intervention for the last two decades. While Aotearoa does produce policy to support intervention, childhood obesity statistics have not decreased. Policy can include community engagement, a process that allows members of the public affected by a decision or interested in an issue to be involved in policy design and development (Department of the Prime Minister and Cabinet, 2022a). Community engagement can be a helpful contribution to policy about social injustice issues if policy teams choose to use it (Department of the Prime Minister and Cabinet, 2020; Levine, 2019). Little is known, however, about how community engagement with children has shaped past policy about childhood obesity in Aotearoa. Community engagement with children or child participation is important because it positions children at the centre of policy goals and aims. There is an international precedent for child participation, which has shown to improve the efficacy of policies. All policy should be well-researched because health professionals, families, or any interested member of the public use government policy for guidance. In Aotearoa, the government also has a commitment to the *UN Convention on the Rights of the Child* (UNCROC) to include child participation and child voice should theoretically be evident in all policy about childhood obesity (Ministry of Social Development (MSD), 2022).

1.2 Positionality

After practicing for several years working as an Auckland-based Plunket Nurse, I began to consider a research enquiry into the childhood obesity epidemic in Aotearoa. The *Before School Check* assessment, the final *Well Child/Tamariki Ora* check, directly measures the occurrence of childhood obesity with four-year-old children (Ministry of Health (MOH), 2021e). The check includes a collection of height, weight, and body mass index measurements and then each piece of data is plotted onto a graph. If a child fell within the 98th centile or higher, a referral was suggested within the

¹ Aotearoa New Zealand will be referred to as Aotearoa from now on throughout this thesis

appointment (MOH, 2021d; 2021e). Then if the family consented, there would be a constructive discussion about growth in relation to lifestyle factors and to see if there were any opportunities for change. As a registered nurse (RN) delivering the *Before School Checks* assessment and managing the GP referral process, I often wondered whether child and family experiences of childhood obesity were translated into policy – if they were there at all. In the community I worked with, there were families living in abject poverty who depended entirely on the support of the state. It seemed unlikely that simply taking the measurements of obesity and then providing simple dietary advice alongside a GP referral was going to change childhood obesity as an outcome. Many of the families I visited were experiencing health inequities that would put them at a greater risk of poor health outcomes and this was outside of their control. Indeed, despite the endurance of this assessment over the last ten years, the statistics around childhood obesity have not changed (MOH, 2021b). Upon realising that childhood obesity statistics had stagnated, I began researching the strategic documents that had informed the *Before School Check* assessment. The line of enquiry in this research project has always been about how policy is contextualised in Aotearoa and the child population affected most by childhood obesity.

1.3 Background & context

1.3.i. Aotearoa New Zealand & childhood obesity

The concerning data around childhood obesity has been part of a poor picture of Aotearoa child health since the latter part of the 20th century (MOH, 2004). The latest results of the *New Zealand Health Survey* show that one third of children in Aotearoa are overweight or obese (MOH, 2021). Within the age group 2–14 years, 11% are obese with a further 20% in this age group classified as overweight (Wild et al., 2021; MOH, 2020/2021). In an international comparison, children of Aotearoa experience the second-highest rate of childhood obesity in the developed world (United Nations International Children’s Emergency Fund (UNICEF), 2020). Aotearoa has not been alone in this struggle and there has been no progress to stem the rate of obesity in children under five years of age globally in the last twenty years (The World Health Organization (WHO), 2021). WHO considers this a global emergency (WHO, 2021). As the incidence of childhood obesity surpasses obesity in the adult population, WHO has issued a “no increase in childhood obesity by 2025” target as a preventative action (Di Cesare et al., 2019, p. 1).

The ever-increasing childhood obesity statistics demonstrate how this issue has eluded government policymakers globally (Di Cesare et al., 2019; WHO, 2016; UNICEF, 2020). The MOH in Aotearoa has measured the rising cases of childhood obesity since 1977 but has not been able to provide effective interventional policy in light of this data (Liu et al., 2020; MOH, 2004; UNICEF, 2020; Vallgård, 2018). Policy design was the target of the last UNICEF report because these texts were decidedly insufficient in supporting the needs of children (UNICEF, 2020). Childhood obesity is a complex medical and social condition, requiring a broad, critical, and compassionate understanding of its causes. A multitude of research shows that this complexity is often not reflected in policy (NCD Risk Factor Collaboration, 2017; UNICEF, 2020; Walker et al., 2019; Wang & Lim, 2012). While childhood obesity medically speaking is the 'excess of fat' in children's bodies, research shows that its origins are a non-linear combination of factors within and surrounding the child (Walker et al., 2019; WHO, 2021). Policy intervention, therefore, should reflect this complexity.

The way policy is crafted for childhood obesity depends on how policymakers view policy as an intervention for this issue. There are several ways to look at the same problem and when considering which actor should assume responsibility, there are two perspectives: (a) citizen, and (b) government. In research about childhood obesity, these are not mutually exclusive, however in policy they are often treated as such (NCD Risk Factor Collaboration, 2017; Vallgård, 2018; Wang & Lim, 2012). When policy is directed at citizens or individuals, a description of pathophysiology and individual behavioural patterns is the focal point of the text (Vallgård, 2018). An individual focus involves understanding the pathway towards obesity prior to birth and highlighting beneficial parental behaviours (Keevers et al., 2008; WHO, 2016). Exercise and activity are encouraged because a decline in physical activity has created an energy imbalance within many children according to WHO (2016). Lastly, dietary advice is directed at individuals and groups with genetic and socio-economic risk factors (MOH, 2016; WHO, 2016). Policy offering guidance around personal choice and accepting individual responsibility is the most prevalent brand of policy around childhood obesity (Bastian, 2011; Green et al., 2020; Greener et al., 2010; Vallgård, 2018).

A more contemporary understanding of childhood obesity recognises those modifiable factors that sit outside of individual control and require government intervention (Di Cesare et al., 2019). Obesogenic environments are frequently discussed by current international and national research as major contributors to childhood obesity as a health outcome (NCD Risk Factor Collaboration, 2017; Wild et

al., 2020; WHO, 2021). An obesogenic environment is one that normalises high-sugar and high-fat foods and presents them as more accessible to the public than other healthier options. Insufficient access to activity is another aspect of the obesogenic environment with WHO (2018) reporting 81% of young people aged 11–17 years are inadequately physically active. The effect of an obesogenic environment can be quantified with nutrition-related risk factors such as hypertension, high adiposity, inadequate vegetable and fruit intake, all linked to two out of every five deaths in Aotearoa (MOH, 2007). The factors that contribute to the obesogenic environment fall under the government's control and therefore policy. Yet there are very few policies that address the obesogenic environment in Aotearoa (UNICEF, 2020; Vallgård, 2018; Wild et al., 2020, 2021).

When governments refuse to address their role in creating public health issues such as childhood obesity with policy, this becomes an issue of social injustice (Levy, 2019). According to Levy (2019) who used the Institute of Medicine's definition of social injustice in the context of public health, social justice is defined as,

What we, as a society, collectively do to assure the conditions in which people can be healthy. This definition refers to policies or actions that adversely affect the conditions in which people can be healthy. Although this type of social injustice is often community-wide, nationwide, or even global, the populations and groups described in the first definition of social injustice—such as impoverished people, people of colour, women, children, older people, and others—usually suffer disproportionately due to these policies or actions (Levy, 2019, p. 4).

Childhood obesity was previously only an issue affecting developed, wealthy countries, but this is no longer the case, indicative of how social injustices have worsened over time on a global scale (Di Cesare et al., 2019; WHO, 2020). As described by the international literature and the UNICEF report, an approach to policy about childhood obesity that encourages individual responsibility has not and will not produce effective policy (Bastian, 2011; Green et al., 2020; Vallgård, 2018). Well-informed strategy has become increasingly important because children who are obese or overweight are likely to remain obese as adults and this needs intervention (WHO, 2016). Childhood obesity as a current public issue is also predicted to place significant financial burden on the public health system in future years (MSD, 2016; Wild et al., 2020). Policymakers must find a way to intervene because obesity in childhood contributes to early death, illness and disability for those children affected (UNICEF, 2020).

1.3.ii. Tamariki Māori & Pacifica children

In Aotearoa, tamariki Māori (Indigenous Māori children) endure high rates of childhood obesity and are 1.6 times more likely than non-Māori children to be obese

(MOH, 2020/2021). For Pacifica children the incidence has been even higher, and this population are 4.7 times more likely to be obese than non-Pacifica children. This issue has been systemically derived and has led to compounding socio-economic realities for Māori and Pacifica families. For tamariki Māori, high levels of obesity are interconnected with high rates of food insecurity and poverty (Beavis et al., 2019; McKerchar et al., 2021). In Aotearoa, tamariki Māori have the right to adequate food and healthcare under UNCROC and the *United Nations Declaration on the Rights of Indigenous Peoples* (McKerchar et al., 2021). However, according to the Health Quality & Safety Commission, “*inequities in health outcomes [for Māori] have persisted despite considerable research and policy efforts, and 60 years of improvements*” (2019, p. 11). McKerchar and colleagues (2021) argue that addressing food insecurity in tamariki Māori requires a decolonising approach where Māori voice and values are centralised in policy. Te Tiriti o Waitangi, the foundational constitutional document of Aotearoa, also demands equal participation in civic life as a Māori right (Came et al., 2020). A precedent for equality is necessary to overcome the hegemony or domination of one particular group over another (Coghlan & Brydon-Miller, 2014). Typically, post-colonial views are hegemonic within policy and are deficit-based causing further health inequities (Matheson et al., 2021; Pham et al., 2021). As the incidence of obesity rises, there is a real need for structural change in policy to address systemic issues of inequity that affect Māori and Pacifica children so significantly in Aotearoa (MOH, 2019/20; McKerchar et al., 2021).

1.3.iii. UNICEF Innocenti Report Card No. 16

Every 1-2 years, UNICEF produces an Innocenti Report Card ranking child wellbeing inequalities of the world's richest countries. In 2020, Aotearoa was ranked 35th out of 38 countries, a patently poor reflection of overall child wellbeing. Specifically, child physical health in Aotearoa was placed very low in 33rd place. In the report, physical health of children was measured using the statistical incidence of child mortality and obesity, and Aotearoa was placed nearly last at 37th for childhood obesity (UNICEF, 2020). The widely reported and researched epidemic levels of childhood obesity within the child population of Aotearoa, contributed to this ranking. There was a recommendation to include children in policy decision-making to help ameliorate issues like childhood obesity (UNICEF, 2020). Policy writers were asked to “*Consult children: Improve children's well-being through a shift in thinking*” (UNICEF, 2020, p. 58). These findings and recommendations served as the topical inception of this research inquiry.

Globally, child policy lacks a comprehensive policy development process. UNICEF identified child consultation as a research gap and called for more diverse

data around child population health issues to improve the effectiveness of policy as an intervention. Health policies by design are interventional documents and should shape the health outcomes seen in the population. As stated by UNICEF, this is not the case for policy about childhood obesity as the research around this health issue has been inadequate (UNICEF, 2020). As children with obesity grow into adults with obesity, current research has predicted that Aotearoa will be left with a population defined by poor health and low productivity (Wild et al., 2020). Children who live with obesity have a higher likelihood of developing diabetes, cardiovascular diseases, hypertension, cancer and gallbladder disease later in life as well as a shorter life expectancy as adults (UNICEF, 2020). The consequences of obesity are usually delayed and leave adult populations with poor long-term physical and mental health complications (UNICEF, 2020). From a socio-economic perspective, childhood obesity is associated with lower educational achievement and reduced lifetime earnings (Boston, 2014). Obesity can also impact children socially and emotionally by limiting participation and lowering overall self-esteem (UNICEF, 2020). However, there were no Aotearoa data cited in the UNICEF report that linked how children viewed their body image to their life satisfaction (UNICEF, 2020). Overall, UNICEF's reporting showed that the child experience appeared to be absent from policy internationally, including child policy in Aotearoa.

1.3.iv. Bronfenbrenner's macrosystem & *the world at large*

The focal point of the UNICEF report was their Multilevel Framework as illustrated in *Figure 1* (UNICEF, 2020). This model was adapted from The Bronfenbrenner Ecological Systems Model to explain the four factors that contribute to the measured wellbeing outcomes (UNICEF, 2020; Walker et al., 2019). The UNICEF adaptation model reduces the four factors to three and is labelled as follows, "*the world of a child*"; "*the world around that child*"; and "*the world at large*" (UNICEF, 2020, p.7). The last stratum is Bronfenbrenner's "*macrosystem*" or "*the world at large*", described as the factors least within a child's control and will be the most important factor for this study (UNICEF, 2020, p.7; Walker et al., 2019). This stratum includes the economy, society and environment as well as identifying education, health and family policies as the context a child lives in. The "*world at large*" sets the precedent for all other systems that follow and should produce positive health outcomes and health equity in the child population. Many wealthy nations, such as Aotearoa, do not use their economic advantage, policies or world at large factors to support their child population towards "*high child well-being outcomes*" (UNICEF, 2020, p. 7).

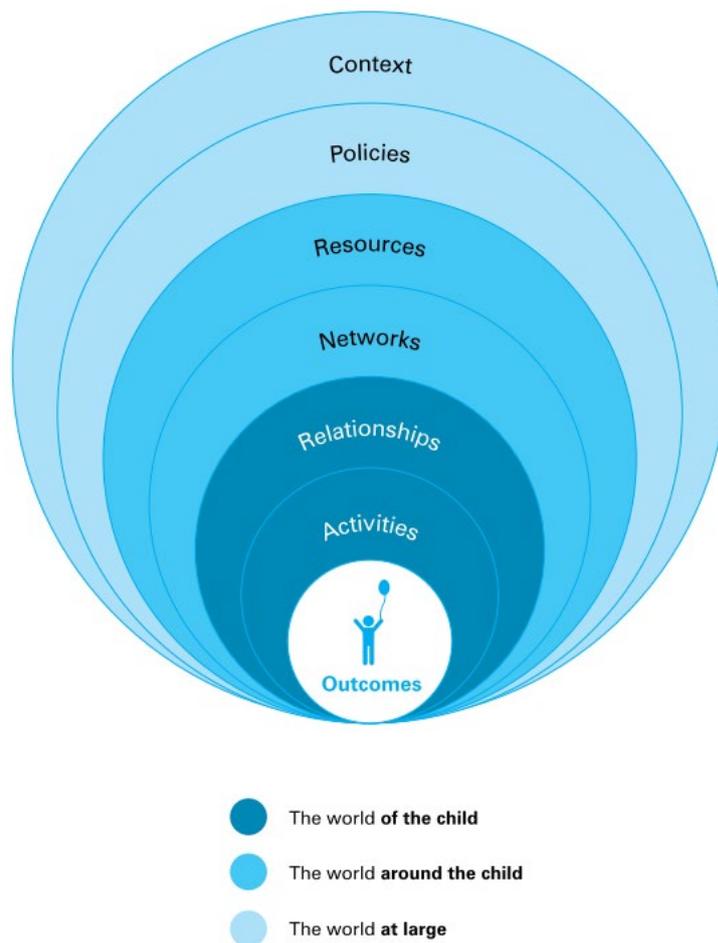


Figure 1: UNICEF's multi-level framework of child well-being (United Nations International Children's Emergency Fund, 2020)

The United Nations International Children's Emergency Fund report used Bronfenbrenner's model to illustrate the impact the "world at large" has toward children. According to the latest UNICEF report, the chasm between children and policy intervention has led to the prominent health inequities we see today (UNICEF, 2020). Countries globally, including Aotearoa, continue to systemically disadvantage its child population where health and wellbeing are concerned with policy because of this disconnect. The "world at large" factor is the least within a child's control and community engagement in policy could bridge that gap (Levine, 2019). Community engagement is well known for delivering an equitable approach to policy issues affected by poverty (Levine, 2019). Poverty as an issue is connected to childhood obesity and outcomes in physical health are undeniably linked with changes in policy as well as socio-economic trends (Boston, 2014; Walton et al., 2009). For example, children living in the most socio-economically deprived areas are 2.7 times more likely to be obese than those living in the least deprived areas (Wild et al., 2021; MOH, 2020/2021). There are widening economic disparities that have put 27% of children in Aotearoa into poverty according to the Child Poverty Action Group in 2014. Policy can

embody a rich understanding of children's perspectives on issues like childhood obesity and this can help ensure that policies and services align with what children need.

1.3.v. Community engagement in policy development

Child participation *through community engagement* brings the child to the centre of Bronfenbrenner's ecological system and their experience of the world around them, to the "*world at large*" (UNICEF, 2020). Using this information, this research project focussed on community engagement as a contemporary policy design feature and as a method of providing equitable policy. Community input represents a commitment to health equity and as described by UNICEF, community engagement with children is lacking in child health policy (Levine, 2019; UNICEF, 2020). Child participation in policy is a form of community engagement that allows children to be involved in policy decision-making and to directly address the social injustices experienced in their lives (Department of the Prime Minister and Cabinet, 2019; Levine, 2019). As an addition to policy design, community engagement can influence strategic documents used to implement change on a community and societal level (Porche, 2021). Positive outcomes can include the kind of policies and actions that facilitate health and health equity into planning and fiscal decision-making (Mahjabeen et al., 2009). Significantly, this level of governance can change the direction of public funds as policy underpins important decisions around economic growth and the wellbeing of all people (Department of the Prime Minister and Cabinet, 2019). The availability of certain resources, specifically nutritious food, and opportunities for activity, are governed by agencies through policy (Sullivan et al., 2021). Participation also engages the community with policy itself as individuals and families are also far more accepting of policies that concern them and their identity (Aschemann-witzel & Bech-larsen, 2016). Child participation ensures policies are relevant and appropriate for the community of interest and provides a sense of 'cultural citizenship' in those who participate (Brown & Jeanneret, 2017; Sullivan et al., 2021).

Aotearoa has a formal commitment with the United Nations (UN) to uphold a child's right to participate in decisions that concern them (MSD, 2022). In 1993, UNCROC was ratified by Aotearoa, however it was a treaty adopted by the UN in 1989 (MSD, 2022). The *UN Convention on the Rights of the Child* is a human rights treaty for children that includes Article 12 detailing a child's right to participate in civic life. The process for formal community engagement, according to the International Association of Public Participation's *Spectrum of Public Participation* (IAP2 Spectrum), integrates five key interventions; informing, involvement, collaboration, empowerment, and

consultation around issues that need solutions or potential opportunities (Department of the Prime Minister and Cabinet, 2019). This thesis of child input through participation in policy will evaluate past policy about childhood obesity in Aotearoa and how the affected child community were involved. Considering Aotearoa and its commitment to UNCROC, it was expected that there would be a child presence in policy about childhood obesity.

1.3.vi. Childhood obesity policy of Aotearoa New Zealand

In recent years, the government focussed on policy design and intervention in primary health care to address childhood obesity epidemic in Aotearoa. In 2016, the MOH said,

...if we can identify children and young people who are overweight and obese and support them to attain and maintain a healthy weight, we can help them not only to improve their wellbeing but also to live longer, healthier lives (MOH, 2016).

The above quote is a part of the *Clinical Guidelines for Weight Management in New Zealand Children and Young People* designed for health professionals in primary health care services and it is consistent with the *New Zealand Health Strategy* (MOH, 2016). Within this strategy, community primary health care services are tasked with identifying, monitoring and supporting families to attain and maintain a healthy weight as well as referring them to a specialist if needed (MOH, 2016). Lastly, the guidelines state that “...addressing overweight and obesity is a priority for our health system” (MOH, 2016a, p. 3). However, health inequities and outcomes have not changed for children in Aotearoa. Since the governing party Labour was elected, they have made only one minor response to existing policy: To continue to roll out the *Healthy Active Learning programme* that existed pre-*Innocenti* report (The NZ Labour Party, 2020). This is another pointed example of where the stated campaign goals of the Labour Party concerning childhood health outcomes, have not translated into real and robust policy (The NZ Labour Party, 2020).

1.4 Key terms & concepts

1.4.i. Policymakers, participants & participation

In this study, there is a distinction between the *policymakers*, *participants* and *participation* and the definitions are provided below.

Policymakers

For the purposes of this study the term, *policymakers*, refers to those people who are recognised for writing the policy texts analysed. This term was used to describe the contributors to the analysed policies within Chapter Three onwards. While the *policymakers* of the policy texts may have been incidentally interviewed for this study, *policymakers* do not describe the *participants*.

Participants

For the purposes of this study the term, *participants*, refers to the interviewees for this study within Chapter Three onwards. The *participants* may have incidentally contributed to the policies analysed as the interviewees are all relevant child health policy advisors/contributors in their professional careers. However, in the interest of ethical safety and privacy there was no professional relationship made between the analysed policies and the interviewees.

Participation

For the purposes of this study the term, *participation*, is used to describe the intentional interaction between citizen and government, as is the civic right of a citizen and in this study, child citizens (Office of the Children's Commissioner & Oranga Tamariki, 2019). The *United Nations Convention on the Rights of the Child* defines *child participation* as,

... ongoing processes, which include information-sharing and dialogue between children and adults based on mutual respect, and in which children can learn how their views and those of adults are taken into account and shape the outcome of such processes (Diaz, 2020, p. 16).

In the literature, definitions for *child participation* vary and participation is often used interchangeably with words like — consultation, co-design, engagement, partnership or involvement (Croft & Beresford, 1992; Diaz, 2020; Sullivan et al., 2021). For consistency in this study, I have primarily used the words participation and community engagement. These words also describe the interaction with the process policy in its entirety and enables people to influence policy outcomes (Diaz, 2020). Participation is an important step in policy development because it should lead to the presence of child/children's voice in policy texts. *Participation* was not related to the *participants* who were individuals who volunteered their time as interviewees for this study.

1.4.ii. Key definitions of childhood obesity

The exact WHO definitions of childhood obesity are from its report called *Obesity and Overweight* and feature under the headings below (2021). WHO

definitions were used throughout this study because WHO is an international organisation known for its impartial and comprehensive understanding of population health on a global level (WHO, 2021).

Obesity: *“Abnormal or excessive fat accumulation that may impair health”* (WHO, 2021, para. 1).

Body mass index (BMI): *“A simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person’s weight in kilograms divided by the square of this height in meters (kg/m²)”* (WHO, 2021, para. 2).

Overweight and obesity for children under 5 years of age:

- *“Overweight: Weight-for-height greater than 2 standard deviations above WHO Child Growth Standards median; and*
- *Obesity: Weight-for-height greater than 3 standard deviations above the WHO Child Growth Standards median”* (WHO, 2021, para. 3).

Overweight and obesity are further defined for children aged between 5–19 years:

- *“Overweight: BMI-for-age greater than 1 standard deviation above the WHO Growth Reference median; and*
- *Obesity: Greater than 2 standard deviations above the WHO Growth Reference median”* (WHO, 2021, para. 4).

As cited in the WHO guidelines above, measurement of obesity uses the BMI where weight is divided by the square of an individual’s height in metres (MOH, 2018). In Aotearoa, a child is considered overweight or obese if their BMI falls into the 90-95th centile of their age group (MOH, 2021e). There are researchers who use the term ‘high adiposity’ and ‘excessive fat accumulation’, however, this study will use either ‘obese/obesity’ or ‘overweight’ instead for consistency (Clarke, 2015; European Commission, 2014; Green et al., 2020; Wells, 2014; WHO, 2021).

1.4.iii. Key concepts in the determinants of health

Two key concepts in this study are *health inequities* and *social determinants of health* and they are frequently used throughout this thesis. The definitions are from WHO (2013, 2018) and serve as the basis of understanding within the text.

Health inequities

WHO describes *health inequities* as systematic disparities in the health status of separate population groups (WHO, 2018). Health inequities are regarded as avoidable and evolve from inequalities within societies. In Aotearoa, there are significant health disparities between those living in different socio-economic conditions indicative of the inherent inequalities in this society (Department of the Prime Minister and Cabinet, 2019). Social and economic conditions create and deny opportunities for preventative action as well as treatment, ultimately determining risk of illness for individuals and groups (WHO, 2018).

Social determinants of health

WHO describes the social determinants of health as “*the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness*” (WHO, 2013, para. 3). These systems are determined by economics, policy and politics (WHO, 2013)

1.5 Gap in the research

As stated above, there are notable gaps in the research about childhood obesity as a child health outcome occurring at epidemic levels in Aotearoa. Furthermore, there is a knowledge gap around how children have participated in Aotearoa childhood obesity policy. The breadth of the research gap is fully discussed in Chapter Two, however the list of recommendations from UNICEF implies the gap has already been identified. A paraphrased summary of the points in UNICEF report stated that:

- a) Aotearoa has the second highest incidence of childhood obesity in the developed world.
- b) Globally, child policy is poorly researched and does not allocate the resources to improve social and health outcomes for children.
- c) Policymakers need to consult with children more than they are to improve social and health outcomes for children with policy.

These recommendations combined form the basis of this research inquiry. To inform future policy about childhood obesity, there needs to be research around how past policy *has previously* included or denied the voices of children.

1.6 Research aims & question

1.6.i. Research question

To understand past childhood obesity policy in Aotearoa and how children have been involved in policy development, the research question for this study was:

How have children's perspectives informed past and current policy related to childhood obesity in Aotearoa New Zealand?

1.6.ii. Aims

This study will:

- Explore community engagement with children on the topic of childhood obesity and how child participation has informed those decisions in past policy.
- Examine policy texts about childhood obesity for the presence of child voice.
- Seek the perspectives of those involved in the policymaking process to understand how children are involved in policy about childhood obesity.
- Seek to understand the relationship between children and policy about childhood obesity in Aotearoa.
- Aim to gather important findings about participation from past policy development to inform future policy about childhood obesity in Aotearoa.

1.7 Methodology & theoretical approach

As stated in the introduction and fully described in *Chapter Three: Methodology & Methods*, the ontological positioning of this research question is interpretive with a constructivist epistemology. Due to the issues of social injustice discussed throughout this research, the methodology was viewed through a critical lens but does not use a critical theorist. The research question was answered using a Merriam's case study methodology, which will include the binding of the case (Merriam & Tisdell, 2016). Eventually, a content analysis supplemented the analytical process alongside the case study methodology to support the research question. This thesis was written with the oversight of Dr. Julie Blamires and Dr. Annette Dickinson. They were consulted for their expertise throughout this process but also to maintain rigour.

1.8 Outline of the thesis

This research project sought to answer the question, *How have children's perspectives informed past and current policy related to childhood obesity in Aotearoa New Zealand?* *Chapter Two: Literature Review* will explore the existing literature about child participation in childhood obesity policy in Aotearoa as well as internationally. The methodology and methods are described in *Chapter Three* and use Sharan Merriam and Elizabeth J. Tisdell's case study methodology and content analysis (Merriam & Tisdell, 2016). Through the data analysis in *Chapter Four: Findings* of six interviews with past policymakers and four policy texts from the period 2016–2021, there emerged the overarching concept model of *invisibility*. Two categories, *exclusion* and *advocacy*, as well as four subcategories *adult voice*, *incompatibility*, *tokenism* and *whānau voice*, supported this theme. The analysis translated into the findings of *Chapter Four* demonstrating that child participation in policy about childhood obesity was minimal to non-existent. Policy was written in a *culture of child invisibility*, an aspect of organization culture. Recommendations derived from this study call for policymakers to consider complex issues like childhood obesity in policy as cross-agency and to always involve community engagement. Policy needed to be based on rights-based documents and exist in a culture of participation. When policy about childhood obesity centred around inequity as a cause, child participation naturally occurred. These discussion points were part of an overall proposal in *Chapter Five: Discussion* to write policy about childhood obesity within a *culture of child visibility*.

1.9 Summary

The latest UNICEF report incited this research inquiry that examined how children's voices have influenced policy about childhood obesity in Aotearoa. According to UNICEF, how policy is designed with research inputs, influences the health inequities we see today in our population health outcomes. UNICEF recognises that partnering with children is fundamental to producing effective policy and has issued recommendations to '*consult with children*' during policy development. Aotearoa children experience one of the highest rates of childhood obesity in the world and this is indicative of a fundamental problem with the policy supporting this public health issue. Community engagement is germane to issues of social injustice and can be very useful in creating meaningful, effective policy. The issue of childhood obesity needs to be addressed with a comprehensive strategy because current research shows that this is a complex social issue, not just a health outcome. The health and social inequities that arise from policy affect Māori and Pacifica children to a higher degree in Aotearoa.

The following chapter is a literature review completed to understand how childhood obesity policy is constructed in Aotearoa and internationally.

Chapter Two: Literature Review

The previous chapter outlined and contextualised the prevalence of childhood obesity as a detrimental health outcome and as a marker of social inequity. *Chapter Two: Literature Review* critically reviews the literature around the research question, *How have children's perspectives informed past and current policy related to childhood obesity in Aotearoa New Zealand?* This literature review was to understand the relationship between childhood obesity and the policy that supports this aspect of population health in Aotearoa. The literature review encompassed international and national publications that addressed how all available policy inputs, such as government research, academic research, and community engagement, were examined in literature both nationally and internationally.

2.1 Introduction

Childhood obesity occurs at the high rate of 30.8% within the Aotearoa child population and, as such, presents as a complex problem for policymakers to address. The way Aotearoa has allocated its resources as a high-income country to mitigate this issue in the past has not created meaningful change to today's population. The predicted costs of the sustained prevalence of childhood obesity to the healthcare system and to the future workforce is deemed unsustainable to the economy of Aotearoa (Anderson et al., 2018). International and Aotearoa-based evidence shows that effective and early policy intervention is crucial. However, current policy must be well informed as well as timely to incite change and to reverse the childhood obesity epidemic. This literature review evaluated the literature about childhood obesity policy development both in Aotearoa and internationally. This included a review of policy inputs such as research and how policymakers use evidence to shape policy texts. Specific attention was given to research around the role children have had in policy about them and their participation in policy about childhood obesity. This review of the literature provided insights into the use of research as an input and the values, interests and the political environments that underpin the eventual policy decisions.

2.2 Search strategy & selection of literature

The UNICEF *Innocenti* report published in 2020 along with its recommendations for child policy, were the starting point for this literature review (UNICEF, 2020). The report outlined three issues:

- a) Aotearoa has the second highest incidence of childhood obesity in the developed world.
- b) Globally, child policy is poorly researched and does not allocate the resources to improve social and health outcomes for children.
- c) Policymakers need to consult with children more than they are to improve social and health outcomes for children with policy.

As a broad overview the review took the following trajectory. The literature review began in phase one with literature that helped to explain the evidence that typically underpins government policy about childhood obesity in Aotearoa. This part of the review focused on how governments use research for policy about childhood obesity, especially while managing complex medical conditions. The search included literature about the underlying epistemologies of the authors and how authorial belief systems shape policy text. The reference lists of current policy in Aotearoa about childhood obesity were examined and a significant bias towards other government policies as well as some quantitative studies was observed. This was conclusively confirmed by the literature nationally and internationally. Phase one also reviewed the potential utility of concepts of traditional and progressive policy development. Phase two was an international search of the ways policy about childhood obesity have been developed. Phase three built on the lack of research about childhood policy and lack of research in policy about childhood obesity. International research was evident about the poor translation of knowledge to policy. Lastly, phase four searched for any literature about participation in childhood obesity policy in Aotearoa, and there was a distinct gap in the research evident. The search strategy was complex, and the four distinct phases are represented below in *Figure 2*.

PHASE ONE: What research is used for policy about childhood obesity

Search 1: What kind of evidence is used for childhood obesity policy in Aotearoa
Review of current childhood obesity policy texts in Aotearoa and their reference lists to see the evidence used
Search 2: Quantitative research for policy about childhood obesity in Aotearoa
Search 3: Data for health policy (international search)



PHASE TWO: How is childhood obesity policy developed

Search 1: Policy development for policy about childhood obesity (international search)
Search 2: Strategy for policy development in childhood obesity policy (international search)



PHASE THREE: Translation of evidence to policy about childhood obesity

Search 1: The policy-research gap in child health policy (international search)
Search 2: Research the policymaking gap (international search)
Search 3: Child experience in policy about childhood obesity (international & Aotearoa search)



PHASE FOUR: How has child voice informed childhood obesity policy

Search 1: Child voice/participation in childhood obesity policy in Aotearoa
Search 2: Research and policymaking gap in Aotearoa

Figure 2: Search strategy & selection of literature

These iterations are presented in full in *Appendix C*. In brief, these concepts are distinguished in the following way:

- 2.3 Government policy research
- 2.4 Bottom-up initiative
- 2.5 Research-policy gap
- 2.6 Policy response to complex health issue
- 2.7 Child participation

The literature synthesis and review are therefore ordered under the subcategories relating to these searches.

2.3 Aotearoa government policy research

Within the government of Aotearoa, the prevalence of childhood obesity is monitored with a self-contained system to assess, forecast, and manage the risk of this

health condition (Richards et al., 2019). The collection of BMI population data is embedded both into voluntary government surveys such as *The New Zealand Health Survey* and a free routine government child health screening service, the *Well Child/Tamariki Ora* (WCTO) Programme (MOH, 2021c). In amongst a broad assessment of health, WCTO clinical data capture the ongoing prevalence of childhood obesity for 0–5-year-olds and The New Zealand Health Survey collects clinical measurements from 2–14-year-olds within each household that volunteers. ‘Measured weight’ and ‘GP referral’ are two important clinical action points that have corresponding quality indicators in the most recent *WCTO Quality Indicator Report* from the *Improvement Framework* (MOH 2021c). The framework aims to establish if “*children are a healthy weight at four years*” and if not “*children with a BMI >98th percentile are referred [to their GP]*” (MOH, 2021d, para. 15-16). Derived variables or indicators of obesity are created from the BMI results of *The New Zealand Health Survey* and biannual clinical results from WCTO (MOH, 2021). All indicators are recorded and available in the Annual Data Explorer and the WCTO Improvement Framework (MOH, 2021a, Richards et al., 2019).

The WCTO improvement framework and *Annual Data Explorer* have both indicated that those with childhood obesity frequently have poor eating habits, low exercise, experience a high prevalence of weight-related comorbidities and psychological difficulties (Anderson et al., 2018; MOH, 2021c, 2021a). These measured outcomes become an input to the evaluation feedback loop that indicates policy performance from the perspective of individual/family experience; population health; and sustainable outcomes for the health system (MOH, 2021c). The government commissioned a review of WCTO that ended in 2020 in response to “*concerns about equity of access, outcomes for tamariki and whānau, and the financial sustainability of the programme*” (MOH, 2019/20, para. 1). The review has indicated that the WCTO programme is unlikely to incite change for issues such as childhood obesity in the foreseeable future.

Governments globally have traditionally prioritised their own data over all other available data as a policy input. This is a trend observed worldwide in child health policy (Zdunek et al., 2021). Government statistics or hard data not independent research has historically been the cornerstone of evidence to support government planning, intervention, and evaluation since the beginning of the modern era (Porche, 2021). A top-down approach to health policy is where the government uses its own health data in conjunction with political, economic and organizational considerations to respond to population health needs (Spray, 2020; Zdunek et al., 2021). By way of

measuring the success of policy, self-generated data have been used to measure government investment in health services and delivery (McGinty et al., 2019; Porche, 2021). The historical dependence on broad statistical data of population health in policy development, is still very evident in today's management of childhood obesity in driving policy direction (McGinty et al., 2019). Numerical values such as proportions, means and totals of childhood obesity are important to government intervention especially when calculating the economic impact per person (Anderson et al., 2018; MOH, 2021b).

However, a unilateral approach to evidence utilisation is not associated with producing the best policy (Purtle et al., 2016). As a case in point, the prevalence of childhood obesity is at epidemic levels and has not reduced over the last ten-year period in Aotearoa despite the ongoing WCTO programme. Glasgow et al. (2012) argues that there has been a dependence on "*decontextualized, standardized implementation of efficacy evidence*" and this has led to a very slow adoption and integration of evidence-based policy intervention (2012, p. 646). Overall, child health policy tends to indirectly measure wellbeing through service uptake and depends on an adult's assessment of children's wellbeing (Department of the Prime Minister and Cabinet, 2019; McGinty et al., 2019). The top-down approach, an approach where decisions are made by leadership at the top, is observed directly in the WCTO programme that firstly measures outcomes as engagement with their programme, then the prevalence of measured childhood obesity and lastly the outgoing referral rate. This measure of wellbeing is really a measure of government investment but mistaken and conflated as the former. As such, most child health and wellbeing research is based on what children and young people either have or do not have, a decidedly deficit approach (Department of the Prime Minister and Cabinet, 2019). This is a binary measure, however, and not necessarily linked to related causes or effective intervention toward the issue of childhood obesity.

2.4 Bottom-up initiative

International evidence shows that inverting the source of evidence to a bottom-up initiative or scientific method, is the other prominent approach designed to accurately address population needs (Zdunek et al., 2021). Children living with obesity in Aotearoa clearly live challenging lives, however, using only population-based statistical evidence with a top-down approach is unlikely to reflect this or create meaningful opportunities for intervention (Glasgow et al., 2012; Wang & Lim, 2012). In

today's world, appropriate research-policy translation is essential for managing *“complex and politically controversial public health policy issues”* like obesity (Glasgow et al., 2012, p. 129). UNICEF attempted to persuade policymakers to take this approach to evidence and the authors led by example in their own report released in 2020 (UNICEF, 2020). To calculate the meaningful statistics in the report, UNICEF authors used data from the World Obesity Federation, United Nations Statistics Division and a database created by NCD Risk Factor Collaboration who work closely with WHO and the Imperial College London (NCD Risk Factor Collaboration, 2017; UNICEF, 2020). However, alongside citing the burden of childhood obesity, UNICEF laid out a comprehensive evaluation of childhood obesity and its solutions using a diverse range of evidence.

The conclusions of this international report reflect a multifaceted, comprehensive, and well-researched approach to childhood obesity in policy. Firstly, the authors of the UNICEF report determined that Aotearoa does not use its economic resources to support children out of poverty. The report also explored the experience of childhood obesity and correlated this with issues of health inequity (UNICEF, 2020; Wang & Lim, 2012). While poverty is a known contributor to childhood obesity, policy rarely acknowledges the impact of social injustice on this issue (Pearce et al., 2019; UNICEF, 2020; Wang & Lim, 2012). Controversially, Purtle et al. (2016) claim that research normally plays a minor role in policymaking, and policy is often not evidence-based. However, a policy's potential to be effective has been shown to be dependent on the degree to which the policy is informed by evidence (Purtle et al., 2016). Lastly, Purtle et al. (2016) discussed the concept of child participation in policy, its lack thereof and emphasised the importance of their contribution in effective policy making as a way of bridging the gap of evidence.

2.5 Research-policy gap in Aotearoa

Part of the research-policy gap relates to the small body of research about childhood obesity produced in Aotearoa. Currently, Aotearoa does not produce enough rich or comprehensive data on its own childhood obesity epidemic (Department of the Prime Minister and Cabinet, 2019; UNICEF, 2020; Vallgård, 2018). For example, there was no Aotearoa data accessible to the UNICEF (2020) authors about 'life satisfaction' for children in Aotearoa, suggesting a deficit in insightful knowledge around the child experience and their perception of wellbeing. This research deficit was also noted by international researcher Vallgård (2018), who said that in Aotearoa

overall assessment of childhood obesity has been minimal, incomplete and in some cases, absent compared to the rest of the developed world. The Department of Prime Minister's and Cabinet in Aotearoa found minimal existing surveys and research that directly asked Aotearoa children and young people about their experiences of wellbeing (Department of the Prime Ministers and Cabinet, 2019). As childhood obesity disproportionately affects the Māori population, and people from deprived households, this issue is underscored by vulnerability and social complexity (Glasgow et al., 2012; MOH, 2021a). This means that Aotearoa policy cannot keep up with modern policy development where policy is information-driven (Machluf et al., 2017).

2.6 Policy response to complex health issue

Obesity is a complex medical and social condition, a fact widely misunderstood by health professionals and policy authors across the world (Glasgow et al., 2012; Green et al., 2020; Greener et al., 2010; Vallgård, 2018; Walker et al., 2019; Wang & Lim, 2012). Confusion around childhood obesity's aetiology has also led to poor translation of valid research into policy (Vallgård, 2018). The incomplete and slow conversion of research evidence to policy for 'wicked problems', is a widely reported issue (Glasgow et al., 2012; West Churchman, 1967). What follows is the classic definition of a wicked problem:

...ill-formulated, where the information is confusing, where there are many clients and decision makers with conflicting values, and where the ramifications in the whole system are thoroughly confusing (West Churchman, 1967, p. 141).

Childhood obesity is a well-known wicked problem and has eluded past policy solutions. A poor understanding of the social determinants of health as a precursor to childhood obesity, has led to policy that is a pervasive, individualistic, neoliberal view of health (Vallgård, 2018).

However, a change in policy direction is achievable. Glasgow et al. (2012) argues that policy now needs a transdisciplinary approach that would address the real causes that include social injustice, inequity and harmful environmental factors that are all led by policy (Raychaudhuri & Sanyal, 2012; UNICEF, 2020). Here it is assumed that serious and complex issues require multiple perspectives and methods to advance effective policy (Glasgow et al., 2012). Glasgow et al. (2012) discusses their Evidence Integration Triangle model which facilitates an interaction between research and policy. The triangle is between 'intervention program/policy'; 'practical progress measures'; and 'participatory implementation process' (Glasgow et al., 2012). The participatory

implementation process aspect of this triangle is designed to include stakeholders, practitioners, policymakers, and citizens to funnel 'high-impact knowledge' into the policy. This model encourages diversity in contributors, timeliness, appropriate and community-led policy that addresses its own needs.

The Evidence Integration Triangle model challenges a pure bottom-up approach to child participation and use of scientific evidence in policy by ensuring policy is also community-informed. While a bottom-up approach does help policymakers to respond to children's experiences, qualitative research alone does not necessarily treat a child as a whole person (Henry, 2015; Spray, 2020). Community engagement alongside research, seen in the Evidence Integration Triangle model, creates community led policy much more likely to address the root cause. Without this step, the pre-existing views of policymakers with regards to childhood obesity leads policy in a direction that blames the individual (Vallgård, 2018; Wiltshire et al., 2018). For example, qualitative research shows that children understand the importance of healthy food like fruits and vegetables and can link eating with a physical outcome (Dresler et al., 2017; Tatlow-Golden et al., 2013). However, research from Aotearoa has shown that even as families and children are aware of nutrition, poor eating habits persist in children who are overweight or obese, indicative of external causes (Anderson et al., 2018). To demonstrate this, using a Kaupapa Māori research design, Beavis et al. (2019) found that four Māori families including adults and children had all experienced income-related food insecurity and were frequently dependent on support from their community. Insufficient access to basic necessities such as healthy food experienced by certain groups, led to health inequities experienced by young Māori families (Beavis et al., 2019). Dresler et al., (2017) and Tatlow-Golden et al. (2013) are examples of research that project normative or deficit-based attitudes to childhood obesity while Beavis et al.'s research indicates that there are factors beyond the individual.

International and national research has shown that appropriate participation from a diverse group of stakeholders, representative of the community, is essential for the development of complex issues in policy (Glasgow et al., 2012; Spray, 2020; Yates & Oates, 2019). Child participation is a strengths-based approach that broadens the scope of understanding around issues that are affected by health inequities (Glasgow et al., 2012; Levine, 2019; Levy, 2019). According to Aotearoa author Spray (2020), to simply consult with children would not be enough for their participation to have a meaningful impact on policy. A comprehensive child-centred approach for example, that allows full participation in policy, might paint a more detailed picture of why

childhood obesity is still so prevalent despite existing policy. For the successful execution of models such as the Evidence Integration Triangle, children must be regarded not only as valid social actors but as having a unique set of qualities. A different form of interpretation of participation is needed using different critical lenses (Spray, 2020; Yates & Oates, 2019). Aotearoa child participation researcher Julie Spray (2020) defines these lenses as the embodied child, which considers the child's construct of knowledge; the social-child, which acknowledges the child's role in relationships; and the public-child, which assumes the child's right to participate in public life. For many adults, this positioning uncomfortably challenges the assumptions of childhood (Spray, 2020). Children need to be treated differently from adults, with their experiences interpreted by adults who are trained to develop policy with a child-centred approach.

2.7 Child participation

According to Aotearoa researchers Brown et al. (2020) and Spray (2020), child participation has been unusual in general child health policy because policymakers have found it difficult to be child centred. Within the policy making process, children are marginalised under an adult-centric and top-down approach (Carroll et al., 2019; Spray, 2020; Yates & Oates, 2019). Significantly, "*children are usually 'invisibilised' at higher levels of public decision-making*" (Spray, 2020, p. 553). Child participation has been limited by adult concerns, such as time constraints, given budgets, political interference and natural hierarchical structures (Spray, 2020). The scant literature where children are involved in policy development highlights that children also hold different constructs of health that fall outside of an adult understanding of health (Martin et al., 2018; Spray, 2020). A misunderstanding of a child's perspective routinely reduces children to passive recipients of policy as opposed to active engagers. Children are without advocacy power, however, as citizens they do have the right to participate in the policy process (MSD, 2022).

There is compelling evidence from other disciplines that child participation can positively impact Aotearoa and its obesogenic environment. Aotearoa child policy researchers Carroll et al. (2017) found that child participation in a redesign of urban space changed the adult's perception of a child-friendly environment. Adults during the design were more concerned with restraint and constraint whereas children wanted a sensory, playful, and social experience. This participation resulted in more play opportunities that were tailored to the child experience (Carroll, Calder-Dawe, et al.,

2019; Carroll, Witten, et al., 2019). Children in Aotearoa are exposed to 7.4 unhealthy food advertisements in an hour within a public space, but this is not reflected in policy intervention (Liu et al., 2020). This is an example of research that would indicate that there is a lack of evidence and diversity in the evidence used to supplement policy about childhood obesity in Aotearoa. This is particularly the case for the inclusion of children themselves in policy about childhood obesity who could provide insights from their own world. In an Auckland urban planning study, play spaces have markedly reduced over the last ten years due to residential intensification and “*child-blind urban planning*” (Carroll et al., 2019, p. 297). As shown by the evidence, child participation improves the environment by participating in policy pertinent to them.

There are several international and national documents that require that voices of children are recognised and represented in government policy, planning and strategy in Aotearoa. Firstly, health policy written in an Aotearoa context must recognise and comply with Te Tiriti o Waitangi (Came et al., 2020, 2022; MOH, 2019). The foundational document of Aotearoa is centred on the concept of a bicultural society where the degree of health experienced by the most privileged groups in a society, should be equally attainable by both Māori and Pākehā (Came et al., 2020; Sheridan et al., 2011). The principle of partnership in our bicultural society is also a right in all issues of governance (Came et al., 2017; Came et al., 2020). As a signatory of UNCROC, Aotearoa has agreed to uphold the rights and conditions for children, including giving children a voice and representation in government and listening to children’s views (MSD, 2022). Lastly, all future strategies must also be shaped by the interests and aspirations of children, young people and their families according to the Children’s Act 2014 (Department of the Prime Minister and Cabinet, 2019).

The literature discussed has provided valuable context and insight into how policy and child policy is constructed in Aotearoa and internationally. There was a noticeable gap, however, in the research with regards to the role of child participation in childhood obesity policy from Aotearoa. There was no evidence to say that children do not belong in policy about childhood obesity or that it would be wrong for this group to be part of this process. There was only broad international and national evidence to say why children are not included in policy in general as well as previous unsuccessful attempts to allow children to participate (Brien, 2018; Fitzmaurice, 2017; Spray, 2020). These usually reflected poorly on policymakers and policy design, not children (Brien, 2018; Fitzmaurice, 2017; Spray, 2020). In Aotearoa, integrating children’s voices into policy has occurred previously for decision-making in other disciplines such as urban planning (Sullivan et al., 2021). Aside from the symbolic significance of children

participating as citizens, children may provide the link policymakers need between causes and effects in childhood obesity within the context of Aotearoa. There are valid reasons to take a child-centred approach as child participation shapes the success of health policy intervention (Spray, 2020). Further research needs to investigate the influence children have had on policy about childhood obesity in Aotearoa to connect these policy texts to the population most affected.

2.8 Conclusion

To conclude, this literature review showed that childhood obesity policy in Aotearoa is mostly supplemented by homogeneous research encapsulating adult concerns. There were two issues that supported this finding from the literature review. Firstly, Aotearoa produces very little comprehensive and/or holistic data about childhood obesity from those who experience it, children. This research deficit has created a gap not just in research but also for those creating childhood obesity policy. Secondly, this literature review *did not find* evidence that children have been included in *development of* childhood obesity policy in Aotearoa. It is possible that children have been included, but so far this has not been *systematically* investigated *through research*. The issue of childhood obesity is a challenging one to manage effectively in the policymaking process and there is currently no pathway. Ways to include children in policy do exist and the Evidence Integration Triangle is a good example. However, policy teams must be willing and supported to use them. These findings present an opportunity to research the way children have influenced policy about childhood obesity in an Aotearoa context. The role children have played in policy about them, could help to produce more effective policy on this urgent public health issue.

2.9 Introduction to the problem

After the literature was evaluated, the next step in this case study project was to form a purpose statement (Merriam & Tisdell, 2016). In case study methodology, the purpose statement and sub questions are included in the literature review chapter (Merriam & Tisdell, 2016; Remenyi, 2013). The purpose statement identifies the knowledge gap in research as described in the literature review and directs the study inductively. The sub questions address “*concepts or variables or constructs*” within the research question, *How have children's perspectives informed past and current policy related to childhood obesity in Aotearoa New Zealand?* (Remenyi, 2013, p. 157).

Purpose statement
<p>Childhood obesity affects one third of the child population in Aotearoa New Zealand. Currently occurring at epidemic levels in Aotearoa, childhood obesity demands urgent policy intervention. Despite what we know about the importance of child participation in policy design, little is known about how children’s voices have influenced policy about childhood obesity. The purpose of this qualitative project was to understand how children’s voices have informed Aotearoa policy related to childhood obesity using case study methodology.</p>
Sub-questions
<ul style="list-style-type: none"> • What defines the relationship between policy about childhood obesity and children’s voices? • In what form do children’s voices present themselves in policy documents related to childhood obesity? • What is the process of policy writing about childhood obesity and how does this influence the presence of children’s voice in policy about childhood obesity? • What contextual and personal factors shape the process of policy writing about childhood obesity? • How does this information inform new theories around how to draw future policy closer to its target population?

Table 1: Case Study Purpose Statement & Sub-questions

Chapter Three: Methodology & Methods

3.1 Introduction

Chapter One: Introduction and *Chapter Two: Literature Review* informed the research question, case study problem statement and its sub questions for this study. Chapter One introduced the UNICEF *Innocenti* report and how its findings led to the question, *How have children's perspectives informed past and current policy related to childhood obesity in Aotearoa New Zealand?* (UNICEF, 2020). Chapter Two's literature review demonstrated that there was a gap in research examining the relationship between childhood obesity policy and the role of children in Aotearoa. Based off the problem statement and sub questions of Chapter Two, *Chapter Three: Methodology & Methods* presents an outline of the research design used in this project including the methodology, methods, and data analysis tools. The chapter begins with an overview of the philosophical positioning of the research including the use of case study methodology. Then an explanation of why Sharan Merriam and Elizabeth J. Tisdell, the case study theorist, was chosen (Merriam, 1998; Merriam & Tisdell, 2016). The methods section follows and includes how the case was bound as per Merriam's case study method (Merriam & Tisdell, 2016). Finally, the data collection and analysis including each framework for interpretation of the different data sources is outlined.

This idea for this study was based off recommendations from the UNICEF report but also related to my experiences working with children as a registered nurse (RN). I wanted to know how the children I saw in the Aotearoa community were connected to government policy documents that related to them. To understand how children informed policy about childhood obesity in the past, data needed to be collected from policymakers and the policy texts themselves. An interpretive paradigm, seeking to understand a human phenomenon from the perspective of those experiencing it, was deemed the most appropriate ontological approach to pursue this line of inquiry (Vaismoradi et al., 2013). While case study methodology can be predicated on a multitude of paradigms, the data collected and analysed for this inquiry was non-numerical, and therefore interpretive-descriptive (Merriam & Tisdell, 2016; Rashid et al., 2019; Remenyi, 2013). Contextual information was essential in this qualitative case study and all data sources were contextualised and tabulated. The method design of this study was inductive, meaning that the research trajectory was determined by the data unearthed during the analysis of the interviews, documents,

and literature (Merriam & Tisdell, 2016). Using Merriam's case study methodology with a constructivist epistemology, new information was constructed from the data to answer the research question. For the sake of rigour, an awareness of my authorial reflexivity, triangulation and an audit trail were maintained and kept throughout (Merriam & Tisdell, 2016; Remenyi, 2013).

Methodology

3.2 Research Philosophy

3.2.i. Ontology

Interpretivism served as the ontological basis of this case study methodology and these theoretical ideas shaped the research process. Case study design, one manifestation of an interpretivist ontology, serves to explore a specific social phenomenon or a case from a relative perspective (Merriam & Tisdell, 2016; Porche, 2021). Case study as a methodological choice, was guided by case study's suitability to investigate policy development, a human-driven process (Lincoln & Guba, 2013). Relativism would say that policy writing is inseparable from the context it is written in, relative to humans that write it and their interpretation of the world (Rashid et al., 2019). As such, an investigation into the inclusion of children's voices and the policy writer's decisions that actively include them in policy, was a research project that fit naturally with an interpretive ontology and constructive epistemology. The idea of interpretivism was deeply entrenched and expressed at three important steps in this project. Firstly, the research question was predicated on the belief or ethical stance that children's voices should be included when compiling policy about them. Secondly, each policy writer's interpretation of the world has a significant impact on the produced policy. Thirdly, using the interpretive lens, I, as a researcher drew from multiple perspectives to understand the social phenomenon. This explains the premise behind the research question, the methodology of the data collection and then the analysis of that data.

The research question of this project assumed that the significance of perspectives, the way humans think, feel, and interpret the world was valid. Furthermore, how the research question was framed assumed that these perspectives would anchor policy closer to the truth or complex social reality of childhood obesity (Denzin & Giardina, 2022). Interpretive research builds a new understanding, exploring the truth as intrinsically linked to the human consciousness (Guba, 1990). This project

considered this to be an important step when developing meaningful and empathetic policy about the targeted population – children living with obesity in Aotearoa (Denzin & Giardina, 2022). The interpretive approach treated children’s expressed experiences as rational truths regardless of age, socio-economic background, and development. Otherwise, the truth of childhood obesity would stem from another set of individual truths, namely policy writers themselves who are influenced by their own context. That subjectivity was explored in this project.

3.2.ii. Epistemology

Constructivism

This project was primarily founded on constructivism, a transactional and subjectivist epistemology (Lincoln & Guba, 2013). Constructivism, according to authors Denzin and Giardina (2022), is where knowledge is constructed through human social interaction and relationship-building. In research, constructivism is used to build new meaning or ideas to explain a studied phenomenon. Constructivism leads to hermeneutical and dialectical methodologies designed to create findings from interactions between the participants and the researcher (Lincoln & Guba, 2013). This epistemology acknowledges the dynamic between the ‘knower’ and the ‘known’, and even positions the researcher in the research (Gelo et al., 2008). Policy itself is subject to multiple views and through understanding a sample of policymakers, the knower’s interpretation of community engagement helped to understand the phenomenon (Guba, 1990). New knowledge about the case was constructed from interviews with policy writers who have produced policy about childhood obesity in Aotearoa. The interpretive and therefore constructivist approach was used to form understanding of the phenomenon using multi-layered perspectives and informed the style of data collection and analysis.

Subjectivism

This project’s use, advocacy, and treatment of children’s voices in guiding policy about childhood obesity, was also underpinned by a subjectivist epistemology. Epistemology is usually characterised as either objective or subjective (Searle, 2010). Objectivism is when the researcher sees knowledge governed by the laws of nature and subjectivism sees knowledge as something interpreted by individuals (Green et al., 2020; Rashid et al., 2019). Subjectivism considers people as those with a consciousness, experience, agency, and as active, engaging beings (Denzin & Giardina, 2022). Without subjectivism, people are treated as inert objects and the researcher considers people as subjects. A lot has been written about objective

statistics around childhood obesity but very little has been said about the policies, written by people, who have determined those statistics. This was why subjectivism was important to this study.

As policy is a product of human industry, the act of inclusion or exclusion of children's voices, represents a pivotal moment of human impact during policymaking. Where humans have made conscious decisions, there is a subjectivity that stems from internal or external factors to those policy writers. These decisions engineer an outcome or a product in a certain direction. There are examples of how public policymakers have viewed a target population either positively or negatively, and this has led to unfair distribution of resources perpetuating health inequalities (Walt et al., 2008). I wanted to focus on the subjective nature of the policy written about childhood obesity that determines how children's voices are included.

3.2.iii. Personal ontology & epistemology

While the methods section did not include a critical theoretical framework, this research project was seen through a critical lens. This lens added a critique of the historical structures and experiences that have caused human struggle (Guba, 1990). My belief systems supported this critical direction as a researcher because the pursuit of social justice is an issue important to me. Acknowledging my ethical principles was part of the subjectivity in this project as it structures my perception of the world and therefore this project (Given, 2008). Children's participation and its influence in relevant policy, was an investigation into how the child experience has emerged in policy, a powerful structure in society. This project "*accepted that historically mediated structures are immutable*" and new knowledge was needed to transform the lives of children with childhood obesity within policy (Morrow, 2000, p. 63-64). I believe policymakers should know how children interact and interpret their social environment before writing policy. I believe there is a power imbalance of adults, that they are largely unaware of, that renders children's perspectives as less or inferior. In this interpretive study, children's perspectives are seen as legitimate and as necessary for policy development around children. Health policies "*... are considered population-based interventions useful in impacting nation's health*" and they are a vehicle that could and should encompass these perspectives (Porche, 2021, p. 25). Policies hold real-world information of what contributes to those context-specific experiences and future policy about childhood obesity needs to be well informed (Porche, 2021).

3.3 Case study approach

This project aimed to answer the research question using case study methodology. There were important components of the research question that led to a case study approach. Firstly, case study is a valuable methodology when answering how and why research questions with well-defined phenomena (Yazan, 2015). In this case, the research methods were used to examine how children's voices had informed policy about childhood obesity and the relationship between voice and policy. However, how-questions are open ended leaving the researcher with a potentially unmanageable project ahead of them. Case study's ability to *demarcate the case* and create clear boundaries around a research topic contributed to the decision to use case study (Brown, 2008; Merriam & Tisdell, 2016). For topics that threaten to become too big for the research question, such as the extensive issue of childhood obesity, binding the case can support researchers to not deviate from the topic (Merriam & Tisdell, 2016). Secondly, childhood obesity is a contemporary issue of social injustice for children and this study wanted to know about how the experience of these injustices had been communicated by children and translated into policy. It was made obvious that this phenomenon of children's voices within policy about childhood obesity was inseparable from its context (Remenyi, 2013). In addition the policy text was derived from a complex set of variables and contextual circumstances influencing the policy writers at the time of policy writing. Qualitative data would be essential to answering the question and the case study approach provides a structured framework to use qualitative data with other sources of data like policy texts. Case study methodology was chosen for its suitability to this research topic and its ability to answer the research question.

3.3.i. Merriam

The socially based phenomenon at the heart of this research project, was explored following critical theorist Sharan Merriam and Elizabeth J. Tisdell's version of case study (Merriam & Tisdell, 2016). Merriam was selected because her framework yields "*an intensive, holistic description and analysis of a bounded phenomenon such as a program, an institution, a person, a process, or a social unit*" (Merriam & Tisdell, 2016, p. 13). In this study, this approach was used to produce qualitative data, however, case study can be used across multiple paradigms including post-positivist (Remenyi, 2013). Merriam's style guides a pragmatic constructivist research inquiry to derive knowledge around the well-defined phenomenon or case (Merriam & Tisdell, 2016). Her theory advocates for and is defined by a well-structured research design process that includes considerable planning, development, and execution. These

practical structures from binding the case, ensure rigor and credibility to case study research (Merriam, 1998; Merriam & Tisdell, 2016)

In Sharan Merriam's case study methodology, her theory emphasises a structured approach, namely the researcher's definition of their case (Merriam & Tisdell, 2016). Using Merriam's theory of case study, the research design needed to be identified as either particularistic, descriptive or heuristic (Brown, 2008; Yazan, 2015). The direction of this study was guided by its focus forming insight into child voice in policy creation, a heuristic quality. As Brown (2008) describes of Merriam's heuristic case study approach,

A heuristic case study is able to shed light on the phenomenon, allowing the reader to extend their experience, discover new meaning, or confirm what is known. It explains the reasons for a problem, the background of the situation, what happened, and why' (Brown, 2008, p. 3)

The operative words of 'how have' of the research question led this study towards an inquiry into the variables that include children's voices in policy about childhood obesity and the complexities around including children's voices. This study aimed to see if children's voices had been acknowledged and used in a valuable and meaningful way and how this was achieved. This study is particularly suitable for a case study design because it is a bounded system and it is contextual (Merriam, 1998). The first step is defining this unit or occurrence in a bounded context.

Methods

3.4 Binding of the case

Case study methodology is employed to gain an in-depth understanding of a specific occurrence such as a process, however, the occurrence or phenomenon must be well defined as a case. The phenomenon studied is reframed as a case because the phenomenon can have boundaries drawn around it, essential for rigorous analysis. For Merriam and Tisdell, the case can be a process and in this study the machinations of policy development were the focus, rather than the outcomes of the process (Merriam, 1998; Rashid et al., 2019). Merriam and Tisdell like other case study methodologists uses a "*delimiting of the object of study: the case*" (Merriam & Tisdell, 2016, p. 73). This is when the phenomenon has defined boundaries that the researcher can demarcate or fence in, and therefore, can also determine what was not studied (Merriam, 1998). The binding of the case is important as it establishes boundaries and

is similar to the notion of inclusion and exclusion criteria (Rashid et al., 2019). According to Brown (2008), “*Bounded' means that the case is separated out for research in terms of time, place, or some physical boundaries*” (p. 2). It may be the limit on the number of people to be interviewed, a finite time frame for observations, or the instance of some issue, concern, or hypothesis. The researcher is challenged to fully understand and articulate the unit under study (Merriam & Tisdell, 2016). *Table 2* captures how the social phenomenon this research project was bound:

<p><i>Social phenomenon:</i> How children's voices have informed or influenced policy about childhood obesity in Aotearoa New Zealand.</p>
<p>How this case was defined:</p> <ul style="list-style-type: none"> - This case concerns how children’s voices were treated in policy concerning childhood obesity, not the outcomes of the policy itself. - To inform means to understand how children’s voices have presented explicitly and implicitly in policy, as well as understanding inclusion and exclusion from policy. This is an exploration of the relationship between children’s voices and policy about childhood obesity. - To search for evidence to understand the case, interviews, documents such as policy and literature will be analysed as data. - Policy, as data, must be no more than five years old. - Only policy writers who have been influential in writing policy about childhood obesity in Aotearoa New Zealand, will be pursued for data collection. - Only documents and people living in New Zealand will be considered for data collection. - Policy must be Aotearoa New Zealand government policy related to childhood obesity, but this could be found in policy about health, education, or social development. <ul style="list-style-type: none"> - <u>Documents to contain relevant words:</u> lifestyle, food, activity, healthier, healthy, childhood obesity, overweight, high BMI.

Table 2: Boundaries that define the case

3.5 Data sources

One of the hallmark features of case study is the use of multiple data sources, a strategy that also enhances credibility through triangulation (Yin, 2014). An analysis of a wide variety of evidence enables scope for an in-depth study of a phenomenon in its real-world context. Merriam and Tisdell consider three data sources essential in data collection — interviews, observations, and relevant official documents such as policies (Merriam & Tisdell, 2016). In this project, the proposed data sources were semi-structured interviews and policy documents. These sets of data are typical of a mainstream oriented policy analysis where the values and voices heard in policy are interrogated as well as how political priority is produced in government (Browne et al., 2019).

3.5.i. Introducing the participants

Rich data from multiple perspectives and in this case, about how children's perspectives have informed policy, was considered essential for constructing new knowledge about the phenomenon (Brown, 2008). This included semi-structured interviews with six relevant contributors to policy who were involved in formulating policy about obesity in Aotearoa. The plan was to interview policy writers and ask about the process of including children's perspectives into policy writing, including the factors that aid or hinder the inclusion of children's perspectives in policy writing. Next, I planned to interview one registered nurse from the College of Child and Youth Nurses (CCYN) NZNO who provides consultation on policy documents. CCYN states on its website that it is "*a voice to foster and promote cohesive child advocacy in the political arena*", an important influence over child health policy in Aotearoa (New Zealand Nurses Organisation, 2014, para. 5). Lastly, I planned to interview a key person from the Children's Commission, but I was not able to secure an interview with a relevant person. All case study methodologists recommend small sample sizes for case study research, so I aimed for a maximum of four participants (Yazan, 2015).

An Auckland University of Technology Ethics Committee (AUTEC) application was approved for four participants to be interviewed for a short semi-structured interview and this can be viewed in *Appendix A*. To source the participants, I used purposive sampling, targeting specific people involved with and/or impacted by policy relating to diet and exercise in children and young people (Emmel, 2013). Relevant participants were identified using publicly available policy documents and government websites. Participants were given an information and consent form that explained the purpose and method of the study and complied with AUTEC guidelines. The four participants were solicited by a variety of methods including through an approved email and individual referral. These documents can be viewed in *Appendices D, E and F*. Eventually, I had six participants after the purposive sampling technique snowballed. I felt this group of six would yield rich data that would support the research question more effectively than just four. An amendment to the AUTEC application (*Appendix B*) was granted (AUTEC Approval Number: 21/165) and I was able to have an additional two participants beyond the original four requested. A descriptive summary of all participants in one table can be viewed in *Appendix G*. Notes and reflections of all participant interviews are in *Appendices H–M*, these include the exact participant introduction from the data and my thoughts from each interview. An audit trail in *Appendix X* demonstrates how the chronological order participants were recruited for

this study (Remenyi, 2013). Upon completion, participants were given a koha or gift of a Westfield Voucher as a thank you for participating in the study.

3.5.ii. Introducing the policies

The policy documents assessed were those produced by the MOH in Aotearoa, within the last five years and concerning childhood obesity. Government reports related to the health status of tamariki Māori and Pacifica children and those statistics specifically related to obesity were also reviewed. It is well documented that these children are more profoundly affected by issues of poverty specifically affecting diet and activity (Beavis et al., 2019; McKerchar et al., 2021). It was important to find out whether the children with the highest needs have their perspectives included throughout the process of policy writing. This was inclusive of documents that advise parents on diet, advise schools of activity in education, and inform health professionals in their clinical practice with regards to diet and activity. I wanted to see how the MOH measures the success of their policies using select indicators in an evaluation model (Porche, 2021). Time frames were left broad and open to allow for the data to be analysed fully. Examples such as the *Child and Youth Wellbeing Strategy* (2019) and grey literature such as research reports produced by the Department of the Prime Minister and Cabinet, would need to be considered during the research process (Department of the Prime Minister and Cabinet, 2019).

Four key policies were selected as data pieces. These policies were chosen because they were no more than five years old and pertained to the issue of childhood obesity in Aotearoa. This timeframe was put in place to strengthen the case in this case study methodology and for a comparative study of policy over time. Specifically, the *Child and Youth Wellbeing Strategy* was chosen because as an overarching strategy that addressed child and youth wellbeing, it was assumed that obesity would be mentioned as a leading comorbidity seen in Aotearoa children (Department of the Prime Minister and Cabinet, 2019). It was also mentioned directly by two interviewed participants as relevant to the study. The *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)* was also mentioned by a participant, and it is also the most recent piece of policy produced related to the topic of childhood obesity (MOH, 2021). The remaining two policies, *Clinical guidelines for Weight Management in New Zealand Children and Young People* and *Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives* were selected for their relevance to the research question (MOH, 2016; 2017). An overview of these key policies is provided in *Appendix N*. This was done to contextualise each text according to Merriam's case study methodology and to understand the machinations behind the presenting text (Merriam

& Tisdell, 2016). Adding descriptive data was also done to enhance the generalisability of the data for the purpose of external validity (Merriam & Tisdell, 2016). For example, each policy was assessed for the presence of indicators, a common component of policy text (Porche, 2021). Indicators, or derived variables, are analysed regularly for signs of change as part of an evaluation feedback loop (Porche, 2021). Some policies had no imbedded indicators making it unclear whether the policy was part of an official policy feedback loop, and this was stated per document.

3.6 Data collection

The data collection began once participants were identified, and a suitable time for the interview was arranged. The first participant I approached asked for the questions before the interview, so I repeated this process with the other participants. The list of interview questions for this semi-structured interview can be viewed in *Appendix O* and they were reviewed by my supervisor before data collection. The interview questions were written with the purpose of gaining the participants perspectives on policy development around childhood obesity (Merriam & Tisdell, 2016). Participants were offered the opportunity to have a support person present during the interview, and this included a cultural advisor or cultural support person if requested. A cultural support person could be sourced through AUT services and were included in the budget plan if necessary. Interviews were between approximately 45-60 minutes.

All interviews were completed over *Zoom* (Copyright © Zoom Video Communications 2022) because we were in COVID-19 level 2 lockdown conditions (imposed by the Aotearoa government), and all my participants were located outside of Auckland where I live. With permission from the participants, the interview was video recorded over *Zoom* and audio recorded with a secondary programme *Windows Voice Recorder* (Copyright © Microsoft 2022) to counter any risk of lost footage. The interviews were based off the semi-structured interview questions, but all interviews developed into a discussion. All data from the interviews were anonymised and participants were given pseudonyms to prevent linking of data to persons. Prior to, during and following the interview, I wrote field notes that provided both descriptive and reflective information from the interviews. This was to increase the external validity by adding descriptive information about the data (Merriam & Tisdell, 2016). *Appendices H–M* capture this information. Ethics approval was granted by AUTECH to collect data in this way (AUTECH Approval Number: 21/165). All interviews were sent to *TranscribeMe!*

(Copyright ©TranscribeMe 2022) as soon as they were completed with the participation to be transcribed. Confidentiality is maintained in this service using encryption of the data as well as a priority task distribution between transcribers (TranscribeMe, 2022). This process took 24–72 hours to be completed and then I could start the analysis of the data.

3.7 Analysis

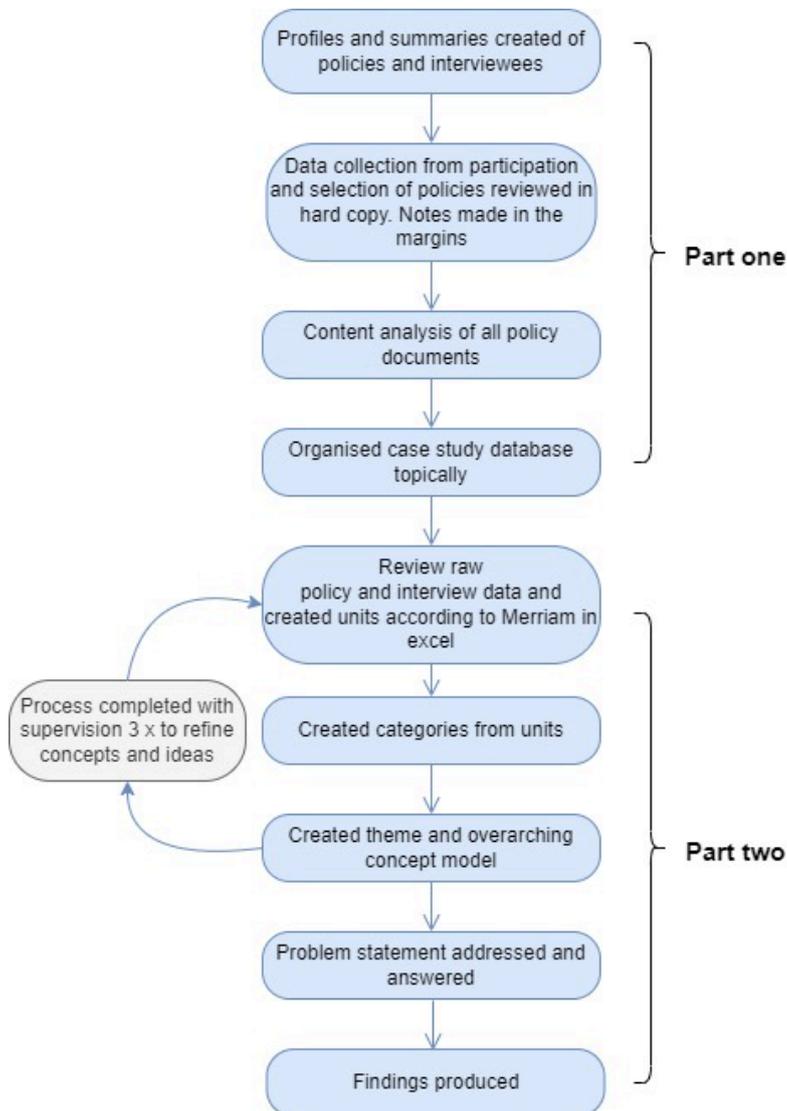


Figure 3: Flowchart of analytical process

An analysis of policy texts, interview data and field notes was completed according to theorist Merriam and Tisdell (Merriam & Tisdell, 2016). The policy texts and participants were each tabulated (*Appendices G and N*) to describe why the data was chosen and appropriately contextualise the data into this qualitative study. In the

analysis described in Chapter Four, the data was broken down into meaningful units. As a data source, policy documents were assessed for their evidence of child voices whether in the form of:

- Data collected by the policy writers from children who had contributed.
- Referenced research cited in each policy text that clearly contained children's voices/perspectives.
- Policy that upon analysis indicated their process inclusive of how and why children's voices were included.

The data analysis assessed the policy and interview data for meaning and insights around child participation in policy about childhood obesity. It was also an analysis of the heuristic qualities of the policy-making process (Merriam & Tisdell, 2016). This process was not linear and in Merriam's analytical approach, the categorical aggregation and search for patterns began during data collection (Merriam & Tisdell, 2016). Within this analysis, several approaches such as content analysis were planned alongside case study to understand how children's voices had informed policy related to childhood obesity. As stated above, this process was heuristic and a search for information that supported learnings around the research question. The eventual emergent themes produced were consolidated into a narrative and a conceptual model that aimed to answer the research question. This interpretive study was exploratory and yielded both concrete and abstract ideas from the data to answer the research question.

All data was collated into a Merriam styled "*case study database*" who drew on the work of case methodologist Richard Yin (Merriam & Tisdell, 2016; Yin, 2009). Since multiple sources of data were analysed simultaneously, a database was necessary to analyse this information all at the same time (Brown, 2008). Analysis in case study methods is in many ways a normal qualitative interpretive process, however, it involves firstly compiling the data into a primary resource package or case study database (Merriam & Tisdell, 2016). The case study database was sorted topically and encompasses all relevant data that contributes to answer the research question. There was so little data that conveyed child participation in the policy texts that the primary resource package was almost exclusively the interview data and field notes. In the end data about commercial interests, obesity in general, equity, other forms of participation and all references lists contributed to the primary resource package collated in excel. This is normal for Merriam's case study approach, as the final write-up or case report has a greater proportion of description than other forms of qualitative research to convey a holistic understanding of the case. The level of interpretation also

extends to the presentation of categories, themes, models, or theory (Merriam & Tisdell, 2016).

3.7.i. Merriam's qualitative coding method

Consistent ideas emerged from all data and these findings were organised into descriptive accounts, themes, categories, models and theories (Merriam & Tisdell, 2016). These forms all represented an analytical level during the analytical process. In an exploratory, iterative and recursive process, the data analysis process pendulates simultaneously along three spectrums; concrete and abstract, inductive and deductive, and finally description and interpretation (Merriam & Tisdell, 2016). Concrete ideas are seen in simple descriptions of a theme or occurrence, however, working the data into higher-level abstractions derives new concepts in theory construction (Merriam & Tisdell, 2016). This part of the process was completed three times to refine the theme or themes and build a complete overarching concept model to support the research question.

3.7.ii. Developing units

Using the purpose statement as a beacon, the analysis began with highlighting and annotating a hard copy of each interview with initial thoughts about segments of data that appeared linked to the research question. An example of this is in *Appendices P* and *Q*. Then a digital version of the data was created with the notes in the margins placed in a column beside the raw data. This started the process of pulling all segments into an excel sheet. This was done according to Merriam and Tisdell's criteria for identifying a segment as discussed below and an example of this is in *Appendix R*. Each interview was refined again, separating out segments that were too large, containing more than one idea. I worked the interview data from the ground up with an inductive data-led flow to determine if there were any patterns or emerging ideas (Merriam & Tisdell, 2016). According to Merriam, analysis and the organization of themes begins by reflecting on the purpose of the whole study with the accompanying sub-questions (2016). The researcher must identify segments or units of data that respond to the research question and purpose statement. A unit of data ranged from one word a participant used or was as large as several pages from a transcript or document, and this approach fitted with Merriam's method (Merriam & Tisdell, 2016). How segments were selected was according to Lincoln and Guba (2013) and Merriam and Tisdell (2016), a unit had to meet two criteria:

1. The segment should have a heuristic quality that explicitly aided the learning and the development of new ideas relevant to the study. The segment could

also be a thought-provoking unit that gives the researcher a reason to take pause.

2. Secondly, each unit should be heuristic and speak to the research question (Merriam & Tisdell, 2016). A unit should be,

The smallest piece of information about something that can stand by itself — that is, it must be interpretable in the absence of any additional information other than a broad understanding of the context in which the inquiry is carried out (Merriam & Tisdell, 2016, p. 345).

3.7.iii. Developing categories

Once the data was identified and segmented, the process of categorisation and abstractions began to be derived from the data (Merriam & Tisdell, 2016; Glaser & Strauss, 1967). Once all segments were independent and separate in excel with the annotated notes beside them, the first step towards categorising the segments began. During this first analysis, I wrote long summaries describing each segment and then reviewed and truncated this information over time, especially as the analysis went on. The researcher worked to refine the categories in an iterative process as I went through the interview data, ensuring that the segments were consistently allocated across the categories.

I compared one unit of information with the next, looking for consistencies in the segments. This was the process of coding, and it started with writing notations in the margins of a transcript or document as seen in the example of *Appendices P* and *Q*. The segments were then pulled together under, or allocated with, other segments that were underpinned by a similar idea or concept, called analytical coding. The codes were noted in a running list of groupings attached to the transcript or on a separate paper. As more data was collected and analysed, the closer the data was to saturation (Merriam & Tisdell, 2016). The categories themselves were worked to meet the following criterion:

1. Categories were responsive to the purpose of the research and research question.
2. Categories were exhaustive and all data that was deemed important or relevant to the study were in a category or subcategory.
3. Categories were generally mutually exclusive. A particular unit of data should fit:
 - a) into only one category, or
 - b) if the same unit of data could be placed into more than one category, more conceptual work was done to refine the categories.

Important to this process was the categorical congruence, where the categories should be consistent conceptually. All categories were compared on a table side by side for consistency and to check they all met the criteria (Merriam & Tisdell, 2016).

3.7.iv. Developing theme(s)

The development of themes was the third level of analysis in Merriam and Tisdell's case study methods and led to establishing inferences, and conceptual models from the categories (Merriam & Tisdell, 2016). The categories described the data, but to some extent, they also interpreted the data. At this step, I began to develop a theory and drew inferences about future activity. Each time the interview data was reviewed again, the previous analysis information was kept but a new sheet was opened with just the units and notes so that new categories and subcategories could be made. A running diagram of subcategories, categories and themes was kept in a *diagrams.net* (Copyright © JGraph Ltd 2005-2021) file, which enabled a visualisation of the flow of ideas to adapt as well as refine the analysis process quickly. Policy and interview data were integrated together with the same codes developed through the analysis. As part of my rigorous iterative process, I changed categories and subcategories and went back to previously analysed data to ensure the analysis of the data was consistent with my changes. My supervisors worked with me during this iterative and interpretative process and helped redefine the themes. As shown in *Figure 3* this process was completed three times to ensure the overarching concept model was supported by robust processes.

3.8 Revision and refinement of the analysis approach

3.8.i. Analysis of the interviews

Through discussions with my supervisors, the analysis method was refined and adapted during the initial stages of this process to meet the needs of the research question. Initially the analysis included a Critical Discourse Analysis framework alongside Merriam and Tisdell's analytical method while analysing the interview data (Merriam & Tisdell, 2016; Mullet, 2018). This was in keeping with an aspect of the philosophical underpinning of this study, which included critical theory. However, during the early stages of analysis, I found that while these frameworks yielded interesting data about interdiscursivity and internal relations of the texts, I could see this information would exceed the bounds of the research question. Instead, I chose to

adopt just a critical lens while using Merriam's style of qualitative analysis (Merriam & Tisdell, 2016).

3.8.ii. Analysis of policy documents

The analysis proposed for policy documents was also revised. Kingdon's framework was excellent for contextualising the policies and establishing how each piece of policy advanced in the policy pipeline, but it didn't support the analysis of child voice in the text (Kingdon, 1984). I needed to see how children's voices had appeared in each document, not how the issue of childhood obesity had been managed in policy. Each policy text was analysed using comparative content analysis instead (Drisko & Maschi, 2015). Case study researcher Dan Remenyi (2013) describes content analysis as an important part of the initial stages of case study analysis as it pulls out significant issues and constructs. Word searches, word counts and numbers of referenced qualitative research per policy were compared and this can be viewed in *Appendices S* and *T*. I acknowledge that the singular words are presented without context, a known weakness of content analysis as a research method (Merriam & Tisdell, 2016). However, this was still done to detect subtle bias or support of child voice. This was decidedly more relevant to the research question that was looking for the presence and influence of children's voice in policy documents. Merriam and Tisdell cited the usefulness of comparative analysis of documents and in this case, policy documents for concept building (Merriam & Tisdell, 2016). According to Drisko and Maschi (2015), a content analysis is used for the purpose of being descriptive and this contributed to the rigour of this study. For these reasons, I decided to use content analysis for the policy documents alongside Merriam's categorical aggregation and coding strategy (Merriam & Tisdell, 2016).

A content analysis of all childhood obesity-related words was completed on all policy documents to identify key concepts and to compare each policy. The first word search was to demonstrate the policies, relevance to the research question. The childhood obesity words were *food, activity, exercise, sleep, food insecurity, poverty, inequality, obesity, overweight, weight, adiposity* and *BMI or Body Mass Index*. This was captured in *Appendix S*. Lastly, an analysis of child voice related words was also completed to detect any examples or allegiance to child voice in the text. The child voice words were *engagement, voice(s), participation, youth voice(s), inclusive, representation, advocacy, inclusion* and *experience*. This content analysis was captured in *Appendix T*.

3.8.iii. Rigour

Rigour is qualitative research's equivalent to reliability and validity to authenticate research outcomes and was a crucial aspect of this research process (Merriam & Tisdell, 2016). This was a regulation process that was ongoing throughout the data collection and analysis phase. Rigour was maintained through an iterative process, audit trail and awareness of researcher reflexivity and triangulation. Firstly, using Merriam and Tisdell's qualitative coding methods promoted an iterative process to analyse the data set and then present it as consistent patterns (Merriam & Tisdell, 2016). This consistency is designed to establish trust and confidence in the findings and was a significant strength to this research project.

A triangulation method was established to build the overall dependability and credibility of this study (Fusch et al., 2018). Triangulation was one method for reducing the impact of unavoidable personal bias to improve the reliability of results (Fusch et al., 2018). In this process, the data points of time, people and space were identified for each instance of data and clearly labelled in each excel sheet (example in *Appendix R*). These are then compared for similarities and differences between the sets of data but can also be viewed over the course of time (Fusch et al., 2018).

Another way to improve rigour is to use an audit trail for all decision-making throughout the research process (Salkind, 2007). In this study a paper trail created in excel detailed all changes inclusive of the rationale for any diversions. It was used to evaluate the decisions made in the research design and served as an ongoing reflection of the experience of researching. The integration of an audit trail in research added credibility by including field notes during data collection. The audit trail can be viewed in *Appendix X*. These were thoughts while analysing data and capturing my role in the study. I captured my initial thoughts on the interviews seen in *Appendices H–M*.

3.9 Researcher biases & assumptions

Researcher reflexivity is where the author acknowledges their own assumptions and bias about their research topic. This can influence both the data collection and analytical stage of research (Galletta & Cross, 2013; Johnson et al., 2020). An important part of ontological positioning is to exercise reflexivity especially with an interpretive-constructive paradigm where the researcher's own reality is a dynamic construct in the study. At the centre of qualitative research was me the researcher who interacted with all participants, triangulated the data, interpreted the information

gathered and formed “*rich, thick description*” (Merriam & Tisdell, 2016, p. 350).

Conducting qualitative research necessitates an understanding that the researcher will always bring elements of themselves to their work (Fusch et al., 2018).

As a researcher, I need to be explicit about my background as a Plunket Nurse as this is a bias. This research topic concerning childhood obesity and child participation in policy, developed after spending five years in the community working as a Plunket Nurse. One assessment I became very familiar with was the *Before School Check* assessment available to all Aotearoa-based four-year-olds (MOH, 2021e). The weight, height and body mass index are all measured for each four-year-old in this assessment, and the results are then discussed in conjunction with a plan if needed with the parent. Parents were often very sensitive about the topic of their child’s weight, an indication of how stigmatised the issue is and how protective they felt of their child’s perception of themselves. These assessments felt very mechanical and clinical, not a process that children and families could feel comfortable in. I wondered how the people on the receiving end of these assessments had contributed to the policies that designed them. It seemed to me that this was a disconnect between policy and citizen. I was also aware that many of the conversations I was having with families of children who were overweight, were also from low socio-economic backgrounds. That is when I started to think about child participation in child obesity policy. However, while familiarity with the subject matter is likely a positive factor, I am accustomed to managing this subject clinically and not from a researcher’s perspective. I am also aware that I do have a progressive outlook and will naturally be focussing on issues of social injustice in the data. The issue of bidirectional reflexivity may be a factor in weakening the reliability of the results and I needed to be mindful of my previous roles (Galletta & Cross, 2013; Johnson et al., 2020). To assess for authorial reflexivity, I always involved my supervisor in the analysis phase to seek feedback about my methods throughout the process. This recursive and reflective process was to ensure this qualitative research process had rigour and quality in its findings (Galletta & Cross, 2013; Johnson et al., 2020).

Chapter Four: Findings

4.1 Introduction

Chapter Four: Findings demonstrates the results of the analysis and findings of this study. This chapter worked to respond and answer the research question, *How have children's perspectives informed past and current policy related to childhood obesity in Aotearoa New Zealand?* and the purpose statement. The analysis of indicated in *Figure 3* yielded the overarching theme of *invisibility*, two categories *exclusion* and *advocacy* and four subcategories *adult voice*, *incompatibility*, *tokenism*, and *whānau voice*. All data was processed from raw data through to theme, category, subcategory and overarching concept model as per Merriam and Tisdell's case study approach (Merriam & Tisdell, 2016). Children were almost entirely invisible in policy about childhood obesity between 2016–2021 and how this concept was developed from the data has been detailed below. This chapter finishes with a response to the purpose statement identified in Chapter Two and then the findings that will be discussed in Chapter Six.

4.2 Findings: Overarching concept model

Through analysis of the participant interviews and key policies emerged an overarching concept model that answered the research question, *'How have children's perspectives informed past and current policy related to childhood obesity in Aotearoa New Zealand?'*. According to Merriam and Tisdell, a simple diagram or model using the categories and subcategories of the data analysis captures the interaction of relatedness of the findings (Merriam, 2009). In the analysis of data *invisibility* emerged as an overarching theme underpinned by two categories *exclusion* and *advocacy*. Each category describes how child voice presented as invisible in the data with four further subcategories as illustrated in *Figure 2*. Each of these will be described in more depth and relate to the research question below.

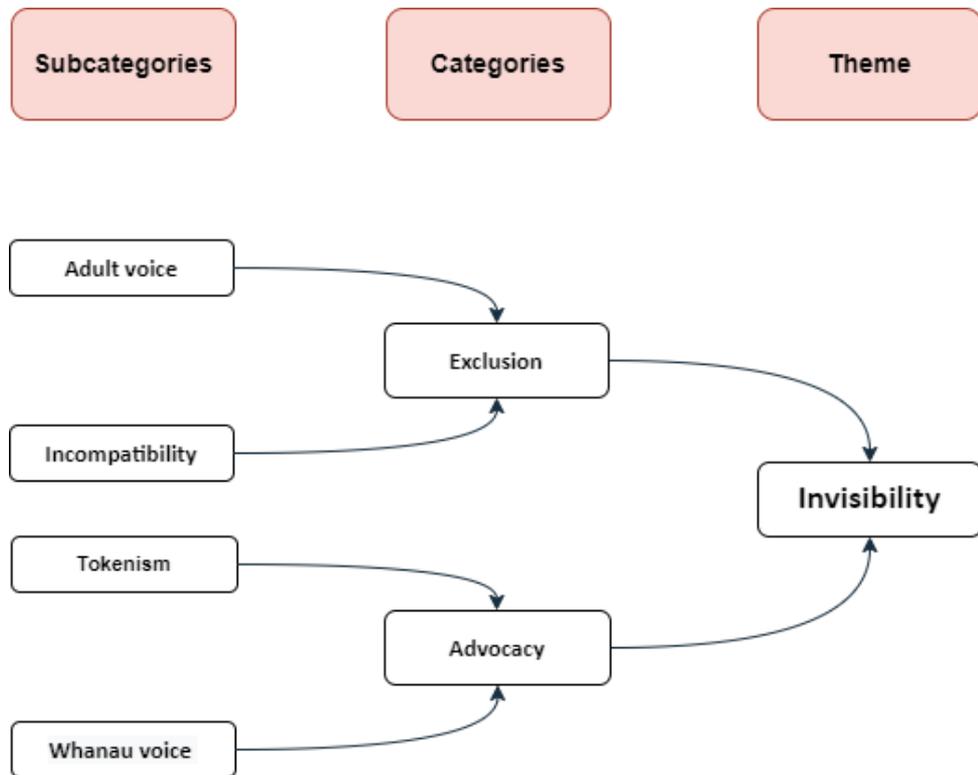


Figure 4: Results of analysis data using Merriam's style of case study analysis

4.3 Overarching Theme: Invisibility

Overall, child *invisibility* circumvented every aspect of policy about childhood obesity policy. An exclusionary culture saw that children were distanced and silenced while *adult voice* that spoke to an adult-centric culture, prevailed in all forms of data. Children were structurally and culturally suppressed by restrictive conditions described by the participants, and this did not promote child participation in the policymaking process. All participants noted the absence of a pathway that would encourage culturally and ethically safe practice with children. However, stigma-based *exclusion* was also a finding within the participant data towards the topics of 'childhood obesity' and 'child participation' and this showed that *exclusion* was intentional. Combined, these factors contributed to the *incompatibility* subcategory that described the contentious relationship between the subjects 'child participation', 'policy' and 'childhood obesity'. The *incompatibility* subcategory was where exclusionary practices came to a head and deflected the text back to the dominant *adult voice*. *Adult voice* and *incompatibility* were separate subcategories but had a pendulous relationship within *exclusion*. Incredibly, despite overt *exclusion* there were two forms of restrictive *advocacy* that allowed for children to be partially heard and visible. Children were found

to contribute through the mouthpiece of the first subcategory *whānau voice* or the second category *tokensim*, a tokenistic version of authentic child voice. Ultimately, a culture of child *invisibility* around policy about childhood obesity meant that child voice was muted, or just repackaged into a diluted form of expression compatible with *adult voice*.

4.4 Category: Exclusion

The first of the two major categories, *exclusion*, was developed from the distinct absence of child voice or support of child voice in policy about childhood obesity. The analysis produced two explanatory subcategories; *adult voice* and *incompatibility* demonstrating, for the most part, that the *exclusion* of children was deliberate. Child participation was not pursued by the participants because engagement did not appear to belong to their set of values and perspectives in the existing culture around policy development. This was most evident in the way that participants talked about child participation as an ideal rather than an actuality or as a concept that had rarely been considered by the participant at all. Participant #4 conveyed this polite dissociation,

I mean I think it's really valuable. I think that that's the ideal, and to work towards that.
(Participant #4)

However, the disconnection between children and policy about childhood obesity ran even deeper. Not only was there minimal evidence of child expression, the texts also did not appear to support the best interests of children with obesity, and this was a significant exclusionary aspect of *adult voice*. As a subcategory, *adult voice* was a set of values that covertly prioritised adult concerns over child concerns within policy development. This was evidenced by a strong focus on individual responsibility and the presence of commercial interests that undermined policy about childhood obesity. For example, policy texts rarely addressed the powerful impact of the government's own economic decision-making nor the health inequities created by the government's own policies. This operational chaos also infiltrated the difficult policy environment and appeared to only support *adult voice* during policy development. Power-based issues rendered child voice as an ill-fit and as outlined by the second subcategory, suffered from *incompatibility*. Through the treatment of 'child participation', 'policy' and 'childhood obesity' seen in the subcategories, *exclusion* was found to construct some of the very systemic inequities that cause childhood obesity through policy. As a result, adult-oriented policy containing stigmatised, simplified and misdirected treatment plans emerged for the issue of childhood obesity.

4.5 Subcategory: Adult voice

The first subcategory entitled *adult voice* was a powerful contributor to child *exclusion*. *Adult voice* was a set of values and attitudes that influenced the management of the three separate components: 'child participation', 'policy' and 'childhood obesity'. The policy text was led by subconscious and conscious adult-centric decision-making around each of these three topics. The attitudes of *adult voice* set the groundwork for structural barriers and incited difficulties ahead during policy development around childhood obesity. This subcategory illustrated the importance of child participation as a human right but also demonstrated how participation is an opportunity to assert all rights through expression. The power of *adult voice* made child participation a rare occurrence and how this shaped policy about childhood obesity, is discussed below.

4.5.i. Adult voice in child participation

Epistemologies that conflicted with community engagement as a policy input, formed the ideological dimension of *adult voice*. Firstly, the prominent epistemologies of participants did not correspond with the notion of community engagement with children. For participants, quantitative evidence was considered more 'valid', regarded as 'scientific evidence' and evidence that held 'more value' or 'more weight' than qualitative. Conversely, community engagement when described by the participants was framed as 'respectful', 'an ideal' and as 'an obligation'. The assertive nature of positivist-informed data such as statistics was consistently described as more appropriate and reliable for policy by the participants. However, as evidenced by the following participant statement, there were indications they were open to other epistemologies,

I very much trained as a quantitative, and I would definitely still say that's where my main interests lie, but I love the added value that qualitative can give you and the sort of richness of the data that's present within the qualitative. (Participant #2)

Child voice was recognised as a 'blind spot' in participants' practice and there was evidence to support the notion that there was an unconscious bias against qualitative research and community engagement. In its entirety, this evidence represented a distinct top-down approach that biased these participants against using interpretive evidence and contributions from community engagement. Indeed, the amount of qualitative research and community engagement per policy text was minimal but did increase as an input over the period examined within this case study as per *Appendix U*.

4.5.ii. Adult voice in policy

The adult-generated conditions around policy design and development, such as time pressures and ministerial demands, led to behaviours that supported *adult voice* over child voice. According to the participants, problem-solving in government was hampered by the need for input from a multitude of groups that resulted in no strategic direction and poorly written policy. The participants were resigned to this fact of government life and policy was seen as more of a symbolic intervention than a pragmatic one. One participant described policy as just “*strategic direction documents... They're so broad or vague that there's not really enough direction often*” (Participant #2). This policy process reportedly led to child participation as an afterthought, rarely experienced by any participant. Both the participant interviews and the policy documents showed that *adult voice* had a tone and character defined by dominance and confidence but also a helplessness or unwillingness to change the status quo in government. Ultimately, the nature of government seemed to serve *adult voice* in decision-making and the *exclusion* of children was a natural consequence.

Adult voice was also characterised by a covertness that offered no context, or rationale for why children faced *exclusion* from policy. Participants dodged questions or provided inappropriate answers to questions about child participation that suggested avoidance. For example, when asked about child participation in policy about childhood obesity, several participants provided examples that discussed participation with clinicians instead. Further evidence of covert behaviour was the absence of information in the policy text about how they were constructed or what had informed their development and key instructions. Both the *Clinical Guidelines for Weight Management in New Zealand Children and Young People* (2016) and *Sit Less, Move More, Sleep Well: Active play guidelines for under-fives* (2018) offered no explanation of how the policy was developed and/or constructed within the text. This was interpreted as both a reflection of the operational chaos affecting the process described above but also an expression of absolute *adult voice*. The *Child and Youth Wellbeing Strategy* was a didactic piece of policy from the Department of the Prime Minister and Cabinet that set out to expose social injustices towards children and therefore took a more transparent approach. The *Child Youth and Wellbeing Strategy* (2019) changed the past trend of behaving covertly and included a chapter called ‘How the strategy was developed’. The *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)* (2021) also exhibited more transparency than its other operational policy counterparts reviewed in this study and included a ‘How we developed these Guidelines’ section. Overall, the findings showed that policy processes were sometimes hidden and did not

explain why children were excluded from three policies. *Exclusion* in this sense, became a dictatorial assertion of *adult voice*.

4.5.iii. Adult voice on childhood obesity

The tone of *adult voice* suggested that childhood obesity as a health outcome, conflicted with the policymaker's value set. This was evident in the way that participants conveyed judgemental and negative attitudes toward childhood obesity. Childhood obesity was described in a beleaguered manner by the participants as 'life-long' and 'challenging' for those affected but also for health professionals to manage. Participants also used language like 'fat' and 'chubbiness' that reflected certain negatory, stigmatised perceptions projected by the public. The derogatory language in the data showed that childhood obesity was seen by participants as a burden and laden with stigma. Childhood obesity was repeatedly noted to affect individual health and socio-economic status significantly, indicative of how difficult or impossible this condition was to treat.

These stigmatised attitudes cast a feeling of hopelessness over policy about childhood obesity, however, participants reflected genuine defeat when managing this population health issue through policy. Firstly, the participants did not espouse past policy about childhood obesity and their devaluation was a hallmark feature of *adult voice*. Policymakers stated that they had created policy that they did not believe to be effective and Participant #6 illustrated this by saying,

Look, I think the policy's probably fairly weak because it won't take on commercial interests, and the food giants — I mean, food giants just do what they like, unless it looks cool to do something different and it's financially beneficial. (Participant #6)

There were also stated reasons fundamental to the policymaking process that rendered these texts incapable of their desired impact on childhood obesity. For example, the policy development lacked robust processes and therefore policy contained ideas that were inconsistent with research. However, the participants offered no solution for this issue and approached it with a despairing attitude. One participant diminished the importance of policy altogether by saying that,

...people's behaviour doesn't really change as a result of policy. I mean, it's the Ottawa Charter approach that supports people to change behaviour. Just writing policy is just the first step, so I wouldn't think it would be a huge factor. (Participant #2)

The data showed that policy was knowingly developed as redundant and known not to serve the children that needed intervention. It is likely these attitudes lay important

groundwork for the next subcategory *incompatibility* where they had a real-world outcome in the construction of policy about childhood obesity.

4.6 Subcategory: Incompatibility

The next subcategory entitled *incompatibility*, was the second subcategory of *exclusion* that furthered the central theme of *invisibility*. There was an observable interchange between 'child voice', 'childhood obesity' and 'policy' that conveyed irreconcilable resistance between all three topics. The three disputing corners of the *incompatibility triad* were:

- Child voice should and could not speak to the topic of childhood obesity. Child voice also did not or could not fit into policy about any topic.
- Policy could and would not effectively accommodate either childhood obesity or child voice.
- Childhood obesity could not be addressed by policy and therefore could not be spoken for by children.

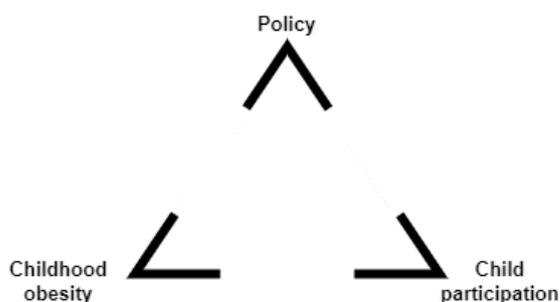


Figure 5: The incompatibility childhood obesity triad

4.6.i. Childhood obesity & policy incompatibility

Childhood obesity appeared incongruent in its proximity to government policy and vice versa. Firstly, several participants had received feedback about existing policy from parents who worried about a public classification of young children as obese:

...And we used to get their letters at the Ministry of Health written to me or to someone saying, "How dare you tell me my child is fat". And they'd send us videos and all sorts of things of their fat children to say, "Actually, he's not fat. He's just slightly chubby". Occasionally, the parents were in the video as well which you could see where the slightly chubbiness was a familial trait, shall we say? (Participant #1)

This statement was interpreted as reflection of how childhood obesity stigma was instilled in both the participants and the public's attitude. Policymakers had clearly

attempted to address public perception as a content analysis showed that 'childhood obesity' as a phrase, had gradually minimised in use over the timeframe 2016–2021. For example, no analysed policy had 'childhood obesity' in the title, seeming to remove or distance itself from the given topic. At the same time, policy texts appeared to pull away from discussing the physical condition and clinical assessment of childhood obesity and presented as more willing to address its causes such as activity, poor diets, and poverty. In the most recent piece of policy, the *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)* (2021) spoke broadly about its causes such as inequity. Even with these efforts, maintenance of positive public perception of policy for a stigmatised population health issue presented as an unresolved issue in all data.

The policy text reviewed did not reflect the real causes of childhood obesity. They mostly adopted an individual responsibility focus and avoided issues of social injustice. Therefore, policy was not used to improve the known contributing social determinants of health. The participants complained that the government co-opted policy about childhood obesity with its own self-interests and had an alternative agenda that conveyed negligible attention to poverty. All participants understood/knew or believed that socio-economic issues and/or poverty strongly influenced the prevalence of childhood obesity. Participants also described how addressing the equity issues that contribute to childhood obesity was the most effective pathway for intervention. However, the message within policy text told a different story:

I remember being at one meeting one day that said there's no point doing any of this stuff until we have a living wage or anything. I mean, there's no point having any policy or guideline stuff on healthy eating because if you can't actually do it, what's the point in having a guideline that says what you should be doing? So I think it's an increasing groundswell to be more cognisant of equity and all these sorts of things. (Participant #3)

Socio-economic-related issues such as poverty were alluded to within the policy texts, but the ideas revolved mostly around motivating people to take personal responsibility for their health. Child participation was described as 'pointless' considering these much bigger and fundamental problems.

Over the course of five years from 2016–2021, policy changed the focus of its guidance but only superficially. There appeared to be a philosophical pull from policy rooted in clinically based findings to a strengths-based, more socially conscious equity-based policy. The two oldest policies from 2016 and 2017 did not make any mention of inequity, however, childhood obesity began to be described in the context of poverty in the *Child and Youth Wellbeing Strategy* (2019). The use of the word *obesity* was

described in the context of income, housing condition or affordability and material wellbeing, all equity-based issues.

While most New Zealand babies and toddlers experience a good start to life, too many live in households that face social challenges, like poverty, inequality, family violence, addiction and poor mental wellbeing (DPMC 2019). These social challenges can result in household food insecurity and make it difficult for parents and whānau to provide adequate nutritious foods. (MOH, 2021 p. 2)

Addressing abject child poverty was clearly at the heart of the *Child and Youth Wellbeing Strategy* and this policy was completed with a new law, the Child Poverty Reduction Act 2018 (Department of the Prime Minister and Cabinet, 2019). Both the *Child and Youth Wellbeing Strategy (2019)* and *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old) (2021)* are associated with a socially systemic cause of childhood obesity as the scope of its management broadened and changed. However, all policies fell short of describing the financial resources that might overcome the issues that cause childhood obesity. See *Appendix V* for the combined lists of equity-based references in each policy.

Lastly, childhood obesity fell under the spectre of more than one government agency, but it was usually managed by medically trained policymakers in the MOH. This appeared to be where siloed government agencies obstructed effective management of childhood obesity by working independently. Childhood obesity was managed primarily with policy from the MOH, however, participants remarked that as a complex health issue it was likely to need involvement from other agencies such as the MSD and the Department of the Prime Minister and Cabinet. There was evidence of discrepancies between the management of childhood obesity depending on which agency produced the policy. The findings showed that when policy was developed by the MOH, childhood obesity was treated as a health condition and was imbued with ideas of individual responsibility. However, when policy came from the Department of the Prime Minister and Cabinet, childhood obesity was treated as systemic issue of inequity. Due to its breadth, childhood obesity was considered by the participants as a 'cross-agency issue' and collaboration needed to come as a directive from higher levels of government to drive change according to three participants.

But then another question I have is around how agile policy is, the time it takes. And how agile it is or isn't. It's not really that agile, I don't think. Only when it comes to political direction. (Participant #4)

The best example of collective action driven by a political party, was evident in the *Child and Youth Wellbeing Strategy*. Child participation was not achieved in the other

three policies, and childhood obesity sat awkwardly mis-managed by neither MOH or MSD.

4.6.ii. Policy & child participation incompatibility

The data analysis revealed that child participation was incompatible to the policymaking process. Exclusion via perceived incompatibility, was exemplified by the reported lack of formal government process to include children in policy. Ultimately, the findings showed that children were, by design, invisible to those making policy because they did not belong to this process. Two participants who had both made significant contributions to current child policy, had never been involved in policy development that had included child participation. Some stigma was attached to the concept of child participation in the interview data, perceiving children as incompatible with the process of policy development. One participant said, “...*there's a whole lot of perceived risk about adults talking to children about things...*” (Participant #1). However, the overwhelming complaint was that participants said that “*there wasn't that much around about how to do it*” (Participant #6) or denied the existence of a framework that provided information about how to enable community engagement. Ideologically, child voice in policy was reportedly still in its infancy and the idea of child participation was discussed but not able to be actioned due to a lack of pathway forward.

...“How do we get the child and youth voice into that quality discourse?” and thinking quite seriously about it. But it's still at the rhetoric stage, isn't it, and the practical — I mean, we were thinking, at the time, various ways. (Participant #6)

In contrast, the *Child and Youth Wellbeing Strategy* used online surveys, face to face interviews and focus groups of children and young people were enabled to feedback to the government about what matters most to them and what made a good life. This extensive report with its five key messages directly fed into the *Child and Youth Wellbeing Strategy* and is a great example of including children and young people's voices in policy development.

4.6.iii. Child participation & childhood obesity incompatibility

All six participants presented as conflicted between traditional and progressive attitudes toward ‘childhood obesity’ and ‘child participation’ within process of policy development. “*So the whole issue of, ‘How do you involve children and their whānau in conversations around obesity?’ is a very fraught one*” (Participant #1). Participant #1 encapsulates the *invisibility* between ‘child voice’ and ‘childhood obesity’ but also between policy writer and the public. The participants treated child participation in the context of policy development around childhood obesity with trepidation and caution.

The participants were not completely opposed to the inclusion of child voice in policy despite their preferred research methods, however, they did describe being too under-resourced. There were ethical concerns that without a policy framework, it would not be safe or appropriate to collect the views of children and young people considering how stigmatised childhood obesity is in the Aotearoa population. A clearer pathway on how to access and use child voice might have alleviated those ethical concerns. As such, the appropriateness of seeking child participation in policy about childhood obesity was questioned. Whether policy developers 'should' attempt to use child voice was discussed from both an ethical safety and cultural safety viewpoint. Collectively, these conditions, attitudes and perspectives left policy writers choosing not to seek child voice or participation in policy about childhood obesity because it was 'fraught' and 'frustrating'. The absence of authentic child voice was evident in 3/4 policies. This same attitude was directed both generally to child policy and specifically towards policy about childhood obesity.

There's urgency, and there's capability. It's really for it to be safe for children because you've got a lot of consent issues and safety issues, and you can't just have children — you've got to do it well...And so we're trying to work on engagement with young people for school-based health services, and we're really struggling to figure out how to do it because we're just not set up — we're set up to engage with adults, and even lots of adults don't feel safe engaging with government agencies, let alone children, so. (Participant #3)

This quote illustrates how even if the issue was 'tabled' and community engagement was discussed, the development team faced an exhaustive ethics process that was perceived as unachievable considering the time constraints. Participants provided examples of where the cultural and ethical safety of Māori and Pacifica children had been compromised for the purpose of saving time around community engagement. Policy was reported to be under-resourced overall, and therefore children were under-served by the results.

The final destructive element of childhood obesity/policy *incompatibility* was evidenced by the broad conflicts of interest of government to its own policy about childhood obesity. These commercial interests undermined the intentions of policymakers and forced policymakers to consider child participation as less important. According to participants, the fate of policy related to childhood obesity was predetermined and this did not include community engagement with children:

No. I think there's these disparate directions. And I guess, in that setting, it was very hard to get the child voice in there as well because there's already different direction. (Participant #6)

The presence of conflicts of interest also reinforced how child health concerns were *incompatible* with the adult-centric world of policy, adding another powerful dimension to *adult voice*. This idea was asserted as the biggest challenge to the efficacy of policy about childhood obesity and kept policy within the interests of the adults writing it.

I wouldn't say it [lack of child voice in policy] would be the biggest factor. I mean, the factors like the cost of fruit and vegetables and marketing of unhealthy food to children has probably a way, way bigger impact. (Participant #3)

This notion of competing commercial interests was seen in only one policy, *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)* (MOH, 2021), with one citation to a 14-year-old MOH document:

Ministry of Health (2007). Implementing and Monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand. Wellington: Ministry of Health.

No other policy, however, referred to the marketing of food and drink to children in the text.

Commercial interests were in a way a subtopic of political influence and the data showed that policy about childhood obesity was often an issue of politics and political agendas. Political motivations determined which issues were treated seriously and participants could identify times when childhood obesity had been side-lined even as it was an ongoing and building population health issue. This prevented meaningful or intended policy from developing and at times from policy existing at all. The sitting government was cited as the deciding factor when it came to final inputs and outputs of policy. Participant #4 identified a previous government's impact on change and said that “...since the National government came in at the end of 2008, and overnight we lost our *Healthy Eating - Healthy Action programme*”, a child obesity related policy. Overall, children, ‘childhood obesity’, ‘child participation’ were all incompatible, excluded and ultimately invisible to policymakers with other priorities.

4.7 Category: Advocacy

The first category *exclusion* and its subcategories gave an overall impression that ‘child voice’, ‘childhood obesity’ and ‘policy’ were subject to bias, superficial and even negligent treatment. These qualities led to a resistance to the inclusion of children in policy about childhood obesity and had resulted in no participation. The second

category of *advocacy* was developed from the data that provided evidence of policies and programmes that had included child voice. *Advocacy* was a subset of the theme *invisibility* because children were hidden behind well-meaning advocates who, again, mostly prevented any participation. There was a clear distinction between child participation and advocacy for a child and this is demonstrated by the two subcategories *tokenism* and *whānau voice*.

These two forms of *advocacy* were highly conditional, impressionable, and suppressed child expression except when the right alchemy was there. The *advocacy* category and its subcategories were most clearly realised in the post-*Child and Youth Wellbeing Strategy* phase where the Labour government drove the direction of this document. The conditions such as political environment and influence of group epistemology both existed on continuums and this variation resulted in no binary outputs in the policies analysed. It was expected that there would be no evidence of child voice in policy about childhood obesity, but child voice emerged as having a far more nuanced presence. *Tokenism* and *whānau voice* were a compelling set of findings that described the resilience of child voice in its relationship to policy about childhood obesity.

4.8 Subcategory: Tokenism

The subcategory of *tokenism* was developed out of the selective approach to *advocacy* of children in policy about childhood obesity. Supportive attitudes and expressions of child voice existed on continuums and depended on the circumstances surrounding the policy development such as the political climate. Political influence had made a clear impact on policy about childhood obesity and whether child voice was included. Overall, even if the critical actors in the policymaking process were supportive, child voice was only ever tokenistically included and used.

4.8.i. The continuums of advocacy promoted tokensim

Philosophical support for child participation sat on a continuum and this contributed to a tokenistic form of participation. For authentic child voice to be present, there needed to be full philosophical support from the teams who believed this was an important input into policy. While the continuum began with positivist epistemologies, there were, however, moments in the policy data where childhood obesity and child voice were seen through an interpretive and bicultural lens. Qualitative methodologies meant that child voice was more likely to be present in the policy texts. In the interview

data, verbalised support ranged from describing prospective child participation as 'important' to emphatic advocacy of community engagement with children. The support for community engagement was overall positive in the interview data but whether it appeared in the text was dependent on the conditions around the development of policy. This meant that there was policy that existed with varying degrees of child voice as an input.

The second continuum that encouraged a tokenistic approach, was the expression of child voice in the policy text. This ranged from cited research that tacitly included child voice to evidence of full community engagement. Most participants could name direct examples of where child voice had been applied to policy related to childhood obesity in Aotearoa. One participant identified the interpretive-descriptive research that captured child voice in the recently published *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)* (MOH, 2021). The Taranaki-based program called 'Whānau Pakari' was also referred to as a good example of a program designed to enhance Māori and child participation by providing a family-based service separate from the medical setting. However, two participants spoke directly about the *Child and Youth Wellbeing Strategy (2019)* as an umbrella policy piece that broadly addressed New Zealand children's health and wellbeing inclusive of childhood obesity. While not a specific policy about childhood obesity, both participants regarded the *Child and Youth Wellbeing Strategy* as the most significant step towards addressing child health inequalities in the history of Aotearoa. Participant #4 stated,

...in terms of my personal view — is that child and youth wellbeing strategy is the most significant policy... And so that makes a great case study around where we're at nationally, in terms of recognising children's right in participation. (Participant #4)

Overt evidence of child participation was so minimal in the analysed policy text that a further content analysis of the referenced material was conducted to assess for any relationship to child voice. I was looking for any example of the lived experience in the form of community engagement and/or qualitative research that used child voice. As previously described in the methods chapter, all reference lists were analysed for surveys, qualitative data, and examples of community engagement. The *Clinical guidelines for Weight Management in New Zealand Children and Young People (2016)* contained no direct examples of child participation, however, there is referenced indirect data used from the *New Zealand Health Survey (MOH, 2021b)*. Similarly, *Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives (2017)* had no direct examples of child participation aside from the data used in *Growing Up in New Zealand*. As seen in *Appendix T, Healthy Eating Guidelines for New Zealand Babies*

and Toddlers (0–2 years old) (2021) contained no explicit use of child voice, however, three referenced qualitative documents contained children’s or Whānau voices from *Growing Up in Aotearoa New Zealand*. The Well Child/Tamariki Ora Framework was referenced as an indirect input. This is collected every six months from the ‘Well Child’ assessments on all Aotearoa children and contains mostly quantitative data. Lastly, the *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)* (2021) references the *Child and Youth Wellbeing Strategy*, a document that does contain ‘child voice’. My analysis of the policy documents also showed how the quality of referenced material improved over time where increasingly the documents were supported by research that contained community engagement.

4.8.ii. Tokenistic advocacy toward advancement of equity & participation

Child participation was used in the policy texts when health inequities were identified as a primary cause of childhood obesity. Child participation appeared as an important mouthpiece for the disenfranchised and vulnerable members of society. As discussed, there was only one policy that included child voice on the topic of childhood obesity and that was the *Child and Youth Wellbeing Strategy* (2019), the most socially conscious text. Within the *Child and Youth Wellbeing Strategy*, here are the two examples where childhood obesity is mentioned explicitly, and it is combined with ideas around equity:

*Are the six outcomes measurable?... These include indicators like birth weight, suicide rates, mortality rates, immunisation rates, teenage pregnancy rates, **obesity rates**, physical activity levels, income levels, housing conditions and educational attainment. These are internationally comparable and there is a strong evidence base associated with them. The more common measures often have an emphasis on physical health, material wellbeing and educational attainment.* (Department of the Prime Minister and Cabinet, 2019, p. 78)

The *Child and Youth Wellbeing Strategy* advanced the idea of equity using child participation and included one direct quote and a paraphrased quote below from children about childhood obesity. They said, *"It is unfair for young people in lower socio-economic communities to miss out on school activities due to financial reasons"*, and *"Access to quality and affordable food was commonly raised as an issue. Healthy food is too expensive and unhealthy food is too cheap and easily available."* School activities have been interpreted as activities that include sport and movement. Both examples are an indirect reference to childhood obesity, however, they are rooted in the lived experience of socio-economic barriers and their impact on body weight.

Ironically, *Child and Youth Wellbeing Strategy* was the least tied to childhood obesity, however, it held the most diverse and complete expressions of ‘child voice’ on the topic of childhood obesity. This finding is likely related to the politically driven development process of the *Child and Youth Wellbeing Strategy*, which led to richer inputs. The new Labour government strengthened the *Child and Youth Wellbeing Strategy* by writing it into the Children’s Act 2014. The Act required public consultation to tie the strategy to issues closest to the target population and the strategy legally had to be updated every three years. The first example of this legislation in action came in the form of three major community engagement inputs into the *Child and Youth Wellbeing Strategy*:

- *Have your Say: Summary report – National engagement in New Zealand’s first Child and Youth Wellbeing Strategy*, Department of the Prime Minister’s Office and Cabinet (DPMC), 2019.
- *What makes a Good Life – Children and Young People’s Views on Wellbeing*, Office of the Children’s Commissioner (OCC) and Oranga Tamariki, 2019.
- As an indirect example, the *Child and Youth Wellbeing Strategy* also used the *Engaging all New Zealanders* benchmark survey report (Oranga Tamariki, 2017).

The work done towards child participation in this document made it the best example of participation as per the *UN convention on the Rights of the Child*.

4.8.iii. The right to participate & advocacy

However, participation and its relationship to equity, was already established by associated rights-based documents. Policies like the *Child and Youth Wellbeing Strategy* supported child participation because it was predicated on documents that advanced and described the cause of child participation. Most significantly, policy had a higher potential for ‘child voice’ when it was aligned with other rights-based documents such as, *Te Tiriti o Waitangi* and the *UN Convention on the Rights of the Child*. Child voice appears intuitively in *Child and Youth Wellbeing Strategy* because both equity and participation are core principles of *te Tiriti*. The same dynamic comes from the UN Convention which outlines ‘the right to participate’ in civic life. In practice, policy writers were already seeking the voices of Māori under *te Tiriti* and this resulted in representation. Engaging and including Māori was only present from 2019 in the data. Arguably, this brought the policy content and intent closer to the target groups values and naturally created more inclusive and richer policy. As more documents were added as references, the more participation-based the policy became, and a pathway for child voice was formed.

Capturing child voice was difficult considering Aotearoa's processes and development teams needed a lot of help to achieve policy that contained child voice. Community engagement was found in data where external agencies had led this process. The policy and interview data also showed that the inclusion of child's voice was led by rights-based agencies, not the government itself. Participant #4 illustrated this new mechanism by saying of the *Child and Youth Wellbeing Strategy* process "that probably signals a change in the times, where the Office of the Children's Commissioner was asked by DPMC to consult with children". These were agencies such as the OCC who work to uphold a child's right to participate in Aotearoa. The Department of the Prime Minister and Cabinet needed to reach the most affected communities and utilised the Office of the Children's Commissioner who conducted two major studies for *Child and Youth Wellbeing Strategy*. This enabled policy teams with a new political direction to use child voice to do so with no challenges.

4.8.iv. Political tokenism & advocacy

There was a strong correlation between the use of child voice in policy and political motive. This was evidenced in both policy and interview data where child voice was used as a political tool to engage with and appeal to the public. The presence of child voice in policy was dependent on the political setting, seen most significantly with the election of the Labour government in 2017 and Prime Minister Jacinda Ardern and the *Child and Youth Wellbeing Strategy* (2019). When reports of child poverty were published from UNICEF in the international media, the Labour Party provided targeted community engagement to understand the issue. There was a concerted effort to make policy real or actual to the public in the *Child and Youth Wellbeing Strategy* by seeking their involvement. This piece of high-level strategy was so influential the *Healthy Guidelines* (2021) then went on to reference the *Child and Youth Wellbeing Strategy*. The inclusion of child voice in the *Child and Youth Wellbeing Strategy*, a policy about overall health including childhood obesity, was a good example of a political party driving participation as a cause. The *Child and Youth Wellbeing Strategy* is distinct as it included child participation, but it was notably powered by considerable political force. The *Child and Youth Wellbeing Strategy* demonstrated how child voice in child policy was possible, but the data showed that the political importance of the child participants appeared to be crucial. This demonstrated the true tensile nature between childhood obesity and child voice that could only be broken by political intervention. Participant #4 supported this finding with the quote "I think it's [participation in policy is] slowly evolving. But it can be more rapid when the government of the day asks for it". Child participation was dependent on political power, and it was a tokenistic effort in the context of this study.

The *Child and Youth Wellbeing Strategy* held the most developed concepts of biculturalism and participation, this document discussed in the text how underlying rights-based documents were the basis for both concepts. Arguably, the presence of other rights-based documents such as Te Tiriti o Waitangi, as well as a meaningful approach to equity and biculturalism, enabled child voice to flourish. Both Māori and child voice existed in the data in various forms of participation, however, neither voice conveyed full participation in the policy development process. Within policy, a tokenistic attitude toward 'voice' in general was evident. There were two policies that had Māori representation on the consulting panel, the *Child and Youth Wellbeing Strategy* (2019) and *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)* (2021) but no policies with child representatives. This would have presented as involvement with the policy development process itself, an advanced state of participation. Language around child participation and voice in policy was minimal and mostly negligible.

4.9 Subcategory: Whānau voice

There were breakthrough moments where child voice was present, appearing in flashes in different forms in policy about childhood obesity. Authentic child voice was present but as part of a spectrum. At first glance, it seemed as if children had had very little participatory involvement in any version of policy about childhood obesity. Initially, a greater emphasis was put on the individual policymakers rejecting the very concept of child voice. However, upon analysis, child voice emerged in a uniquely Aotearoa-specific form influenced heavily by individual and group identity. Group and individual epistemologies do determine the value of child voice in policy about childhood obesity but in a New Zealand context, 'child voice' manifested itself regularly as *whānau voice*. All forms of data favoured *whānau voice* demonstrating that for many people of Aotearoa, 'child voice' is often synonymous with *whānau voice*.

Whānau voice was the most prevalent and consistent 'voice', encompassing, and a worthy advocacy alternative to 'child voice' in the policy analysis. All policies used elements of *whānau voice* as supporting data, framed as 'indirect' in the applied examples category. *Whānau voice*, for a multitude of reasons, was frequently cited as more important and assumed as the best form of *advocacy*. The participants rationale for *whānau voice* included ease, ethics and safety, cultural safety, and appropriateness for age. The use of *whānau voice* clearly relieved some *invisibility* around children and

their participation in policy from both policy contributors and their families. The subcategories presented compelling arguments and explanations for why child voice remains largely absent from policy about childhood obesity in the context of Aotearoa and why whānau voice is present instead. *Appendix W* illustrates the degree and type of 'voice' that exists per policy.

4.9.i Indirect advocate of child voice

Whānau voice showed that there were a multitude of ways child voice can appear in policy indirectly under the guise of their family who perform an *advocacy* role. The use of surveys designed for adults and young people appeared to be an intentional but indirect form of data collection for *whānau voice*. As all participants answered questions online within their family home, the answers were assumed to be influenced by other family members in the home. By design, policy developers could assume or want the answers of the questionnaire to be reflective of family life and opinion. It could also be related to language barriers preventing participants from independently responding to a questionnaire. Regardless, there is likely a large degree of *whānau voice* in online questionnaire responses or indirect sources of child voice. The voice continuum began with using indirect examples, usually from already collected data such as the *Auckland Youth Survey*, *Well Child/Tamariki Ora framework*, *Engaging all New Zealanders* benchmark survey report or the *New Zealand Health Survey* (MOH, 2021e, 2021b). The *Auckland Youth Survey*, an online survey of young New Zealanders' views, was described as a commonly-used early-stage input. The *Well Child/Tamariki Ora Framework* is completed by adult parents or guardians and as an input would most likely be both *adult voice* and *whānau voice*. The *Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives* (2018) and *Healthy Eating Guidelines for New Zealand babies and toddlers (0–2 years old)* (2021) both used data from *Growing up in New Zealand* (Growing up in New Zealand, 2020). This longitudinal study explicitly interviews families with their children, not usually children on their own, for research purposes. It was clear from the data that all policy included the voice of either children or their families but this ambiguity reinforced the theme of *invisibility* and child voice.

4.9.ii. Invisible child voice through unethical practices

Policy development was regarded as a deeply unregulated and sometimes led to an unethical form of *advocacy* to achieve any form of participation through community engagement. *Whānau voice* was unethically acquired through data collection from large groups when there were significant time constraints that prevented

due process around ethics approval. According to the participants, much of policy was written on 'no data or very limited data', however, two participants disputed this by saying that "...a lot of unofficial research goes on...".

So I could have some hui, and I could do some one-on-one interviews, and I could interview everyone from kaumātua down to the mokopuna at the immersion schools, but I would still — the question comes, "Do you have to do a HDEC proposal for that?" Probably, I think, is the answer, even though you're only doing it for policy as opposed to publish for research, because it's still research. So I think that raises an issue, and that was an issue that I raised at the ministry when I was there to say, "How are you ensuring that you're keeping the people that you are researching safe?" And the answer sometimes was, "We're not researching. We're just asking them questions." (Participant #1)

Participant #1 here acknowledges the presence of policy teams in the community, specifically Māori immersion schools and their involvement in child policy. Then Participant #3 confirms this as a routine practice, again with another vulnerable group, Pacifica children.

...that cultural appropriation that we always do to Pacific People; go and ask them lots of questions, and then, "Oh, thanks a lot," and then publish something using their IP and never acknowledge them. I mean, that's a bit old school, but that has been done a lot. (Participant #3)

Both examples of unethical instances, where the due process for gaining ethics approval had been side-stepped, involved Tangata Whenua and Pacifica people. This data suggests that the time constraints around policy development put targeted vulnerable populations at risk. These conditions promoted unethical practices and prohibited community engagement altogether. It also indicates that the 'voice' heard in policy is likely an amalgamation of people, most likely families in central accessible locations like Marae or community meeting places. This form of *whānau voice*, although unofficially collected, subjected children to another form of *invisibility* in policy texts.

4.9.iii. Children seen in the context of family

Whānau voice as a reality but also as a desired outcome in research for child policy, was a reoccurring presence throughout almost all the data. Not only were children's voices generally overlooked or hidden in the policy research process but there was also evidence to show that the participants viewed children's voices as indistinguishable and inseparable from their family's voice. Three participants felt *whānau voice* should be used as opposed to child voice and rejected the idea of child voice as a concept. *Whānau voice* was repeatedly asserted as more appropriate for children younger than five and participants spoke of using parent's voices 'as a proxy'

to advocate for their children. When the participants were asked about child voice in policy development there were both direct and indirect assertions to say that they did not agree with inquiring specifically with children. This was derived from a belief that children belonged to an adult's sphere.

Evidence from the interview data showed that te ao Māori approach as one where you would intentionally inquire about a child's experience through their family. This presented as a distinct cultural diversion from European individualist mentality and indicative of the collective society Māori people live in (Brougham & Haar, 2013).

Participant #3 stated,

And we might be talking about children, and in my case focusing kind of on young people, but children and young people can't and don't and shouldn't exist without their family. And that's kind of a common view across all — I mean, that's common to all children, but our indigenous culture tends to even value that more strongly, I think, or articulate it and have more tikanga and a more world view around that. So ideally, we would seek the voice of young children and young people, but we would actually be seeking the voice of families around how to support families to be nurturing environments. (Participant #3)

The cultural aversion to the concept of child voice was a significant finding where the Te Ao Māori perspective supported *whānau voice* over child voice. In Te Ao Māori, children are part of whānau or family as Māori are a collective society culturally (Brougham & Haar, 2013). Children's perspectives under this framework, are inseparable from their family, especially when children are very young. However, the Māori perspective challenges the individual approach expected in child participation. How an internationally defined 'child voice' is managed in Aotearoa considering its bicultural society, did not appear fully reconciled in the data.

4.9.iv. An actuality of advocacy

When child voice was agile, actuality of identity was seen in the policy texts and interview data. Aotearoa's identity appeared actualised in the policy text when culturally specific-qualities were apparent. Recognition of *whānau voice* conceptually at the level of government, is in itself an expression of biculturalism. This is a diversion from the idea that policy is informed by the policies construct of participant choice and control. Instead, 'whānau voice' stems from the idea that children are part of a group called whānau and contribute to projected family ideas or *whānau voice*. This concept is not about control or the gatekeeping of children's voices but a collective idea of 'voice'. *Whānau voice* has developed organically in the policy world, and it helped inform all analysed policy documents relating to childhood obesity. Moving forward, an acceptance of *whānau voice* may be the best approach for issues such as childhood obesity that are regarded as 'fraught'.

4.10 Addressing the purpose statement

In case study, researchers form a purpose statement to direct study to describe the gap in research around a certain topic (Merriam & Tisdell, 2016). As stated in Chapter Two, the statement for this study was:

Childhood obesity affects one third of the child population in Aotearoa New Zealand. Currently occurring at epidemic levels in Aotearoa, childhood obesity demands urgent policy intervention. Despite what we know about the importance of child participation in policy design, little is known about how children's voices have influenced policy about childhood obesity. The purpose of this qualitative project was to understand how children's voices have informed Aotearoa policy related to childhood obesity using case study methodology.

While this was an inductive study, the assumption behind this statement is that children have informed policy about childhood obesity. However, the findings did not show sufficient evidence to support this statement and the opposite was true: Children's voices have not informed or even minimally informed policy about childhood obesity. In the findings, the term 'informed' was interpreted as 'visibility' and this explains the overarching theme of 'invisibility'. The overarching concept model formed from the analysis showed that children had low or no visibility in policy about childhood obesity.

4.11 Summary of findings

In summary, children had low visibility within Aotearoa policy texts about childhood obesity between 2016–2021. The analysis of Chapter Five, including the overarching concept model, led to findings that contributed to the understanding of the subject.

Child invisibility: There was almost no child voice in policy about childhood obesity between 2016–2021. This study found that if children were not directly involved in the policymaking process, they had little to no presence in the text. Child voice was both intentionally and unintentionally left out of almost all policy about childhood obesity analysed in this study and this was described in the *exclusion* category.

Prominent voices in policy about childhood obesity: There were two distinct voices that had informed Aotearoa policy about childhood obesity: adult voice and whānau voice. The concept of child participation and participation itself emerged as distinct from the

UNCROC definition of child participation. While child voice did appear in one text, children were advocated for as opposed to actively participated with policy in the second category called *advocacy*. There were two forms of advocacy evident; a tokenistic form of child voice in the *tokenism* subcategory and a family voice described in the subcategory *whānau voice*.

Adult voice: Adult voice was the voice of adults, and their ideas of child incompatibility with policy dominated. Adult voice excluded children from participation in policy about childhood obesity. All participants could identify reasons why this had occurred, which included structural exclusion and philosophical exclusion in the *adult voice* subcategory. Then a sense of *incompatibility*, a second subcategory, where the topic childhood obesity conflicted with the concept of child participation. There was also no pathway to include children safely in policy, especially for difficult policy issues such as childhood obesity.

Participation barriers and tokenism: Tokenistic attitudes and treatment are still prevalent in both child and Māori participation in policy development. Advocacy of children still seemed to support the needs of adults over children and this form of participation did not overcome the power differential. There were homogenous data inputs into policy about childhood obesity, mostly quantitative data meant child voice had a framework and did not fit with most policymakers preferred data source. Participation of children and therefore the voice of children were most evident in the context of all referenced rights-based documents and the involvement of child advocacy agencies.

Whānau Voice, an Aotearoa New Zealand phenomenon: Whānau voice was a form of collective participation that had occurred in the data and occurred in both informal and formal contributions. Whānau voice was used as an alternative to child voice and is an Aotearoa concept in policy about childhood obesity. This could be a safer pathway to formally include children in policy.

A culture of child invisibility: Policy about childhood obesity was written in the context of an organizational culture that this study called a *culture of child invisibility*. The overarching concept model implied that there was a *culture of child invisibility* that normalised the absence of children in policy that concerned them.

Identifying social injustice encouraged participation in policy about childhood obesity: The decision to exclude children was normalised in this culture but had dire

consequences to policy about childhood obesity. In this study, the very health inequities that cause childhood obesity were a result of the broad government decision-making that supported commercial interests. Adults managed childhood obesity policy independently of social injustices and as one of personal responsibility. Early policy about childhood obesity had developed from encouraging individual responsibility to more recent policy acknowledging systemic inequity as a cause. As issues of social injustice were increasingly discussed, more participation was evident showing how entwined the subject's 'participation' and 'social injustice' really are.

Chapter Five: Discussion

5.1 Introduction

The research question of this study was: *How have children's perspectives informed past and current policy related to childhood obesity in Aotearoa New Zealand?* The analysis produced the critical finding: Children have *not* informed childhood obesity policy in Aotearoa because they were invisible to policymakers. The case study analysis developed further findings that were heuristic of the culture around policy development, and the overarching concept model seen in *Figure 4.2* of the previous chapter. Adult voice and ideas of child incompatibility with policy dominated this culture around policy, leading to a lack of child voice across child obesity policy between 2016–2021. The decision to exclude children was normalised in the culture but had negative consequences to policy about childhood obesity. In this study, the very health inequities that cause childhood obesity were a result of the broad government decision-making by policymakers. Policy teams approached the issue of childhood obesity not through a lens of social justice, but rather through a construct of personal responsibility. On the rare occasion policymakers used child participation as a policy input to mitigate the issues of social injustice, child voice was treated tokenistically or heard through whānau voice. While not a true example of child participation according to UNCROC, the use of whānau voice did suggest an indirect way of bridging the gap between child policy and the lived experience of children (MSD, 2022). Whānau voice was an attainable, culturally and ethically appropriate avenue for children to participate in policy. Overall, the culture of child invisibility diminished complex issues like childhood obesity and produced policy that underserved the community.

To turn the tide and improve child participation in childhood obesity policy, the findings show that policymakers need to embrace a new *culture of child visibility*. In this policy culture, child policy benefits from the oversight of multiple government agencies. There is a growing body of literature that argues that childhood obesity is an issue of social injustice and when policymakers acknowledge this as a cause, child participation is shown to appear in the text. Policy also needs to be predicated on rights-based documents that outline the principle of participation such as Te Tiriti o Waitangi, to ensure that community engagement is part of the policy development (Came et al., 2020). Once participation is established as a shared value, policymakers need access

to a pathway to include children that is ethical and protective of all involved. Ultimately, to raise the profile of children in childhood obesity policy, policy authors need to be supportive and supported to include child participation within a *culture of child visibility*. A discussion of these findings is considered with theoretical conjecture using the literature (Remenyi, 2013). Lastly discussed is how the results of this study can be extrapolated to other fields of study about child voice in policy and the limitations of this study. (Remenyi, 2013).

5.2 Child invisibility: No child voice in policy about childhood obesity

In this study there was negligible evidence of child voice in policy about childhood obesity between 2016–2021 in Aotearoa. Children almost never participated in childhood obesity policy. This finding demonstrated a salient point: If children are not directly involved in the policymaking process, they have little to no presence in the text. According to the critical literature and pertinent rights-based documents, children should be visible in all policy texts about childhood obesity (Came et al., 2020; Glasgow et al., 2012; McKerchar et al., 2021; MSD, 2022; UNICEF, 2020).

The *Child and Youth Wellbeing Strategy* was the only policy examined in this study that included child participation, which included two examples of authentic child voice on the subject of childhood obesity (Department of the Prime Minister and Cabinet, 2019; Office of the Children’s Commissioner & Oranga Tamariki, 2019). The presence of this participation was dependent on several factors. Firstly, international and national advocacy groups have campaigned for children to have a greater presence in all child policy, and in the findings the participants were acutely aware of the need to improve child visibility (Brown et al., 2020; Horgan & Kennan, 2022; Martin et al., 2018; UNICEF, 2020). Secondly, the policymakers were reportedly under duress from the Department of the Prime Minister and Cabinet to be more inclusive of children. To address this issue the policymakers consulted advocacy organisations such as the Office of the Children’s Commissioner that were outside their policy team (Brown et al., 2020; Office of the Children’s Commissioner & Oranga Tamariki, 2019). International authors, Horgan and Kennan (2022) found that there is a known preference for policymakers to outsource child participation to external agencies to overcome internal barriers.

There were, however, elements of tokenism noted in the *Child and Youth Wellbeing Strategy* and this selective treatment furthered the theme of invisibility. It appeared that policymakers had *advocated* for children as opposed to allowing more direct forms of participation (Department of the Prime Minister and Cabinet, 2019; Hart, 1992). In this study, the stigma of childhood obesity was found to be a major barrier to the inclusion of child voice in an environment where child participation was already not pursued. The findings from this study described a culture that did not support child voice, one in which adult voice/whānau voice was not only louder but consistently preferred. International and national evidence shows that policymakers should be more concerned with the way child participation is used in child policy (Brown et al., 2020; Spray, 2020). This is discussed in greater detail below in 5.3.ii.

5.3 Prominent voices in policy about childhood obesity: Adult voice & Whānau voice

5.3.i. Adult voice

Adult voice was found to be the loudest voice heard in all analysed policy regarding childhood obesity. The findings showed that *adult voice* was not just the *voice of adults*, but also a tone that expressed adult-centric attitudes toward children, childhood obesity and child participation in policy. *Adult voice* appeared uninterested in the experience of children with childhood obesity and preferred quantitative methodologies. *Adult voice* demanded children and their families take individual responsibility for their health and this philosophy was rarely interrogated by policymakers. At the same time, *adult voice* made self-interested decisions such as prioritising commercial interests over child health that did not improve health inequities. Within both the policy and the interview data, it was clear that the views of adults had hegemonically influenced and directed the way in which childhood obesity policy had developed in Aotearoa. According to the literature, these findings are contraindicated to effective policy about childhood obesity (Keevers et al., 2008; UNICEF, 2020; Vallgård, 2018).

The dominant presence of *adult voice* in childhood obesity policy seemed to be due to adult voice being an easier path for policymakers who could not manage child participation in policy. All participants, for instance, complained of time pressures being an aspect of the policymaking work environment. When expedience is a top priority, methodologies are selected based on speed to meet the needs of the agency.

Community engagement with children was not considered to be a time efficient input and participants perhaps downplayed its importance to justify its exclusion considering their challenging environment (Arai et al., 2015). According to the participants, policy teams had to respond to ministerial demands quickly and therefore rapidly produced policy was a highly valued outcome. Additionally, the culture observed to be adhered to by the participants was likely a reflection of the political leadership in policy, a factor known to shape organisational behaviour and attitudes (Sherman et al., 2014). However, this explanation was only one finding that does not account for this study's other findings which conveyed in finer detail the complex ideologies and attitudes commonly held by policymakers creating childhood obesity policy. The critical literature shows that the characteristics of *adult voice* belong to a long history of paternalism, new paternalism, and neo-liberalistic ideas which have influenced medicine and policy in Aotearoa (Keevers et al., 2008).

Adult voice was characterised by a reliance on the biomedical model to understand how childhood obesity had emerged in the child population. According to the policy text itself, most policymakers had trained as physicians first and thus viewed the causes of childhood obesity through a homogenous biomedical lens. The interview data of this study also showed that participants themselves understood that childhood obesity was complex and caused by a wide array of socio-economic as well as politico-economic issues beyond an individual's control. However in spite of this understanding, there were three biomedical-driven policy texts that outlined guidelines and considered childhood obesity to be direct consequence of poor dietary habits and a lack of exercise (MOH, 2016a, 2017, 2021a). According to Green et al. (2020), this reductive perspective of obesity is based on the biological assumption that,

...obesity represents excess body fat accumulation, approximately 20 per cent or more over 'ideal' body weight, caused by the amount and quality of food consumed, activity levels and behaviour. (Green et al., 2020)

Notably, WHO's current definition of obesity does not describe the causal relationship between body fat and individual habits (WHO, 2021). Conversely, Green's definition of the biomedical model does describe such a relationship which was commonly utilised in policy about childhood obesity from developed countries in the literature (Green et al., 2020; Greener et al., 2010). A comprehensive picture of childhood obesity taking complexities and systemic causes into account was not evident in three policies of this study and was a limitation of these policies as effective interventions.

A consistent theme identified through the data analysis was that *adult voice* presented a simplified understanding of childhood obesity which led to unbalanced and ill-informed policy advice. *Adult voice* in this study valued pathologised policy and, as per the research, was encumbered with moral judgements (Wiltshire et al., 2018). When policy about childhood obesity is predominantly predicated on the biomedical model, international researchers Wiltshire et al. (2018) state that pathologised policy is often the result. Pathologised childhood obesity policy typically includes weight management programmes as this addresses the central biomedical metrics – weight and BMI (Green et al., 2020; Greener et al., 2010; Wiltshire et al., 2018). Pathologised policy can manifest simply as advice to exercise more and avoid foods that are high in sugar to maintain a healthy body weight. Policy authors in these policy texts assume that individuals can and should individually make choices that are rational with respect to their own weight management. This is a common realist assumption of the scientific method (Wright, 2018). When obesity is a metric outcome, the biomedical model assumes that individuals have consciously *chosen* an unhealthy lifestyle, which is a morally-bound judgement (Wiltshire et al., 2018). Pathologised policy would ascribe high activity as behaviour belonging to people of a healthy weight. The reverse is to regard those who report low exercise as having a poor set of personal values if they are also overweight or obese (Lee & Macdonald, 2010). *Adult voice* held linear, Eurocentric and reductive views that did not take into account the conditions around decision-making nor did they consider social or cultural factors that shape people's food and exercise practices (Green et al., 2020).

Adult voice used paternalistic guidelines to 'tell' the public what to do about childhood obesity. Consequently, the topic of child participation had a discombobulated presence in the participant data as it stood out as being from a very different school of thought. The paternalistic attitudes observed in the data and characterised *adult voice* have been observed in both the healthcare setting as well as social policy (Diaz, 2020; Keevers et al., 2008). The biomedical perspective, beset with hegemonic power created a blueprint for policymakers to deliver paternalistic policies for childhood obesity (Pham et al., 2021). In a paternalistic interaction, the doctor or policy writer overpowers the patient with their biomedical knowledge and diminishes the knowledge the patient has about themselves. Doctors/policymakers often believe they are behaving ethically in this relationship. However, the principle of beneficence outweighs the importance of the patient's autonomy as it would for a parent-child relationship (Shutzberg, 2021; Vallgård, 2018). Without a two-way dialogue of communication, potential other causes of childhood obesity maybe unknown to the doctor or policymaker. A relationship that works in equal partnership to achieve a shared goal

does not exist where there are strong paternalistic tendencies. *Adult voice* was also arguably the voice of *new paternalism*, a step beyond paternalism. A term coined by Lawrence Mead (1997), new paternalistic ideas in policy in effect recommend the surveillance of the most vulnerable members of society and are known to manifest policy that attempts to control behaviour (Keevers et al., 2008). This imbalance is normalised and is a key aspect of the neo-liberal discourse seen in conventional medicine, policy development and research in Aotearoa (Keevers et al., 2008; Shutzberg, 2021). These findings about paternalism in *adult voice* lay the groundwork for the *invisibility* of children in policy about childhood obesity in Aotearoa.

5.3.ii. Barriers to participation

The very concept of participation in child health policy, specifically in policy about childhood obesity in Aotearoa, was the subject of discussion in this study. The research question intended to seek evidence of the participation of *individual* children with policy about childhood obesity in accordance with Article 12 of UNCROC (McKerchar et al., 2021; MSD, 2022). However, in this study, there was little to no evidence of individual child voice because of several identifiable barriers to child participation presented in the findings.

Firstly, participation as a concept was routinely misunderstood by the participants in this study. There were several commonly used participatory words such as engagement, consultation and partnership and these were all used interchangeably in the data, but according to Roger Hart's *Ladder of Participation*, these terms do not necessarily share the same definition (Hart, 1992). The participant data also showed that child participation was a concept that was broadly interpreted across the two settings of healthcare and policy. This led to some confusion in the interviews where participants provided inappropriate answers about child participation in healthcare when the question was about child participation in policy. Findings in Diaz's (2020) study concur and highlight that some of the confusion can be explained by acknowledging that participation exists in both policy and healthcare but for different reasons. In modern healthcare service delivery, individual participation is employed because patients are regarded as consumers, an aspect of neoliberalism (Keevers et al., 2008). This is the idea that a rational citizen could provide feedback on a service and go somewhere else if they were dissatisfied (Diaz, 2020). However, in public health or social policy produced unilaterally by the government, there are no other options. If policymakers provide only individual child participation or provide no participation pathway, policy can be delivered hegemonically and against the will of the people it is designed to affect (Diaz, 2020). This creates a compelling case for

formalising alternative pathways for child voice such as *whanau voice* in policy as discussed below in 5.3.iv.

Child participation methodologies were uncommon in the current culture of policy, and this was another barrier to participation. The participants' methodological preferences were evident in the homogenous set of quantitative data as well as other government policies/strategies used in each policy's reference lists. There was a dearth of qualitative research and/or community engagement with children in the policy texts. The participants also held negative attitudes toward qualitative policy inputs and community engagement, and these attitudes appear to stem from learned evidence hierarchies in policy development. Evidence hierarchies have a powerful role in shaping health professionals' views about the research they draw on to shape policy (Porche, 2021). Porche's recent publication *Health Policy (2021)*, tabulated a series of evidence hierarchies that rank each piece of evidence and their worth to policy as an input. One evidence hierarchy, the *Joanna Briggs Institute Evidence [5] Levels for Effectiveness*, placed *observation-descriptive studies* at level 4 and *expert opinion and bench research* last at level 5 (Porche, 2021). This ranking would explain why there was minimal evidence of child voice and the limited support for child participation. These findings demonstrate the systematic rank of research that led to a homogeneous style of evidence and set of attitudes used to support policy aims.

Child participation was often considered fundamentally incompatible with policy about childhood obesity and policymakers deliberately chose not to involve children (Martin et al., 2018). In the eyes of the participants, child participation was inappropriate and unnecessary. The collection, interpretation, and integration of child voice into policy took time and an expertise that no participant claimed to have. Participants emphatically stated community engagement was impossible with the restrictive conditions policymakers were working under. Aotearoa child participation researcher Julie Spray (2020) argues that policymakers are apprehensive because there is a misplaced emphasis on what voice is for children. To Spray, having a voice in policy is not just a platform from which to speak but a meaningful interaction where adults listen, interpret and address children's needs (Spray, 2020). Spray describes the interpretation as requiring a lens that sees "*critical perspectives on power, knowledge production or embodiment that children may not explicitly articulate*" (Spray, 2020, p. 2). The participants were therefore accurate in stating that child participation would take a degree of skill, however a claim of impossibility due to this requirement is clearly overstated. Child voice in policy therefore remains an achievable yet unimplemented goal.

In the current study, a consistent theme across the dataset was participants' expressions of concern about child participation in policy about a stigmatised subject. The participants regarded community engagement with children about childhood obesity as too controversial and 'fraught'. These concerns were further entrenched by policy about childhood obesity that was poorly received by the public and the hostile feedback did not promote participatory ideas with policymakers. The participants identified safety and the ethics behind child participation in policy around a stigmatised subject like childhood obesity as an issue. One clear attempt in the findings to make policy more approachable and to limit stigma as a barrier was to reduce the term *obesity* in the overall texts over time. These findings are consistent with researchers Brown et al. (2020), Glasgow et al. (2012) and Spray (2020) who found that adults in decision-making positions are concerned about child participation. To improve engagement with childhood obesity policies, guidance from the EU Commission and WHO recommends a strengths-based approach as there is a known risk of bullying as a result of stigmatisation (European Commission, 2014; WHO, 2017). Reducing the use of the word *obesity* also potentially met the needs of a more progressive political agenda. The Labour party has followed this advice and has not produced an obesity-labelled policy while in government (MOH, 2016; MOH, 2017; Department of the Prime Minister and Cabinet, 2019; MOH, 2021). WHO also state that healthy eating and exercise should be encouraged for all children regardless of whether they are overweight or obese and this should be the focus of the policy (WHO, 2021). Continuing a strengths-based approach may encourage more participation in childhood obesity policy and improve the visibility of children.

Overall, policymakers in this study preferred to advocate for children as opposed to allowing for child participation. The participants reportedly had no training or framework to work from even if the input of child voice was desired. According to child participation researchers Fitzmaurice (2017) and Spray (2020), how a child's contribution would or could shape policy is very poorly understood by policy writers. Without training, evidence by Kosher and Ben-Arieh (2020) and Barnes (2012) has shown that adults take on a rescue or protection approach to children. In the context of children as constituents, paternalistic attitudes are also stronger towards both child and parent and this is consistent with other international research (Brien, 2018; Denburg et al., 2021; Kosher & Ben-Arieh, 2020). Jackie Brien (2018) describes this as adult male templates or deficit-based templates that define children as subservient, submissive, and dependent. International authors Brien (2018) and Kosher and Ben-Arieh (2020) found that children are excluded from policy based on their perceived dependency and

lack of ability. Vis et al. (2011) also found that child welfare workers were against participation because they wanted to protect children from discussing difficult experiences. A desire to protect even extended to one study that found that adults in decision-making positions in child protection were concerned about corrupting a child's innocence through their participation (Marmor et al., 2017). In this study, this evidence about stigmatisation and advocacy in child policy was especially pertinent to understanding undisclosed barriers in child policy formation.

5.3.iii. Tokenism

In this study where child participation was utilised in policy development, child voice emerged as tokenistic and minimal. The *Child and Youth Wellbeing Strategy* used two quotes about childhood obesity in their strategy however the policy ultimately projected an advocacy-approach rather than a participatory-approach (Department of the Prime Minister and Cabinet, 2019). While children did participate, the treatment of child voice became tokenistic as children had no choice about the way their voice was communicated and there was no feedback loop back to those who participated (Fitzmaurice, 2017; Hart, 1992; MSD, 2003). A tokenistic outcome is regarded as low-level participation and Roger Hart (1992) considers this non-participation. It is also non-participation according to the government's own assessment of participation, *IAP2 Spectrum of participation* (Department of the Prime Minister and Cabinet, 2022). Tokenism can work to deter relevant and vulnerable parties from participating and compounds the issue of inclusion of child voice in other policy (Hart, 1992). It is important to allow for full participation because according to the literature- children are not naïve and are aware of when their participation is just a charade (Bessell, 2011; Hart, 1992; Leeson, 2007; Spray, 2020). These findings are especially important considering the vulnerable groups who may not participate in future policy about childhood obesity based on their past experiences of tokenism.

5.3.iv. Whānau Voice: An Aotearoa New Zealand phenomenon

In this study the conversion of child voice to whānau voice was consistently found in each policy document and was one example of Aotearoa identity actualisation. Whānau voice was a naturally occurring voice was interpreted as any contribution to policy that had involved the wider family and had included children but was not exclusive to child participation. Whānau voice was considered by most participants in this study to be a more appropriate input especially when dealing with very young children and, most importantly, tamariki Māori. Whānau voice also circumvented ethical barriers around individual child participation that all participants were anxious about. The voice of whānau is a form of informal collective participation seen in policy

(Jongsma et al., 2018). In Aotearoa, researchers Sullivan et al. (2021) found that child participation in policy had only occurred through a guardian or parent but did not define it as whānau voice. Education researchers Jacobs et al. (2021) found that whānau voice asserted the socially and culturally situated experiences of young children, and families wanted to be considered as the experts in their children's lives. In a search about whānau voice in general child policy, the literature fell short of describing the intentional role whānau voice could play in conjunction with child voice or in place of child voice in policy. While these findings of the present study are promising, whānau voice in policy is still in a prospective ideological phase especially with regards to difficult subjects such as childhood obesity.

5.4 A culture of child invisibility

The findings showed that the most important population — children — were invisible to writers of policy about childhood obesity. Policymakers did not 'see' children or the value of their participation, but they also did not know the means to be inclusive of children. Children in this study were invisible in policy by design. The factors that would have facilitated participation belonged to a philosophy outside of this policy culture. The categories *exclusion* and *advocacy* were expressions of the culture of child invisibility, an aspect of organisational culture that promoted only *adult voice* in policy. The belief systems of this culture ensured that there were minimal opportunities to support children in their right to participate in policy about childhood obesity. The participants of this study described a lack of partnership as well as participation between policymakers and children, and this was an issue minimally critiqued in the data. The powerful assertions that defined exclusion rendered children's input as inappropriate and unimportant. Developing policy about childhood obesity was also difficult and children were culturally excluded and their contribution was restricted through advocacy when the adults who dominated the policy space felt overwhelmed by this health issue. This was most evident in the incompatibility triad described in Chapter Four where the topics — 'policy', 'childhood obesity' and 'child participation' — could not be fluidly integrated together. When child participation did occur, the *culture of child invisibility* allowed for a tokenistic treatment of child participation, or a form of collective participation — whānau voice. To advocate for children as opposed to the participation of children, entrenched the *culture of child invisibility*.

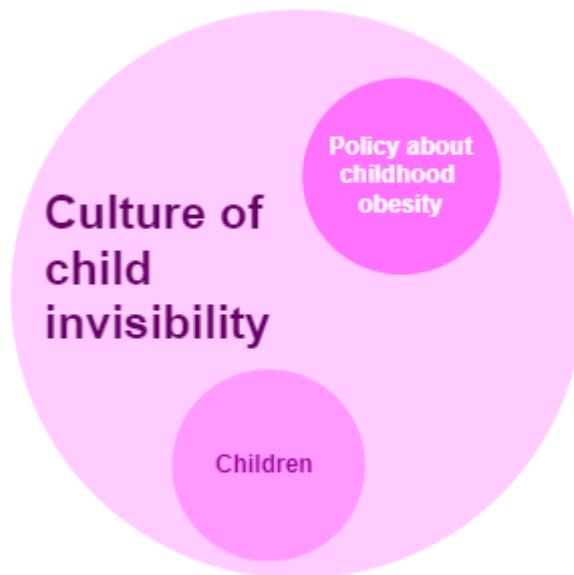


Figure 6: Illustration of how a culture of child invisibility does not support the participation of children in policy about childhood obesity

5.4.i. Organisational culture

The participant dataset highlighted that child voice, by design, was unlikely to appear in policy about child obesity given the organisational culture around policy development. In this study, the culture of child invisibility had an important relationship to the covert adult dominance and child subservience that was evident in policy about childhood obesity. In the data, adult voice was characterised by dominance, confidence, and presented as the natural mode of expression. The findings of Chapter Four were a valuable insight into the organisational culture to which adult voice belonged and showed how adult voice performed as its mouthpiece. The way the participants spoke about their beliefs demonstrated how these paradigms learned from education, experience, and political contexts, helped to create meaning and complete difficult policy problems. *Adult voice* as a subcategory embodied these shared beliefs that were hegemonic in nature and worked quietly to exclude children from policy (Pham et al., 2021). As researcher Janet Farrell Leontiou explained aptly in her work around organisational culture, “*pay close attention to the talk, and one will come to understand the culture*” (Farrell Leontiou, 2020, p. 4). The machinations of an organisational culture are often deliberately cloaked in secrecy, another assertion of power, and this is also congruent with the findings of Chapter Four (Chandler et al., 2017; Sherman et al., 2014).

5.5 Identifying social injustice issues encouraged participation but two obstacles interfered

As mentioned above, and indicated across the dataset, children voices were included in policy when policymakers utilised external child advocacy groups because it removed a barrier to inclusion. Similarly, when issues of social justice were identified as significant contributors to childhood obesity, policymakers behaved inclusively. Issues of social injustice appeared to create a reason to advance child visibility because the human rights of children were in question. Early policy about childhood obesity had developed from encouraging individual responsibility to more recent policy acknowledging systemic inequity as a cause. As issues of social injustice were increasingly discussed over time, more participation was evident showing how entwined the subject's participation and social injustice really were. However, in this study, the very health inequities that cause childhood obesity were a result of the broad government decision-making that supported commercial interests. Adults managed childhood obesity independently of social injustices and as an issue of personal responsibility. There were two major obstacles preventing issues of social injustice from being cited in the text: the policymakers themselves and conflicting commercial interests to policy about childhood obesity.

5.5.i. Obstacle one: Policymakers

In this study, those with *adult voice* decisively sidestepped equity *issues* as a cause of childhood obesity regardless of the research because it was not consistent with their scope of practice. Despite the known association between obesity and poverty in the literature, this study showed that the subject of equity was avoided in all policies except the *Child and Youth Wellbeing Strategy* (Department of the Prime Minister and Cabinet, 2019). In the data, policymakers continued to produce biomedically-based guidelines even when they were conscious of the fact that the resulting policy would lack effectiveness. This style of intervention is underpinned by two concepts previously discussed, firstly the view that pathologises obesity, and secondly a health management style that adopts a paternalistic approach (Wiltshire et al., 2018). However, a list of biomedically-based guidelines to achieve a healthy diet and exercise regime is only helpful advice to give to those who can access the necessary resources. This style of policy encourages people to take individual responsibility and does not consider individuals and their resources. On the other hand, policies that consider family budgetary constraints and understand how those can define a child's quality of life, have an equity-based approach. Individual responsibility-

approach and an equity-approach were two styles of childhood obesity policy that were seen in both the current study and the literature.

In this study, three out of four policies (MOH, 2016a, 2017, 2021a) were imbued with an “*individual will to health*” and encouraged individuals to independently take responsibility for their wellbeing (Wiltshire et al., 2018, p. 6). This neoliberal position rules out examining any broad contributing health inequities that reside outside an individual’s control, such as poverty. The promotion of individual responsibility is very frequently the basis of today’s Aotearoa population health policy and policy about childhood obesity is no exception (Matheson et al., 2021). Internationally, Bastian (2011) found that in Australian policy about nutrition the focus is still largely on modifying individual behaviour as opposed to examining the social determinants of health (Bastian, 2011). When health policy is created under a neoliberal economic construct, it is viewed as market-oriented reform policy or economic rationalist policy (Keevers et al., 2008; Matheson et al., 2021). These health policy documents inform an individualisation of healthcare services that relieves the government of the financial burden that would come with being accountable or helpful to people who need them (Keevers et al., 2008; Matheson et al., 2021; Wiltshire et al., 2018). As Matherson et al. states:

... New Zealand’s courting with neoliberalism over the past 20 years has led to systems that emphasised individual responsibility over collective and system actions, and that despite stated aims of equitable access to healthcare for all in significant policy documents, the current system perpetuates systemic disadvantages. (Matheson et al., 2021, p. 2)

Keevers et al. (2008) argue that neo-liberalism utilises the top-down approach explored in Chapter Two to diminish the role of the government and raise the profile of the markets. In this scenario, the individual is accountable and should make the choice to use services that would help them. Policy development is often completed without consent or participation and tends to craft interventions that conflict with group or individual value sets (Greener et al., 2010; Nuffield Council, 2007). Authors of childhood obesity policy often assume people will deny themselves the social relations and pleasure gained from eating food (Wiltshire et al., 2018). These assumptions are all made by the adults creating policy without the consultation with children and with no mention of the external social inequities that cause childhood obesity.

There appeared to be a relationship between the neoliberal erasure of any consideration of social inequities and the exclusion of children. Devoid of participation, *adult voice* was able to minimise the impact of poverty and emphasise ethnicity as well

as lifestyle choices instead. Two policies from 2016 and 2017 both correlated ethnicity with childhood obesity (MOH, 2016a, 2017). While there is a higher incidence of childhood obesity in Māori and Pacifica people, comprehensive management of childhood obesity involves acknowledging the individual and family socio-economic context (Jacobs et al., 2021; Wang & Lim, 2012; Wiltshire et al., 2018). Identifying ethnic over-representation in a statistic while only issuing guidance involving taking personal responsibility has racist implications in these policy texts. It is therefore not surprising that the policies that discussed ethnicity did not include participation. In the research space, however, the topics — child participation and childhood obesity — are linked and presented together, especially in recent research (Di Cesare et al., 2019; Martin et al., 2018; UNICEF, 2020). If policymakers felt that childhood obesity were a collective issue of systemic inequities as does this research, this may have been a pathway to community engagement and non-discriminatory views. However fear, stigma, and an attitude of individual responsibility seen in all data drew the policymakers to avoid participation and produce ineffectual policy text.

5.5.ii. Obstacle two: Commercial interests

The dataset indicated that government policy has served as a poor intervention in managing childhood obesity in Aotearoa because there are commercial interests that strongly undermine these strategies. In the *exclusion* category, participants argued that (a) policy about childhood obesity was inherently ineffective, and (b) there were conflicts-of-interests that undermined the efficacy of policy about childhood obesity. Research by Kersh et al. (2011) suggests that those subcategories are in fact linked and occur consecutively. The unaddressed conflicts-of-interest is *why* policy about childhood obesity was overall not effective. The most recent policies, the *Child and Youth Wellbeing Strategy* and *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)*, both attempted to deviate from the traditional style policy design seen in the older documents (Department of the Prime Minister and Cabinet, 2019; MOH, 2021a). They both identify poverty and equity as having a major impact on child health of Aotearoa but *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)* also references the impact that marketing to children has (MOH, 2021a). The epidemic of childhood obesity is a by-product of a multitude of adult-centric decision-making such as prioritising economic interests over population child health within a neoliberal agenda (Keevers et al., 2008).

The dataset indicated that the “*commercial determinants of health*” was subtly more important than the social determinants of health (Hill & Friel, 2020, p. 1; Matheson et al., 2021). Conflicting commercial interests were referenced only once

childhood obesity policy, *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)* (MOH, 2021a). This reference was the one acknowledgement of the government's role in creating childhood obesity in all policy data analysed and yet the participants were emphatic about the realities of conflicting commercial interests. Matheson et al. (2021) discussed "*commercial determinants of health*", in research and about how the alcohol and tobacco industries hegemonically impact female health:

In exploring who benefits from individual, consumerist ideologies, Hill and Friel [14] examine how commercial interests impact the health of women and girls through corporate policies, practices and products that are increasingly affecting population health... Increasingly operating in sophisticated, multi-level ways to protect their market freedoms and their privileged position in society, these companies are able to further undermine the health of women and girls and exacerbate global health inequalities. (Matheson et al., 2021, p. 3)

This evidence suggests the wider government must regulate its own policies and their external role in childhood obesity as opposed to placing blame on the individual. The same could be said for highlighting issues of poverty and inequity, which are broad economically derived concerns in policy. In this study, addressing conflicting commercial interests within the policy text, was a nascent aspect of childhood obesity policy documentation.

To the participants in the study, the government has always addressed its immediate economic interests before population health concerns. This prioritisation has been a concern on a national and international scale for two decades (Di Cesare et al., 2019; Greener et al., 2010; NCD Risk Factor Collaboration, 2017; UNICEF, 2020; Vallgård, 2018; WHO, 2016, 2021). WHO describes the commercial threats to child health as "*dangerously underappreciated*" and childhood obesity as a leading health risk (WHO, 2020, p. 1). Despite longstanding recommendations from WHO and UNICEF to impose strong regulations over external policies that lead to childhood obesity, this has not happened in Aotearoa (Di Cesare et al., 2019; Liu et al., 2020; UNICEF, 2020). Commercial interests contradicted the messages in existing policy designed to promote healthy behaviours in children and young people (Liu et al., 2020). The presence of high sugar, fat and salt content food and drink ubiquitous in the Aotearoa media and retailers has been maintained by the governments own commercial interests. Liu et al. (2020) conducted a study that focussed on the space-time exposure of Aotearoa children to unhealthy food marketing that occurs in public outdoor spaces. Liu et al. (2020) found that children were exposed to 7.4 unhealthy

food advertisements for every hour they spent in outdoor settings. This rate was nine times higher than for healthy food advertisements. They also surmised that if advertising of unhealthy consumables was banned in residential areas within 400m of both schools and playgrounds, such an intervention would reduce this exposure by 50%. International research shows that advertising has been linked to a preference for and purchase of unhealthy foods by families and children who are obese in Latin America (WHO, 2020). Liu et al.'s study (2020) asserted that future policy needed to incorporate these findings to be impactful around the issue of childhood obesity. WHO also argues that statutory measures are required, and the English Government suggests one: a levy on sugary drinks (WHO, 2017). Other policies need to address the compounding influence of availability in the obesogenic environment in Aotearoa.

5.6 A culture of child visibility

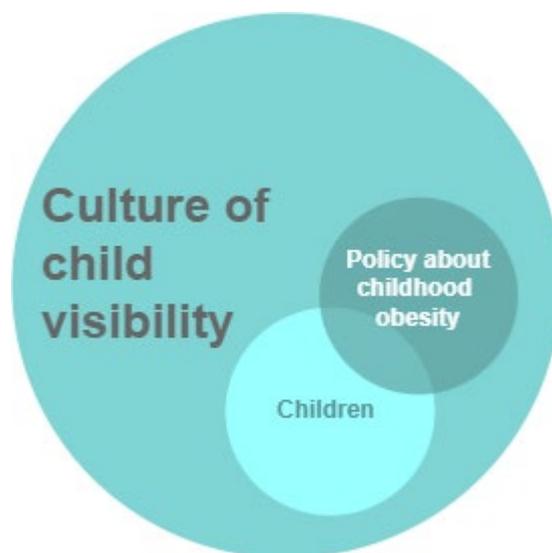


Figure 7: Illustration of how a culture of visibility could support the participation of children in policy about childhood obesity

Currently, children sit in a liminal space in their relationship to policy about childhood obesity, a product of the policy environment. However, there were signs in the data that policy development was on the precipice of a new phase of visibility, a concept discussed in the current child policy literature (Horgan & Kennan, 2022). This section of the discussion explores how the culture of policy development can change to improve the future of child participation, childhood obesity and the policy design. In this potential culture, children are visible even when their issues are taboo or difficult to

manage. As seen by the *Child and Youth Wellbeing Strategy* there has been one example of child participation in policy about childhood obesity, however, this was born from a *culture of child invisibility* and bears all the hallmarks of being as such (Department of the Prime Minister and Cabinet, 2019). Children have the right to participate as per UNCROC and the sitting government holds primary responsibility for its implementation of this right (Kennan et al., 2021; MSD, 2022). Policy about childhood obesity needs to be immune to the impact of commercial interests that conflict with population health concerns and participation is key. There were three critical factors that led to the inclusion of child voice in policy about obesity: An equity-based focus, a culture of participation surrounding policy, and most importantly political force. As Matheson et al. (2021) states:

To make progress when it comes to reorienting our systems away from patriarchal systems of power that are furthering inequality, we need the perspectives of women, and others who are marginalised, to hold weight and influence. A shakeup of who determines social priorities and what our systems value paves part of the pathway to a more sustainable and equitable future (p. 3).

5.6.i. Addressing a complex health issue with policy

In this study's findings, child participation was an emerging but relatively unexplored way of managing a complex topic in policy. The biggest issue it seemed, was the way policymakers interfered with child participation by imposing barriers and therefore stunted an otherwise more comprehensive policy design process. This treatment was counterintuitive to childhood obesity, a very difficult medical and socially-derived condition to manage with policy (Vallgård, 2018; Wild et al., 2021). According to the literature, community engagement is a component of policy design worth considering for difficult issues of social injustice (Levine, 2019). Martin et al. (2018) found in her study of child voices in health policy development that children see health as being influenced by broader contextual issues. This finding is consistent with national and international research, where child participants did not associate stress or unhealthy eating as being issues of individual responsibility (Reeve & Bell, 2009). Children's perspectives were consistent with existing research about childhood obesity which underscores the importance of consultation (Wang & Lim, 2012). A framework suitable for complex child policy issues is currently not available and remains an area in need of further development in Aotearoa.

5.6.ii. Child voice: An equity-based policy focus

The findings of this study showed that the policies that included child voice and participation had a focus on inequity as major cause of childhood obesity. Child participation was antithetical to the paternalism seen in *adult voice*. However, as

mentioned above there were major philosophical and clinical views that prohibited policymakers from viewing obesity as an issue of social injustice. By design, positivist research removes policy developers from the target population's complex lived experience and this was every interviewed participant's preferred research method. Child participation fell under the spectre of an equitable approach to policy about childhood obesity and achieving equity was framed by the participants as secondary to larger concerns such as commercial interests and political interference. However, equity, marketing and the lived experience are all linked, and most participants failed to make that connection and spoke of them as separate issues. Child voice, if used as an input, has a role to play in ensuring that policy outcomes are equitable or at least that those indicators consider equity (UNICEF, 2020).

An Australian Government inquiry into obesity...identified that the majority of actors framed obesity either as an individual or a structural issue with relatively few suggesting that obesity policy should address the issue of social inequality (Browne et al., 2019).

The lived experience expressed through child voice must be considered a valued input by policymakers. This paradigm shift poses a huge challenge to policy writers to explore the "*nuances, contradictory experiences and diverse practices*" of the target population and how these people reconcile their health with their identity and culture (Wiest et al., 2015; Wiltshire et al., 2018, p. 6). By using more qualitative research and community engagement, this subjective, ungeneralisable data could include information about why certain people become overweight or obese in childhood. A different approach and a greater effort within the policy process needs to be in place to understand the complex array of equity-based and social issues causing childhood obesity.

There were promising signs in this study that future policy about childhood obesity would be equity-based. As shown in the findings section, all participants and the most recent policy were concerned about the impact that commercially advertised food and drink had on the prevalence of childhood obesity. The ascendance of these attitudes could build in the concept of equity and create more effective future policy. An equity-based framework is one where the locus of control within policy about childhood obesity has scaled up from individual responsibility to addressing government level factors (UNICEF, 2020). This is an approach to policy about childhood obesity that frames the choices people make as defined by other government policies and not individual choice (Nuffield Council on Bioethics, 2007; Vallgård, 2018). Within current research there is now a large emphasis on the reducing of exposure to marketing and unhealthy food to New Zealand children as being a key aim around childhood obesity

prevention strategy (Liu et al., 2020). Policy with this approach addresses other policies that create systemically caused childhood obesity and allows for child voice and participation.

5.6.iii. Culture of participation

In this study, the policies about childhood obesity were not written in a policy culture that supported child participation. The participation effort did not achieve its full potential for any interested party or stakeholder in any analysed policy including the *Child and Youth Wellbeing Strategy* (Department of the Prime Minister and Cabinet, 2019). There were tokenistic attitudes seen in both child voice and Māori voice in the policy text. Overall, Aotearoa needed a policy-making culture of participation to realise child voice in the policy texts about childhood obesity. Developing participatory processes is “*improved [with a] conceptualisation of Article 12 and a greater understanding of the measures needed to give effect to this right*” (Kennan et al., 2021, p. 1931). Brown et al. (2020) explains the tokenism observed in this study or selective use of participation by describing the “*lack of participation ecosystem*” in Aotearoa (p. 554). A participation culture, particularly child participation, at this stage is undeveloped with minimal understanding or infrastructure to support policymakers with this idea (Brown et al., 2020; Spray, 2020). Aotearoa researcher, Spray (2020), also notes that child participation requires a process of reconceptualising children and grounding the analysis of child participation with childhood theory. Her child participation analysis of the *embodied-child*, the *social-child*, and the *public-child*, provides three different understandings of the way children view health intervention (Spray, 2020). This interpretation challenges predetermined adult-centric assumptions of children and translates to meaningful application into policy. Spray also discusses the interpretation of the child perspective and how important critically analysing a child’s construction of knowledge is in understanding its value. In a *culture of child visibility*, ideally policymakers would have the appropriate training and include policymakers who would naturally utilise child participation.

The choice of underlying documents or references used in the policy texts established a relationship between child participation and voice in policies. All policy documents, aside from the *Child and Youth Wellbeing Strategy* were heavily informed by quantitative research, particularly in the older policies that frame childhood obesity clinically. The diversity of research inputs increased over time in the findings, as seen in *Figure 7* and *Appendices U* and *V*. When resources were varied and included research from diverse methodological perspectives, the likelihood of child participation increased. However, even if the evidence used is robust, it was *how* policymakers used

evidence to support policy intervention that was the key factor (Brown et al., 2020; Hart, 1992; Spray, 2020). Vallgård (2018) also found that worldwide, the statements made in policy about childhood obesity were rarely substantiated by evidence and that the cited research was at times “*misinterpreted or disregarded*” (p. 295). As current policy about childhood obesity is ineffectual according to the literature and the findings of this study, perhaps there needs to be significant change in research methods and sourced literature in policy. The literature establishes the known issues concerning the choice of supporting documents and evidence to policy about childhood obesity (Glasgow et al., 2012; Green et al., 2020). Spray also suggests using more rigorous and diverse qualitative methodologies when constructing child policy in Aotearoa (Spray, 2020). All types of cited evidence were an important indication of how connected the policymakers were to children, participation, and childhood obesity.

The data from the policy texts showed that the specific underlying participatory documents were essential for establishing the idea of participation in policy about childhood obesity. In the reference lists there were instrumental participatory documents, such as legislation, Te Tiriti o Waitangi, evidence provided by the Office of the Children’s Commissioner, that were utilised appropriately by policymakers. In the *Child and Youth Wellbeing Strategy*, there was a clustering of rights-based documents referenced and the presence of child voice as evidenced in *Figure 7* (Department of the Prime Minister and Cabinet, 2019). The final piece of policy, the *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)*, (2021), referenced the *Child and Youth Wellbeing Strategy* that encompassed all participation inputs but held no child voice (Department of the Prime Minister and Cabinet, 2019). Rights-based documents are known to counter the unilateral perspectives of policy writers, as they speak to groups as a whole or a collective (Diaz, 2020). Without any reference to a document that valued participation, it was very unlikely that child voice would appear.

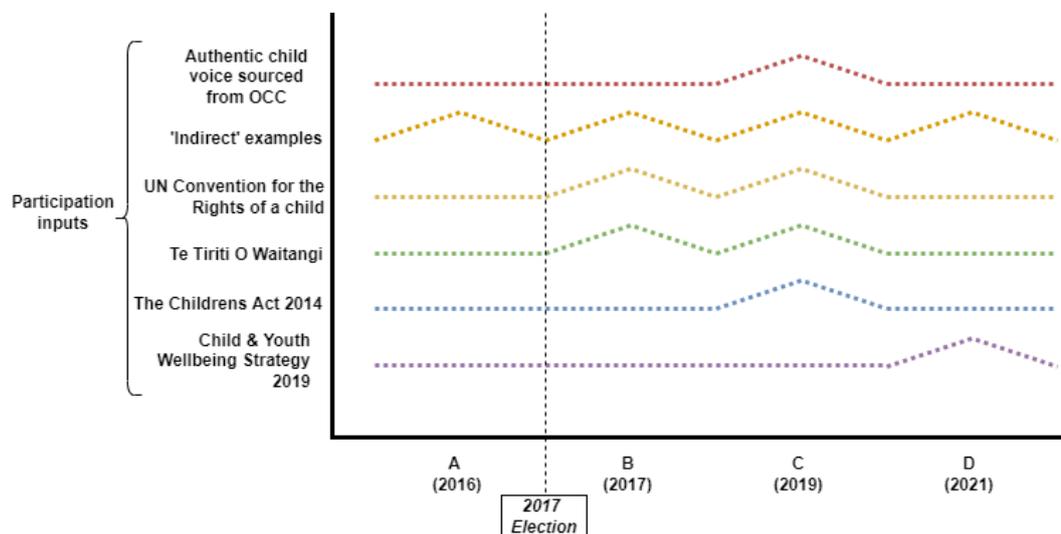


Figure 8: Graphical depiction of participatory documents and child voice evidenced in each piece of policy

A flat line indicates no evidence, however, an indented line indicates evidence found during analysis.

A - Clinical guidelines for Weight Management in New Zealand Children and Young People, **B** - Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives (2017), **C** - Child and Youth Wellbeing Strategy, **D** - Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old) (2021)

Lastly, the dataset indicated that when political parties were supportive and intentional about participation, child voice was heard and visible in policy about childhood obesity. As illustrated above, the appearance of child voice in the *Child and Youth Wellbeing Strategy* (2019) came about after the election of 2017. The election of the Labour government seems to have contributed to a change in attitudes toward child policy and resulted in the *Child and Youth Wellbeing Strategy* (Department of the Prime Minister and Cabinet, 2019). Managing the highly publicised issue of child-wellbeing in Aotearoa with a participatory approach, distinguished the new Labour government from the previous National government. This idea of political influence in policy is supported by Came et al.'s (2018) study demonstrating that public health policy documents produced by the Clark and Key governments between 2006 and 2016, rarely address te Tiriti O Waitangi or the Treaty. Te Tiriti as described previously outlines the principle of participation and sets a crucial precedent for any participation (Came et al., 2020). The political environment affected the way policy was produced and, in this study, a Labour government supported child voice in one policy related to childhood obesity.

5.7 Extrapolations & implications

There are several ways the findings of this study could be applied or extrapolated to other fields that fall outside of this case (Merriam & Tisdell, 2016). As stated in Chapter Three, this case was bound by its Aotearoa context, expressions of child voice, government childhood obesity policy and was confined to the period 2016–2021. This research could have implications for childhood obesity policy in other countries, future Aotearoa childhood obesity policy and expressions of child voice in other policy.

To contextualise the findings back into UNICEF's report, the results support the long-standing argument from UNICEF that policies create public health concerns (UNICEF, 2017, 2020). According to UNICEF, under-researched child policy where children very rarely participate has led to issues such as the childhood obesity epidemic in Aotearoa. Indeed, the lack of child input was evident in all policies analysed and there were discernible conflicts of interest such as commercial interests that were all but ignored. This study's findings imply that there is more work to be done to reform policy development around childhood obesity and where there are issues of social injustice. Notably, the *Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)* was produced post-UNICEF report suggesting that policymakers do not follow international guidelines closely or take the example made by the *Child and Youth Wellbeing Strategy* (Department of the Prime Minister and Cabinet, 2019; MOH, 2021a). The absence of child voice in childhood obesity policy was framed as *invisibility* in this project and is a concept that was already discussed as 'invisibilised' by Spray (2020). The findings of this study contribute to the overall understanding of children's relationship to policy about childhood obesity, a stigmatised subject. The findings also spoke to how policymakers behave around difficult topics and manage them at the level of governance. Children were mostly not included and therefore their voices were rarely in the policy texts. The nature of invisibility in this project could have implications for other child policy in Aotearoa and internationally, especially for policy related to child poverty reduction.

Whānau voice could be a formal contribution to child health policy produced in Aotearoa. While family voice is not a new addition to the body of literature, as clearly described and framed as *collective participation* by Diaz (2020), the Aotearoa version 'whānau voice' was rarely discussed. Whānau voice or family voice was a phenomenon that occurred naturally in every policy and seemed particular to Aotearoa. Whānau voice according to the findings, was not specific to Aotearoa policy about

childhood obesity from 2016–2021. This finding would suggest that whānau voice is an ever-present form of unique Aotearoa expression that is in other forms of policy but not acknowledged or formally facilitated. This is important in our understanding of the way children really contribute and describes how Aotearoa indigenous cultures prefer to contribute their thoughts and opinions. This could have implications for future child policies and policy design for effective community engagement.

The date range for this project could be a significant factor in forming generalisable findings from this study, a known strength of case study (Brown, 2008; Merriam, 2016). For example, this study paid particular attention to the political context around this date range and provided as much description as possible for the sake of rigour (Merriam & Tisdell, 2016). This included information such as sitting governments and their stated political agenda, new legislation and the production of new strategies that influenced the analysed documents. These factors were discussed in relation to the outcomes seen in the data. The best instance of this was the Labour party's political agenda appearing to promote participatory pathways. This finding could contribute to a wider understanding of Aotearoa political influence and its connection to child participation in Aotearoa policy related to issues of social injustice.

5.8 Strengths & Limitations

In an evaluation of this methodology and methods, there were some reflections on how I carried out this process as well as the strengths and limitations of the study design itself. As a novice, this study may bear some of the hallmarks of early researcher study, however, I consulted with my supervisor every 2–4 weeks throughout this project to strengthen the findings.

Design choice

As a strength, the case study as study design was well matched to the research question. The binding of the case served to limit the research to the timeframe of 2016–2021, and this was all that was needed to demonstrate the very minimal participation of children in policy about childhood obesity. Extending this timeframe further into the past, outside of the binding of the case is unlikely to have added any further knowledge or meaning to this case. Potentially, there may have been some merit in examining further policy from the MSD for child participation in policy related to childhood obesity. Although, as most participants stated that there were very few

avenues to include children, it is likely that the occurrence of participation is minimal across all agencies with all child-related policy.

Data collection

I was very satisfied with the quality of participant data from this project; however, I would adjust my pace in future projects. I contacted participants and organised my data collection as soon as I had ethics approved in July. Within the ethics approval application were my semi-structured interview questions and I felt confident in going ahead with my interviews. I completed the data collection in four weeks, and this was a lot quicker than I had anticipated. Due to the niche nature of the topic, I had assumed that it would take me months to secure interviews with willing participants, but the opposite was true. This was seen in the snowballing of participants in the purposive sampling and suddenly there was a group of participants ready to be interviewed. If I completed this project again, I would approach it with more faith that I could organise the participants at a pace that would serve the research process, particularly the analysis process. In case study methodology, the analysis begins after the first point of data collection. I was also not able to secure a participant from the Office of the Children's Commissioner until six months after data collection by which time I had completed the analysis phase of this project. This was a potential limitation of this study.

Analysis

Using multiple sources of data to triangulate to understand the issue of childhood obesity policy and child participation supported this line of enquiry well. The results were enriched by policy texts, participant transcript data and field notes that were all combined into a case study database. In the future, I would use a programme like NVIVO to assist with the categorisation of the qualitative data. Initially, as a novice researcher, completing this manually was an excellent way to acquaint myself with the data's themes and ideas as well as the analysis process. Data was inserted into excel sheets that were then converted finally into the primary resource package. However, as a more experienced researcher, I would probably start the organisation of the data using NVIVO after a period of familiarising myself with margin notes and field notes. The manual analysis of qualitative data was very rewarding but slow, and the use of excel was inefficient and not a good method for keeping data. The use of data analysis programmes does not diminish the quality of the data and would be necessary for large ongoing qualitative research projects.

5.9 Conclusion

To conclude, children were invisible in Aotearoa policy about childhood obesity from 2016–2021. This study provided a greater understanding of how children are really positioned in policy about childhood obesity and, that is to say, children are *not* well positioned in policies about them. This discussion advanced some themes that emerged through the analysis such as the overwhelming presence of adult ideas and priorities in child policy texts seen in *adult voice*. There was an established aversion to using child voice in policy, especially around difficult subjects such as childhood obesity in the literature. *Whānau voice* was a significant finding in this study, however, there has been minimal research completed about this as a way of appropriately including child voice in policy. The literature has a very good idea of what policy for difficult child issues could look like, however, it still seems to be in an ideological phase, and this was also proposed in the finding, a *culture of child visibility*. This culture includes a participatory environment that encourages and normalises participation and was affirmed by the international literature. Finally, childhood obesity was germane to the issue of social injustice, and participation occurred when social justice was a central focus of the text, this was consistent with the literature. While this was a study about childhood obesity, many of these findings are transferable to other policies about stigmatised subjects concerning children. This study affirmed the reporting around policy development by UNICEF and contributed to the understanding of family voice in an Aotearoa context as well as the influence of Aotearoa politics on child policy and issues. There were some limitations to this study, which included a lack of one participant from the Office of the Children’s Commissioner, however, overall case study supported the needs of this study sufficiently.

Chapter Six: Summary

6.1 Summary

The results of this study showed that children were almost invisible with no voice in policy about childhood obesity between 2016–2021 in Aotearoa. The voices of adults and whānau mostly dominated these texts and there was a tokenistic treatment of child voice if it appeared. Policy about this issue needed to be centred around children and the experience of children to improve the quality of the policy text. Participation in policy about childhood obesity could be teased out into three separate subjects — ‘participation’, ‘policy’ and ‘childhood obesity’. During the analysis, these three subjects were found to be incompatible with one another, rendering policy texts ineffective. Policymakers themselves were the biggest barrier to the inclusion of children, feeling as if their contribution would be too hard to collect considering the ethical and safety issues. Participation was much more likely to happen if participatory documents were cited, issues of social injustice were recognised and the agencies in government worked collaboratively. Childhood obesity was a very difficult subject to manage with policy but evidence from UNICEF and the literature consistently show that child participation would form more effective policy for this public health issue.

A culture of child visibility needs to be central to the development of policy about childhood obesity to improve this outcome. *A culture of child visibility* begins with the recognition of children’s rights with rights-based documents in every piece of policy produced. This includes the acknowledgement of indigenous children’s rights with Te Tiriti o Waitangi and the UN Declaration on the Rights of Indigenous Peoples. *A culture of child visibility* is not exclusive to the *adult voice* of those who make policy, children are part of this culture, have a voice and this is normalised. Child voice encompasses children’s perspectives on topics like childhood obesity but is also an opportunity to assert children’s rights in policies about them. In policy about childhood obesity, child voice can defend children’s rights around issues of social justice which are known to cause childhood obesity.

6.2 Recommendations

While this study had limitations, the findings do contribute to a greater understanding of how children have informed policy about childhood obesity in

Aotearoa. Here are the recommendations to create future policy about childhood obesity in Aotearoa:

- All policy about childhood obesity needs to be created in a *culture of child visibility*. This begins with recognising how adults can obstruct, with intent, well-meaning policy designed to improve children’s lives. This is done by casting a shadow over children, rendering them invisible and without a voice. Government agencies need to form cultures of participation for all of Aotearoa and this will normalise this process in policy development.
- All future policy about childhood obesity needs to be focussed on managing equity in Aotearoa and how this can impact the child population. The prevalence of childhood obesity is merely a symptom of a greater problem, social injustice is created by the government’s own policies. Policy that encourages individuals and whānau to take personal responsibility for childhood obesity is ineffectual and symbolises an abuse of government power, particularly toward Māori tamariki and Pacifica children.
- Childhood obesity is a very difficult medical and social condition to manage with policy. A system to manage and monitor difficult population health issues that incorporates multiple agencies in government, community engagement and a diverse range of resources should be considered.
- All future policy about childhood obesity needs to explain its process and be transparent. This issue is affected by power and who holds this power needs to be held accountable in the process of policy development.
- All future child policy about childhood obesity created in Aotearoa needs to be predicated on child-rights documents such as te Tiriti and the UN Convention on the Rights of the Child. These documents describe what participation is, and policy was much more likely to include child participation if rights-based documents were recognised.

6.3 Further research

This research project presented several avenues for further research. More research needs to be completed around the concept of invisibility in other child policies and this has influenced the output of those policies. It is very likely that children are invisible in other child policies, and this has real world consequences. There is still a gap in the research about how to successfully manage difficult subjects like childhood obesity in policy. Managing stigmatised subjects for vulnerable groups like children needs further development in research but also in policy. A model for child visibility

policy design in an Aotearoa context would go a long way, not just to help children with obesity but all children affected by issues of social injustice. More research, trialling and political direction needs to be present to shape the *culture of child visibility* around policy development to allow children's voices to regularly flourish in policy in Aotearoa (Horgan & Kennan, 2022; Vallgård, 2018). Furthermore, how a *culture of child visibility* can address complex health issues such as childhood obesity in policy needs to be explored. Whānau voice was an Aotearoa specific finding in this study but there is very little information on how to use this form of expression intentionally in an Aotearoa context. Further research needs to be completed around deliberately using whānau voice as a pathway for child participation with stigmatised topics that concern children.

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Appendices

Appendix A: Ethics approval



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

21 June 2021

Julie ~~Blamires~~
Faculty of Health and Environmental Sciences

Dear Julie

Re Ethics Application: **21/165 How New Zealand children’s perspectives have informed past and current policy related to healthy eating and activity: Case Study**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 21 June 2024.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: kim.arrowsmith@aut.ac.nz; annette.dickinson@aut.ac.nz

Appendix B: Ethics approval amendment



TE WĀNANGA ARONUI
O TĀMAKI MAKĀU RAU

Auckland University of Technology Ethics Committee (AUTEC)

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14 July 2021

Julie Glamires
Faculty of Health and Environmental Sciences

Dear Julie

Re: Ethics Application: **21/165 How New Zealand children's perspectives have informed past and current policy related to healthy eating and activity: Case Study**

Thank you for your request for approval of amendments to your ethics application.

Minor amendments to your ethics application have been approved allowing the inclusion of further participants.

I remind you of the **Standard Conditions of Approval**.

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

For any [enquiries](#) please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: kim.arrowsmith@aut.ac.nz; annette.dickinson@aut.ac.nz

Appendix C: Literature search method

Phase one

This initial search was not particularly helpful as I was trying to conduct a literature search about the general types of research used in policy about childhood obesity and the results did not fulfil this brief. I refined this in search two of phase one by searching specifically for studies about the use of quantitative research in policy about childhood obesity. I had assessed some of the reference lists in existing policies about childhood obesity and noticed that there was a heavy bias toward quantitative evidence. I assumed that there would be evidence to support this in a literature review. Again, this did not yield information about policy development using quantitative research and I began to wonder whether statistics or hard data was the preference. Search three proved to be successful and I could see that governments underpin all policy with government produced data. I began Chapter Two with a review of the literature around the statistics, indicators and 'hard data' that support the childhood obesity policy we see today.

Database	Limits	Terms searched	Search results
Search one			
EBSCO (Health: Medline, Social policy: SocINDEX)	2017–2022 Scholarly (peer-reviewed) journals. Language: English Subject: Research for Aotearoa New Zealand policy about childhood obesity.	childhood obesity OR obese children OR overweight children AND policy OR strategy AND research input OR research AND new zealand OR aotearoa OR Aotearoa New Zealand	46 *not applicable to research question
Search two			
EBSCO (Health: Medline, Social policy: SocINDEX)	2017–2022 Scholarly (peer-reviewed) journals. Language: English Subject: Quantitative research in Aotearoa New Zealand policy about childhood obesity.	Quantitative research OR quantitative AND childhood obesity OR obese children OR overweight children AND policy OR strategy AND research input OR research AND new zealand OR aotearoa OR Aotearoa New Zealand	3 *not applicable to research question
Search three			

EBSCO (Health: Medline, Social policy: SocINDEX)	2017–2022 Scholarly (peer-reviewed) journals. Language: English Subject: Statistical data in Aotearoa New Zealand policy about childhood obesity.	statistics OR data OR poll or survey OR percentages AND childhood obesity OR obese children OR overweight children AND policy OR strategy AND research input OR research AND new zealand OR aotearoa OR Aotearoa New Zealand	34
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Phase Two

I decided I needed to conduct a very general search of the international literature around public policy development to get an understanding of the decisions around inputs into policy. I broadened the limits to 2012–2022 and did not limit to Aotearoa. This search introduced me to the concepts of traditional and progressive ‘transfers of knowledge’ to policy, top-down and bottom-up approaches.

Database	Limits	Terms searched	Search results
Search one			
EBSCO (Health: Medline, Social policy: SocINDEX)	2012–2022 Scholarly (peer-reviewed) journals. Language: English Subject: Policy development for policy about childhood obesity.	Child health AND policy OR strategy AND policy development OR policy making OR policy design	167
Search two			
EBSCO (Health: Medline, Social policy: SocINDEX)	2012–2022 Scholarly (peer-reviewed) journals. Language: English Subject: Strategy for policy development in childhood obesity policy.	Childhood obesity OR obese children OR overweight children AND child health AND policy OR strategy AND policy development OR policy making OR policy design	25

Phase three

In this phase I explored what was interfering with the transfer of knowledge between policy and the existing body of research. To UNICEF, policies concerning children were under-researched and not enough research existed. To enhance policy, UNICEF suggested policymakers research children's perspectives through a process of consultation, and this occurs mainly through community engagement. I wondered if there was any research that described the connection between policy about childhood obesity and community engagement or participation with children.

Database	Limits	Terms searched	Search results
Search one			
EBSCO (Health: Medline, Social policy: SocINDEX)	2012–2022 Scholarly (peer-reviewed) journals. Language: English Subject: The policy-research gap in child health policy.	Child health AND policy OR strategy AND policy-research gap OR research barriers OR policy making OR policy design	0
Search two			
EBSCO (Health: Medline, Social policy: SocINDEX)	2012–2022 Scholarly (peer-reviewed) journals. Language: English Subject: Research policymaking gap.	Research policymaking gap	6
Search three			
EBSCO (Health: Medline, Social policy: SocINDEX)	2012–2022 Scholarly (peer-reviewed) journals. Language: English Subject: Child participation in policy.	childhood obesity OR obese children OR overweight children AND policy OR strategy AND child participation OR child involvement	21

Phase four

In this phase I explored the connection between child voice and childhood obesity policy. Firstly, I searched for evidence of child voice in childhood obesity policy in Aotearoa and when that yielded no appropriate results, I looked to international research.

Database	Limits	Terms searched	Search results
Search one			

EBSCO (Health: Medline, Social policy: SocINDEX)	2012–2022 Scholarly (peer-reviewed) journals. Language: English Subject: child voice in childhood obesity policy.	childhood obesity OR obese children OR overweight children AND policy OR strategy AND child voice OR perspective OR experience AND new zealand OR aotearoa	14 *no appropriate results, thus illustrating the gap in research
Search two			
EBSCO (Health: Medline, Social policy: SocINDEX)	2012–2022 Scholarly (peer-reviewed) journals. Language: English Subject: Research policymaking gap.	childhood obesity OR obese children OR overweight children AND policy OR strategy AND child voice OR perspective OR experience AND new zealand OR aotearoa	417

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

You will need to sign a consent form to be part of this research.

What will happen in this research?

All that is required from you is a 45-60 min interview of questions that have been approved by AUTEK. We can meet in a location that suits you, this could be in a neutral, public spaces, offices, cafes such as university buildings. If unable to meet face to face due to Covid 19 restrictions then video interviewing will be arranged. We would like to offer a koha or gift of \$40 for your time.

A face-to-face interview is the preferred method of data collection however if in the case of a future lock-down, we may have to complete the interview using video conferencing. In this scenario we will ask that you sign, scan or photograph the consent form, and then return it to us over email. The information recorded will only be shared with the researchers and your information will remain confidential if the findings are published.

You will be sent a summary of the findings over email once they have been compiled.

What are the discomforts and risks?

We would be very grateful for your contribution to this study however we do appreciate that there is an element of risk. While we will not be using your name in any research findings however due to the small community of policy writers and contributors, you *might* be identifiable. We need you to be aware that there is this risk and with your consent, you will be acknowledging this risk.

How will these discomforts and risks be alleviated?

This interview will only be about what you do in your professional capacity. You will be offered the opportunity to have a support person present during the interview, and this includes a cultural advisor or cultural support person if requested. A cultural support person will be sourced through AUT services.

What are the benefits?

The data collection, aside from contributing to my master's qualification, will also provide some insight into the way policy is written about New Zealand children. New Zealand children unfortunately experience poor health outcomes in comparison to children living in other first world countries. This research could lead to further developments in the way we include children into research written about them. The hope is that long-term this could help to improve the social determinants of health for New Zealand children.

How will my privacy be protected?

We will not be mentioning your name in any published work that is derived from this research. However, as mentioned above, we cannot guarantee you won't be identified from the findings of this research. The researchers involved in this research will be the only people handling the data and its findings and they are subjected to all normal expectations of confidentiality as required by AUT.

To reassure you, we are happy to send through the interview questions before we interview you. You are not under any obligation to answer questions that make you feel uncomfortable and you can withdraw from the interview at any time without any repercussions.

Confidentiality of the participants and their contribution to data collection will be managed through establishing our ability to maintain confidentiality from the start. The community of policy writers and contributors to child health policy is small and the participants could be identified by someone within the community. During the actual interview, you and the researcher will be the only two in a room or space. The interview will be recorded and kept for the

researcher's data collection purposes but shared with only the researchers and applicant. There will be no questions about your personal life, only about what they do in a professional capacity.

After the interview you are welcome to a provision of the transcript to edit and delete any material you may wish. The data will be stored in a secure repository with AUT and destroyed after six years. The only people who have access to this data are the researchers.

When publishing the findings, no names will be attached to the research.

What are the costs of participating in this research?

I would need 45-60 minutes of your time for a face-to-face interview.

What opportunity do I have to consider this invitation?

We will keep this invitation open for two weeks and then send a follow up email just to confirm whether you would like to be part of the study or not.

Will I receive feedback on the results of this research?

Yes, after findings have been collated, you will be sent a URL link with a summary

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Julie Blamires, julie.blamires@aut.ac.nz, 021525549

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, ethics@aut.ac.nz, (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Kim Arrowsmith

kim.arrowsmith@aut.ac.nz

Project Supervisor Contact Details:

Dr Julie Blamires

julie.blamires@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEK Reference number *type the reference number*.

Appendix E: Participant consent form


TE WĀNANGA ARONUI
O TĀMĀKI MAKĀU RAU

Consent Form

Project title: *How New Zealand children perspectives have informed past and current policy related to healthy eating and activity: Case Study*

Project Supervisor: *Dr Julie Blamires*

Researcher: *Kim Arrowsmith*

I have read and understood the information provided about this research project in the Information Sheet dated 22 May 2021.

I have had an opportunity to ask questions and to have them answered.

I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

I agree to take part in this research.

I wish to receive a summary of the research findings (please tick one): Yes No

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):
.....
.....
.....
.....

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEK Reference number type the AUTEK reference number

Note: The Participant should retain a copy of this form.

April 2018 page 1 of 1 This version was last edited in April 2018

Appendix F: Participant invitation email

Dear (name of participant),

My name is Kim Arrowsmith and I am a master's student at AUT University. I am undertaking a research project looking at the extent to which children's opinions/perspectives are included in the process of child health policy writing in New Zealand. Due to your significant role in child health policy, I am kindly inviting you to participate in this study titled:

'How New Zealand children perspectives have informed past and current policy related to childhood healthy eating and activity: Case Study'

As you will be aware, according to the recent 'United Nations International Children's Emergency Fund ("UNICEF") Innocenti report', New Zealand children have the second-highest rate of obesity in the developed world. The report concluded with a recommendation to imbue future policy with a deeper understanding of children's perspectives. This research hopes to find out what helps and hinders the process of including children's voices in policy written about healthy eating and activity.

My aim is to undertake face-to-face interviews with 4 individuals who have been involved in writing, influencing, and commenting on child health policy in New Zealand. The interview should take approximately 45-60 minutes. This can be at the university, your office, your home, and at a mutually agreeable time.

Participation is completely voluntary and the only cost to you will be your time. You may withdraw from the study at any time. The study is confidential, therefore, it does not require you to provide your name or any other identifying information.

If you would like to participate in the study please let me know. In addition, I have provided in the attachment the Information Sheet and Informed Consent.

Thank you for your time and participation.

Yours sincerely,

Kim Arrowsmith, BNurs, BDes, PGCert (Health Science)

Appendix G: Participant profiles

	Profession/Position	Policy contribution
Participant 1	A paediatrician	Made a significant contribution to Well Child/Tamariki Ora Programme in their advisory role. Belongs to advisory groups in the Ministry of Health.
Participant 2	A nutritionist working in academia	Contributes regularly to current child health policy related to childhood obesity from the Ministry of Health.
Participant 3	A nutritionist	Worked as a policy advisor and as a senior portfolio manager for the Ministry of Health in family and community teams.
Participant 4	A public health physician	Worked as a clinical advisor in child health policy related to childhood obesity at the Ministry of Health but now works as a clinical partner for ACC.
Participant 5	A union nursing advisor	Reviews, consults, and contributes to child health policy related to childhood obesity from the Ministry of Health.
Participant 6	A paediatrician	Works part time as a senior advisor to child and youth team at the Ministry of Health.

Appendix H: Portrait of Participant #1

Time, place and person
Location in time: 20-Jul-2021 Location of space: Interviewer was in her office at the university and the interview was completed over zoom. Interviewee was in his home office.
Participant description of relationship to child voice and policy about childhood obesity
Interviewee: <i>"I'm a paediatrician, and for 20 years, I was the chief advisor in charge of Youth Health at the Ministry of Health. I've held a number of other roles that involve advocacy and developing policy for children as well, and that's been with the Royal Australasian College of Physicians as chair of the Policy and Advocacy Committee."</i>
My impression of how the interview went
Looking at how child voices have influenced policy about childhood obesity allowed me to look at the process of community engagement itself. This interview was extremely informative of the process and ideology behind policy writing. Participant appears to have been at the helm of this exact topic for much of his career, confident in speaking to children's voice/ participation and policy. As a paediatrician, he encouraged his students to engage in qualitative research. Spoke about the 'Garbage Can' approach, describing the process of policy writing as very messy. Recommended three other people to interview, which led to snowballing. Policy is often based off unofficial research due to the constraints of HDEC/ethics. No mention of MSD or family-related policies and obesity. Should have asked about relationship between MOH and MSD working together to improve childhood obesity. Many examples of child participation/voice but scattered. Suggested numerous big picture thinking ideas, include children's voice in the census.

Appendix I: Portrait of Participant #2

Time, place and person
<p>Location in time: 01-Aug-2021 Location of space: Interviewer was in her office at the university and the interview was completed over zoom. Interviewee was in her office at work.</p>
Participant description of relationship to child voice and policy about childhood obesity
<p>Interviewee: <i>"I am based here in the department of medicine at the University of Otago and have a background predominantly in nutrition, nutrition trained, but have moved into sort of sleep and physical activity as well."</i></p>
My impression of how the interview went
<p>Made connection between family policy and overweight children. Quantitative research is absolute/strong preference of researchers who write policy. White people writing quantitative research/policy about poor Pacifica and Māori families. Not much value seen in qualitative research, quantitative more valid.</p> <p>There were two issues:</p> <ul style="list-style-type: none">- Consulting with children on policy written about them.- Including qualitative research when referencing policy. <p>Policy is often written with no references at all. Prejudice toward qualitative. Is it that qualitative research isn't valid or you does not rely on people's views. Biomedical model influences health policy.</p> <p>Quantitative research is a power dynamic, the researcher studies the population. Qualitative = Considered/richer personal policy. Interesting that I'm using qualitative researchers to study and better understand quantitative researchers/policy writers. This was quite a short interview with a policy contributor who had really only contributed to guidelines around healthy eating in infants and small children. She held strong views around quantitative research.</p>

Appendix J: Portrait of Participant #3

Time, place and person
Location in time: 22-Jul-2021 Location of space: Interviewer was in her office at the university and the interview was completed over zoom. Interviewee was in her office at work.
Participant description of relationship to child voice and policy about childhood obesity
<i>Interviewee: "My current role is a senior portfolio manager in the family and community team, and looking after school-based health services is the focus of my work. And so our school-based health services are delivered in secondary schools, so I'm focused on the youth age group, so year 9 to 13. I'll just talk about my previous roles in the ministry, where that's kind of the tie-up with the child nutrition. So I've been at the ministry for 16 years. My first role here was as a policy adviser working on the food and nutrition guidelines and the WHO Code of Marketing of Breast-milk Substitutes, and I was working in sort of the public health part of the ministry and working in what was called the nutrition and physical activity policy team. I think that's what we were called. Yeah. So while I worked in that team for about seven years - I think it was that long - I worked on the food and nutrition guidelines for healthy pregnant and breastfeeding women, and that was a revision of previous guidelines. And then, I worked on the kind of first half of the revision of the zero-to-two guidelines up to the stage of the first draft."</i>
My impression of how the interview went
Only interview with a Māori identifying participant who had a Māori perspective on policy writing and children's voices. This interview offered the most unique perspective on why children who identify as Māori may have minimally informed policy about childhood obesity. Participant #3 was confident in speaking to this topic but this relates to her previous job. Didn't read the questions before the interview. Emphasis on Ottawa Charter being more influential than policy in changing behaviours. Very focussed on the idea of personal responsibility taking policy in the wrong direction. Participant #3 had a Māori focus, and wanted to address kaupapa Māori in policy.

Appendix K: Portrait of Participant #4

Time, place and person
Location in time: 30-Jun-2021 Location of space: Interviewer was in her office at the university and the interview was completed over zoom. Interviewee was in her cubical at her workplace.
Participant description of relationship to child voice and policy about childhood obesity
<i>Interviewee: "I'm a public health physician, and I'm currently employed as a clinical partner at ACC. I've been in this role for a year and a half. And prior to that, I was at the Ministry of Health, on and off for 9 of the preceding 12 years. But for 6 years, I was clinical advisor, child and youth health, from December 2013. And had roles from December 2007 mostly in the child and youth space at the ministry."</i>
My impression of how the interview went
Clinical Advisor in Child Youth and Health. Very articulate and could speak about most current health policy. Spoke extensively about Child Youth Strategy and its total lack of effect on the health and wellbeing. Policy is very politically motivated. Spoke to the policy machine, policy and operational policy. Not enough policy about healthy eating and activity in general. Time pressures affect quality of policy. Very upset with the current government's input into child wellbeing. Not much better than National government. The Office of the Children's Commissioner had not had much impact.

Appendix L: Portrait of Participant #5

<p>Time, place and person</p>
<p>Location in time: 01-Aug-2021 Location of space: Interviewer was in her office at the university and the interview was completed over zoom. Interviewee was in her office at work.</p>
<p>Participant description of relationship to child voice and policy about childhood obesity</p>
<p>Interviewee: <i>“In my current role I work for New Zealand Nurses’ Organisation, and I have the role of Professional Nursing Advisor, which — NZNO being both a union and a professional organisation, the PNA role, for short, it is part of the professional side. And so that role has lots of scope and responsibilities, and we support members both individually, around professional issues, but we also support groups with professional development and contributing to the development of NZNO publications like guidelines and factsheets and position statements, as well as we support some of the groups that-- the clinical speciality groups. I’ve reviewed policies and updated them in the well child context, for example, [inaudible] spending policies in the WHO code policy, and reviewed resources that are developed for parents around introduction of solid food to babies and that kind of nutrition. And I’ve contributed to professional development on best practice and policy. I contribute to submissions. That helps shape policy. So there might be Ministry of Health or other ministerial consultations, for example on the taxing of sugary drinks or the supplementation of foods, for example folic acid, etc, or the marketing of foods to children. So I might independently give my own feedback. I might give feedback directly to the submitter, to the group coordinating, or I might give it to the person collating an NZNO organisational feedback. And I also will share my initial thoughts with the college as they prepare a group submission that’s under their name. And they might do that directly to the group that’s coordinating the consultation, or they might do it as part of a NZNO one.”</i></p>
<p>My impression of how the interview went</p>
<p>This interview felt very dismissive of the research topic at the time, and I was personally disappointed about the experience of the interview. I felt as if this interview wouldn’t yield quality data — until I went to analyse it. Ultimately, this interview produced data that revealed prejudice and a biomedical approach toward the research topic. Upon reflection, I now think I was personally offended by this participant’s attitude rather than critically examining the responses to my questions. Interested in equity — bicultural approach. She seemed a bit removed from policy that concerns obesity. Offers advice, contributes to policy writing but doesn’t write it. Quantitative research, more valid. There would be capacity to involve children in the process, however it comes to opinion. No lip service given to this as a concept. ‘It would inform the how as much as the what’ — qualitative research. Documents like the ministerial guidelines tend to be based on quantitative research. It has to be balanced. Idea for the future: Dedicated role to keep eyes across the process, encourage focus groups and present.</p>

Appendix M: Portrait of Participant #6

Time, place and person
<p>Location in time: 03-Aug-2021 Location of space: Interviewer was in her office at the university and the interview was completed over zoom. Interviewee was in his office at home.</p>
Participant description of relationship to child voice and policy about childhood obesity
<p>Interviewee: <i>“I’m a paediatrician by training. My current role part time is with the Ministry of Health. I think that’s how you contacted me. I do three days a week as their chief adviser to the child and youth team. So that’s a clinical adviser to the child and youth area. And that sits under the population health directorate, but my role here crosses right across the different directorates because child and youth matters come up in all areas, not just population health but also DHB systems and disability and mental health. So I get called in various directions to offer clinical advice into those areas. And as pertaining to this, sometimes that clinical advice — because I sit amongst policymakers. Some are portfolios managers and they’re managing portfolios, and some are policy writers. And so I sit amongst policy writers who seek advice on various bits of policy that are coming through which then go through to advise the ministers what they’re asking for. That’s where that Ministry of Health role sits. My other hat is as a general community paediatrician in West Auckland. And in that area, I work clinically in the wards but also in clinics around the territory. Prior to taking the ministry role, I was in the northern regional clinical network leadership group for child and youth across the northern region. And so that was around the health system organisation, that sort of thing. So I always had that sort of population health influence alongside the clinical work. That’s a long way of saying what I do.”</i></p>
My impression of how the interview went
<p>Participant 6, a policy writer and practicing paediatrician appeared the most interested in finding ways on a clinical level as well as policy to include children’s voices in policy. Had some peripheral involvement in child participation with child and youth wellbeing strategy – the only participant to have this experience. Very passionate about conflicting commercial interests and how this affects policy about childhood obesity.</p>

Appendix N: Policy profiles

Policy	Ministerial department	Year	Authors	Summary
<i>Clinical Guidelines for Weight Management in New Zealand Children and Young People</i> (New Zealand Ministry of Health, 2016a)	Ministry of Health	2016	Professor Jim Mann, Mr Richard Flint, Amy Liu, Dr Rinki Murphy, Dr Teuila Percival, Assoc. Prof Rachael Taylor, Dr Lisa Te Morenga and Dr Jim Vause. There was also input from internal stakeholders Dr Harriette Carr, Louise McIntyre, Laura Fair, Prof Hayden McRobbie, Dr Pat Tuohy, Dr Helen Rodenburg, Kiri Stanley, Anna Jackson, Elizabeth Aitken.	<ul style="list-style-type: none"> • Clinically based policy that provided guidelines for general practitioners to manage body weight in children and young people (New Zealand Ministry of Health, 2016a). • This piece of policy was based off the <i>Childhood Obesity Plan</i> released in 2015 from the Ministry of Health and sat in tandem with the <i>New Zealand Health Strategy</i> (New Zealand Ministry of Health, 2016b). This policy was also designed to support another initiative, <i>Health Target: Raising Healthy Kids</i>, an umbrella programme encompassing the B4 School Checks programme (New Zealand Ministry of Health, 2016c). • These guidelines were to help identify, assess, and manage childhood obesity in the community for clinicians. The impetus to produce these guidelines originated from data showing that the impact of childhood obesity has a "serious long-term effects on the health and wellbeing" (MOH, 2016, p. 3). • Improving health inequities was an aim of this policy, acknowledging the social disparities experienced by different groups such as Māori and Pacifica people in the community. • There were no indicators cited for this policy and therefore it is unknown how this policy was evaluated.
<i>Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives</i> (New Zealand Ministry of Health, 2017)	Ministry of Health	2017	Elizabeth Aitken, Dr Harriette Carr, Grant McLean, Dr Hayden McRobbie, Diana O'Neill and Dr Janine Ryland from the Ministry; Penina Kenworthy, Karen Laurie and Scott MacKenzie from Sport New Zealand (SportNZ); and Dr Mary-Ann Carter and Kate Rawson from the Health Promotion	<ul style="list-style-type: none"> • Set of guidelines for general practitioners to use when advising families about child activity (MOH, 2017). • 'Interpretation' of the Review of Physical Activity Guidance and Resources for Under-fives produced by the Ministry of Health in 2016. • Alludes to the long-term benefits of active lifestyle and the way physical activity improves health outcomes. • Based off the Childhood Obesity Plan released in 2015 from the Ministry of Health and the New Zealand Health Strategy (MOH, 2016b).

			Agency (HPA). The Eating and Activity Guidelines Physical Activity Technical Advisory Group who included Associate Professor Scott Duncan, Associate Professor Erika Hinckson, Associate Professor Chris Button, Dr Sandra Mandic, Dr Sarah-Jane Paine and Professor Rachael Taylor.	<ul style="list-style-type: none"> No indicators for policy cited in this document.
<i>Child and Youth Wellbeing Strategy</i> (Department of the Prime Minister and Cabinet, 2019)	Department of the Prime Minister's Office and Cabinet	2019	Rt Hon Jacinda Ardern, Prime Minister and Hon Tracey Martin, Minister for Children; Office of the Children's Commissioner and Oranga Tamariki.	<ul style="list-style-type: none"> Broad strategy document designed to reduce child poverty and the long-term consequences of poverty for Aotearoa New Zealand children (Department of the Prime Minister and Cabinet, 2019). Unusually, the <i>Child and Youth Wellbeing Strategy</i> was "led from the highest levels of the Government – by the Prime Minister and the Minister for Children and their departments" (DPMC, 2019, p. 10). In a cascading series of events, the production of the <i>Child and Youth Wellbeing Strategy</i> was triggered by the 2017 UNICEF report and then the incoming Labour government launched it the same year (United Nations International Children's Emergency Fund, 2017). New Prime Minister Jacinda Ardern also made child poverty her signature issue and herself the Minister for Child Poverty Reduction as stated in the <i>Child and Youth Wellbeing Strategy</i> (Department of the Prime Minister and Cabinet, 2019). Combined with the widespread reporting of the UNICEF report and political motive, there were also increasingly poor statistics around child poverty. These influences are reflected in the stated indicators of the <i>Child and Youth Wellbeing Strategy</i> report itself which included 'material wellbeing', 'child poverty' and 'food insecurity' – all indicators that impact the issue of childhood

				obesity. Indicators identified by the 2013 New Zealand Census, Statistics New Zealand, Ministry of Social Development, and Ministry of Health (Department of the Prime Minister and Cabinet, 2019).
<i>Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)</i> (New Zealand Ministry of Health, 2021a)	Ministry of Health	2021	Dr Sarah Gerritsen and Dr Sally Mackay, School of Population Health at The University of Auckland, and Anna Jackson, Ministry of Health, with guidance from Louise McIntyre and Dr Harriette Carr, Ministry of Health, and the Maternal, Infant and Toddler Technical Advisory Group (MAT0-2 TAG). The advisory group included Professor Clare Wall, Associate Professor Cath Conlon, Mafi Funaki-Tahifote, Associate Professor Anne-Louise Heath, Anne Hodren, Kass Jane, Emily Jones, Robyn Lawrence, Sande Mareroa-Gates and Professor Lesley McCowan.	<ul style="list-style-type: none"> • Set of guidelines for families to choose healthy options for their 0–2 year-old children (New Zealand Ministry of Health, 2021a). The <i>Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old)</i> was based off the findings developed from the Growing Up in New Zealand cohort study (Growing up in New Zealand, 2020). The findings showed that many Aotearoa New Zealand children were introduced to food and drink high in sugar, salt and fat at a very early age. The origins of childhood obesity start early as these “<i>foods add excess energy to the child’s diet, may accustom the child to their taste and displace nutrient-dense healthy foods</i>” (MOH, 2021). • This piece of policy used indicators identified from the <i>Well Child/ Tamariki Ora Quality Improvement Framework</i> (New Zealand Ministry of Health, 2021d).

Appendix O: Semi-structured interview questions

1. What is your role?
2. What has been your involvement in policy about childhood obesity in New Zealand children?
3. Do you believe children are fairly consulted and involved in the process of policy writing in New Zealand?
4. Is it important to you that children are involved in the process of policy writing?
5. Have you ever been involved in an inclusive process where children's opinions were included in policy written about childhood obesity?
6. Have you ever been concerned about a lack of involvement of children in policy written about childhood obesity?
7. What obstructs the process of obtaining children's perspectives while producing policy?
8. What promotes the process of obtaining children's perspectives while producing policy?
9. Do you think the process of policy writing is a fluid, evolving process?
10. Have you ever been concerned about the equitable nature of policy written about childhood obesity?
11. How have children who identify as Māori been included in policymaking?

Appendix P: Example of notes in the margins of Participant #4 transcript

Transcribe Me!

Politics vs Politicians

Policy makers driving CV of politics don't have expectations

S1: 09:25

S1: 09:50
CV mechanism is weak no feedback loop.

Idea about formally including in policy

S1: 11:16

S2: 11:18

S1: 11:18

S2: 11:32
Voiced barrier to collecting CV. Adults sphere.

S1: 12:06

S2: 12:15
"I think"

Example of using children's voice

S1: 12:32

S2: 12:46
Politics vs. Politicians
The influences around policy!

S1: 13:19
- Policy business unit

TranscribeMe

- Quantitative, scientific evidence, literature

- Operational policy - what policy maker has decided (policies)

setting expectations if the political settings aren't and nothing is going to be actioned as a result. So I wouldn't want to set children's-- yeah. If we're not going to make a difference or seriously consider some things, then I wouldn't be going-- do you know what I mean?

[inaudible] speaks to a process issue. You would like some kind of feedback loop, or obviously, an action to happen. And there's clearly maybe a disconnect there. Where you're worried that something like that won't happen. And other interviewees have mentioned this as well. So--

I think, yeah. I think it continues to be weak. So in terms of mechanisms for health, the first thing I was involved in was with the first child component of the New Zealand Health Survey that was done in the mid-2000s. But they have been looking at-- that was the first child component, but it was the voice of the caregiver. So there has previously been challenges around, "We should be getting the voice of the child. So when we do our regular New Zealand health survey, can we do a component of that to incorporate children's voices?" And that would give you a regular mechanism for obtaining children's voices. I do think, to a certain extent, that is the best way of taking a good feel across the nation. If you're not doing focus groups. And the Growing Up in New Zealand study, I was involved with the policy forum for that. So that's [across?] [inaudible] government investment and a cohort of children, soon to be young people. Growing up, what are our-- [inaudible] involved with the design. What are the priorities for asking, initially the parents? And then it's progressed towards a children's component for that. And I think that's really important. Sometimes for younger children, it's the parents' voice.

Used as a proxy?

Mm-hmm.

Right. Yeah. So we the adults or the guardian as a proxy for a child to speak. I guess it's not entirely the same. I don't know. Well, how do you feel?

Well, yeah. No, it's not the whole. It's definitely not the same. But sometimes if we're talking about healthy eating from the younger ages-- so I've been involved with breastfeeding, and SUDI prevention, so sudden unexpected death in infancy. Then that's kind of in the adults' sphere, but it is talking about infant and children nutrition and sleep and wellbeing.

[inaudible]. Yeah. I guess difficult with children who are very, very young. Yeah. Yeah.

Yeah. But certainly from school age, upwards. I think Growing Up in New Zealand has been able to get drawings and some comments, and progressing as the age, and stage, and development of the child grows.

As far as sort of evidence used when writing policy, do you find that it is usually very quantitatively based?

I'd say "Yes". Quantitatively and also scientific evidence, and literature alongside that. There was one of my other thoughts around policy. So within the ministry, there's policy within the policy arm. But then there's also operational policy, and what we decide in terms of our guidance and guidelines. So there's different kind of policy wheels. Sorry, that's led me back to the [inaudible].

No. Could you talk about that a little bit more? Policy wheels?

3

Appendix Q: Example of notes in margins of Child and Youth Wellbeing strategy (Department of the Prime Minister's Office and Cabinet, 2019)

While most New Zealand children and young people are doing well, the distressing reality is that many are not experiencing anything close to a good life.

National data and international comparisons provide some insights into the relative wellbeing of New Zealand children and young people. According to the UNICEF report cards for 2014 and 2017, children and young people in New Zealand often obtain higher-than-average competencies in education compared to other countries, but there is considerable scope for improvement in many other areas.

Improving the wellbeing of those who are missing out

Too many children and young people are facing significant, often ongoing, hardships and challenges in their lives.

- Nearly a quarter of New Zealand's children and young people (up to 250,000) are growing up in households considered to be in poverty, when the cost of housing is taken into account.
- It has been estimated that an even greater number of children and young people (nearly 300,000) experience or are exposed to family and sexual violence every year.
- Around 6,400 children and young people require the care of the State due to family violence, being abused or neglected, or through youth offending.
- Half of all lifetime cases of mental illness start by age 14 and the number of young people accessing specialist mental health and addiction services has more than doubled in recent years.

- New Zealand has the highest suicide rate for young people aged 15 to 19 years when compared to other countries.

The 2017 UNICEF report card, which assessed 41 high income countries against nine of the United Nations' Sustainable Development Goals,⁸ gave New Zealand an overall league table ranking of 34 out of 41. New Zealand ranked 38 for 'good health and wellbeing', but was in the bottom three for 'ensure healthy lives and promote wellbeing for all at all ages';⁹ and for the number of children living in a jobless household (one in seven).⁷

The concluding observations of the United Nations Committee on the Rights of the Child (2016) noted serious concerns in a range of areas including violence (including family violence, abuse and neglect); the high prevalence of poverty among children; disparities in access to education and health services for Māori and Pacific children and their families; and the disproportionate number of Māori and Pacific People in poverty and material hardship; and concerns about children in State care and the criminal justice system. Other issues that New Zealand fared poorly on included housing affordability and obesity.¹⁰

New Zealand will never be the best place in the world for children and young people if these challenges are not addressed. This is why the Strategy places a clear priority on those with the greatest needs. See page 60 for more details.

Does not mention obesity

First mention of this as an issue. Not expanded on yet affects 1/3 NZ children. Covered amongst other significant socio-economic issues. Mentioned but not prioritised according to how UNICEF report structured it, obesity was under Physical health

Appendix R: Example of initial stages of coding in excel

Participant #1 interview by Kim Arrowsmith				
Analysed using Qualitative code analysis (Merriam)				
Stage 3: Explore the background of each text. Examine the social and historical context and producers of the texts. Location in time: 20-Jul-2021, completed over zoom. Location of space: Interviewer was in her office at the university. Interviewee was in his home office Interviewee: I'm a paediatrician, and for 20 years, I was the chief advisor in charge of Youth Health at the Ministry of Health. I've held a number of other roles that involve advocacy and developing policy for children as well, and that's been with the Royal Australasian College of Physicians as chair of the Policy and Advocacy Committee.				
'How have children's perspectives informed past and current policy related to childhood obesity in New Zealand?'				
Stage 4: Code texts and identify overarching theme:	Notes from the margins	Sub Category	Category	Themes/thread
the disability area has done reasonably well with some input from children and young people, at least into disability policy.	<i>Using quantifier 'I think': Issues of human rights and advocacy. Why have the disability sector done so well in this area and how have they got around governing forces</i>	Similar examples in related areas where CV have been used	Change indicators Encouraging signs/indications of change in a different environment	EMERGING GROUND-UP APPROACH Group & Individual epistemology determines the value of CV and CO: 'The policy is informed by the policies construct of participant choice and control.' CV and CO are seen at times with these lenses: - interpretive - bicultural -Realism
such as the Auckland Youth Survey, to get an idea of young people's needs and their views on a range of things.		Expressed support and/or opportunity for change	Change indicators Encouraging signs/indications of change in a different environment	EMERGING GROUND-UP APPROACH Group & Individual epistemology determines the value of CV and CO: 'The policy is informed by the policies construct of participant choice and control.' CV and CO are seen at times with these lenses: - interpretive - bicultural -Realism
that's slightly indirect when it comes to policy because it becomes an input to policy which doesn't always exist at that stage.	<i>Direct and indirect. The scale of influence - to what extent is this listening to youth voice or tokenism. Ladder of participation</i>	Indirect examples	Applied examples: Examples of CV applied to CO policy: Spectrum of theoretical to actionable	EMERGING GROUND-UP APPROACH Group & Individual epistemology determines the value of CV and CO: 'The policy is informed by the policies construct of participant choice and control.' CV and CO are seen at times with these lenses: - interpretive - bicultural -Realism

Appendix S: Table developed from content analysis demonstrating obesity related words from the content analysis

	Cause related words to childhood obesity							Descriptive words related to childhood obesity				
	Food	Activity	Exercise	Sleep	Food insecurity	Poverty	Inequality	Obesity	Overweight	Weight	Adiposity	BMI or body mass index
<i>Clinical Guidelines for Weight Management in New Zealand Children and Young People, 2016</i>	28	41	10	81	0	0	0	54	18	104	5	27
<i>Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives, 2017</i>	2	54	3	165	0	0	0	20	2	4	1	3
<i>Child and Youth Wellbeing Strategy, 2019</i>	29	8	4	1	7	125	104	2	0	1	0	0
<i>Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old), 2021</i>	230	19	1	4	8	1	1	17	8	9	0	1

Appendix T: Table developed from content analysis demonstrating occurrence of voice and participation words from content analysis

	Engagement	Voice(s)	Participation	Youth voice(s)	Inclusive	Representation	Advocacy	Inclusion	Experience
<i>Clinical Guidelines for Weight Management in New Zealand Children and Young People, 2016</i>	6	0	3	0	0	0	1	1	1
<i>Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives, 2017</i>	0	0	3	0	7	0	0	1	7
<i>Child and Youth Wellbeing Strategy, 2019</i>	28	15	9	6	5	4	3	2	23
<i>Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old), 2021</i>	0	2	0	0	0	1	0	0	6

Appendix U: Table developed from content analysis demonstrating number of qualitative inputs per policy and community engagement

	Stated child representation during consultation process	Stated Māori representation during consultation process	No. of research references related to child voice found in each policy document	Qualitative research referenced	Community engagement referenced	Indirect examples or one step removed from original source
Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old) (MOH, 2021)	No	Yes	4	Gerritsen S, D' Souza A, Goodsell- Matthews T, et al. 2020. Food Hardship and Early Childhood Nutrition: Glover M, Waldon J, Manaena- Biddle H, et al. 2009. Barriers to best outcomes in breastfeeding Gontijo De Castro T, Gerritsen S, Wall C, et al. 2018. Infant Feeding in New Zealand: Adherence to	No evidence	DPMC. 2019. Child and Youth Wellbeing Strategy. Wellington: Department of the Prime
Child and Youth Wellbeing Strategy (MOH, 2019)	Yes	Yes	4	No evidence	What makes a Good Life – Children and Young People's Views on Wellbeing, Office of the	No evidence
Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives (MOH, 2018)	No	No	1	Morton S, Atatoa Carr P, Grant C. et al. 2014. Report 3, Growing Up in New Zealand: Now we are two: Describing	No evidence	No evidence
Clinical Guidelines for Weight Management in New Zealand Children and Young People	No	No	0	No evidence	No evidence	Ministry of Health. 2016b. Tier 1 Statistics 2015/16: New Zealand Health Survey. Wellington: Ministry of

Appendix V: Table developed from content analysis demonstrating equity-based references in each policy document

Policy	Equity based references in each policy
Clinical Guidelines for Weight Management in New Zealand Children and Young People, 2016	<ul style="list-style-type: none"> - Ministry of Health. 2014. <i>Equity of Health Care for Māori: A framework</i>. Wellington: Ministry of Health.
Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives (MOH, 2017)	<ul style="list-style-type: none"> - Ministry of Health. 2016c. <i>Pae ora – Healthy futures</i>. URL: www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures (accessed 15 July 2016). - Ministry of Health. 2014b. <i>‘Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–2018</i>. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/ala-moui-pathways-pacific-health-and-wellbeing-2014-2018 (accessed 21 April 2017).
Child and Youth Wellbeing Strategy, 2019	<ul style="list-style-type: none"> - Utter, Jennifer, et al, ‘<i>Rising Food Security Concerns Among New Zealand Adolescents and Association with Health and Wellbeing</i>’, <i>Kōtuitui: New Zealand Journal of Social Sciences Online</i>, 13:1, 2017, pp. 29-38. - Statistics New Zealand, ‘<i>Child Poverty Statistics: Year ended June 2018</i>’, https://www.stats.govt.nz/news/childpoverty-statistics-released - Perry, Bryan ‘<i>Household Incomes in New Zealand, Trends in Indicators of Inequality and Hardship 1982-2017</i>’, Ministry of Social Development, 2018, p. 158.
Healthy Eating Guidelines for New Zealand Babies and Toddlers (0–2 years old), 2021	<ul style="list-style-type: none"> - Gerritsen S, D’Souza A, Goodsell-Matthews T, et al. 2020. <i>Food Hardship and Early Childhood Nutrition: Findings from Growing Up in New Zealand with a focus on food hardships for tamariki Māori and Pacific children</i>. Wellington: Ministry of Social Development. - Glover M, Waldon J, Manaena-Biddle H, et al. 2009. <i>Barriers to best outcomes in breastfeeding for Māori: mothers’ perceptions, whānau perceptions, and services</i>. <i>Journal of Human Lactation</i> 25(3): 307–16. - Ministry of Health. 2019a. <i>Household Food Insecurity Among Children: New Zealand Health Survey</i>. Wellington: Ministry of Health.

Appendix W: Table developed from content analysis demonstrating types of voice expression evident in each policy document

No child voice in policy	Adult voice in policy	Whānau voice in policy	Child voice in policy
Nil	Healthy Eating Guidelines for New Zealand babies and toddlers (0–2 years old) (2021)	Healthy Eating Guidelines for New Zealand babies and toddlers (0–2 years old) (2021). Whānau voice data from: <ul style="list-style-type: none"> <i>The Whānau Ora Framework</i> <i>Growing up in Aotearoa New Zealand Longitudinal Study.</i> 	Child Youth and Wellbeing Strategy (2019). Child voice data from: <ul style="list-style-type: none"> <i>Have your Say: Summary report – National engagement in New Zealand’s first Child and Youth Wellbeing Strategy</i>, Department of the Prime Minister and Cabinet, 2019 <i>What makes a Good Life – Children and Young People’s Views on Wellbeing</i>, Office of the Children’s Commissioner and Oranga Tamariki, 2019.
	Child Youth and Wellbeing Strategy (2019)	Child Youth and Wellbeing Strategy (2019). Whānau voice data from: <ul style="list-style-type: none"> <i>Engaging all New Zealanders Benchmark Survey report</i>, Oranga Tamariki, 2017. 	
	Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives, 2017	Sit Less, Move More, Sleep Well: Active Play Guidelines for Under-fives, 2017. Whānau voice data from: <ul style="list-style-type: none"> <i>Growing up in Aotearoa New Zealand Longitudinal Study.</i> 	
	Clinical Guidelines for Weight Management in New Zealand Children and Young People, 2016	Clinical Guidelines for Weight Management in New Zealand Children and Young People, 2016. Whānau voice data from:	

		<ul style="list-style-type: none">• <i>The Aotearoa New Zealand Health Survey 2016</i>	
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Appendix X: Audit trail

Date	Action description	Supervisors' input	Notes
27.01.21	Supervision with Julie	Discussion about PGR1.	
28.01.21	Supervision with Julie	Discussion about amendments made by Julie.	
12.03.21	Supervision with Julie	Julie read through PGR1 draft after Claire Hockings provided feedback.	
22.03.21	PGR1 submitted to Julie Balloch	Read application and provided amendments before approving it.	
16.04.21	PGR1 tabled at PGRC meeting		
20.04.21	PGR1 provisionally approved		
26.05.21	Supervision with Julie		
26.05.21	Ethics application submission	Read application and provided amendments before approving it.	
02.06.21	Ethics committee returned application with amendments	Read application and provided amendments before approving it.	
21.06.21	Ethics approved		
25.06.21	Ethics amendment increasing number of participants	Julie Blamires requested increase in participants, which was approved.	
25.06.21	Supervision with Julie		
09.07.21	Interview for data collection: Participant #2	Sent to be transcribed by <i>TranscribeMe!</i>	Notes about interview in field notes document.
13.07.21	Interview for data collection: Participant #3	Sent to be transcribed by <i>TranscribeMe!</i>	Notes about interview in field notes document.
19.07.21	Interview for data collection: Participant #1	Sent to be transcribed by <i>TranscribeMe!</i>	Notes about interview in field notes document.
22.07.21	Interview for data collection: Participant #5	Sent to be transcribed by <i>TranscribeMe!</i>	Notes about interview in field notes document.
30.07.21	Supervision with Julie		
30.07.21	Interview for data collection: Participant #4	Sent to be transcribed by <i>TranscribeMe!</i>	Notes about interview in field notes document.
03.08.21	Interview for data collection: Participant #6	Sent to be transcribed by <i>TranscribeMe!</i>	Notes about interview in field notes document.
22.08.21	First copy of literature review written	Julie Blamires read and edited. Recommended to slow down and start writing methodology.	
27.08.21	Supervision with Julie and Annette		
09.09.21	Supervision with Julie		
10.09.21	Changed critical methodologist from Yin to Merriam	This was recommendation from Julie who felt Yin was too positivist.	
10.09.21	Changed research question from 'healthy	This was a recommendation from Julie who felt that my	

	eating and activity' to 'childhood obesity'	work was more clinically based and focussed on childhood obesity.	
24.09.21	Supervision with Julie		
04.10.21	PGR8 submitted	Read application and provided additions before approving it.	
11.10.21	First copy of methodology/method written and sent to Julie	Julie Blamires read and edited. Recommended thinking about frameworks for analysis.	Addressed amendments.
29.10.21	Supervision with Julie		
29.10.21	Second copy methodology/method written and sent to Julie	Julie Blamires read and edited. Recommended thinking about frameworks for just policy documents. Will adopt a critical lens to the methodology.	Left amendments on recommendation from Julie. Concentrate on analysis.
29.10.21	Began analysing Participant #4 interview	Julie has said that she is happy with progress and will review analysis later.	Themes: Implicit v explicit, idealisation of child voice application of child voice, priorities in strategy.
07.11.21	Began analysing CYWS using Kingdom three streams theory		
09.11.21	Supervision with Julie and Annette	Video recording of meeting kept. Supervisors happy with progress.	
16.11.21	Began analysing Participant #1 interview		Themes: absence, hesitancy and rudimentary, stigma. Used excel sheet to analyse and word doc to store categories/ themes.
19.11.21	Began analysing Participant #3 interview		Themes: heterogenous contribution, idealisation, absence, hesitancy, biomedical and qualitative lens. Used excel sheet to analyse and word doc to store categories/ themes.
21.11.21	Began analysing Participant #5 interview		Themes: hesitancy, absence, rudimentary and inconsistent application. Used excel sheet to analyse and word doc to store categories/ themes.
22.11.21	Began analysing Participant #6 interview		Themes: absence, undeveloped application, emerging urbanity.
23.11.21	Began analysing Participant #2 interview		Themes: absence, developed, hesitancy.
24.11.21	Began comparative analysis of policy documents		Word analysis and qualitative analysis comparative analysis.

26.11.21	Supervision with Julie	Video recording of meeting kept.	How do I frame opportunities and examples of good CV as themes and categories? They are inconsistent. Taking on commercial interests as a category or just something to talk about?
27.11.21	Refining subcategories, categories and themes on diagram.net and revisiting original data in each interview		I will use this alongside analysis.
28.11.21	Second analysis of Participant #4, opened new spreadsheet for new analysis		
03.12.21	Second analysis of Participant #1, opened new spreadsheet for new analysis		
04.12.21	Second analysis of Participant #5, opened a new spreadsheet for analysis		
05.12.21	Second analysis of Participant #3, Participant #6 opened a new spreadsheet for analysis		
06.12.21	Second analysis of Participant #2, opened a new spreadsheet for analysis		
06.12.21	Refining subcategories, categories and themes on diagram.net and revisiting original data in each interview		I will use this alongside analysis.
09.12.21	Supervision with Julie	Discussed categories and subcategories.	
11.11.21	Julie reviewed three transcripts for her own perspective and emailed them through		
12.11.21	Supervisors' considerations of transcripts created revision of categories and subcategories		
13.12.21	Supervision with Julie	Discussed categories and subcategories again.	
14.12.21	Began writing out analysis	Revised analysis again.	
28.12.21	Started incorporating policy into categories		
01.01.22	Changed one policy for analysis	National Healthy Eating Guidelines for DHBs deemed not relevant, and Sit Less, Move	

		More, Sleep Well: Active Play Guidelines for Under-fives (MOH, 2018) was used instead.	
17.01.22	Supervision with Julie	Discussed themes, categories and subcategories. Julie requested more work on these to synthesise.	
18.01.22	Submitted findings and appendices for review		
10.02.22	Supervision with Julie and Annette	Discussed findings as a whole and revisited.	
16.02.22	Sent draft diagram of themes, categories, and subcategories for review	Julie provides feedback to say it is on right track.	
21.02.22	Submitted re-written Findings considering all feedback and literature review for review		
25.02.22	Started Discussion chapter		
07.03.22	Received feedback for literature review		
11.03.22	Received feedback for Findings		
16.03.22	Supervision with Julie		
23.03.22	Submitted revised Findings section		Sent with 'overarching concept model' updated for third time.
31.03.22	Received feedback for Findings	Advised to rewrite/refine 'Exclusion' section.	Re-wrote and updated with 'Incompatibility triangle of childhood obesity'.
02.04.22	Pulled together all sections of thesis and created table of contents	Advised to put all chapters into one document and continue with Discussion chapter.	
20.04.22	Discussed Findings chapter as Julie felt it needed to be more concise fluid between paragraphs		Reviewed whole chapter again and edited down.
29.04.22	PGR8 submitted and signed off by Julie	Recommendations to edit, add appendices, table of figures and references to document.	
04.05.22	Supervision with Julie	Face to face meeting, discussed style and tone of the findings chapter.	Reviewed whole chapter again afterwards and re-edited for tonal consistency.
15.05.22	Findings chapter reviewed and edited by external reader	Light editing of chapters 1 and 2 and restructuring of chapters 4 and 5.	Created chapter 4 – Analysis, chapter 5 – Findings and Discussion. Put policy/participant overview into methods section.
19.05.22	Supervision with Julie	Discussed analysis and findings as well as discussion. Discuss how this has contributed to the literature.	Will look up Merriam's style of findings and discussion chapter.

27.05.22	Meeting with Julie	Chapters 3-5 reviewed by Julie.	Chapter 4 absorbed into chapter 3 and appendices as per discussion.
02.06.22	Chapter 5 submitted to Julie		
20.06.22	Thesis proofread		